A study of the role of the acute health care chaplain in England

Thesis

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OF THE ROLE
OF THE
ACUTE HEALTH CARE
CHAPLAIN IN ENGLAND

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ABSTRACT

This thesis explores the world and work of the acute health care chaplain in England through an examination of chaplaincy history, literature and experience. The core evidence used in the thesis is a body of empirical material within which health care chaplains articulate for themselves the key issues of working within Acute Care. This material provides an insight into how health care chaplains understood and managed their roles in hospitals during the early part of the 1990s.

The thesis falls into three parts. The first part sets the study within a particular framework explaining the method and sociological background to the study. Chapter 1 explains the rationale and content of the study. Chapter 2 sets out the objectives and methodology undergirding this study of the role of the acute health care chaplain. Chapter 3 places the study within the sociology of professions and contextualises the place of clergy in today's society.

The second part of the thesis presents the data. Chapter 4 provides the necessary historical background in order to understand how health care chaplaincy has developed since the establishment of the National Health Service in 1948. It also presents necessary information on the organisation and delivery of acute care in England, in order to contextualise the chaplains' responses to Health Service reorganisation in Chapter 6.

Chapter 5 evaluates chaplaincy literature in order to build up a systematic picture of how chaplains have described and reflected on their roles and functions. Chapter 6 presents the core empirical evidence and reveals how chaplains seek to come to terms with their particular environment and how their value and belief systems interact with practice. Chaplains describe how
they do their work through their articulation of a range of roles, functions and activities. They express their understanding of the core tasks of chaplaincy work and discuss what helps or hinders them in fulfilling these tasks. In reporting the chaplains' perceptions about conflict, this study investigates how values operate in practice and how conflicts are resolved. Chaplains' use of time, and the literature they produce to communicate the nature of their chaplaincy departments, are also explored to examine the qualitative data and complete the picture of what chaplains do and why and how they do it.

Part three of the thesis presents the conclusions. Chapter 7 analyses the data in the light of both the methodology undergirding the study and the sociological context. It presents the picture that emerges from both the data and this analysis of chaplaincy in acute care. It discusses the range of roles, functions and models of chaplaincy presented in Part 2 of the work. Chapter 8 places the empirical evidence within the context of the impact of recent NHS reforms. It discusses the impact of organisational and managerial change on chaplaincy. Chapter 9 concludes the thesis by discussing its outcomes, limitations and possible ways forward for chaplaincy and chaplaincy research in the future.

Central to this thesis is the hypothesis that chaplains experience a measure of tension about both their role and function as they operate in the two worlds of the Church and the National Health Service. This study seeks to show how chaplains seek to resolve this tension; largely by giving priority to the needs and expectations imposed on them by the particular context within which they find themselves. There is little sign of grand theory or overarching strategy.

Abstract (2)
ACKNOWLEDGEMENTS

The journey of the process of this research has been a long and rewarding one. It dates back to 1990 and has taken me to some fascinating places. Many individuals have helped to shape and refine this exploration of the role of the health care chaplain.

Thanks to chaplaincy colleagues at the Queen Elizabeth Hospital Birmingham, from 1990 to 1996. The patients and staff provided a stimulating environment out of which the early part of this research took shape. Peter Harvey, a consultant psychologist, acted as my work supervisor during that time and helped me to ask questions and live with the uncertainties around illness and organisational change.

During 1996 the Bishop of Birmingham, the Rt Revd Mark Santer, gave me the opportunity to have a small parish base which allowed me considerable time, freedom and critical distance from chaplaincy work. This move enabled me to complete the research and I am indebted to the Bishop for his support. Thanks are also due to the parishioners of Middleton and Wishaw for supporting me in my study.

My supervisors Professor David Cox and Dr Stephen Pattison have been a constant source of challenge, advice and encouragement. They have helped me broaden my horizons and sharpen my critical reflecting. I am grateful to the Open University for its external support and advice throughout and especially to staff within the School of Health and Social Welfare.

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A number of people have read drafts of the work: the Revd Mark Pryce, the Revd Canon Dr Brian Russell, Canon Ronald Coppin, the Revd Lizzie Hatchman and Professor Leslie Houlden. Paddy Crowhurst's secretarial support has been invaluable. The archives department of the General Synod of the Church of England and Canon John Barton's exhaustive library on hospital chaplaincy both helped with source material. The College of Health Care Chaplains supported this research with a grant to finance work around the interviews.

Finally, I am grateful to the many hospital chaplains who gave of their time and services so generously. In doing so they provided the research with a distinctive set of material which forms the core of the thesis. Thanks to all of them for their honesty and hospitality.
PART ONE

THE FRAMEWORK
CHAPTER ONE
INTRODUCTION

1.1 Background to this study
Chaplains are employed by the National Health Service on either a full-time or a part-time basis. Their function is generally assumed to be chiefly pastoral care. This takes a variety of forms. For some it involves offering the religious care (visiting, prayer, worship, Sacraments) for those whose stay in hospital deprives them of the ministry of their home churches. For others the chaplain may have a particular responsibility to offer support for patients and their relatives at times of crisis. More recently there has been a recognition of the chaplain’s role in the pastoral care of hospital staff, and of the fact that, in a changing society reflective about its values and purposes, the minister of religion represents something significant which meets a need for value, meaning and direction (Speck, 1988. chapter 8; Woodward, 1995, chapters 6 & 7; Stoter, 1995, chapters 16, 17 & 18; Stoter, 1997).

The latest available figures for the number of whole-time and part-time chaplains are as follows. As at 31st December 1997 there are 321 whole-time chaplains in England. Of these 286 are Anglican, 31 are Free Church and 4 are Roman Catholic. There are in the region of 1,500 part-time chaplains who are divided fairly equally between denominations. This figure is an estimate because there is no central register or organisation that monitors part-time appointments.¹

¹ The source for these figures is the General Synod of the Church of England’s Hospital Chaplaincies Council Annual Report, 1997 p.14 (G51245)
This is the first major study of the role of the acute health care chaplain in England in recent decades. It builds upon and develops the work of Michael Wilson (1971) whose *The Hospital - A Place of Truth* explored the role of the hospital chaplain at The Queen Elizabeth Medical Centre in Birmingham. This is discussed in Chapter 5. Two other recent studies have examined how chaplains have engaged with individuals and groups from 'other faiths' and philosophies of life such as Buddhists, Hindus, Jews, Muslims and Sikhs (Olumide, 1989; Beckford and Gilliat, 1996). There is some description of the duties of the chaplain but they concentrate on how the chaplain responds to the needs of other faith groups.

This study is limited to the work of the chaplain in an acute setting. Two studies from chaplains working in mental health settings bear upon this piece of work. Pattison (1982) constructs a critique of a specific type of pastoral care in psychiatric hospitals. He argues for a type of pastoral care that is socio-politically aware and committed. Browning (1986) examines chaplaincy models in mental health with a view to making recommendations for a community-based model of chaplaincy in the light of the closure of psychiatric hospitals. Legood (1998) has collected together reflections on ‘sector’ ministry (those ministers of religion who do not work in a parish or with a congregation) though there is little detailed discussion of the role of the chaplain in this book.

It is the purpose of this introductory chapter to outline the rationale for the study, contextualise the thesis and explain some of the author's personal background and experience which bear upon the subject.
1.2 **Rationale for the Study**

This thesis will explore the world and work of the acute health care chaplain and evaluate models of chaplaincy work in health care. Through a number of detailed interviews this study will explore what motivates or attracts individual clergy to do such work. Hospital chaplains are widely perceived by their churches as having entered a 'specialist' and 'sector' ministry. (Van de Creek, 1995; Legood, 1998). Many who join the health service often spend a considerable portion of their ministerial career as chaplains. Are they motivated by the combination of autonomy and immediacy, the relationship between life crises and spirituality, or are there other factors? For example, does a specialist ministry offer more demands and fulfilment than a more general parochial ministry? This study will seek to explain what sustains individuals in health care chaplaincy work.

It will locate chaplains within the structure of the acute health care system. It will explore the ways in which chaplains work with both health care staff and the ill, and analyse how chaplains conceptualise relations to support and clinical staff, management and patients. The study will explore how far the chaplain is seen as a general 'socialised carer' within the institution, yet offering a distinctive resource of spiritual, religious and pastoral care.

The year 1998 marks the 50th anniversary of the establishment of the National Health Service. There is some movement from the National Health Service being regarded as a public service which was relatively comfortable with the language of vocation and public service, to a body that has accepted the rhetoric of 'commissioning', 'competition' and financial accountability (Rivett, 1998; Pattison, 1998; Appendix 7). While some doctors and nurses still regard their career...
as a vocation (Whipp, 1997), as will be seen, the chaplain remains a living symbol of the tension between vocation and career. We shall explore how chaplains have coped with the changes they see in the National Health Service, and the pressures that chaplains bring to bear on those with whom they work. We shall also explore to what extent hospital chaplains have been able to stand outside recent changes in the health service, and examine their critical reflections upon the culture of the organisations within which they work.

There is a long history of Christian involvement, going back to the early centuries, with aspects of society such as the care of the sick (Sheils (Editor), 1982). There can be a tension as a result of the idea that the Christian religion involves being at odds with the world around (Neibuhr, 1951, p.xii; Ford (Editor), 1989, p.86). At the heart of this belief is that while Christian life must be lived in the world, it is not to be of the world. It has been the duty of priests and prophets to take those who become enmeshed in the trivial affairs of this world and to turn them towards eternal objectives and expectations. Thus, the Church has often been seen to exist in a hostile and evil world and to have a mission to denounce and resist the transient culture within which it lives. At other times it has sanctified earthly institutions while at the same time recognising their unfinished character, compared with the ultimate destiny of humankind. In any case, there has been the overriding motive of compassion, inspired by the teaching and healing activity of Jesus himself (Rowland, 1988; Pailin, 1990; Benne, 1995; Voder, 1997).

This study will explore whether the office and role of chaplain is now subsumed under a wider social agenda that may operate at more of a distance from the initial (primarily spiritual) intentions of
chaplaincy. In other words, do chaplains cope with the tensions implicit both within their role and in Christian belief by underplaying the distinctive theological element in their identity and role in favour of involvement with society? We shall investigate whether the norms and behavioural expectations defined by society prove more compelling to chaplains than the particular rules and obligations resulting from the expectations of the Church and its understanding of ministry and pastoral care. This shift has been defined as secularisation, the tendency to give priority to the needs or expectations imposed by the non-religious situation in which individuals or groups find themselves. It will be discussed in Chapter Three (Gill, 1989, 1997; Hornsby-Smith, 1991; Wilson, 1982; Davis, 1994).

Through an examination of the history and the literature around health care chaplaincy, this study will chart how the role of the hospital chaplain has been transformed as individuals and teams adapt to the recent changes within the National Health Service. In the light of this discussion, we shall try to see what the likely implications for chaplaincy might be for the future. Can chaplains still be seen primarily as a spiritual or religious resource, or will they be part of a wider culture of support? We shall find that some chaplains have specialised in certain types of pastoral care, for example, staff support, bereavement counselling, teaching and education as ways of gaining some measure of organisational and work security or indeed as conscientious expressions of their vocation in present circumstances.

This concludes the overall rationale of the thesis and situates what follows within a framework of organising presuppositions and
At this point it is important to say something about the field of study within which the thesis is located. This study is an examination of the role of the health care chaplain. The chaplain exercises pastoral care in a wide variety of ways. Pastoral care draws upon a number of disciplines (Pattison, 1988; Graham, 1996; Gerkin, 1997). It has roots in scripture, theology, ecclesiology, philosophy, psychology, psychiatry, anthropology and sociology. Therefore any study of the role of pastoral carers (in this case hospital chaplains) cannot be monolithic. In this discussion use will be made of the sociology of professions and pastoral theology within the context of an analysis of the contemporary health care scene. While the author's training is in theology, this study will need to locate the theological identity of the chaplain within a wider framework which can account for the ways in which chaplains reflect on what they do. It is important to locate the study within a sociological framework in order to understand the nature of role and profession. The study draws on pastoral theology as a background discipline which enables the study to examine the relationships between theory and experience in the practice of chaplaincy in acute hospitals. The study will critically uncover the meaning of pastoral care constructed from the literature.

At this point some definitions of the terms 'pastoral care' and 'pastoral theology' are necessary as they relate to this study. Pastoral care is that aspect of the ministry of the Church which is concerned with the wellbeing of individuals and of communities. Clebsch and Jackle (1967) identify four main pastoral functions: healing, guiding, sustaining and reconciling. They suggest that pastoral care gains its distinctive quality by 'representative' Christian persons and by dealing with problems within the context of ultimate meanings and concerns. These definitions relate to the practice of chaplaincy and will be explored further in this study.

Practical theology designates a primary theological discipline alongside others (for example, biblical studies or church history). Pastoral studies indicates an interdisciplinary reflective activity of the relationships between theology, pastoral practice and the social sciences. These studies relate to the range of ministerial activity including chaplaincy. It follows therefore that pastoral theology is the theological underpinning of ministry embracing the concern for the whole people of God. (Ballard and Pritchard, 1996, page 24).

This study draws on and contributes to these disciplines in its exploration of the role of the chaplain.
history and experience of chaplains. It will examine assumptions and ways of thinking in order to describe as accurately as possible the conceptual context of the role of the health care chaplain (Berry & Wernick, 1992; Frank, 1995; Pannenberg, 1985).

1.3 **A Personal Perspective**

It is necessary to explain a little of the author's own personal perspective which has motivated the study and generated the rationale discussed above.

Elements of this personal perspective are identifiable in a debate on the National Health Service in the House of Lords on 6th November 1996.

My Lords, I am grateful for the fact that the noble baroness, Lady Jay of Paddington, has pinpointed public service values.

We know that managing scarce resources is a painful business because of the difficulty of deciding priorities. I draw your Lordships' attention to an area where the allocation of resources has increased, although the value of this particular area is long-term and the results cannot be quantified in terms of quick patient cure.

I refer to the way in which in the past five years Trusts and Authorities have noticeably increased the number of fully-funded, full-time hospital chaplaincies posts. This increase in posts, which brings the number of Anglican full-time hospital chaplaincy posts to over 300, is an example of treating value in its deeper sense. Here we have an example of treating the patient as a whole person. Here we have an example of appreciating the role of hospital chaplains, and of treating them on exactly the same footing as other members of staff. They are members of the whole hospital team. They are under the disciplines of accountability and standards of performance. They play a considerable role in maintaining the morale of staff. Much of their ministry is to the staff, as well as to the patients.³

The Rt.Revd. Prelate, the Bishop of Exeter talked about hospital chaplaincy services. I knew that (the Health Service Reforms) had gone too far when I met a hospital chaplain the other day who told me he was terribly busy. I asked whether there had been a particularly harrowing event. He said that there had not; it was

³ The Lord Bishop of Exeter, Debate on the NHS, 6th Nov. '96 (House of Lords Hansard pp. 650-651)
just that he was having trouble adding up the figures in his business plan for next year.\(^4\)

The Rt. Revd. Prelate the Bishop of Exeter rejoiced in the increasing number of fully-funded hospital chaplains who now work in the NHS. That is the result of the internal market, which gives more certainty and autonomy to Trusts. Those Trusts have recognised the value of hospital chaplains, not only in seeking to look after the spiritual needs of patients and staff, but so often as the most perceptive of people. They see the whole organisation and they act effectively as the patients’ advocate.\(^5\)

I was appointed to a health care chaplaincy post during the Spring of 1990. The post was senior Anglican chaplain to the Queen Elizabeth Hospital in Birmingham. This hospital is a large 700-bed regional specialties unit with 3,000 staff. My joining the hospital coincided with the National Health Service reforms which brought about major structural and cultural change within the health service. The proposals in *Working for Patients* were incorporated in *The NHS and Community Care Act 1990*. This was published in November 1989 and received the Royal Assent in 1990, paving the way for the “NHS market” to come into operation from April 1991.\(^6\) After a period of listening to many of the senior administrators and managers within the hospital I committed myself to building up and developing the resources and profile of chaplaincy within the teaching hospital. From this perspective the period of change provided particular opportunities for chaplaincy. All departments within the hospital were exploring, at a fundamental level, the nature and functions of their life and work. This audit included both an assessment of the quality of the various health care processes and interventions, and an account of the resource implications of the work: the changes

\(^4\) Baroness Hayman (House of Lords Hansard p. 701)

\(^5\) Baroness Cumberlege (House of Lords p. 705)

\(^6\) The NHS market was 'created' by separating purchaser and provider roles. District health authorities took on responsibility for purchasing health services. Hospitals and other units became NHS Trusts. An increasing number of GP practices entered a fund-holding scheme and with others were involved in purchasing services through a variety of mechanisms. Contracts, or service agreements, provided the link between purchasers and providers. See Ham C (1994) *Management and Competition in the New NHS*, Radcliffe, Oxford.
demanded that all aspects of activity within the hospital be costed.
It was, therefore, a natural part of conversations with a very wide and
diverse range of people across all departments within the hospital to
ask what was the role of chaplaincy within the activities of a
teaching hospital.

A number of senior managers and medical staff in the unit asked
some searching questions about the nature, purpose and outcome of
the activity of the chaplaincy team.\textsuperscript{7} My own notes during this
period indicate that there was a major task to be done in relation to
perceptions about the role and function of a chaplain in a hospital.
It was also, I believed during that period, important for the
chaplaincy department to stand alongside other departments as
fellow health care professionals, both responding to the structural
and cultural change, and developing a network of relationships and
activities within the hospital that would secure the department's
survival and development. (Assuming, of course, that its position
could be justified in the new climate).

A key element in this early fertile period of thinking and activity was
my own participation in management training. I attended, as head of
the chaplaincy department, major educational and training events
organised by the hospital and district health authority, on quality
management, marketing and business planning. This required the
department to think much more systematically about the tasks and
functions of its work. It also required a review of the resources of the
department and the sources of its funding.

The results of this thinking and activity were significant and they
reflect the comments made by the Bishop of Exeter. Against a
background of financial stringency and cut-backs in South
Birmingham Health Authority, the chaplaincy team tripled its

\textsuperscript{7} During June - December 1990 which was part of my induction period into the hospital, the question
most asked was.. "Please explain what you do?"
resources from £40,000 to £150,000 per annum for staffing, between 1990 and 1993. Its strength continued to increase with the development and use of lay volunteers within the team. More significantly there was a change in the perspective of other health care professionals who came to acknowledge and value wider roles of chaplains within the hospital. These roles included concern for the corporate and institutional life of the hospital; input into educational courses and training; and the support of staff during critical periods of change. This present situation is reflected in the comments of Baroness Cumberlege. She notes that other Trusts have seen the value of hospital chaplains as the ‘patients’ advocate’, and in their perceptions of the organisation as a whole.

However, none of these changes was made without a certain cost. Within my own involvement with the management of change and the building up and development of the profile of chaplaincy within the unit, I continued to experience a measure of personal tension and professional paradox. My own political views caused me to ask some sharp questions about the value of such radical change within the health service. My theological and ethical framework and values were often at variance with particular dominant features of the new structure and culture. I often wondered whether it was possible to cost and evaluate the kind of pastoral activity, the listening to and supporting of individuals and families in acute illness, that took up a significant portion of my working week. I was concerned about the tension between my own theological training, experience and skill.

It is important to note here that one of the weaknesses of this thesis is the omission of any analysis of other health care staff’s perceptions of the role of the chaplain. This is discussed in Chapter 9. The assertion here that staff came to acknowledge the value of the chaplain is based on the department’s success in attracting resources during organisational change and financial difficulties (the hospital was one of the last to be granted Trust Status by the Government in 1995). Further, the chaplaincy department has attracted national publicity by a visit from officials from the Patients’ Charter department of The Department of Health. This visit and the work of the department was featured in *The Patients’ Charter News* (Issue 9, May 1993 - ‘Chaplaincy services in South Birmingham’ p.1-3).
and the philosophy of the management culture in which I immersed myself, especially in relation to the survival and development of the work in the hospital. This tension is expressed by Baroness Hayman as she articulates her own anxiety about the extent to which the chaplain ought to be preoccupied with business planning.

This brief description of my own initial situation is necessary to explain the background to this thesis. It was as a result of the articulation of some of the dilemmas and paradoxes in my work as a chaplain that I made the decision to explore them in a systematic and detailed way. 

In summary, I wanted to grasp the question of what the future of chaplaincy might be in the light of NHS reforms and changes; how chaplains cope or engage with their institutions; how chaplains shape their job and communicate who they are; how chaplains have engaged with change, and especially recent changes within the National Health Service.

1.4 The Content of the Study

The thesis falls into three parts. The first part outlines the basic framework of the thesis. This chapter has set out a rationale for the study and offered some explicit presuppositions of the author's personal perspective. Chapter Two explains the objectives and methodology of the study, setting the empirical work within the literature around qualitative research. Chapter Three sets the study in sociological perspective, drawing upon insights from the sociology.

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\[\text{During the early period of my mapping out a framework for the thesis the possible titles were - 'A Ministry of Paradox In A Place of Paradox?'; 'The health care chaplain; between worlds?'; 'Change In Perceived Need, Value and Role of health care chaplains'; 'The health care chaplain; one role many functions'; 'The Hospital chaplain; confrontation or collusion?' These titles sum up the dimension of the dilemma that I was struggling with in my day to day work.}\]
of professions and literature which sets the clerical profession in a sociological perspective.

Part two contains the core data. Chapter Four offers an historical perspective on chaplaincy, chiefly from 1948 to 1998, charting how chaplaincy has grown and developed over these years, and setting this growth within the context of changes within acute care. Chapter Five analyses all of the literature of acute health care chaplaincy, drawing out the key themes and influences. Chapter Six represents the summary of fifteen interviews with current acute health care chaplains. This chapter forms the empirical evidence which is the main focus and basis of the original contribution of this study.

Part three offers a number of critical reflections and conclusions in the light of parts one and two. Chapter Seven offers an analysis of the data. Chapter Eight discusses the impact of organisational change on chaplaincy. Chapter Nine concludes the study with a critical evaluation of its strengths and weaknesses. It also offers some reflections on the future of health care chaplaincy in the light of the whole piece of research.

The Appendices offer supplementary material gathered during the stages of the research. In particular they include an analysis of how chaplains spend their time and a summary of chaplaincy business plans, literature and job descriptions.
2.1 Objectives

The objectives of this study are to explore the world view and work of the acute health care chaplain through

(a) an historical account of the main features of how health care chaplaincy was established and has been developed between the years 1946 and 1998;

(b) a detailed examination of published and unpublished documentary material and oral accounts about the nature and practice of acute health care chaplaincy;

(c) a detailed empirical record of focussed interviews with acute health care chaplains about how they understand and manage their roles in health care.

All of this material will be located within contemporary discourse of the sociology of professions and recent work on the location of the clergy within contemporary English society. Part Two of this thesis presents this material in three chapters. Chapter Four presents the historical features. Chapter Five presents the documentary evidence and Chapter Six summarises the main features of the empirical evidence generated through the interviews.

It is the purpose of this chapter to discuss two particular research traditions, interview techniques and documentary analysis as an appropriate framework within which the data is generated and analysed.
The decision to use qualitative sample survey to examine the chaplains' role was based on the assumption that this approach better served the nature of the topic researched. This approach provided greater scope to explore the chaplains' 'world' and allowed them to articulate their role within the acute hospital.

These in-depth interviews enabled the participants to illuminate subjective experiences and meanings within a framework. Possible outcomes were not preselected or specified in advance, though certain assumptions were articulated at the start of the study (see the Abstract). This approach respected and affirmed the perceptions of chaplains and allowed scope for these perceptions to be explored in greater detail and depth.

Thus the in-depth interviews which were carefully tested and sampled as part of the research process, gave the participants a more effective mechanism by which to articulate tentative concepts. This method allowed participants a better, reliable voice in the process of researching understandings of the role of the chaplain. The process allowed the researcher the opportunity to explore in close detail the chaplains' self concepts, world views and ultimate loyalties. In conclusion, this approach enabled the chaplains' voice to have authority and belongingness, uniqueness and relatedness, reliability, relevance and validity.

The selection of the fifteen chaplains was made after considerable consultation both with the Hospital Chaplaincies Council and the College of Health Care Chaplains. Particular attention was given to a balance between denominations, gender, geographical location, type of hospital (teaching or non-teaching) and as having a
representative voice and profile within the wider constituency of chaplains. The aim of this choice was to give the sample reliability and as strong an objectivity as possible.

### 2.2 Introduction to the Methodology

In order to construct a viable picture of the professional activity of chaplains and how they might be situated within the acute health care sector across a given time, it was necessary to draw on a methodology which would give access to and analysis of information derived from a multiplicity of sources.

The methods employed in this study were drawn from two research traditions: grounded theory through interviews, and documentary analysis. These two research traditions provided the tools to construct a chronological and thematic picture of professional change and development. The history and literature of health care chaplaincy were collated and analysed together with a contemporary investigation of chaplaincy work and self-understanding through fifteen in-depth interviews. These two routes provided adequate data which related both to actual and relevant events and to the diversity of interpretations of the role and work of the health care chaplain today. The material is presented in both an historical and thematic order, and relates both to a socio-historical and contemporary context. The data were collected over a five-year period between December 1991 and January 1997.

It was inadequate to rely on documentary evidence alone to provide sufficient in-depth knowledge about how chaplains understand and manage their work. Interviews were selected as the core source of
information about the motives, beliefs and actions of health care chaplains, particularly in the light of the re-organisation of the Health Service between 1989 and 1992 (Fetterman, 1989; Rogers, 1989; Patton, 1987, 1990). It is important to note that health care chaplains are numerically a small group and have generated a relatively small literature base about their work. In recent years, certainly since 1988, very little has been written about how they understand their role within the contemporary situation. Interviews were therefore chosen as the method most likely to reveal the more subtle features of professional activity and reflection on the role necessary to provide an authoritative account of the role of the health care chaplain.

This chapter will address the design of the study and offer some critical reflection on the advantages and disadvantages associated with the research techniques of interview, methodology and documentary research. The chapter will also describe decisions around sampling, construction of interviews, access arrangements and other procedures involved in the collection of data. A description of the decision-making process and an account of the rationale of the study are provided to give a record of the research which could be used either by others for replication or further work and elaboration.

In Part One which outlines the framework of this study it is important to establish the methodological adequacy of the data in relation to questions of reliability and validity.
2.3 **Grounded Theory and Interview Methodology**

The gathering in of qualitative data through interviewing is regarded by many researchers as one of the most useful forms of data collection and it takes a number of forms (Yin, 1994; Oppenheim, 1992). Oppenheim (1992) identifies two primary forms of interview: the standardised and the exploratory approach, the latter being qualitative, a free style interview which allows for more in-depth discussion and exploration of the themes. For the purposes of this study the exploratory interview was adopted using a set of semi-structured questions (a sample copy of the interview questionnaire is included in Appendix One).

The aim of this semi-structured interview was to enable the generation of ideas and to have access to perceptions and knowledge of each of the individuals on a range of questions related to how they understand their role and function (Fetterman 1989; Oppenheim, 1992; Patton, 1987, 1990; Yin, 1994; Strauss, 1987; Bryman and Burgess, 1994).

It was the purpose of the interviews to provide sufficient information within which to generate theory about the role of the health care chaplain. This principle is often associated with the specific methodological approach first suggested by Glaser and Strauss (1967) which they term 'grounded theory'. The issue of grounding involves not just appreciation of a particular method but includes also epistemological questions. These have to do with the intrinsic relationship between subjectivity and objectivity in research. In turn they are part of a wider debate about human enquiry and the social construction of scientific knowledge (see, for example, Denzin and Lincoln, 1994).
One of the long-standing debates in the human sciences concerns the relative merits of quantitative and qualitative approaches and methods in research. The debate involves many inter-related issues and concerns, but two main strands have been identified by Alan Bryman (1988) as the 'technical' and the 'epistemological' versions. In referring to the technical version of the quality/quantity debate, Bryman suggests that the choice between qualitative and quantitative methods is primarily a practical matter of deciding which approach is most suited to the research question or problem at hand. Hence some problems are best addressed by experiments and closed questions and involve the use of numeric data. Conversely the research questions will require the gathering and analysis of unstructured, non-numeric material, as for example in protocol studies, discourse work, interviewing, and participant observation. The epistemological version of the quality/quantity debate involves wider and more fundamental questions regarding the nature and practice of science, and the generation and legitimation of knowledge. Here quantitative and qualitative approaches are often seen as distinctive, and possibly incommensurable, research paradigms.

On the one hand the quantitative paradigm is premised on a natural sciences approach, seeking to establish objective knowledge of the universal laws of cause and effect through the testing of a specific hypothesis against phenomena in the empirical world. Quantification is seen as the *sine qua non* of the natural sciences paradigm because it renders theoretical concepts observable, manipulable and testable.
On the other hand the qualitative paradigm privileges the search for meaning and understanding rather than abstract, universal laws. It tends to assume a constructivist epistemology which points to the ways in which knowledge is generated within networks of social activities and systems of socially constructed meanings. The gathering and analysis of non-numerical data is deemed to be desirable within this paradigm because it frees researchers to explore, and be sensitive to the multiple interpretations and meaning which may be placed upon thought and behaviour when viewed in their context and in their full complexity (Lincoln and Guba, 1985).

In the attempt to explore the role of the health care chaplain the methodology of this thesis stands within the qualitative paradigm. The core of the data attempts a sensitive exploration of chaplains' own understandings as seen from their local frames of reference or from inside their own socially situated phenomenal worlds. It allows them to articulate what the world of health care chaplaincy looks like from their own perspective and context.

The term 'grounded theory' has two meanings when associated with the original work of Glaser and Strauss (1967). First, they invoke the notion of grounding theory in experiences, accounts, and local contexts. In this sense the term is also used by other researchers working within the qualitative paradigm to signify the 'goodness' (that is, goodness of a particular piece of research) (Bryman and Burgess, 1994). Second, it is used to describe a method. This involves specific analytic strategies formulated for handling, and making sense of initially ill-structured qualitative data (Bell, 1993).
can be seen in, for example, Turner (1981), Rennie, Phillips and Quartaro (1988), and Strauss and Corbin (1994). As in the original theory, these accounts present a number of specific qualitative data-handling strategies including:

- the generation of low-level categories to describe relevant features of the data corpus, and which closely 'fit' the data;
- creating definitions of and linkages between categories at different levels of abstraction;
- making constant comparisons between cases, instances and categories in order to explore fully the complexities of a data corpus;
- theoretical sampling of new cases where new data are likely to extend emergent theory.

These are useful strategies for the researcher at the level of organising the research process (indexing, coding, sampling), although Glaser and Strauss present them as aids rather than methodological prescriptions. Their purpose is simultaneously to liberate and discipline the theoretical imagination (Henwood and Pidgeon, 1992), in a way that facilitates the development of conceptually dense representations.

Another value of the grounded theory approach is to legitimise alternative and progressive scientific practice. By demonstrating that rigour is not solely restricted to verification in science, it helps to undermine the false dichotomy between 'soft' qualitative and 'hard' quantitative research.

2.3.1 Induction and the Problem of Grounding

A fundamental problem arises on considering Glaser and Strauss' original account of grounded theory. Theory cannot simply 'emerge'
from data because all observation is pre-interpreted in terms set by existing concepts and theory. Indeed, Glaser and Strauss are aware of the possible contradiction in their work between an inductivist approach to analysis and the need actively to encourage the researcher in the creative and interpretive process of generating new theory from qualitative data. (See also Strauss and Corbin, 1994.) Hence they note that ‘the researcher does not approach reality as a \textit{tabula rasa}’ (1967, page 3).

In beginning to reflect upon some of the disadvantages of interview methodology, contemporary feminist writings on theory and method should be considered at this point. Feminist researchers have had a long-standing commitment to grounding knowledge in participants’ own worlds (that is, in this case, in women’s own worlds and experiences). Often this commitment has led feminist researchers to use qualitative methods (Holloway, 1989).

The feminist position moves the discussion forward from induction and pure phenomenology by recognising that the meaning of women’s experience is always mediated. Whilst feminist accounts may often start from women’s experiences, many writers recognise that these experiences cannot be directly mirrored or necessarily always taken at face value (Holloway, 1989; Duelli Klein, 1983). Two points tend to be made in connection with this issue. First, there is a necessary inter-dependence of the subjectivities of the researcher and the participants in the research process. Second, and at a wider level of analysis, the women’s experiences are constructed as meaningful within cultural frameworks, and social and power relations. Minimally one can argue that this interplay involves at least four forms of subjectivity;
participant's own tacit and declared understanding;
researcher's perspectives and interpretations;
cultural meaning systems which inform and link the participants' and researchers' understandings, and which are inter-related with relations of power;

acts warranting particular interpretations as valid within social or institutional networks.

It is sufficient to note here that there is no simple answer to the problem of 'grounding' in grounded theory, or indeed in any other approach within the qualitative paradigm. In turn this implies that the question of ascertaining the validity or 'goodness' of qualitative research is a difficult one (Henwood and Pidgeon, 1992).

Some qualitative researchers have argued for a criterion of respondent validation. This means that the researchers' interpretations should subsequently be recognised and agreed to by participants in the study. However, because it is not possible simply to hold a mirror to reality - no matter how well grounded is the account - validity claims in qualitative research cannot be based solely upon appeals to the correspondence between the researcher's own account and the participant's experience and views. The appeal to respondent validation is also rendered problematic, given research which points to the inescapable role of discourse/ power relations and ideological systems in constituting both respondents' and researchers' outlooks and views.

Other writers have counselled caution against over-reliance on key informants' interviews. Yin (1994) and Fetterman (1989) warn
researchers to be aware of possible distortion and contamination based upon an interviewee's desire to please or tendency to adopt the researcher's theoretical or conceptual framework. Whilst acknowledging the impossibility of excluding such bias and subjectivity, this present study attempted to minimise these through a number of measures which are outlined below in the section dealing with the study procedure.

In conclusion it is worth reflecting on some insights generated from hermeneutics and post-modernist epistemological positions. The concern is that any suggestion of criteria may revive again the spectre of absolute foundations for knowledge, whether this be in the participant's phenomenology and experiences or in the rules of scientific method. Nevertheless two considerations are deemed to be important in assessing the usefulness of research ideas. First is generativity: to what extent do they facilitate further issues and questions for research? The second is rhetorical power: how effective is an idea in persuading others to accept the argument?

The importance of persuasion suggests that there may be a further path to be trodden in the evaluating of research claims. If the art of persuasion is to secure agreement without using purely physical means of coercion, then presumably this implicitly assumes that there must be at least some further basis or grounds for the force of a particular position. This being the case it should be possible to draw out features of arguments which seem, for some reason, to be better founded than others. These reasons will include matters such as apparent depth and soundness of evidence and logic. The arguments are also inherently social and related to their purpose and context of use.
Another argument in favour of taking the task of assessing the relative merits of knowledge claims seriously is Harding’s (1991) development of feminist standpoint epistemology. Harding makes an important distinction between ‘weak’ and ‘strong’ objectivity in science. Weak objectivity occurs when the inevitable layers of subjectivity are over-written or obscured but not obliterated. In moving towards strong objectivity, the researcher makes public the full range of interpretive processes involved in knowledge production. Research that seeks to reveal rather than obscure the hand of the researcher and the social basis for knowledge has, by this account, some claim to providing more adequate knowledge.

The precise details and implications of providing reflexive and strongly objective accounts of research are just beginning to be worked through (see, for example, Nielsen, 1990; Bhavnani, 1993). Certainly many issues are involved and they are not easily resolved. It is clear here that it is important to address the complexities of both researcher and researched. This follows acceptance of the principles that knowing, like seeing, always starts from some embodied, socially-situated vantage point (Harraway, 1991). Within such a view, experiences are, of course, also part of local and more global fields of social and textual production. Other central theoretical issues are likely to include the emotional and political commitments of the researcher, rendering visible the unseen through textual analysis of variation and difference, and the role of gender/power relations in the research process.

Well grounded research must also address a constellation of similar concerns, as part of its attempt to reveal the basis for its knowledge.
claims in the multiple forms of subjectivity which inevitably are involved in research. For the purposes of this research, there can be no question of claiming absolute foundations for knowledge. It does attempt to avoid the mistaken assumption that concern for the social and textual practices of science necessarily implies a wholly relativist position regarding what counts as good and useful knowledge.

2.4 **Documentary Evidence**

For the purposes of this thesis the term 'document' is applied to written material. The current study has sought to employ documentary evidence as a supplement to the interviews. Such evidence can be divided into two categories, primary and secondary, according to the extent to which the people constructing the documents were engaged directly with the issues at hand (Calvert, 1991; Duffy, 1987). This study utilises a number of primary sources of documentary evidence, bringing them together for the first time. These were derived from a series of sources acknowledged in Part Two of this thesis (official correspondence, memoranda of professional organisations, journal editorials and articles, private and official communications, minutes of meetings of professional organisations, course and training documentation, official, State and professional publications and various written reports for or to chaplaincy organisations (Holloway and Wheeler, 1996; Morse and Field, 1996; Robson, 1993).

2.4.1. **Advantages and Disadvantages of Documentary Evidence**

The advantages of using documentary sources have been outlined by Yin (1994) and Patton (1987, 1990). Yin argues that documents have the advantage of being stable and of being open to repeated
examination and review (Yin, 1994). As evidence they are first-hand and immediate in providing data of historical events, characters or places and enable the researcher to chart events, people, activities and issues over a given period of time (though they may of course contain inaccuracies of fact or judgment). Further, they are resistant to the influence of the researcher, though bias and misunderstandings in the process of interpretation may still occur. The main disadvantages of documentary evidence lie in the spheres of retrievability, access and bias in selection when the access may be limited (Patton, 1990; Yin, 1994).

2.4.2 Sampling Decisions about Interviewees and Documents
In the current study the ideal total unit of analysis would have comprised of spoken and written material concerning acute health care chaplaincy between 1946 and 1998. Achieving the total unit of analysis is seldom if ever possible and as a result sampling decisions are necessary (Holloway and Wheeler, 1996; Krippendorff, 1988; Patton, 1990). These decisions are applicable to the social actors secured as key informants as well as available documentary evidence. Holloway and Wheeler (1996) argue that the appropriate sampling strategy is one which provides adequate and relevant information of sufficient quality. In this study the principal sampling strategy is based on the selection of a number of diverse interviewees which would provide sufficient detail to describe and capture the central themes and understanding of the role of the chaplain. It was necessary to select fifteen current health care chaplains who would reflect the geographical, denominational, gender, age and experience profile of health care chaplaincy. Following these exploratory moves, confirmatory and disconfirmatory measures were employed (Patton, 1990). These represent cases that fit or else are at odds with
emerging patterns and elaborate them, adding depth, detail, richness and credibility (Patton, 1990). In the discussion about sample size and qualitative research designs, Patton argues that the validity, meaningfulness and insights generated from qualitative enquiry have more to do with the information richness of the cases selected and the observational/analytical capabilities of the researcher rather than with sample size (Patton, 1990). In this respect therefore it was the purpose of the qualitative interviews and the selection of them to maximise the diversity of information by careful choice of individuals.

The two main questions which guided the decisions about whom to interview and what information to seek for this study were:

- what printed documentary evidence was available, which best reflected acute health care chaplaincy from 1946 to 1998?

- who was available to provide an informed account of the role of the health care chaplain and would be willing to share knowledge, memories, views and experience with the interviewer? (Holloway and Wheeler, 1996; Pilgrim, 1990).

2.4.2(1) The documentary sources used were those which involved professional concerns, primarily those highlighted by the key informants during the in-depth, semi-structured interviews. These sources included both published documents in the public domain and unpublished documents held in private possession. The published documents mainly consisted of the following journal and newsletter publications. The current titles are:

- The Hospital Chaplain 1961 - 1992, which became The Journal of

- Correspondence and circulars from the Hospital Chaplaincies Council to Anglican diocesan Bishops and diocesan Advisers on hospital chaplaincy.
- Annual Reports from the Hospital Chaplaincies Council.

These core sources of commentary on events and situations were considered likely to provide a rich source for the concerns of both hospital chaplains and others. As a set of documentary data they provide a comprehensive reflection of the major concerns within health care chaplaincy.

2.4.2(ii) Use was also made of supplementary documentary data such as Minutes of meetings of the College of Health Care Chaplains Council and sub-groups of which the author was a member from 1992 to 1996. Other data included Department of Health circulars on spiritual care and other published data held in the private possession of a long-serving senior hospital chaplain, recently retired. Each item employed as research data is fully referenced in Part Two of this thesis.

2.4.2(iii) Interviews

As was described above, the researcher sought out key respondents to provide in-depth, semi-structured interviews which might reflect a range of concerns about the role of the health care chaplain. A balance was achieved, in a number of respects: between denominations, across geographical locations within England, in types of acute hospital (teaching or general) and with regard to both gender and length of experience as a chaplain. The decision to
select and employ key interviewees was based on the work of Pilgrim (1990) and Plummer (1983). They show that the interview material could be employed and justified as a source of triangulation for the printed material (and vice versa).

In addition to the interviews, each interviewee was asked to supply a sample of two weeks' diary analysis which reflected in detail their professional activity during that period. An overall analysis of how this group of chaplains spent their time performing particular roles and functions, is included in the Appendices and discussed in Part Three of the thesis. Further, each of the interviewees was asked to supply written documentary evidence about chaplaincy within their own particular hospital. This documentary evidence included leaflets given to patients and staff about the work of chaplaincy, business plans, job descriptions and educational material used in training which aimed to develop awareness and understanding of chaplaincy amongst staff. This documentary evidence is also included in an Appendix and discussed in Part Three of the thesis. These two sets of documentary evidence gave important opportunities for the researcher to analyse and assess the connections between the descriptions chaplains gave of their roles and jobs within the interviews and how these related to what they wrote about their work and professional performance into their diary analyses.

2.5 **Access Arrangements**

Much of the historical material about the early period of the establishment of chaplaincy within the National Health Service was contained in the archive department of the General Synod of the Church of England in London. The remaining material was...
collected by the author from a number of chaplains and other sources, but in particular two recently retired health care chaplains. Access to those to be interviewed was arranged by an initial letter of introduction, followed by discussion over the telephone to confirm the arrangements and to explain the nature of the research. All interviewees were familiar with the author through his editorship of The Journal of Health Care Chaplaincy, and contact over a number of years at annual chaplains' conferences. Two pilot interviews were conducted and the questions within the semi-structured interview only slightly modified in the light of these pilot interviews. Each of the in-depth interviewees was visited within the context of his or her own environment, with the exception of two who were interviewed at an annual chaplaincy conference. A full transcript of an interview is included in Appendix One.

2.6 Data Gathering, Organisation and Analysis

The organisation of the interview data is based on the structure suggested by Patton (1990) who described data from open-ended interviews as consisting of direct quotations from people about their experiences, opinions, feelings and knowledge. This data are organised in thematic form, following the order set out within the questionnaire. Issues, reflections and experiences are summarised, wherever possible in the interviewee's own words. Further approaches, attitudes and beliefs are compared and contrasted within Chapter Six.

Much of the documentary evidence is ordered, arranged and organised into a thematic and chronological narrative of the events and activities shaping health care chaplaincy in England from 1946...
to 1998. The bulk of this evidence is contained in Chapter Four which explores chaplaincy from an historical perspective. The remaining literature discussing the roles and functions of health care chaplaincy over periods of change is contained in Chapter Five, where the literature is summarised and analysed.

2.6.1 Data Gathering
Each of the interviewees was visited within his or her own health care institution (with the exception of two) for a part of the day. A semi-structured interview lasted between 45 minutes and one hour 15 minutes. The interview was preceded by some considerable conversation about the nature of the research and some general conversation about how each individual chaplain was feeling about aspects of his or her work. The visit to each of the hospitals included a tour of the hospital, sometimes a meal with chaplaincy colleagues and the collection of supplementary evidence, which gave the author a picture of the life and work of each chaplaincy department. The visit to each hospital was particularly important in yielding an informal and subjective sense of how each individual chaplain interacted with a very wide variety of staff. Some of these impressions are discussed in Part Three of the thesis.

2.6.2 The organisation of the data
As described above, the data are organised into three main chapters in Part Two of this thesis. The data are structured and presented in a way which reflects and is informed by the interpretive schemata derived from a Sociology of the Clerical Profession discussed in Part One of Chapter Three. This systematic approach permits many sources of data to be combined to confirm the existing picture or to demand a re-examination leading to an alternative picture of the
role of the acute health care chaplain. Wide cross-collaboration of the differing data sources was thus undertaken, and the differing views and perspectives surrounding the key issues combined to provide a coherent and consistent analysis of the role of the health care chaplain.

2.6.3 Data Analysis

There are a number of stages to the analysis of the data. The author's biases and presuppositions were discussed in Chapter One. While there was certain amount of testing of these presuppositions, the research attempted to allow both the documentary and interview data to speak for themselves about the chaplain's role.

The author worked with a chronological scheme of events surrounding health care chaplaincy and in particular as it had adapted and responded to changes in the Health Service since 1990. These themes and issues are picked up in Chapter Five and developed through a thorough thematic examination of chaplaincy literature. This process took place over a period between 1992 and 1996 punctuated by the interviews of chaplains. Attempts were made at consistency and careful notes were made during and after all visits about the picture of chaplaincy that emerged in each health care institution.

The data were read through and main themes identified. These themes were highlighted and are discussed in the presentation of the material in Chapters Four, Five and Six. In this data analysis there is a generation and development of categories informed by the work of Larkin (1993) and the researcher's own knowledge as a health care chaplain between 1990 and 1996. The researcher was
able to elaborate on the outline of history already accessed in which previous knowledge and previously established themes were brought to the study. A combined chronological and thematic analysis was employed in the construction of a final narrative which is presented in Part Two.

2.7 Methodological Adequacy of the Data

There has been some discussion of the issues around objectivity and subjectivity in qualitative research, but it is also necessary to address questions concerning the reliability and validity of the data.

2.7.1 Inadequacy of the data

The use of interviews as a means of obtaining data carried hazards and flaws. While there may be always gaps between what people say and what people do, it is inevitable that interviews also depend upon the accuracy of an individual's memory (Patton, 1987, 1990; Yin, 1994). Interviewees may vary in their ability to articulate reality and there may be some lack of understanding about what is required by particular questions.

Plummer outlines three critical criteria of adequacy. These are cooperation, high consciousness and accessibility (Plummer, 1983). In this study each of the informants was a willing participant in the study. While there was some disagreement about the nature of the questionnaire, there was no detectable reluctance to engage in conversation about a chaplain's role and work. Some of the respondents were chosen in part because they were significant leaders in the chaplaincy world, and two of them had written widely about health care chaplaincy. Their high status and practical involvement in key aspects of official activity or close relations with
those so engaged, ensured their position as informants of high consciousness and accessibility.

2.7.2 Adequacy of the documentary data.

This has been discussed in some depth above. It remains to be said that the advantages of this method have been demonstrated repeatedly in social science, even by those critical of its application (for example, Cain and Finch, 1991; Silverman, 1993, 1997). It is sufficient to end this Chapter by summarising the four main criteria for methodological adequacy stemming from the work of Platt (1981) and Scott (1990). These are authenticity, credibility, representativeness and meaning. These are said to assist in the assessment of validity (Scott, 1990).

With regard to authenticity, the documentary material is, as has been pointed out, largely the publications of one official body or another. It is important to note that a significant range of the available material was sampled in order to form a credible picture of the role of the health care chaplain. The official documents and published material naturally convey only one particular viewpoint in relation to the events in question, and, once this is recognised, it may be taken to enhance rather than diminish the quality of the data for current research purposes. In the current study, taped transcripts and copies of tapes were offered to respondents to allow alterations to be requested. In addition, some respondents viewed the relevant chapters, thus providing validity checks. Of course it is impossible to eliminate bias, but all attempts were made to ensure the credibility of the material.
In view of the fact that all of the available written data about chaplaincy were researched, it is reasonable to claim that the features elicited and highlighted were typical or representative of those involved in chaplaincy during the time frame under consideration. Scott (1990) noted two sub-categories of representativeness which are necessary to the adequacy of documentary data - survival and availability. The core data sets derived from official and largely published material (except the Minutes of the Council and Sub-groups of the College of Health Care Chaplains) and are all deposited in library facilities and archives which ensure both survival and availability.

The issue of the generation of meaning through interviews and data presents greater problems and has been discussed above. The study has attempted to present a coherent picture of the role of the health care chaplain through constant interrogation of the material as the thesis has progressed from one theme to another (Mason, 1996; Scott, 1990).

2.8 Ethical Issues
Ethical dilemmas arise for all researchers in the social sciences (Rogers, 1989), and there was one particular issue which emerged in nine of the fifteen interviews. In respect of informed consent, the interview material contained a number of references to events which respondents were only willing to share if anonymity was guaranteed in any subsequent publication. The researcher agreed to give this guarantee and sensitive passages were checked with interviewees.
2.9 **Conclusion**

This concludes a comprehensive overview of the objectives and methodology undergirding the framework within which this study is conducted. The next chapter will take an overview of the sociology of the clerical profession.
3.1 Introduction

It is the purpose of this chapter to locate this study within a wider sociological and ecclesiastical context. This will provide a context within which the core themes which underpin the thesis are both understood and explained.

In order to achieve this the chapter is divided into two parts. The first part will place the study within a summary of the thought of sociologists who examine the concept of professions. It will introduce definitions and interpretations of 'professions' (section 3.2) including frameworks which follow Durkheim (3.2.1), Weber (3.2.2), Marx (3.2.3) and Foucault (3.2.4). In particular issues of social closure, professional dominance and autonomy, and managerialism, and matters relating to the recent NHS reforms are discussed. The particular relevance of these definitions, frameworks and issues to health care chaplaincy is drawn out and discussed.

The second part of this chapter presents background material on the sociological position of the clergy in society. This material will locate the health care chaplain within a wider framework in order to explore the issues of the role and function of the chaplain in the NHS.

At this point some clarity about the use of the words 'chaplain' or 'clergyman' is required.
The health care chaplain is, almost without exception, a priest of the Church of England or minister of another denomination. The range of designations such as 'clergyman', 'minister', 'parson' and 'priest', indicates the variety of ways in which the religious functionary of the Church of England and, in some cases, other denominations may be regarded. However, a basic and fundamental distinction can be maintained between theologically derived and historico-sociologically derived terms, notably, between the terms 'priest' and 'clergyman'.

The term 'priest' as normally used is a theological term which denotes a religious status. The term 'clergyman' is more often seen as an occupational role among many within society. So, for the purposes of this chapter, the collective term 'clergy' will be regarded as the best term corresponding to other occupational or professional roles, for example, doctor or lawyer. It is a term which includes both male and female clergy. No study of the clerical profession published to date has taken account of the ordination of women. Whilst the ordination of women in the Church of England is relatively recent (to the diaconate in 1986 and to the priesthood in 1995), other churches in England have ordained women for much of the present century (Presbyterians accepted women for ordination in 1921, the Church of Scotland accepted women ministers in 1968, and the Methodist Church, while having women preachers since 1930, ordained women in England in 1974). Clearly sociological studies referred to in this chapter do not take into account gender issues and further work awaits to be done on the sociology of the clerical profession in the light of the ordination of women.

As of 1997 there were 286 Anglican whole-time chaplains (working in both acute and mental health care) working in the NHS. 55 of these are women. There are a total of 9,314 stipendiary parochial clergy.
and a further 979 clergy working in such areas as the forces, prisons, higher education and theological colleges. Health care chaplains therefore represent 2.8% of the total number of stipendiary clergy in the Church of England.¹

¹ These figures are taken from G S Mis 492 (1997) Statistics of Licensed Ministers at 31 December 1996 (Church of England, Advisory Board of Ministry).
PART ONE:

The Sociology of Professions

3.2 Definitions and Interpretations of 'Professions'

Sociologists have provided a range of interpretations and descriptions of professions. In some respects definitions have been generated by professionals themselves and are referred to as the taxonomic approach, encompassing trait and functionalist models (Klegon, 1978; MacDonald, 1995). These definitions have tended to emphasise the idea of professionals (those working within professions) as people having unique skills which are put to the service of others. In recent times this view has been modified and in some cases virtually inverted. Illich (1977a) discusses a new medicine as a threat to health and talks of welfare professionals as disablers in the process of the delivery of health care (Illich, 1977b). Others, reflecting upon the rise of the new middle class, argue that welfare professionals manipulate those less powerful than themselves in their own interests (Gould, 1981).

Despite this discourse, largely from professional academics, for many lay, ordinary people the word 'professional' implies both special skills and propriety. The term also implies accreditation, efficiency, competence, integrity and altruism (Pilgrim and Rogers, 1993 page 81).

It follows therefore that to be unprofessional is to behave incompetently, unethically, inefficiently or even fraudulently (Watson, 1997). These features accurately reflect the use of the term by health care chaplains in Chapter Six of this study, and through their literature analysed in Chapter Five.

Contemporary sociologists largely agree on some basic propositions about characteristics of professionals.

1. Over the past two hundred years professionals have grown in influence, and expanded in both number and in types, particularly in this century.

2. Professionals provide services to people rather than produce material goods.

3. Professionals have a higher social status than manual workers through their salaried or self-employed status.

4. A professional status increases as a function of the length of training required to practise (doctors being an obvious example of this).

5. Professionals claim specialist knowledge about the work they do and would expect to define and control that body of knowledge.

6. Credentials give professionals a public and political credibility (Pilgrim and Rogers, 1997 Chapter 5).

However, this is only a rough consensus and there is much disagreement about how professions should be understood from a sociological perspective. There follows a discussion of the main frameworks used within the sociology of professions and their relevance to health care chaplaincy.
3.2.1. **The neo-Durkheimian framework.**

Durkheim saw professions as providing a disinterested and integrative social function. For the Durkheimian tradition, professions are a source of community and stability within society. They are a positive social force which counter-balances the tendency of egotistical individuals towards fragmentation. They do this by regulating their own practitioners, and ensuring good practice through codes of conduct. Overall, professions regulate conduct in the interest of clients and to the benefit of the society within which they live (Pilgrim and Rogers, 1997, Chapter 5; Denzin, 1972; Saks, 1995, Chapter 1).

Within this general tradition the identification of a *checklist* of characteristics which distinguish professional from non-professional occupations forms the basis of a 'trait' approach (Carr, Saunders and Wilson, 1993; Goode, 1957; Jones, 1994). This was used as a measure of the gradual progression of an occupation along the path to professionalism. Characteristic features include formal educational and entry requirements, special skills and techniques based on theoretical knowledge, altruistic motivation and possession of a code of ethics (e.g. Watson, 1995; Denzin, 1992; Saks, 1995).

In this approach, professionalisation is seen as a process by which occupations attempt to become professions by progressively acquiring these necessary characteristics. The relative success or failure of each aspiring profession has led to the creation of intermediate forms, described as 'semi-professions' or cases of 'incomplete
professionalisation' (Denzin, 1972; Etzioni, 1969). The professionalisation of the clergy, with their theological education and system of qualifications is an example of the general growth in the professions or professionally aspiring groups. Formerly the training of the clergy, like that of the medical and indeed other professions, was rudimentary and haphazard. In the case of the clergy, until about thirty years ago, this was true in the strictly pastoral area. In the recent period, partly perhaps as a response of the churches to the expansion of the caring professions and the welfare state, the churches have sought to become as expert and professional as the statutory sector. Practical and pastoral practice has been introduced in clergy training and development together with both psychology and sociology, and these disciplines have been absorbed into both training and practical ministry (Ballard, 1998). However, the only official requirement for appointment of a health care chaplain is to be a recognised priest or minister within a particular denomination; no further specialist training being required (although a new post-graduate qualification in Chaplaincy has been developed at Leeds University for the academic year 1998 - 1999). In other words, clerical status rather than more specific qualifications remains the only official criterion of suitability for health care chaplaincy. This is a strictly limited application of the trend towards professionalism. The question of whether the clergy should in any case be regarded as a profession is discussed below.

The relevance of the neo-Durkheimian framework to health care chaplaincy lies in the process by which chaplaincy has attempted to

3 While this model has not so far been directly relevant to chaplaincy, it does bear upon issues around the relationship between ordained and non-ordained chaplaincy team members, and upon the attempts by the College of Health Care Chaplains to promote itself as the professional association for chaplaincy with a code of professional ethics.

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regulate a skills and outcome approach to its work through the Health Care Chaplaincy Standards document.\(^4\) In the preface to this document occupational standards are described as the standard of performance expected in a given work role for chaplains, and these chaplaincy standards are described as offering managers a definition of competent performance in the workplace.

3.2.2. The neo-Weberian framework

The Weberian tradition (Freidson, 1970, 1997, 1983; Johnson, 1972; Larkin, 1983; Witz, 1992; Abel, 1988) emphasises that the professions employ strategies for specific ends: to advance their own social status, to persuade clients about the need for their own service, and to corner the market in that service thereby excluding all competitors. Two notions in particular emerge for those following Weber, those of social closure and professional dominance (Pilgrim and Rogers, 1993). These notions are relevant to the current study.

(i) Social Closure

This concept has been elaborated by Parkin (1974, 1979) and Murphy (1985, 1986) who argue that collective professional social advancement rests upon social closure. A monopoly is achieved to work in a specialised way with a particular group of clients (for example medical practitioners treating sick people) so that occupational groups seeking a similar role are excluded. Professionals thereby restrict access to the rewards and privileges of a particular job (MacDonald, 1985). Through a sharp definition of the boundaries, others are denied access and thereby kept in a state of ignorance. The maintenance of social status for professionals depends, in part, on their capacity to persuade others on the outside

\(^4\) See the framework of standards reproduced in Appendix 2

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of their defined boundaries that they offer a unique service. A variety of rhetorical devices are used to persuade others of particular or special qualities (Larkin, 1993; Parkin, 1979, 1982). To do this, professionals must justify a peculiar knowledge base that has a scientific or technical rationality, yet also requires interpretative skills which render it resistant to reduction (Pilgrim and Rogers 1993; Turner, 1985, 1987). Medicine as a whole can be seen to provide such accounts to the world. Saks (1992), taking the example of alternative medicine, argues that attempts of this kind to persuade the public are not guaranteed to succeed.

The more formal attempts by chaplains in recent years to offer a distinctive service, based on national standards and agreed outcomes may be seen as illustrative of social closure. Chaplains' attempts to establish a unique body of knowledge (see Appendix Two) to underpin a new therapeutic terrain in spiritual and religious care, to the possible exclusion of others, together with their specialised activities in the area of bereavement, death and dying, staff support and education, may be interpreted as attempts to control a knowledge base which is distinctive, thereby securing their professional role and relevance in the health care institution. On the other hand, the use of lay associates in chaplaincy tends in the opposite direction or at least creates a 'grey area': much depends on the individual chaplain's way of relating to and supervising such persons.

(ii) **Professional Dominance**

The second feature of this Weberian picture is that of professional dominance. Professionals exercise power over others in three ways.
1. Professionals have power over clients. The client expresses a need for the service that professionals offer and becomes dependent upon them. The client is kept in a state of ignorance, insecurity and vulnerability because of an imbalance in specialised knowledge. This imbalance is reinforced if the professionals operate within their own space or territory rather than that of the client. The treating of people in hospital rather than at home is an obvious example of this (Hugman, 1991; Parkin, 1979; Larkin, 1983; Turner, 1985; Witz, 1992).

2. Professionals exercise power over their new recruits. A hierarchy is common in professions with senior practitioners and trainers exercising control and discipline over their juniors. Trainees are dependent on their superiors for career progression, thereby securing a sense of submission and deference to the senior professional on the part of the junior (Parkin, 1979).

Professionals may seek to exclude competitors, as is the case of orthopaedic specialists keeping chiropractors and osteopaths out of official health service practice (Saks, 1992).


Power relations are crucial to neo-Weberians. It is a matter of the gaining and retaining of power over clients, new entrants and other occupational groups working with those clients. Witz (1992) argues that demarcationary strategies in creating, controlling and negotiating role boundaries all serve to sustain or extend the
material advantages, status and comforts of the middle class professional in society.

This notion of professional dominance is relevant to this current study. The effects of this dominance may account for health care chaplains often feeling a level of marginalisation, role anxiety and insecurity. This anxiety is caused by, in part, the reality that the chaplain does not feel understood (and by implication affirmed) by the health care institution. The culture of the acute hospital is shaped by medical dominance (see 3.4) within which the chaplain may experience a marginalisation of role and identity. While the setting up and development of the College of Health Care Chaplains has been part of the process of professionalisation (defining credentials, creating a distinctive knowledge base, cornering the market), between 1996 and 1998 there has been a gradual decline in membership following the discussion of the affiliation of the College with the M.S.F. Union. This in part reflects disagreement among chaplains about the relationship of professionalisation and formation (to be discussed below), and the resistance, by some, to being excessively influenced by an audit and outcomes culture at the expense of theological distinctiveness. These issues are discussed by chaplains themselves in Chapter Six and evaluated in Chapters Seven and Eight. From another point of view, the negotiations with the M.S.F. Union may be seen as alternative route to the securing of professional dominance.

Another significant factor in the context of this discussion concerns the role of other faith communities in Britain in the provision of spiritual, religious and cultural care for their adherents. While some chaplaincies have included provision for patients and staff of other
faith communities, there is an ongoing debate about how far the
distinguishing of Christian chaplaincy ought to be maintained
within a multi-cultural environment. This was discussed at a major
consultation of the Hospital Chaplaincies Council with the
Department of Health in October 1997, and found expression in
disagreement about how the State ought to celebrate the 50th
Anniversary of the Health Service in July 1998. The Department of
Health asked that the main celebration in Westminster Abbey on 5th
July 1998 should be multi-cultural and include a range of religious

In relation to point 2 above (page 43 (ii) Professional Dominance)
concerning how professionals exercise power over their new recruits,
it is worth noting here that there are two main pay scales for
chaplains; for whole-time chaplains and whole-time chaplain’s
assistants. Many large acute hospital chaplaincies connected with
university medical schools require that a whole-time chaplain has
undergone a ‘training’ as a chaplain’s assistant. A proportion of the
chaplains interviewed for this study managed teams with a number of
colleagues or assistants working under them. There are some
indications that this hierarchy is breaking down as fewer clergy are
attracted to health care chaplaincy posts.5

3.2.3. The neo-Marxian framework

While the neo-Weberian focus might be described in terms of
horizontal relationships between professionals and those they work

5 Confidential correspondence between the author and two Hospital Chaplaincies Council advisers. It
has not been possible to ascertain why fewer clergy are attracted to hospital posts. One H.C.C.
adviser suggested that parish clergy were less attracted to the health service because of perceptions
around the negative effects of the 1990 reforms. The other adviser suggested that health care
chaplaincy was financially less attractive because of recent salary increases of the parish clergy
(chaplains earn (on average) £23,000 without accommodation, and Anglican parish clergy on average
£15,500 including a house).
with as colleagues or clients, the Marxian tradition in its conceptualisation of power relationships focuses on vertical structural relationships. The issue for neo-Marxians is, 'Where do professionals fit into a social structure which is characterised by two main groups - those who work to produce wealth in society, and those who own the means of production and exploit these workers for profits?' (Doyle, 1979; Larson, 1997; Johnson, 1977; Saks, 1983, 1995). It follows that sociologists following a Marxian tradition of analysis have had conceptual difficulties with the professions. For example, Saks in a recent study develops a theoretical and methodological framework for investigating the degree to which professional groups translate their altruistic ideologies into practice. Analysing the response of the medical profession to acupuncture over the last two centuries, he argues that the predominant climate of rejection runs counter to the public interest and has also been heavily influenced by professional self-interest (Saks, 1995).

Professions are deemed to be either part of the ruling class or part of the proletariat, or else they are now deemed to constitute a particular social class with features which are contradictory. The first type of claim is made by Navarro (1979), who argues that the medical profession constitutes part of the ruling class in capitalist society. On the other hand Oppenheimer (1975) argues that the control by knowledge-based professions over their work has been eroded by State bureaucracies, so that they have become part of the working class ('proletarianisation' or 'de-professionalisation'). Oppenheimer understands the collectivist strategies of professions as being similar to trade union defences of working class terms and conditions of employment.
The third position is articulated by Gough (1979) and Johnson (1977) when they argue that professionals hold a contradictory position in society. They are not capitalists though they serve the interests of capitalists. They do not produce goods and surplus values and therefore cannot be regarded as full members of the proletariat. However, most professionals are in some sense employees and so they are limited by vulnerabilities and interests similar to those of the working class. For instance, health care chaplains might be seen as being in this contradictory position: they are both agents of social control, acting on behalf of the welfare capitalist National Health Service, and vulnerable to the same exploitation as any other group of workers by their lack of control.

Some writers on professions associate other elements with a broadly Marxian analysis: for example Parry and Parry (1977) use Weber's notion of closure and Oppenheimer's 'proletarianisation' thesis in a discussion of the rise of militant trade unionism within the ranks of the British medical profession. They argue that Weber anticipated Oppenheimer's insights and thus produce a position which sees no conflict between the Marxian and Weberian types of analysis of modern professions.

However, it is now common for sociologists to approach their work eclectically as they draw on more than one theoretical tradition. For Turner this has become a prescription for analysis:

A satisfactory explanation of professionalisation as an occupational strategy will come eventually to depend upon both Weberian and Marxian perspectives.

(Turner 1987, page 140)
If we turn to view our subject in the light of a Marxian framework it is curious and problematic to find that chaplaincy retains an enormous control over its life and work. No chaplains in Chapter Six of this study articulate any threats from other groups within the National Health Service to their services. However, despite the absence of threat, there is still a measure of anxiety. This may be surprising in view of the development of counselling and therapeutic services within the National Health Service and a growing interest by nurses in spiritual and religious care (Stoter, 1997; Davis and Fallowfield, 1991). The diversification of health care chaplaincy through its widespread use of volunteers for visiting patients in ward areas may also be noted in relation to the discussion about professionalisation, though it may be said actually to enhance the professional and skilled status of chaplains themselves (see pages 42-46). This is discussed at further length in Chapters Seven and Eight.

3.2.4. Foucault and the Post-Structuralist Framework

Foucault, working within a post-structuralist framework was interested in the relationship between knowledge and power (as with Weber and Marx). In particular Foucault and his followers attempt to map out discourses associated with particular periods and places. This notion of discourse includes both forms of knowledge and practices associated with that knowledge (Ward, 1998).

This framework provides a different way of looking at applied knowledge and professional work. It has no notion of a clear or stable power discrepancy between professionals and clients or between dominant professions and subordinate ones. Rather, power is dispersed and cannot be simply or easily located in any particular groupage. It is bound up with dominant discursive features of a
particular time and place, though these may be changed and resisted. For Foucault and his followers the ways in which the person, the body and mind of an individual, is now described or constructed (measured, analysed and codified), are central features of contemporary society (Pilgrim and Rogers 1997). Medicine has a central role in regard to interests in diagnosis, testing, assessment and observation, and the treatment, management and surveillance of sick and healthy bodies in society (Freidson, 1997a, 1997b; Ward 1998).

3.3 Managerialism and the Recent NHS Reforms

With the introduction of general management and recent NHS reforms in the late 1980s and early 1990s, there has been a significant impact on health care professionals. Part of this impact has been upon medical autonomy and dominance through the extension of managerial control over clinicians (Strong and Robinson, 1990). The drive for quality and management control over audit and outcomes is part of the process of change initiated by the reforms (Longley, 1993; Saltman and Von Otter, 1992). However, Elston (1991) argues that none of these changes should lead us to assume that medical autonomy and dominance have declined. This position is confirmed by Cox (1991) who shows that the Griffiths general management strategy has been used by medical practitioners in securing management positions over other health care groups. He argues (1991) that though general management was in part designed to challenge medical autonomy, there is little evidence to suggest that the authority of the medical consultant has been diminished through the changes in how the Health Service is organised and structured. Gabe, Kelleher and Williams (1994) have re-examined medical dominance in the light of the NHS reforms, and concur with
Cox when they conclude that the powers that be in medicine continue to enjoy both status and influence in the Health Service.

Witz (1994) explores the expansionist strategies of nursing through the growth of degree courses, and discusses whether this might be viewed as a threat to medicine. While nurses have achieved a measure of autonomy and begun to undertake certain medical procedures, there has been little serious threat to medical dominance (Witz, 1994), though some re-shaping of nursing as a profession is undoubtedly taking place.

It will become clear from the present study that the NHS reforms have seriously threatened the traditional autonomy of health care chaplains. In Chapter Six they will share their experience of how they have been forced to become more accountable since the introduction of general management in the National Health Service. They have been made to respond to a number of challenges about the outcomes of their work in the delivery of health care. Some have secured and developed their position in the light of these challenges, and some have clearly struggled to respond appropriately and creatively.

3.4 Professional Autonomy and Professional Dominance

It is worth focusing in more detail on these aspects of professional status. In terms of closure, Freidson (1970a, 1970b, 1977) argued that the basis of medical power stemmed from the legally and politically sanctioned monopoly over the organisation and control of work unique to its wielders within the health division of labour (Freidson, 1970). This freedom to control the content and terms of work, the power of self-regulation and freedom from external
judgment, contributed to a position of strength in relation to potential competitors, protecting medicine from boundary encroachment from other occupations.

A key element in the maintenance of this power has rested in the control of the application of medical knowledge and skills, affording medicine a unique degree of autonomy. If the same occupational knowledge and skills were also held by others, asserted Freidson (1970a), this would represent a lack of autonomy as the profession would then be open to evaluation and criticism by outsiders. Thus the authority to supervise training and award qualifications has assured the maintenance of professional status (Freidson, 1970, 1970b). Also necessary has been the public recognition that the unique and effective nature of medical knowledge and skill is assured, thus making the public willing to grant the special status of autonomy (Freidson, 1970a). Nevertheless, without the operation of other factors, the knowledge-base of an occupation is not in itself sufficient to secure professional status, though it may be used as a resource to support claims to a monopoly jurisdiction (Freidson, 1970a; Larkin, 1983). The actual key to the power of medicine lies in its relationship with the State, which ultimately granted the authority essential to medical hegemony and dominance in the health division of labour (Freidson, 1970a, 1970b).

The power of medicine has in fact extended beyond self-regulation, given its monopoly over the control and organisation of health care in the wider division of labour. Medicine has the power to direct and evaluate the work of other occupations engaged in the care of patients, without being subject to such gaze itself. The paramedical occupations, in consequence, have been excluded from the vital task
of diagnosis, their work is supervised by medicine, and they lack control over their own knowledge base (Freidson, 1970a, 1970b; Larkin, 1983). This formed the basis of Freidson’s model of professional dominance, in which medicine successfully subordinated other occupations within the health division of labour; a dominance which in turn sustained its autonomy (Freidson, 1970a). Medicine, it was claimed, then determined to a large extent the role definitions of the subordinate paramedical groups (Freidson, 1970a, 1970b; Johnson, 1972). This is important for the current study because it recognises the profound difficulties that those professions allied to medicine have had in developing their professional autonomy within the health care organisation. Chaplaincy has had difficulty in defining itself as a form of paramedic group or, in other words, persuading others that chaplaincy is in itself a therapeutic service. From this perspective, therefore, it has remained consistently on the margins of the debate about therapeutic intervention in the health care process. This is reflected in chaplains’ inability to reflect insightfully on how other professional groups see their service, and in their strong reaction against medical dominance and managerialism in the present NHS reforms (as we shall see in Chapters Six and Seven). It does not, however, explain the increase in chaplaincy appointments since the introduction of the NHS reforms in 1990.

3.5 Conclusions to Part One

This concludes part one of this Chapter which has outlined and discussed the implications of the sociology of professions, having in mind its bearing on chaplaincy. It is evident that there is no agreed general definition of ‘profession’ and when it is used by chaplains in Chapters Four, Five and Six, it can be interpreted in a variety of ways. A number of debates are relevant to the development of
chaplaincy in this study. These include:

(a) The process by which chaplaincy has attempted to regulate its work through the promotion of a distinctive skills, knowledge and training base.

(b) The impact of the professional dominance of both managers and doctors on the culture of the NHS in general and the autonomy of chaplains in particular.

(c) The discussion about social closure (3.3.3.(i)) is significant in respect of the issue of whether ordained chaplains alone should offer pastoral spiritual and religious care. This is an issue of identity and of how chaplains achieve a measure of organisational security within their hospitals.

(d) The post-structuralist framework (3.2.4.) related to how chaplains handle the relationship between knowledge and power in their work. This discussion concerns the question of how chaplains use their theological knowledge within their work and their reflections on the context of the hospital. In other words, it will be important to explore the relationship between ‘professional’ and religious identity.

**PART TWO:**

**The Sociology of the Clerical Profession**

**3.6 Introduction**

Before discussion of the role of the chaplain it is necessary to locate the chaplain within a wider understanding of what has happened to the Church and clergy since the 1960s. This part is background material which is general in nature and provides some illumination of why chaplains might reflect upon their role in the ways they do.
There follows a brief evaluation of secularisation followed by an overview of the clerical profession.

3.7 **Secularisation**

An issue for this study is how far the role of the health care chaplain is marginal to the mainstream of both social life in general and the health care institution in particular. It is necessary here to discuss and evaluate the nature of secularisation.

Secularisation is the process of social change in which 'formal' religion loses social significance. That process may be many-sided and may occur over a shorter or longer period. Its major manifestation occurs as religious agencies lose the social functions which, in traditional societies, they have typically fulfilled. More obviously secularisation also occurs when religious bodies lose control of property and resources; when religious personnel diminish in number and undergo a loss of social status; when religious ideas and beliefs are increasingly relinquished by the general population; and where there is growing neglect of religious practices. Whilst popular conceptions of secularisation focus primarily on religious practice, particularly on the decline in recent decades in church attendance, this is no more than one facet of the process and by no means the sole or even the salient criterion of secularisation (Wilson, 1982, chapter 6; Hamilton 1995).

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Secularisation is a neutral term describing the pattern of social development. It should be distinguished from secularism. Secularism is an ideology which advocates the abolition of religion and the transfer of the ancillary social functions of religion to secular agencies. In contrast secularisation is a non-evaluative term describing empirically established social trends. Secularism may, in certain respects, have forwarded the processes of secularisation, but there are other non-ideological forces at work which have more directly and significantly influenced its course.

The privatisation of religion, a process by which religious agencies have relinquished or reduced significant aspects of their social and public performances, and confined themselves to servicing private needs, is equally seen as one facet of the more general secularisation process, and one of its more recent manifestations in western society (Habgood, 1983, chapter 5).

In recent western history, secularisation has occurred as religion has lost its former primacy over other institutions. In times past, secular authorities were legitimised by religious agencies (residually in coronations), whilst endorsement by religious leaders was particularly sought for the pursuit of particular social policies, including warfare. So for example, knowledge and the institutions in which it was purveyed, the universities, were for many centuries the domains of theologians and church leaders. The education of children was primarily in the hands of the clergy. Even in the maintenance of health, religious ministry was prominent, both in the diaconal office (still so in Germany) and in the provision of infirmaries and hospitals (Russell, 1980; chapter 4).
The decline of influence in public affairs has had the effect of focussing religious activity on the private lives of those who accept its ministrations. Religion has become increasingly more a matter of predilection than of public responsibility (Habgood, 1983). This process of privatisation has placed the emphasis on the functions of religion as the source of celebration, solace and reassurance. Simultaneously, as religion has been largely excluded from its earlier role in reinforcing constitutional, political, social and cultural arrangements, so the opportunity has arisen for the churches to criticise and challenge the policies and activities of governments. (The Faith in the City Report (1985) is an example of this where the Thatcher Government's policies were criticised as having destructive consequences for the inner city). Some church spokesmen see the process of structural differentiation as altogether salutary in allowing the churches, now freed from extraneous entanglements, to present a less compromised spiritual message. For the purposes of this thesis, the question about how free an employee of the National Health Service is to offer any critique and challenge to it is central and crucial: if such a one is religiously motivated, whether aware of these terms or not, he or she is acting on the basis of the secularisation process and the privatised role of religion just described.

Privatisation is the restriction of the influence of religion to the private lives of individuals, but even in this limited sphere religion no longer has free rein. The operation of modern society increasingly depends upon refined division of labour and structure of roles, particularly in economic activities. The expansion of role systems has been the major manifestation of rationalisation, as human activities have become more and more specialised and co-ordinated.
as an essentially impersonal system of relationships. This development has extruded from modern forms of social organisation much of the personal affectivity by which relationships were characterised in more communally organised societies. Religion was readily capable of infusing with spiritual values the relationships that prevailed in that older order, but that capacity diminished once society had become role-articulated. Rationalisation, by which individuals seem to be reduced to the equivalent of machine parts, has been a powerful agency of secularisation at an individual level and some have argued that it is present in the structures and culture of the National Health Service (see Appendix 4). Yet there can be other reactions to change. It may be that the tendency to appoint more chaplains is an attempt (perhaps unconscious) to turn the hospital into a 'village' and imbue it with old communal values.

The decline in voluntary allegiance to religious beliefs and support for religious organisations provides some evidence of secularisation, even though it is not the central part of the phenomenon or indeed the whole truth about the place or religion. In Britain there has been in recent decades a decline in the numbers professing belief in God (and even more particularly belief in a personal God), and in an after-life. Confessions, confirmations and baptisms have decreased per head of the eligible population in almost all Western countries, albeit at different rates. Many Anglican and Free Church buildings have closed, congregations have diminished, while the number of clergy has fallen both absolutely and relative to population. Anglicans and Catholics alike find ordination candidates difficult to recruit and, once recruited, to retain, so the average age of clergy in Western Europe is steadily rising (though in Britain nothing like as sharply as, from example, in France). Sociologists have developed the
concept of the internal secularisation of religion, alluding to the
departure from older doctrinal, liturgical and ethical traditions.
Thus, the ideas of God as exacting father and judge and of people as
inherently sinful have lost currency as the secular culture has shifted
from paternalism to fraternalism, or rather certain kinds of
egalitarianism. The high cultural form of liturgy has been replaced
by the use of the vernacular in liturgy (whether English rather than
Latin or modern rather than 16th century English) and freedom for
spontaneous ecstatic expression in charismatic renewal. The
traditional ascetic ethic which encouraged men and women to
forsake gratifications in this world, perhaps partly in order to
accumulate reward in the next, has given way to teachings better
accommodated to the hedonism and conservationism of
contemporary secular society (Habgood, 1983; Gill, 1996 chapters 7
and 29).

The dominant contention of the secularisation thesis is that whereas
religion once fulfilled latent and overt functions in all the
institutional areas of society, today those functions are increasingly
supplied by deliberate and calculated rational action which makes
no reference to the supernatural or else by various kinds of secular
myth-making. The modern social system, unlike traditional
societies, operates increasingly on the assumption that the social
order is human-made rather than God-given. Associated with this
process there appears to have been a considerable diminution of
voluntary recourse to traditional religious patterns of thought and
practice of religious rites and ceremonies. All this renders religion an
increasingly private concern and a minority interest. Support for
established religious institutions, ideals, teachings and values, was
formerly forthcoming from society at large (and in many cases from
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the State itself). As that support diminishes, so personal faith rather than public performance becomes the primary locus of whatever religious commitment remains. Once a relatively integrated religious culture fragments, those who do persist in seeking a religious orientation to the world enjoy unrestricted private choice from a diversified range of often newly-emergent and socially-unrooted beliefs and practices that offer personal reassurance or therapeutic or compensatory benefit. Widespread indifference, the privatisation of much of such religious expression as does exist, and the emergence of new movements and cult practices, may be regarded as the usual accompaniments of this secularisation process.

A further aspect of secularisation should be mentioned here. First, although the philosophical and societal changes of secularisation have been summarised in, for example Russell’s work, and often presented as the background to the Church’s history in the modern Western world (e.g. Hastings, 1986), it cannot be assumed that these changes necessarily indicate a decline in religiosity among people at large. Most people have a view of the world, reality and their place in it made up from a variety of sources, including some which are not strictly compatible with one another. In religious terms this is the phenomenon sometimes described as ‘folk religion’, ‘common religion’, ‘natural religion’, or ‘implicit religion’ (Bailey, 1997). Leaving aside its varied origins, ‘folk religion’ can be described as a largely verbal, proverbial kind of outlook, which may utilise symbols and practices, and even ideas, from the major religious systems, whilst arranging them in a generally idiosyncratic or unsystematic form. In many cases, it is rarely talked about and is held as part of the care of private life. From one aspect, often emphasised by Towler (1974), folk religion may be evidence that secularisation does not
necessarily lead to loss of religious belief. Thus, as Towler again argues, secularisation may involve the de-clericalisation and fragmentation of religion, rather than its extinction. This may go some way to accounting for how the health care chaplain picks up on residual beliefs as they emerge in conversations around illness. This thesis about the widespread persistence of belief, alongside the decline in any formal attachment to churches, is developed by Davie and described by her in the sub-title of her book on the exploration of religion in Britain since 1945 as 'believing without belonging' (Davie, 1994).

One further point about secularisation concerns the effects of social geography of Britain on religious practice. As early as 1964 the Paul Report argued that there were considerable difficulties in the parochial system - in other words churches were simply not in places where the population largely lived. Paul agreed that the changes in population distribution over a network of parish boundaries which remained largely static had led to many parishes becoming anachronistic since the Church could not effectively relate to the community - or indeed the Church building might have no community to which to relate. There was also the fact that more people were living longer, and quite often emigrated on retirement to a new location or settlement. These factors have obvious implications for the work of the clergy, whose distribution and occupational identity are largely tied to a geographical area, and who are already committed to working for a good deal of their time with elderly people. Arguably it may also point to an increasing anachronism in the theoretical basis of the parochial system; namely, the existence of settled identifiable communities bound by kinship and association, and embracing established religious values. This too is

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bound to affect clergy’s self-image and roles (Towler and Coxon 1979; Russell, 1980; Burgess, 1987, 1993).

3.8 **An overview of the clerical profession**

This section is a brief summary of the findings of five most relevant and contemporary sociological studies of clergy of the Church of England (Paul, 1964; Ranson, Bryman & Hinings, 1977; Towler & Coxon 1979; Russell, 1980; Burgess, 1987, 1993). The purpose of the section is to summarise the findings of these studies in order to build up a general picture of the Anglican clergy with particular reference to the marginalisation of their status in society. This section will also discuss whether clergy might appropriately be regarded as professionals in the light of the main substance of this chapter.

Throughout the 20th century the clergy have become fewer in numbers. In 1901 there were 23,670 Anglican clergy which marked a peak; thereafter they have declined relative to the growth in population. Over the century the total population has risen from 16.9 millions to 41.3 millions and the ratio of clergy to population has declined from 1 to 1,043 to 1 to 2,271 in England. In 1961 there were 18,749, but by 1997 the figure had reduced to 10,579 clergy (Russell, 1980; Tiller, 1983).

Not only are the clergy declining in numbers, but they are becoming more elderly as a group. Paul (1964) points out that in 1851 the average age of the clergy was 44, but in 1951 it was 55. This figure has however remained constant since that date (Brierley and Wraith, 1996; Burgess, 1993).
The recruitment and selection of clergy has changed significantly since 1945. In January 1942 the Archbishops of Canterbury and York established a Commission on Training for Ministry. The final report (known as The Durham Report) was presented in 1944 and is generally regarded as the turning point for the selection and training of the clergy (Burgess, 1993, page 61).

The report reiterates the fact of the decline in numbers of ordinands; it notes the secular character of contemporary thought and public policy, the ‘worthless’ character of much of modern literature, the development of secular welfare agencies and the assumption that science is contrary to faith. It asserted that the churches had failed to meet the needs of many people in industrial areas, while in the countryside movements of people had disturbed traditional patterns of religious observance and church influence (Durham Report, 1944, paragraphs. 7-12). The Report makes two particular points which relate to this discussion:

There is general agreement that the intellectual calibre of many candidates (for ordination) is unsatisfactory and in particular that the number of men of first-class ability seeking ordination is seriously insufficient. It may be for this reason that the clergy count for less than used to be the case with educated men ...

... There is a serious lack of specialists of many kinds within the ordained ministry. Such specialists might be a source of strength to the Christian Church, binding its fabric into the structure of society at many critical points (Durham Report, 1944, paragraphs. 40 & 43).

As a result of the Durham Report a uniform system of selection was established through a central organisation. Whereas before 1945, the Bishops’ prerogative of ordination was largely exercised either personally or through diocesan training committees, after 1950 it was exercised primarily through the Central Advisory Council of
Training for Ministry (CACTM), with diocesan bodies and officers servicing the central machinery by preliminary preparation. The motivation behind this change was largely the desire to produce a more efficient system (within limited finances) and to uphold standards that would be uniform (Burgess, 1993, page 66). This marks the beginning of the long and steady development of the modern phase of theological education in the Church of England which culminated in Education for the Church's Ministry (ACCM paper No.22, 1987) which sought to establish a thoroughly thought-out central core syllabus to be followed by all candidates in training for ordained ministry (Burgess, 1993, page 27).

In the face of declining numbers, the clerical profession has been under pressure to alter the requirements to accommodate those who formerly would not have qualified. The Church has never had an absolute entry requirement and a Bishop has always been free to ordain whom he chooses. In the early decades of the 20th century, almost 91% of ordinands attended Oxford or Cambridge (Russell, 1980, page 266). In the period after the First World War, the number of non-graduates began to rise and in 1979 48% of those ordained were not university graduates (Towler & Coxon, 1979, page 148). Schemes leading to the furthering of Non-Stipendiary Ministry and local NSM have diversified the picture still more (see 3.8.2. below).

In conclusion, the picture of the clergy that emerges here is that throughout the 20th century the clergy are becoming fewer in numbers, older and less well paid in real terms (Russell, 1980, page 269). They are less academically qualified and more orientated to the parochial ministry (Towler and Coxon, 1979). Surveys (admittedly
not as recent as one could wish) that have evaluated the effectiveness of clergy training show that clergy appear to be more interested in the cultivation of the cognitive (theoretical) rather than an effective (practical) style (Towler & Coxon, 1979). This leads to an emphasis on book-orientated and rational forms of expression with a reliance on personal motivation and achievement (Towler & Coxon, 1979, chapter 8).

3.8.1. The Clergy's Role

The clergy may be said to have a diverse collection of roles, rather than one which is uniform and concentrated. Russell (1980) shows how this is largely the result of historical processes in which the Church and clergy have played different parts in the life of the nation and the communities which make it up.

Russell's study identifies the areas in which the early 19th century clergy were active. Some of these were prescribed for them by virtue of their ordination: leader of public worship; performer of rites of passage such as baptisms, weddings, funerals; celebrant of the sacraments; pastor and catechist. Other areas fell to the clergy by a variety of circumstances: thus the clergy's role as dependably educated local figures originated from their place in mediaeval society as the only literate people to be found in many communities (hence 'clerks in holy orders'). Over the years the close connection between Church and State led to the clergy undertaking a whole variety of functions on behalf of civil government, some of which were later taken over by paid government officials. These functions included justices of peace, almoners, officers of public health and teachers (Russell, 1980, pages 146-203).
Russell traces the ways in which these roles were transformed during the 19th century, particularly after 1830. So, for example, the growth of statutory elementary education, particularly after 1870, led to the creation of a new occupation group of teachers.

Other roles either disappeared or were transformed by a change in the clergy's own self-perception. For example, after the repeal of the Test and Corporation Acts in 1828 and the 1829 Catholic Emancipation Act the State could no longer be depended upon to safeguard the Church of England's social monopoly, and this gradually led to a new (more limited) conception of the clergy, built around their roles of leading worship, celebrating the Sacraments, teaching the Christian faith and providing pastoral care to parishioners. With these changes went other adjustments in the social status of the clergy. However, the developments were slow and the position of the Church of England as 'established' still colours the lives and work of many parish clergy in a way foreign to ministers of other churches.

As society developed through the industrial revolution, one of the major effects of social changes during the Victorian era was that the clergy's work was increasingly orientated away from the wider community towards the Church itself. Many 19th century clergy were deeply involved in schools and poor relief but they were simply swamped in the teeming population of the industrial cities (Chadwick, 1970). Wilkinson (1978) noted that it was only the experience of the chaplains, during the first World War, that revealed the extent of the alienation of most British men from the churches.

To turn now to clerical roles in the 20th century, Ransom (1977) and colleagues identify six roles and rank them in order of priority for the
churches surveyed, including the Church of England. Ordinands and clergy ranked the following six roles in order of priority: teacher, preacher, pastor, priest, administrator and organiser. Although this study is not recent, it gives some indication of how the pastoral role of the work of the clergy continues to be classed as a significant aspect of a clergy person’s role and self-identity. This result is borne out by comparison with health care chaplains as they rank in order of importance the roles they fulfil.

If we put these roles and summary of sociological evidence in the context of our examination of the process of secularisation, a picture emerges of the marginality of the clerical profession in today’s society. Victor Turner’s discussion of liminality may be useful at this point (Turner, 1969). Liminality emerges as the second, transitional or threshold stage in Van Gennep’s survey of rites of passage (1906), from one social or religious status to another; a state of anti-structure between two structured states. Turner goes on to extend the concept to describe situations which are marked by an absence of formal structures or conventional relationships which he terms ‘communitas’. He argues that communitas, while essentially spontaneous and often of limited duration, may also be used as the basis for different sorts of social or religious organisation, thus leading to institutionalisation. On this understanding, it is possible to view life as a student as a liminal phase, whose anti-structure is in time replaced by the structured life of the world outside of the college or university. To remain with the attitudes and lifestyle of a student after graduation would be increasingly seen as a sign of eccentricity by others. Also, since Anglican clergy do not undergo quite the degree of occupational socialisation at theological college comparable to, say, the Roman Catholic priest, they are arguably
more likely to conform to the norms of society around them after ordination (Burgess, 1987, 1993). This has a bearing on a recurring theme in this thesis, whether health care chaplains experience conflict between the world of religion and the world of health care, and how far such conflict is resolved in favour of the context within which they work.

3.8.2. Non-Stipendiary Ministry

Perhaps the most significant development within the clerical profession itself in recent decades has been the emergence of a new model, which marks a divergence from the dominant model. The group (known as non-stipendiary ministers) is comprised of men and women, who having been selected by the same procedure as the full-time clerical profession, are trained to become clergy (by evening classes and residential weekends) while remaining in full-time employment. This idea had been discussed for some time (Russell, 1980, page 285), but it developed in the 1960's in the Church of England (and other churches in due course) as a result of a decline in numbers and the inability of the Church of England to pay for full-time clergy on the same scale as in the past. Following a report in 1968 the Bishops approved such training in 1970 (Russell, 1980 page 286). By 1977 there were 183 priests in this category and by 1990 1200 (Burgess, 1993).

The reaction of stipendiary clergy to this group has been varied. Some believe that the development has created a poorly trained group of people and the conviction that no professional can view the ministry as something that can be adequately performed on a part-time basis or (to use a not uncommon theme) as a hobby (Russell, 1980, page 287). On the other hand, this kind of reaction raises in
an acute form the question of where precisely we should locate the minister's professional identity. It is also worth noting here the decline of common socialisation of clergy through the widening of training and methods of education for the clergy beyond monolithic theological college experience.7

Burgess (1993) argues that non-stipendiary ministers (NSM's) should be viewed as only a very limited success. He shows that the introduction of this group has alleviated some of the problems over numbers but they do not appear to have made any significant changes to clerical self-perception. This may be due to the fact that they are still largely working in the framework of traditional clerical models (for example, parish priest), and using theological ideas about ministry which function in effect as counterweights to their secular employment, rather than, for example, being 'priest-workers'. Their parochial orientation (in almost all cases) is an acknowledgement of the dominant influence which this type of ministry exercises over the Church of England. This parochial orientation and traditional perceptions of the clergy as a middle-class professional group seem to have limited the hope that NSMs would offer a means of contacting people alienated from the churches. This defensiveness has not enabled the clergy as a whole to adapt to new styles of ministry or new ways of relating to society (Burgess, 1987 page 86; Russell 1998 page 287). A considerable number transfer in due course to stipendiary ministry.

3.8.3. The clergy as a professional group

Most sociological accounts of the clergy follow the general assumption that the clergy are a profession, to be ranked alongside lawyers, doctors, teachers and other professional groups (Perkin, 1989). Two of the surveys have questioned this view, principally Russell (1980). Russell examines how clergy in the 19th century did begin to adopt the marks of a profession, with a gradually developing system of training, examinations and selection. Of course, the clergy's sense of themselves has always been changing and adapting to circumstances. As the clergy slowly ceased to be part of the rural elite (like the squire) and became more 'professional' (like the doctor). Russell argues that the apparently 'professional' developments of the clergy from the 1850's on have been overtaken by a new phase, now under way, in which the Church begins to operate more like the voluntary societies (for example the Red Cross) with fewer professionals and more part-time voluntary workers. And it is this situation (resulting from a decline in Church attendance, fewer vocations to full-time ministry and secularisation) that brings an identity crisis. The crisis is focused in two major issues to be discussed further in this thesis: first, whether to struggle to maintain public social recognition, either by negotiation, as health care chaplains do, or by offering specialised secular skills such as counselling or therapy, but in either case with the threat that the 'spiritual and religious' tasks are left in the background; and second, how far to concentrate on the distinctively religious role and to work primarily with those in the churches, or else more alongside other, 'caring' agencies as a part of a team representing one, somewhat marginal, area of activity.

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In this context the issue for health care chaplaincy is whether to accept a distinctive professional model - or else to resist it, and if so how, in an increasingly differentiated society (Ballard, 1998; Lyall, 1995). It is a matter of how far the clerical role, professional as it may be in certain ways, needs even for professional purposes to retain a certain amateurism, generality and marginality. Russell traces the development of the professions and sees them resulting from the increasing diversity of societies as they make the transition from rural and agrarian to urban and industrial organisation. He lists the ways in which the clergy have adopted a functionalist or trait approach to developing a professional model for themselves, and this was referred to above in relation to health care chaplaincy. There are however difficulties in describing the clergy as a profession in a number of significant areas.

The first concerns that of career structure. Once ordained, the clergy have no career structure and preferment (or career development) depends upon a system of organised patronage, exercised by bishops or other ecclesiastical officers but also by persons and institutions outside the ordained ministry such as the Crown, colleges, party organisations and lay patrons. It is also extraordinarily difficult to dismiss a clergy person from post, and it almost never happens for theological incompetence. When incumbents were appointed to a parish they could retain that job for life. It is only recently that they were forced, by legislation, to retire at 70. Further, clergy have only recently received more or less equal pay for equal work, and it was not until the 1930s that any effective pension arrangements were available for the elderly or infirm clergy (Russell, 1980).

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8 It is worth noting here that this could also be said of barristers, that is - they have no fixed career structure and have a dependence on patronage.
It is true that the clergy have a strong ethos of service, both of God and other people; that they have a distinctive form of dress, language, folklore and a sense of group solidarity. On the whole these secondary professional attributes, which emerged after the governing concept of a body of professional knowledge, have been accepted or pursued. However, other occupational groups may possess these secondary characteristics but not be regarded as a profession.

A central concept in relation to the question of whether we should see the clergy as a profession relates to the assumption that theology is their body of theoretical professional knowledge. This will form a central factor in the evaluation of the roles, functions and models of chaplaincy in Chapter Seven. Theology may be seen as the theoretical expression of a religious world-view and the basis of morality and order. But the clergy have no monopoly of theological knowledge, any more than they have a monopoly of other broad professional characteristics, such as a vocation to public service. Towler and Coxon and Russell all conclude that theology cannot be seen as a professional body of knowledge for the clergy, not least because a formal training in the subject emerged relatively late in the history of the clergy as an occupational group; precisely in the period, that is, gradually from the mid-nineteenth century onwards.

There are other problematic questions over the nature and use of theology which are highlighted through the interviews represented in Chapter Six. It is not clear how much theology as currently conveyed in the course of clergy training is of use to the health care chaplain, and how confident they are in the practical use of religious discourse in their work. Some chaplains have turned to Chapter 3. page 74
psychotherapeutic knowledge or managerial language as a source of security for their work.

Towler and Coxon argue not only that the clergy are not a profession, but also that they are not an occupation in the modern sense either. They are people who occupy a traditional place in society, rather like the squirearchy or the nobility, but whose actual work is not related directly or uniformly to that position. An earl may be a soldier, a banker, a farmer, a politician or a fashion photographer; 'earl' denotes rank not occupation. The cleric may function as a registrar, a custodian of an ancient public building, a school manager, a local politician, a teacher, an ecclesiastical bureaucrat or a health care chaplain, but 'clergy person' is a statement of status not function. According to this view the distinctiveness of the clergy derives now from their being the agents of a marginal institution, rather than from performing a distinctive task or possessing a distinctive skill. That agency role may be expressed in any number of different work situations.

It would be possible to evaluate the clergy by saying that of all the professions they are the only one which has retained its 'basic' functions and roles from a traditional, undifferentiated society. During the 18th century their social status rose to the level equivalent of the gentry (though they always had a high status), with whom, or in place of whom, they exercised a wide variety of functions appropriate to a traditional society. Between 1780 and 1830 they played a key role in maintaining the fabric of a society that was in rapid transition, but after that date their stop-gap social functions were gradually taken from them and their monopoly threatened by a new attitude of the State towards religious toleration.
(Hastings, 1986). They thus sought a new identity, and constructed one out of their traditional religious functions, viewed partly on the model of the emerging professional middle classes. Their social position, inherited from the past, placed them where the professions desired to be; the development of theology as a more formal field of knowledge in which one could be trained allowed them to regard this as their area of specialist knowledge; while the Victorian belief that morality and social order rested on religious belief ensured their continued social utility. At the same time, their place in society meant that they could not gain control of important areas of their life, in particular, the refusal to relinquish the property rights of patronage ensured that no self-regulating career structure could emerge, while party interests within the Church added to the diversification of power and also undermined the cohesion of the clergy (Russell 1980).

Before concluding this section it is important to note (without discussing in any detail) what some commentators have described as institutionalised sex-discrimination in relation to the clerical profession. There is a tension between those individuals and groups who believe that the Church is a 'traditionalist' organisation and those who believe that the future is 'adaptionist' (Russell, 1980 chapter 19; Gill, 1989). This tension has focussed on the integration of women into the priesthood of the Church of England and views about the acceptability of homosexual lifestyles amongst lay and ordained Christians. The traditionalist approach has resisted acceptance of both women, and gays and lesbians; the adaptionists have argued for acceptance and integration (Coates, 1989; Irvine, 1997 chapters 8 and 9).
These two issues are relevant in the discussion about professionalism and the clergy because, at present, the churches embody employment policies which discriminate against women, gays and lesbians. There are no contracts of employment with equal opportunities policies which promote an equitable framework for clergy employment (Obelkevich and Catterall, Editors, 1994 pages 169-172)

In the light of this evidence we may therefore make two major statements about the Anglican clergy. The first is that in spite of a general belief to the contrary, in many respects they are not a profession in the normal definition of the word; even though they may have some features characteristic of a profession, these are secondary rather than primary ones. In the case of the health care chaplain it is true that aspects of their adaptation to the changing context within which they work, mean that they have exhibited characteristics which demonstrate aspects of professionalisation, but they cannot be regarded as a health care profession alongside other professionals in the Health Service. The second is that the paradigm of the Anglican clergyman is of the single-handed parochial person. This is not simply the result of the discovery that the great majority (76% according to Towler and Coxon) work entirely or mainly in the parochial ministry. Rather it is because the parish encapsulates several key characteristics of the Anglican clergy and is the basic unit of Anglican life. This is a significant point in relation to how health care chaplains choose to define themselves in ecclesiastical terms.

If we try to think in normative terms, as best we can we may say that the parish is to the clergy person what the manor is to the squire:

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While these issues are not raised directly in the interviews with chaplains in Chapter Six (see section 6.2.1) a number of others commenting on this research at various points of its history have suggested that the National Health Service (as a secular employer) is attractive to women, gays and lesbians because of its non-discriminatory policies and environment.

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the geographical and social context in which their social status is expressed. It gives meaning to the rank conferred on a person by ordination, by ensuring that there is a community which will respond to his or her actions, and respect their status. This is in contrast to most other professions in which the practitioner is required by clients on the functional basis of the specific and limited service which can be provided. This almost symbiotic relationship between the clergy and the parish may explain other things about them. For example, it may explain why the majority of clergy find it impossible to conceive of ministry outside of the parochial context. Specialist ministries, like health care chaplaincy, in the Church of England are usually undertaken by people to whom the Church gives no specialised training beforehand. Specialist ministers may sometimes complain of feeling isolated and we may comment at this stage that health care chaplains tend to define themselves in reaction or response to this parochial model whether gladly or sadly, they feel themselves to be displaced parish clergy (Legood, 1998).

3.9 Professionalisation and Formation: a pastoral dilemma

There are, however, factors pointing in a different direction. The question of whether health care chaplains have become professionalised in recent years finds expression in the way pastoral carers, both within health care chaplaincy and beyond, have explored their identity and self-understanding as they work in institutional settings. The controversy over the professionalisation of pastoral care is illuminated by sociological analysis in terms of role conflict. In recent years, pastoral care in general, and to some degree health care chaplaincy in particular, have increasingly assumed the form of a modern profession with the emergence of national professional
societies, the promulgation of standards, accreditation of training programmes and certification of pastoral care givers. The professionalisation movement has stirred criticism, not over the effort to ensure good quality pastoral care, but over the way these developments seem to contribute to its secularisation (Wilson 1983, page 125).

It is apparent that some kind of balance needs to be struck. We have seen that professionalisation involves the process by which an occupation defines and claims for itself a body of knowledge, and that sociologists have sharply different perspectives regarding professionalisation. The functionalist tradition focuses on the special contribution of the various professions to modern society, based on their commitment and knowledge, maintenance of high standards of service delivery and collectivity-orientation (in contrast to self-orientation). The Weberian tradition understands professionalisation as a process of occupational control for the purpose of increasing the power and autonomy of an occupational group, and also of guaranteeing the scarcity of the service through monopolising the gatekeeper function, thus protecting its economic status.

Some in chaplaincy and pastoral care have advocated greater professionalisation and drawn upon the functionalist argument. They stress the importance of standards for the competence of carers as a protection for employing organisations and individual clients. The emphasis on standards of competence for pastoral care givers is shared by all of the major pastoral care associations in the British Isles, but the churches do not require it for their pastoral care.
A controversy in the sphere of pastoral care over professionalisation concerns the nature of those standards. The same role conflict we see confronting individual chaplains working 'between worlds' is writ large in the collective conflict over the legitimate reference group for standards. Chaplains might be perceived to be in the middle between the expectations of more secular professional groups within the health care organisation on the one side, and the expectations of the more theologically orientated religious communities on the other.

The professional role-partner groups exerting influence on the pastoral care community, of which chaplains are a part, are primarily health care managers and central Government who have generated a national framework of standards. The problem is that pastoral care (in this case) is a religious activity and therefore its special body of knowledge, to a significant degree, is religious knowledge, itself perhaps better described as a kind of wisdom centred on spiritual practice and experience. Religion in modern society is far from central, often misunderstood and highly pluralistic. In terms of standards, religion does not qualify as public truth (as medical science or legal knowledge do), but only as private belief - though of course clergy (and others) pass examinations and obtain qualifications in theology. According to this understanding, the religious content of pastoral care should not be made part of its professional standards or enter into questions of assessment. Under these constraints, pastoral care is hampered by pressure to marginalise the religious content. Here then there may be some role anxiety for chaplaincy in the development of itself as a distinct profession. It holds within it the material of conflict in both form and content. This conflict concerns the appropriateness of the role of religion, in relation to identity and to function.

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Influences from other directions, chiefly within the religious community want to pull pastoral care towards a more theological identity. Central to these expectations is the assertion that religious knowledge and understanding have the character of public truth. Pastoral care on this view, is part of a search for or a proclamation of Christian truth, and this is essential for adequate definitions of the care seeker's situation as it is in the care giver's role. Truth is understood here both as personal truth and universal truth.

Campbell (1985) argues that pastoral care, as conducted in a Christian setting expresses 'a love that seeks truth, while yet (being) conscious of the dangers of the judgmentalism that can impede that search' (Campbell 1985, pages 73-74). This viewpoint challenges pastoral care to resist the cultural hegemony of secular thought and invites secular agencies to consider questions of values and fundamental principles. Campbell believes that clinical pastoral education exemplifies the cultural captivity of professionalised pastoral care:

(CPE) tends to freeze pastoral care in the images of human need and distress created by contemporary depth psychology, without providing the means for demythologising the current world view, exposing its cultural and historical relativity and its inadequate imagery (Campbell 1985, page 81).\(^{10}\)

To resist secularising influences, Campbell urges pastoral care to sustain the sociology of knowledge perspective toward modern culture. He stresses the need for the formation of the pastoral care giver. Formation is a concept with strong roots particularly in the Roman Catholic tradition, referring to the preparation of future priests in Christian spirituality. Again, Campbell writes;

\(^{10}\) For a further comment on Clinical Pastoral Education see Chapter Five, section 5.2.7, Footnote 7, page 119.
formation entails not merely the acquisition of knowledge or the fostering of skills, but also the development of character. It suggests that a state of being must precede any action, any doing. It implies an holistic approach to those undergoing preparation, one that deals with their emotions, attitudes, and value commitments, so far as these related to the knowledge and skills required for pastoral care (Campbell 1985, pages 79-80).

Campbell believes the professional model for training pastoral care givers within a number of settings fails to provide a 'formation' experience, partly due to the separation of theological study and practical experience. Hauerwas (1981), Duffy (1983) and Mudge & Polling (1987), all emphasise 'formation' models of Christian life, pastoral care and care giver training.

These debates are relevant in that they find expression in the struggle over 'professional' and 'religious' identity which chaplains express for themselves in chapter six. They find particular expression in the tensions between being and doing, as chaplains reflect upon the nature and function of their work within health care institutions.

3.10 Conclusions

On the whole this general survey of sociological evidence goes some way to explaining certain issues which impinge upon how the health care chaplain may feel a measure of marginality and role anxiety. Briefly these are the factors which bear upon the data outlined in Part Two of this thesis and discussed in Part Three.

1. A strong emphasis on the autonomy of the clergy. One of the functions of the professional model is to provide a rationale for this, though it depends upon a continued adoption of a view of a
professional person which is deficient in this case. Attempts by health care chaplains at professionalisation strategies ought to be viewed within this perspective.

2. The reality of marginalisation can be interpreted in two main ways. One is to view the clergy as separate from the normal secular social structure, and therefore to project them as potential mediators between classes and groups in society (this accounts for a distinct self-understanding described by health care chaplains).

3. The other interpretation of marginalisation can be seen in the stress on liminality as the means of authenticating ministry and the associated holiness and 'merit' imputed to the clergy's separation in their calling from the mainstream of social life.
PART TWO

THE DATA
4.1 Introduction

It is not part of the task of this thesis to write a history of acute health care chaplaincy, still less to add anything to the considerable body of literature on the history of hospitals in England and Wales (Smith, 1964; Rivett, 1986; Granshaw and Porter 1989). It is, however, necessary to say something about the history of chaplaincy in order to see aspects of the present provision in perspective.

Religions and healing have often been normally closely related (Shells (Editor) 1982). Virtually every known human culture and faith tradition has not only sought to define health and illness, but has also offered tools for diagnosis and therapy. Not even the present-day ascendancy of 'scientific' medicine in advanced industrial societies has fully eclipsed the capacity of religious world views to attempt to throw light on physical and mental well-being, or the conditions that threaten it. Religions also remain a fertile source of moral, metaphysical and spiritual ideas for ways of responding to the ethical, personal and social problems which arise from the application of modern medical science (Pattison, 1989; Woodward, 1995). In addition to these fairly abstract contributions of religions to our ways of thinking about health, healing and illness, there are also intensely practical connections between religious organisations and health care.
In the Middle Ages there was a close relationship between 'hospitals' and the Church, ranging from provision by monasteries for the sick and elderly, to the special hospitals - the Lazar Houses - established in many places for the segregation and support of lepers, and to the hospitals charitably founded to care for the sick in their physical and spiritual need. Inevitably many of those in charge of mediaeval hospitals were priests or members of the religious orders founded for this express purpose, and there can have been little or no distinction between the medical or physical and spiritual care, the latter generally expressed in the Church's formal rituals for life and for dying and death (Pelling and Smith, 1991).

Many modern hospitals, in the UK for example, are direct descendants of these religious institutions; the healing arts of religious specialists laid some of the foundations for the medical profession; and the ethos of the nursing profession owes much to more recent religious inspiration (Bradshaw, 1994). This is not, of course, the entire story of modern medicine's origins. In fact, religious forces have sometimes obstructed the progress of scientific advance in relation to medicine (Lawrence, 1991).

As an example of continuity through change, two hospitals serving Londoners from the 12th Century - St Bartholomew's and St Thomas' - were brought to a temporary end by the dissolution of the monasteries and refounded as royal hospitals a few years later. In both cases, on refounding, a paid hospitaller was appointed who was to be in holy orders, and to be primarily responsible for providing religious ministrations to patients. In the case of the hospitaller at St Bartholomew's hospital, he was also responsible for food supplies, for looking after patients' properties, and for some medical work.
This illustrates the workaday approach to a priest's role in the hospital (Barry and James, 1991).

In the 18th Century, which has been referred to as the age of hospitals (Granshaw and Porter, 1989), when a great many now famous hospitals in London and the provinces were founded, it would appear that in all cases the founders were conscious of the duty to provide for the spiritual and religious, as well as the material or physical care of their patients. In some hospitals the chaplain was specifically appointed and his office endowed; in others a local clergyman was made responsible, with or without financial remuneration (Pelling and Smith, 1991).

The practice of appointing a clergyman to look after the religious needs of hospital patients became more widespread by the 19th Century. The first major legislation requiring the appointment of chaplains did not occur until the Lunacy Act of 1890\(^1\) when every mental hospital was obliged to appoint an Anglican chaplain. By this time Parliament had already attempted to regulate the position of Anglican chaplains in other types of hospitals by making them subject to the Private Chapels Act of 1871.\(^2\) This was the law which required whole-time Anglican chaplains to be licensed by their local Bishop, and part-time chaplains to be licensed for this particular purpose if their hospital lay outside their parish boundaries. These and other Acts of Parliament\(^3\) were important in locating health care chaplaincy firmly within the Church of England's organisational structure. They also helped to bolster the notion that chaplaincy was a regular, integral part of health care at a time when England

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\(^1\) 'History of the Appointment of Hospital Chaplains within the National Health Service' in

\(^2\) A handbook on Hospital chaplaincy

\(^3\) HCC 1987, pages 7 - 10
had a bewildering variety of public, private and charitable hospitals (Thompson, 1990). The great majority of chaplains in public hospitals were Anglicans. Roman Catholic priests and Free Church ministers tended to visit their own people or to be available in their local hospitals for members of their own churches on a part-time basis. They were not usually in a position to minister to the entire hospital (except in institutions run by their respective churches), and their claim to use hospital chapels was sometimes challenged, or not put forward in the first place.

4.2 The Nationalisation of Health Service Provision

Given the accumulated custom and practice, as well as the statutory framework for hospital chaplaincy which had evolved in the 19th century, it is not surprising that the early proposals and the legislation for a nationalised health service in the 1940s incorporated schemes which placed chaplaincy on an even firmer footing. The Government had given an undertaking as early as 1946 that hospital chaplains would be retained in the proposed National Health Service (NHS), and the Church Assembly had appointed a Hospital Chaplaincies Commission at the same time to enquire into the future status of chaplains in the soon-to-be-nationalised hospitals.4

The National Health Service Act, 1946, came into force on July 5th 1948 (Rivett, 1998). Under this Act, England and Wales were divided into 14 regions, each controlled by a Regional Board. In addition to these 14 regions, certain hospitals were placed in Teaching Groups,

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4 I am very grateful to the staff at the General Synod of the Church of England Archives Department at 615 Galley Wall Road, London SE16, for their assistance in giving me access to original correspondence between the Ministry of Health and the Archbishop of Canterbury’s office in Lambeth Palace between 1946 and 1952. This correspondence indicates that there was some considerable anxiety on the part of the Church of England about the effects on the provision of spiritual ministrations to hospital patients of the advent of the NHS in 1948.
under the control of Boards of Governors. These Boards were independent of the Regional Boards and dealt direct both with the Ministry of Health and with the hospitals under their control; but the other hospitals and institutions within each regional area were grouped under Hospital Management Committees responsible to the Regional Boards, which in turn were responsible to the Ministry of Health. The advent of the National Health Service, therefore, enabled standards to be set by the Ministry for the whole country. The Church of England seized the opportunity to lobby the Ministry of Health to set down how hospitals might provide for the spiritual and religious care of its patients. The interim reports of the Hospital Chaplaincies Commission in 1948 and 1950, as well as its final report of 1951, show how closely the Church of England monitored the proposals, the legislation and the emergent practices of the NHS which had come into being in 1948.⁵

The Commission’s final report states:

In October 1946, the Archbishop of York was assured by Lord Listowel, replying for the Government in the House of Lords, that “the maintenance of chapels and other expenses connected with the services will, of course, be part of the running cost of the particular hospital, and will be provided for in the annual budgets”; and in December of 1946, Mr Aneurin Bevan, the then Minister of Health, gave a similar assurance to a deputation led by the Archbishop of Canterbury. The Commissioners had the opportunity of many discussions with permanent officials of the Ministry of Health.⁶

The correspondence indicates that Bevan himself took a personal interest in these evolving conversations and twice gave assurances to the Archbishop of Canterbury that he felt it was vital for each

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⁵ Church of England, Church Assembly, Hospital Chaplaincies Commission, Final Report CA1003, August 1951.

⁶ Hospital Chaplaincies Commission, Final Report, CA1003, August 1951, page 2.3. Chapter Four. page 88
hospital to have a chaplain working in it.\textsuperscript{7} While for the most part these negotiations were formal, in that they attempted to establish a framework of terms and conditions for chaplains, a picture emerges of a widespread acceptance that the majority of staff and patients would have some allegiance to the Church of England, which would thereby endorse the appropriateness of Anglican chaplaincy in hospitals. One small point of discussion is worth noting here. It relates to the understanding of ministry within the Church of England during this period. It is clear that there was some resistance from Lambeth Palace to promoting chaplaincy as a professional alternative to parochial ministry. The reasons for this resistance are not evident, but they seem to be related partly to possible financial disparity with the parish clergy and the latter's possible disparagement. However, the Archbishop's Office at Lambeth Palace resisted the suggestion that clergy, as a professional class within the hospital, ought to be paid at the same rate as hospital consultants.\textsuperscript{8}

There is also an interesting contemporary comment about the role of the hospital chaplain which is worth noting here because it will be a significant theme in the thesis. At the summer session, 1948, of the Church Assembly, the Hospital Chaplaincies Commission presented an interim report (CA 871). In an attempt to define the duties of a chaplain it states:

\textsuperscript{7} October 1946-August 1950, correspondence with Ministry of Health and the Bishop of Ely on behalf of the Archbishop of Canterbury. It is not clear why Bevan felt it was important for each hospital to have a chaplain and what influenced this conviction.

\textsuperscript{8} Correspondence between the resident chaplain of Guys Hospital and the Bishop of Ely: 'I am told by an officer of my own hospital that the chaplain as a professional man, can only be compared with the medical staff, and that the status that is usually accorded to him is that of a hospital consultant.' (The Revd. W D Giddey, 17th August 1950). - General Synod Archives, London.
Without laying down any specified time limit, unless a chaplain has a special occasion, he should not remain too long in hospital service. In a hospital the chaplain sees most of his flock for only a short time, and has little or no opportunity for developing his ministry. In the development of a structure for terms and conditions for chaplains, care must be taken to ensure that clergy do not opt for hospital service as an alternative to the mainstream work of the Church in parishes.⁹

A series of Circulars issued by the Ministry of Health in 1948¹⁰ advised Regional Health Authorities, Hospital Management Committees and Boards of Governors (of teaching hospitals), that they should provide for the spiritual needs of patients and staff, set aside a room for a chapel and appoint a chaplain or as many whole-time and part-time chaplains as would be required to serve each hospital, subject to overall ratios of roughly one whole-time chaplain for every 750 in-patients.¹¹

Further assumption of the widespread allegiance to the Church of England among health care staff is indicated through the instructions in the Circular to hospitals to do everything possible to arrange the hours of duty of nurses and other staff so they can attend services in the chapel. Elderly retired nurses still recall well-established religious observances and routines in which they participated under the guidance of the chaplain, as part and parcel of hospital life (Bradshaw, 1994). This may also indicate a vestige of the links between the care of the sick and religion referred to above. It is interesting to note at the end of this section that this agreed framework was in place and regarded as a general ruling until 1977.¹²

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¹⁰ HMC (48) 62; BG (48) 65; RHB (48) 76.
¹¹ This condition was relaxed in the case of teaching hospitals and hospitals which had employed whole-time chaplains prior to nationalisation.
¹² A Handbook on Hospital Chaplaincy, 1987, page 10
This relates to the discussion in Chapter Three of both professionalisation and secularisation. As the populations' allegiance to the Church of England has weakened, the chaplain's role has become less understood and therefore more marginalised. The chaplain has been less able to rely on being regarded as standing on an equal basis as the doctor with an appreciation of their status and role by nurses and other health care workers.


In 1962 a working party was set up by the King Edward's Hospital Fund for London, ... to consider the role of a chaplain in hospitals of all types, the qualities and training desirable to fulfil it and to make recommendations. This working party was chaired by Mr Selwyn Taylor, Dean of the Post-Graduate Medical School of London, and a consultant surgeon at the Hammersmith Hospital. It consisted of twelve members from a very wide range of groups and religious denominations, including the Jewish community.

The Report, A King's Fund Report on the Hospital chaplain: An enquiry into the role of the hospital chaplain, consists of four parts. The first describes the role of the chaplain in relation to the patients and staff, and in the provision of religious services in the hospital chapel. There is a widespread recognition of the importance and significance of the chaplain's role in the delivery of health services in the hospital. It is interesting that in three pages of the final chapter of Section 1, the Report describes the importance of training for chaplains. This reflects the growing corporate identity of hospital chaplains in the country through their annual conference at Oxford,

13 published by the King's Fund, London, 1966
and indeed, the fact that many significant figures who were to shape chaplaincy during the next two decades (for example, Norman Autton) were to remain in hospital service as a long-term vocational alternative to parochial work. The Report also seems to indicate a growing interest during the early sixties in co-operation between ministers of religion on the one hand and members of the medical profession.

A conference at Lambeth Palace, held at the invitation of the Archbishop of Canterbury in 1962, saw the foundation of the Institute of Religion and Medicine, and a number of courses heavily used by hospital chaplains were being developed in health-care focussed pastoral studies and care (for example, the Diploma in Pastoral Studies course at the University of Birmingham, and the Pastoral Clinical Training Programme organised at St George's Hospital, London, by Norman Autton).

The second part of the King's Fund report provides practical advice about supporting the chaplain in his work through a further clarification of the process of appointment and the necessity for appropriate provision of chapel, chaplaincy rooms and voluntary assistance for the chaplaincy service in the hospital. Many of the recommendations are practical in their focus and serve to secure further and develop the role of the hospital chaplain in the National Health Service. It is clear from Hospital Chaplaincies Council Annual Reports\(^\text{14}\) that the Report had some small measure of success in clarifying the role of the chaplain and encouraging hospitals into more effective communication and collaboration with chaplains. The final two parts provide resource material of useful

\(^{14}\) CA1656 Hospital Chaplaincies' Council Annual Report 1967 (787) 

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contacts, addresses and further reading for chaplains.

Two other reports which attempted to achieve similar objectives are worth noting here. (It is not clear what the relationship of these three reports is to each other because they all three cover much of the same ground.) In 1965 the Bishop of Lichfield, Chairman of the General Assembly of the Church of England Hospital Chaplaincies Council (GAHCC), and also a member of the Birmingham Regional Hospital Board (BRHB), arranged a working party in that region. The Secretary of the group was Ken Povey (then Assistant Secretary of the BRHB and himself a member of the GAHCC). The group produced recommendations on hospital chaplaincy in a booklet *The Hospital Chaplain* which was the nearest thing so far available to a handbook for chaplaincy. This was used by the Department of Health and other regional Boards. It is interesting to note from this report and the Tunbridge Report (described below), that many senior church figures had good personal relations with influential administrators in the health service. This clearly had an effect upon the support and encouragement of hospital chaplaincy during this period and beyond.

In the early 1970s, following the introduction of 'Salmon structures for the nursing profession' and ahead of the proposed 1974 changes in NHS management (Rivett, 1998), the Bishop of Lichfield, then Chairman of the General Synod's (the former Church Assembly) Hospital Chaplaincies Council, and Ken Povey, now training officer of the BRHB, invited representatives to a consultation hosted by the BRHB.

15 Published by Birmingham Regional Health Board, 1967 as The Hospital Chaplain. Chapter Four. page 93
From this meeting came the first attempts at a working party to unite the variety of organisations involved in chaplaincy to produce an agreed handbook and policy on chaplaincy. The working party, chaired by Sir Ronald Tunbridge and under the direction of Mr Bernard Law, a former NHS administrator, who had become Secretary of the Hospital Chaplaincies Council in 1972, was convened and published its full report to the General Synod in 1973. Again this provided a useful handbook explaining with some clarity the nature of chaplaincy and the role of the chaplain within the hospital. In many ways the Tunbridge report was a significant political attempt by the Hospital Chaplaincies Council to secure chaplaincy in the NHS structures:

the Council believe that what the working party is proposing are the logical consequences of tendencies that have grown up and been developed since 1948. They believe that the new National Health Service structure provides opportunities for this to be developed further in the ways suggested, and for experiments to be tried. ... The Council will initiate discussions with the Secretary of State for Social Services, with a view to their implementation in the new National Health Service in 1974.

It is clear that these three reports offered little new advice to hospitals, but in them there is a steady securing of chaplaincy within the structures of the Service, and the development of an appreciation of the role of the chaplain. The Tunbridge Report acknowledges progress in its review of the NHS’s first twenty years of operation and put down implicit markers for the services impending reorganisation in 1974:

The most important change effected in 1948 was that the chaplain was paid for his work, and was paid by the State from money provided by Parliament. His position in the hospital was recognised and the importance of that position emphasised. The number of official chaplains increased because every hospital was required to appoint them, rather

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than the spiritual ministry of patients being left - as it was in some cases before 1948 - to the perhaps changing goodwill of local Church and hospital.\textsuperscript{18}

4.4 The 1980s. A Steady Development of Chaplaincies in the Health Service

The next decade marks a significant institutionalisation of chaplaincy within the very structures and patterns of the Health Service. Although the Ministry of Health (followed by the Department of Health and Social Security (DHSS) and the Department of Health) subsequently revised its advice on chaplaincy several times, the basic framework for appointments, remuneration, payment of fees for training chaplains and use of chapels remained in effect until the mid-1980s.\textsuperscript{19} Whole-time chaplains' numbers had been increasing only slowly since the early 1970s, and plans for new hospitals constructed on the nuclear design ruled out 'full inter-denominational' facilities because of the high costs involved. By default therefore an Anglican dominance continued within hospital chaplaincy appointments, in spite of the high ratio of Roman Catholic patients in some areas, or indeed, in cities like Birmingham, very significant numbers of people from other faith communities (Beckford and Gilliat, 1996).

In 1982 the General Synod Hospital Chaplaincies Council received an invitation from Roderick Pickes of the Training Directorate of the NHS to mount a consultation to consider the future shape of

\textsuperscript{18} Church of England, General Synod, Hospital Chaplaincies Council, \textit{The Hospital Chaplain}. (London, Church Information Office 1973, page 5).

\textsuperscript{19} See \textit{Handbook on Hospital Chaplaincy}, London, Hospital Chaplaincies Council, 1987. This Handbook outlines the relationship between the National Health Service and the Churches. It provides a framework of the conditions of service for hospital chaplains and gives practical advice to hospitals about how to provide the necessary support for chaplains to fulfil their duties. It also addresses the issue of the relationship of Christian denominations and 'non-Christian faiths' (pages 52-55) and chaplaincy training (page 67-71). There are also historical and pastoral essays on chaplaincy (pages 7-25; 74-88).

\textit{Chapter Four. page 95}
chaplaincy in the light of the NHS Management changes. In what might be regarded as a watershed in the history of chaplaincy, a meeting was held at the NHS training headquarters in Harrogate. Luke Gormley of the Roman Catholic Centre for Ethics gave a paper on theology and medical ethics, and Roderick Pickes acted as the NHS consultant. The main result of this meeting was the setting up of a working party on new criteria, which became part of the only document on the subject officially endorsed by the National Health Service - *Handbook on Hospital Chaplaincy*, published by HCC in 1987. It also hastened the amalgamation of the Church of England and Free Church Hospital Chaplains Fellowships which, together with the Whole-time Chaplains Association, were to become the basis for a new organisation set up in 1990, the College of Health Care Chaplains.  

1984 is the date when the DHSS implicitly acknowledged that the original criteria for deciding whether the appointment of whole-time chaplains was justified and how to make an appointment had been too restrictive. In 1984, advice to Health Authorities (PM(84)10) to consult the Joint Committee for Hospital Chaplaincies' *Advisory Notes on the Criteria for the Appointment of Hospital Chaplains*, when they were considering the appointment of whole-time chaplains, indirectly resulted in an increase of roughly 50% in the number of whole-time chaplains in the following few years. The number of

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20 Information from the Revd Robert Clark, Chief Executive of the Hospital Chaplaincies Council in a conversation, June 1993

21 The Church of England and Free Church Hospital Chaplains Fellowship were a national organisation with local branches throughout England and Wales. They produced a newsletter which developed into a journal and from 1961 held an annual study conference. The whole-time chaplains Association was established in 1973 as an attempt to have a 'chaplains' Trade Union' and negotiated terms and conditions with the Whitley Council of the NHS and with the Hospital Chaplaincies Council. The College of health care chaplains was set up in 1992 amalgamating these groups into a new body. It had sub-branches (based on Regional Health Authorities), an annual subscription, a Journal and an annual study conference.
whole-time chaplains in England rose from 183 in 1984 to 266 in 1990.22 Nevertheless, the new criteria did not change the fact that nearly all whole-time chaplains continued to be recruited from the Church of England, while the 4,500 or so part-time chaplains were divided fairly evenly between the Church of England, the Roman Catholic Church and the Free Churches.23 It is interesting to note that despite the fact that the population of England and Wales already contained sizable communities of Hindus, Jews, Muslims and Sikhs, there were few signs that hospital authorities were seriously considering ways in which pastoral and religious care might be provided for members of these faith traditions in health care organisations. It is also interesting to note (a theme to be developed later in the thesis) that, despite the gradual decrease in the numbers of those having any formal links with the Church, and the developing secularisation of culture, the numbers of paid clergy in the National Health Service continued to rise. It is not clear what the reasons for this increase are. This will be addressed and discussed at a later stage of this thesis.

4.5 The 1990s and NHS Re-organisation

Despite the considerable upheaval within the structures and culture of the National Health Service during the late 80s and early 90s, chaplaincy continued to develop itself into a body which could clearly define the nature and function of its work, committed to audit, evaluation, skills training and professional development.

22 The HCC Annual Report to the General Synod for 1985 included the following quote from an article published in the Health & Social Services Journal on "treating mind, body and soul": "which group of NHS staff has doubled its numbers over the past 10 years, scarcely raising a comment from the public and government? Which group of staff did most patients in a survey say they would like to have consulted while in hospital? Which staff work a 16-hour day on a public holiday, regardless of whether the hospital is full or not? Answer: hospital chaplains".


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The roots of the most recent and far-reaching transformations of the NHS can be traced to late 1987 when the government announced an extra allocation of £101 million to meet acute needs in many areas of health care. The in-depth review of the NHS which took place in 1988, and which echoed many of the ideas generated by an earlier Working Party to examine alternative ways of financing the increasingly costly NHS, laid the foundations for the White Paper *Working for Patients* published in January 1989. In addition to preserving the principle that most funding for the NHS should continue to come from taxation, the White Paper proposed to create 'internal markets' in health care by, for example, stimulating competition between the providers of health services, and by turning GPs and Health Authorities into purchasers of hospital services. It also permitted hospitals and other services to opt out of direct control by Health Authorities and to become self-governing NHS Trusts. The main aims were to enhance the scope for choice, to increase efficiency, to allow the market to force down costs in the face of competition, and to make medical staff more accountable to health care managers. At the same time the White Paper *Caring For People* (1989) proposed parallel changes in arrangements for primary health care, particularly in the provisions for Local Health Authorities to become purchasers of care from a variety of service providers. The National Health Service and Community Care Act of June 1990 translated most of these proposals into law, despite opposition from the British Medical Association and other Health Service workers and patient groups. The implementation of the proposals after April 1991 had to be phased in more slowly than the Government had intended because of concerns about the financial situation of some Health Authorities.
Another important influence on the recent evolution of the NHS was the creation of the Office of Public Service and Science and, within it, of a Citizens’ Charter Unit to monitor the extent to which Government departments complied with the aim of making agencies of the State more responsive to citizens’ needs. In other words, this was an attempt to improve the quality of the service that citizens received from the State. As part of this initiative, the Patients’ Charter (launched in 1991) laid down patients’ standards of care and targets for health care providers to achieve, and ways of assessing the performance of the NHS.  

This background is significant because despite the rapid change and the insecurity within the Service, dominated by financial constraints, the first of the nine national standards in the Patients’ Charter specifies: ‘... respect for privacy, dignity, and religious and cultural beliefs.’

Allowing for all the changes that have taken place in the ideological tone and the public relations sensitivity of Government publications since the creation of the NHS, and the establishment of chaplaincy as part of the Health Service, the language of Standard One of the Patients’ Charter, represents some significant shifts in the Government’s view of how what it called ‘spiritual needs’ of staff and patients in health care should be met. Religion was no longer confined to what chaplains provided. It was presumably incumbent on every NHS employee to show respect for religious beliefs. No distinction was made between the standards of respect demanded for Christian and non-Christian beliefs. Indeed the press release which

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accompanied the Department of Health's guidelines issued in January 1992, on 'meeting the spiritual needs of patients and staff: good practice and guidance'; made much of the fact that the new guidelines made explicit for the first time the need to provide for the needs of patients of all religions. It is also important to note that the Department of Health did not consult the Hospital Chaplaincies Council or the Church of England when it produced this document. This led to correspondence between the Bishop of Exeter, Chairman of HCC, and the Department of Health.

Now that most NHS self-governing Trusts have had a few years in which to work out their new status, there seem to be two main ways of interpreting the implications of Health Service re-organisation for chaplaincy, and, more particularly, for relations between Church of England chaplains and members of other faiths. On the one hand, there are grounds for thinking that the NHS Trusts have tended to give whole-time chaplains, most of whom are Anglicans, more discretion and more control over the work of chaplaincy teams than they previously had under the DHSS's dispensation. This hypothesis appears to have the support of the HCC:

The overwhelming number of Trusts now require that the whole-time chaplain, in addition to discharging the particular denominational duties for patients, relatives and staff, also assumes the responsibility for managing and co-ordinating all the Trust's chaplaincy services. This includes holding, and bidding for, the chaplaincy budget, making local arrangements on performance-related pay, being subject to the routine staff appraisal system, and providing in-depth information locally for the Trust on all areas of spiritual care for Christian and non-Christian alike.

It is important to acknowledge that NHS trusts are not obliged to

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25 [HHS(92)2].
26 Hospital Chaplaincies Council Annual Report, 1993
have chaplains at all. While there is some recognition of the need of hospitals to meet the spiritual needs of patients (NAHAT, 1996) there is no statutory obligation to employ a chaplain.

On the other hand, though practical effects are so far small-scale, managers are within their rights to seek to achieve an appropriate fit between local circumstances and local arrangements for spiritual care by providing non-Christian spiritual care without the mediation of Christian chaplains. This new situation is significant in the present context. Though there is a widespread assumption that the increase in chaplaincy appointments means a further securing of chaplaincy within the National Health Service, there are indications that, given the context of health care in Britain today and the official policies governing it, chaplaincy is open to radical change, and this is borne out by the interviews with chaplains in Chapter Six.

It is only from about 1988 that the Church of England, by way of the General Synod and the Hospital Chaplaincies Council, has come to realise that to be effective in the Health Service it must work co-operatively with all churches and organisations involved in chaplaincy, and this realisation has led to the establishment of the Ecumenical Joint Committee for Hospital chaplaincy, with Free Church and Roman Catholic representation. However, the most significant move in the 90's has been the establishment of the College of Health Care Chaplains, as an attempt to form an umbrella organisation which would represent chaplains and develop training on an ecumenical basis. In addition to these co-operative structures the Free Church Federal Council has a Hospital Chaplaincies Board

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28 Some Chaplaincies now describe themselves as 'Departments of Pastoral, Spiritual and Religious Care' for this reason (Olumide, 1989; 1994).

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secretary who works for the Free Churches in their appointments to hospitals and Trusts while the Roman Catholic Church works through local Bishops. The result is some considerable fragmentation and poor communication between respective bodies. The Executive Officers from the various groups are beginning to meet for the informal exchange of information on the immediate plans and problems of the respective organisations. At the time of writing there continues to be some significant fragmentation of a different kind as the College of Health Care Chaplains attempts to develop its professional base by seeking Union status, so that it can negotiate on behalf of chaplains with Trusts. These diverse groups have to address the structural challenge to work together to enable subjects requiring a response to outside bodies (Department of Health, Trust, etc), which are common to all organisations, to be co-operatively and simultaneously handled by all chaplaincy bodies. Changes in contemporary NHS management systems, together with developments within churches, will force all chaplaincy bodies to seek new ways of providing, selecting, servicing and training chaplains for the NHS in the future.

However, despite these developments, there continues to be a sharp rise in numbers of hospital chaplains. The number of full-time chaplains in England and Wales has risen from over 266 in 1990 to 320 in 1996, while salaried part-timers have more than doubled from around 600 to 1,500. This fact was reported in the Health Service Journal. The Revd Robert Clarke, Chief Executive of the Anglican Hospital Chaplaincies Council, made this comment:

Chaplains were spending less time on religious duties and more on broader roles, such as support for stressed staff. Since the reforms, Trusts have chosen to employ their own

chaplains, but demands have also burgeoned.

In an editorial in the same issue of the *Health Service Journal* a thoughtful comment upon the role and function of the chaplain in today's Health Service was provided, making the following contrast:

On the eve of the NHS reforms, hospital chaplains were a worried breed. In the face of the Department of Health's resolute refusal to guarantee the future of chaplaincy, they remain skeptical at managers' assurances that Trusts would not neglect spiritual matters in the new, harsh business-like NHS. They saw support services being cut back, and reasoned that as their work was not quantifiable in material terms, they would soon fall victim to the tyranny of the bottom line.

However, the editorial goes on to point out that the numbers have increased and presents the following conclusion:

We should not detract from the achievement of chaplains themselves. They have been quick to adapt to changing times, mostly undaunted by the demands of writing business plans and managing budgets, enthusiastic to embrace the challenges of the modern NHS, no longer as 'purely religious functionaries'. Their success is a tribute to their commitment and integrity. But the most important development in their role is the service they provide to NHS staff ... major organisational change, coupled with burgeoning demands on services with limited resources, have taken their toll on staff and their morale. Helping with the consequences of that may become the chaplain's main preoccupation for the next five years.30

### 4.6 Multi-Faith Joint National Consultation. October 20th and 21st 1997

This consultation was organised by the Revd. Robert Clarke of the Hospital Chaplaincies Council in order to reflect upon the provision of chaplaincy and spiritual care within the National Health Service. Its aim was to put chaplaincy onto the agenda of the new Labour Government and ascertain something of the future vision of health care in the U.K. It is significant to note that representatives of all

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faith communities were included in this consultation. These representatives were from Jewish, Bahá'í, Hindu, Islamic, Buddhist, Roman Catholic, Anglican and Free Church communities.

It attracted three main keynote speakers - Baroness Flather spoke on 'The vision of and respect for the philosophy and spiritual values of Britain in the multi-racial/cultural/religious society of the 21st Century'. The Secretary of State for Health, Frank Dobson, explored the government's philosophy behind NHS provision. The Chief Executive of the NHS, Alan Langlands, addressed the conference on what present government policy means for the organisation of the NHS and how spiritual care of NHS patients should be planned for the future.

The outcome of the conference was inconclusive. It was agreed that all faith communities need to work together to follow up the planning of the provision of spiritual care. At the time of writing it is envisaged that faith communities will work together in the re-drafting of HSG(92)2, 'Meeting the spiritual needs of patients and staff' in the light of the consultation discussions.81

4.7 Conclusion

In tracing the recent history of chaplaincy a number of key issues have emerged which will be developed further in this thesis. In particular, we note the special historic and contemporary links between religion and healing which have developed into a particular investment in the role and function of the chaplain in a hospital.

81 Conversation between the author and a council member of the College of Health Care Chaplains, July 1998.
Since the establishment of the National health Service in 1948 there has been a steady increase in the number of chaplains employed by the Health Service and after 1990 by Health Care Trusts. During the decade 1962-1973 a number of reports established with some clarity the role of the chaplain and this was both understood and affirmed by both the Churches and the Health Service. This was built upon in the decade leading up to NHS reforms (1980-1990) when a national system of advice on appointment, remuneration, fees for training and the use of chapels was widely accepted and used, enabling chaplains to secure further secure and to develop their position and role.

The NHS re-organisation provided a further opportunity for chaplaincy to adapt to a change in circumstances and the number of appointments increased. The precise reasons for this are unclear but there is some indication of the value of chaplains in the management of change through staff support.

The next chapter will examine what chaplains have written about, who they are and what they do.
5.1 Introduction

An understanding of acute health care chaplaincy in historical perspective is closely related to the ways in which chaplains have written about who they are and what they do. There follows a comprehensive summary of the published work on acute health care chaplaincy since the establishment of the National Health Service in 1948. This chapter divides into three main parts. The first part will describe and assess the main contributions to the literature in this area. The second part will draw out and summarise issues explored in the Journal of Health Care Chaplaincy from 1961 to 1996. The third part will discuss the main themes emerging from this literature.

5.2 PART ONE: Directive Literature and Reflective Literature

In broad terms the literature in this area falls into two categories. The first consists of works that have the character of handbooks in which chaplains describe the nature, role and function of their work within the context of an acute hospital. The second category consists of works that attempt to take a broader view and reflect theologically and politically upon the nature of health care chaplaincy and its relationship to personal, professional and educational development. The works of Cox (1995), Autton (1968, 1982) and Speck (1988) are discussed in this part as providing examples of the chaplaincy handbook as directive literature.
5.2.1. Cox: ‘A Priest’s Work in Hospital’

In 1955 Cox edited a handbook for hospital chaplains and others of the clergy who visit hospitals. This handbook of hospital chaplaincy remained an important introduction to the whole area for over ten years. It certainly influenced many subsequent publications, not least the work of Autton and Speck. It also provided the framework used by the Hospital Chaplaincies Council of the Church Assembly, and then the General Synod of the Church of England for their editions of A Handbook of Hospital Chaplaincy. There is in Cox’s handbook a clarity about the role of the chaplain as communicating faith to people in hospital. In other words, in his day, Cox had confidence in a knowledge base. The book gives comprehensive information for chaplains and constantly reminds the reader that hospital chaplaincy demands particular skills and is not an ‘opt-out’ from the pressures and difficulties of parish work. There is a strong affirmation of the influence of Christian belief on society and the ways in which it shapes the culture of the hospital. Within it however, despite this sense of the widespread acceptance of Christian faith, the group indicate the threats to their role from the development of psychological medicine and the difficulties of proving whether ‘a clergyman’s visit could be of much benefit’ (Cox, 1955, page 74).

An implicit agenda of the book arises out of a desire to encourage and affirm the place of religion in the modern health service on the one hand, and to fulfil the need for chaplains to understand the hospital, its functions and how they work within it on the other. These are major themes in this chapter of the thesis.

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2 J G Cox, A Priest’s Work in Hospital, London SPCK 1955. Cox was a retired chaplain having previously worked as chaplain of Horton and the Manor Hospitals, Epsom. He acted as the editor of this book on behalf of the Church of England Hospital Chaplains Fellowship, assisted by the Revd. D.H. Boyling, Chaplain of the United Sheffield Hospitals. The Committee who produced the book consisted of six hospital chaplains.
The opening chapter of Cox’s book describes the theology of the chaplain’s ministry. The author argues that the chaplain is the theologian in the institution, ‘interpreting the hospital to itself’ (Cox, 1955, page 1). It follows that if professionalism flounders as discussed in Chapters seven and nine, it may be recent (as far as consciousness goes) because articulate clergy (like Cox) were in 1955 confident of their theological expertise. Some of the surveys discussed in Chapter 3 have as their focus non-theological and non-religious factors. It follows that they do not fully take into consideration what for many was the key to and centre of the clerical role expressed here in Cox: the chaplain as religious expert. The context of this interpretation is a static, fixed and absolute sense of a Christian truth and all interpretation and experience are weighed in the light of this lasting unchangeable truth. It follows then that the chaplain’s role is to enable patients to understand themselves and what is happening to them in the light of Christian belief about evil, suffering, health, death, healing, destiny and redemption. Each of these themes is considered in the context of health care chaplaincy, drawing upon theological writings of William Temple, O.C. Quick and E.L Mascall.

The health that the priest is concerned with is the right function of the soul towards God, by means of the theological virtues infused in baptism (Cox 1955, page 11).

The part of the physician (and surgeon) is not to “heal” in the transitive sense, but to facilitate or remove obstacles to the action of the soul (Cox, 1955, page 15).

It becomes clear from this theological chapter that the task of the chaplain is to bring people to faith or to nurture faith already held. Priests see themselves as religious experts.

Chapter Two describes the place of the chaplain in the life of the hospital. It sees the work in terms of a priest caring for and even
presiding over the hospital community. The text assumes a
stability of the community in which it is possible to build up long-
term relationships with both staff and patients. Within this
context the priest stands for God, pointing towards the meaning of
sacrifice to the glory of God (Cox, 1995, page 45). The priest
listens because

A hospital, in the Christian view, must serve the patients
for their own sake - or more correctly, for God's sake whose
creatures and servants they are - not for any other reason
(Cox, 1955, page 46).

The priest is to help the patient understand what God is doing to
and for them in their experience and to mediate God through
prayer, scripture and sacrament.

The core of the book provides a clear description of the place of
chaplains in the health service, and how hospitals work. It goes
on to offer practical advice to the chaplain about various aspects
of ministry, including Communion, work with sick children, the
elderly, the mentally ill and finally in Chapter Nine the work of the
chaplain with the staff. While there is a comprehensive and clear-
sighted understanding of aspects of the particular chaplain in
context, his role is described wholly in terms of a religious
functionary, and the framework is theological and overtly religious.

5.2.2. Other Handbooks: The Sheffield and Birmingham Guide

Cox's guide or handbook provided a template for other subsequent
publications. In the next decade, both the Sheffield Regional
Hospital Board and the Birmingham Regional Hospital Board
produced similar summaries of the nature of acute health care
chaplaincy. The central feature of these publications (written
before sensitivity to gender language was common) is the clarity

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3 Sheffield Regional Hospital Board, Anglican Chaplains Advisory Committee, A Guide for Hospital

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with which the chaplain's function is described.

He sets the healing work of the hospital in the context of God's providential plan for making men whole. He brings to the patient the knowledge of the love of his Creator through the ministry of word and Sacrament (Birmingham Regional Board 1967, page 6).

Both guides have the same table of contents and this includes a description of the hospital and how it is organised; how a chaplain is appointed and what facilities they need to function; how a chaplain's pastoral ministry takes shape (with, for example, sick children, the elderly and long-stay patients). It also concludes with a list of agencies to which the chaplain might refer, for example, the Churches' Council of Healing and the Guild of St Barnabas for Nurses.

5.2.3. The Work of Autton

During the 1960s Norman Autton was a significant figure in both the political arena of the Hospital Chaplains Fellowship and the Hospital Chaplaincies Council as well as in the training and fostering of chaplains. In 1968 he published Pastoral Care in Hospitals, in a series published by SPCK called The Library of Pastoral Care. With this volume Autton established and developed his reputation as a leading authority in chaplaincy. When the book was published he held the post of Director of Training of the Church Assembly Hospital Chaplaincies Council. It followed previous books by him in the same series: The Pastoral Care of the Mentally Ill and The Dying and the Bereaved. The 1968 volume is aimed at hospital chaplains and is an updated version of Cox in providing a practical handbook set out in eight chapters and four appendices. Autton's aim is to secure for the hospital chaplain a recognised and respected place, based on professional standards in the teamwork of the hospital.
Chapter One opens up the roles and the functions of the chaplain by exploring the question, 'What does chaplaincy involve, and what does it mean?' Autton believes that the chaplain must have a clear and well-defined sense of the task in a developing of professionalism through the demonstration of skill. The function is described in clear and unambiguous theological language as being ‘To show (to the patients) the Christ already at work in them in their midst' (Autton, 1968, page 2). He argues that 'the priest is called and set apart by God, to pray and to give meaning to existence, by making God real and relevant. The priest describes the function of reconciliation and interpretation in terms of binding up the brokenness of human existence' (Autton, 1968, page 2). The priest stands for something other and different: his task is to watch, talk, pray and listen. Autton is anxious to clarify the distinctiveness of the role as he compares the chaplain's ministry with parish ministry. He goes on to compare and contrast general and psychiatric hospital chaplaincy.

In the main section of this chapter Autton discusses the concept of pastoral counselling by describing in specific terms the art of pastoral conversation, the art of communication, the art of asking questions, and the art of listening. This section reflects the author's experience and is practical and pragmatic. Autton describes clearly what a chaplain should know in order for these tasks to be executed. This knowledge includes the following areas: spirituality, theology, psychology and sociology. Further, the chaplain should know the patient, the problem and the pain. This knowledge base opens up into a prescriptive list of what the chaplain should do: care, comfort, challenge, relate, refer and respond. The chaplain should have confidence, compassion,

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4 The concept of professionalism is used here to denote a skills or trait approach to chaplaincy. Autton might be regarded as the first innovative voice in the development of a skills approach to chaplaincy which generates specific training needs. This issue is discussed in Chapter Three. Chapter Five. page 111
courtesy, patience and love, and should be available and sensitive to the needs in the present acute health care context.

Autton's work, both in this book and in the training courses that he developed, is an important watershed in the development of chaplaincy self-understanding. He managed to hold together both theory and experience, as this text demonstrates. It shows a reflective practitioner at work. The complexities and problems are overcome, in part, Autton argues, if the chaplain is clear about his identity. There follows from this a clarity about the values and the activities that are shaped by them. Undergirding the text is both an appreciation of the range of complex experiences that the chaplain faces, and helpful theological and psychological theory.

Autton goes on to describe the chaplain's ministry to staff and the institution pointing towards the possibilities of work and cooperation with the medical, nursing and administrative staff. He demonstrates his sympathy for the range of complex decisions and choices medical staff have to make, though the book is placed in social and historical context by the comment 'The chaplain is to be invited to say prayers at the commencement of meetings of the Board of Governors' (Autton, 1968, page 60).

Autton's own contribution to the development of chaplaincy lies in Chapter Seven as he explores the chaplain and his training. Autton sets out the importance of training, reflecting his own key national position in the field of hospital chaplaincy. He argues for the clinical training of priests under supervision in a system where most chaplains were to work as an assistant in a large hospital before appointment to a senior post. Autton describes appropriate training in the following way: 'An integrated programme of both theory and practice, individually supervised by an experienced

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Against this background Autton frames some questions to help shape the training: ‘How do the staff function: Who are they?’ ‘How the patient functions: Who are you?’ ‘How the chaplain functions: Who am I?’ While much of the language of this book is critical and theological, Autton foreshadows later developments that would breathe a different spirit, in the following reflections (in reference to the work with staff): ‘Learn some of their language so that a meaningful dialogue can take place (it is equally important, of course, for them to become familiar with his!)’ (Autton, 1968, page 116). ‘It is in the inter-disciplinary relationship that the chaplain will search for his own identity’ (Autton, 1968, page 120).

The chaplain however has a special claim to power (i.e. God): ‘It will be for him to remain aware of the ultimate concerns of a power that not only completes them (concerns of the staff), but also transcends them’ (Autton, 1968, page 121).

The theological framework is made absolute and clear:

Such questions cannot be studied apart from the basic understanding and affirmation of the basic Christian doctrines of God, man, sin and salvation, and the whole theology of sickness and suffering. The chaplain cannot be of help until he understands the use of and meaning of such theological concepts in human existence (Autton, 1968, page 117).

Autton has adopted some of the insights of psychology, sociology and counselling (1968, page 13 and Chapter 7 ‘The Chaplain and His Training’) but he is still fundamentally the Sacramental man. The chaplain prays on behalf of all those who do not pray and ‘operates’ an altar:
At the altar all his ministry will find fulfilment ... He will bring to the altar the work of the surgeon operating on the heart of a young child and at that precise moment he becomes as vital a member of the theatre team as those who stand before another table where life new is being given and blood shed (Autton, 1968, page 128).

For Autton the chaplain is set apart, 'separated and unique' (1968, page 2). The chaplain is a professional (a pray-er) man with 'remedies' (1968, page 2) and confidence because he knows exactly why he is there. It is possible to conclude that Autton virtually subsumes medicine beneath the chaplain's sacramental role.

Autton describes what the chaplain needs in himself to perform the functions that are described in his book. The list of qualities is idealised and prescriptive; the chaplain must be physically strong, socially adaptable, ecumenically flexible, emotionally mature, mentally alert, theologically sound, and spiritually alive!

Autton's influence over the development of health care chaplaincy was exercised as the Director of Training for the Hospital Chaplaincies Council from 1967 to 1972 and then whilst at the University Hospital of Wales in Cardiff from 1972 to his retirement in 1985. He continued his links with the Hospital Chaplaincies Council and initiated a number of training courses for theological students and clergy. He trained two of the chaplains interviewed in Chapter Six as chaplains' assistants.

This thinking is summarised in A Handbook of Sick Visiting published in 1982 by Mowbrays. It systematises his thinking about the skills approach to the induction and training of both lay visitors and provides an outline plan for a three months' residential clinical training programme for clergy. These programmes are reproduced in Appendix Three (alongside the
Health Care Chaplaincy Standards Document in Appendix Two) as representing a key piece of work about how chaplains were being encouraged to develop a distinctive knowledge base. It is important to note the differences and continuities of Autton's work. In 1968 Autton addressed his work to the chaplain outlining a description of the chaplain's ministry in a hospital. In 1982 Autton's perspective had widened and his work is addressed primarily to lay visitors and others in churches who want to participate in pastoral care. This development acknowledges both the wider context of the hospital and community and the reality that the chaplain cannot fulfil the work of pastoral care alone:

Small groups of trained pastoral teams, with the widest representation in their membership, people of various denominations and different sectors of society, can call forth a unique level of pastoral care. In such a concept of shared leadership in which the Christian community moves from the need to receive ministry to a willingness and ability to give ministry, pastor and people become co-partners with mutual roles to play, working together in mission with a caring responsibility to one another. (Autton 1982, page vii-viii).

There is a movement in Autton's work from an understanding of the chaplain as the sole agent of pastoral care towards team work which includes other denominations and especially lay people. In this case the chaplain is the sole enabler and trainer, so the centrality of his or her function has changed whilst remaining crucial.

5.2.4. Speck: 'Being There'

The final book reviewed in this section of literature in the handbook category is Peter Speck's 'Being There': Pastoral Care in Time of Illness. This book follows on from Autton in the SPCK tradition in their New Library of Pastoral Care. This series of volumes aims to meet the needs of people concerned with pastoral care, and to improve their knowledge and skills in this field. The
significance of Speck’s book is important - it has remained the standard work on hospital chaplaincy since the early 1990’s. In the Preface, Speck highlights the context of considerable uncertainty both in Church and State about issues around illness, health and healing in the face of an expansion of treatment and technology and against the background of limited resources. He argues that the medical model of care has been radically challenged, and that in the light of this it is neither possible nor desirable to provide a definitive book applicable to all; each person involved in chaplaincy must work out what illness means according to context. There is a key sentence in the Preface which is a sub-text running throughout the whole book and deserves further comment and reflection: ‘Pastoral care has been forced to examine its own validity and, at the same time, to examine the skills and techniques of psychology and medicine (etc.) and to incorporate them where relevant’ (Speck, 1988, page x).

There are then important issues about the function and purpose of pastoral care being raised by Speck, who wants to encourage a professional approach so that the Church can demonstrate that it has a valid contribution to make in this area.

Speck examines our experience of illness, drawing on his understanding of some of the psychological literature to expound issues of labelling and stigmatising in our culture. He develops an understanding of culture as the pattern of behaviour usually accepted by a group, and goes on to demonstrate that the world shares a complex variety of ideas about what illness means in terms both of the interpretation of symptoms and of the provision of a label attached to them. He describes beliefs about illness, categorising them into a range of ‘logics’. In this description it is demonstrated that becoming ill is part of a complex process,

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particularly in the hospital context where the illness becomes 'medicalised'. Much of the understanding in this text draws upon psychology and some sociology rather than theology. The section ends with a description of four kinds of obstacles to recovery. Speck goes on to explore the pastor as agent and chaplaincy as the agency of care. He argues that self-awareness and self-development in ministerial training have become hallmarks of professional care. In his exploration of boundaries in pastoral care, he recognises the need to set limits and the equal need for pastoral supervision where areas of vulnerability can be opened up and faced. Hospitals are difficult places where unresolved needs and conflicts in the pastor's own life may emerge, and in this process of emerging may have a crucial effect upon the care given. A strengthening of the chaplain's identity therefore involves coming to terms with his or her own losses and feelings about these experiences. It is strengthened if the pastor is aware of the framework of his or her 'philosophy of life'.

Chapter Three in Speck's work is crucial to the subject of the development of the chaplain's identity, and particularly in working out the tools necessary for the roles and functions of chaplaincy. Speck distinguishes between spiritual and religious needs through a particular case study. It is his interpretation of the case study that religious needs are symptoms of something deeper and more significant, that is, a spiritual 'search'. These fundamental needs relate to an underlying search for meaning in the illness. The expression of religious need hides something that is more significant for Speck; engagement with the situation in its wholeness and depth. There were some half-explicit questions earlier in the previous chapter in connection with this. For example, do people choose those with whom they want to explore meaning in their lives? Why, in the Britain of the 90s, should it
be the chaplain and what does the chaplain represent for the patient? How far is it possible to be explicit, let alone articulate, about one's needs - even if one knows what they are? The area of the understanding of what religion is and how it relates to our framework of interpretation of such needs is very complex.

Speck's position is this. Spiritual needs relate to ultimate issues, a search for meaning, the 'why' questions in life, and religious needs are one expression of spirituality. He enquires whether people are authentic, real and honest with the chaplain, and what might facilitate the exploration of meaning and purpose. He describes the priority function of the chaplain as being the creation of a relationship of trust which allows the expression of feelings and fears. Openness in the style of approach and the giving of opportunities for space leading to trust therefore become the key functions of the chaplain's work. It will be important to compare this conceptual approach to the nature of chaplaincy with the findings from the interviews in the chapters that follow in Chapter Six.

Much of the rest of Speck's book is concerned with helpful practical suggestions for the chaplain in the context of the hospital. For example, in Chapter Six he looks at lay visiting schemes as an important extension and development of the chaplain's work. It is not until chapter Eight that he describes the institutional and community structures and the context within which this visiting and pastoral work happen. He sees Christian theology as one significant perspective among the many by way of which all seek the truth.

Speck's work stands apart from that of Cox and Autton in its Chapter Five. page 118
reflection about the nature of health and a recognition that illness is a complex reality. However, like its predecessors, this book remains a piece of literature directing those involved in pastoral care towards appropriate action. It aims to provide practical guidance on working with individuals and groups and through its 'handbook' status has achieved a widespread authority within chaplaincy. Eleven of the interviewees had this book on the bookshelves of their offices.

Speck's work, like Autton in 1982, recognised the importance both of ecumenical team work with lay people as a resource for delivering pastoral care in the hospital. These factors may be shaped, in part, by the changing nature of acute care in general and the reduction in average length of stay in particular (Harrison and Prentice, 1996, chapter 8).

**PART TWO : Reflective Literature**

5.2.5. **Introduction**

The remaining pieces of literature may be grouped together as works of innovation and exploration in chaplaincy. They do not attempt to offer any systematic guide or framework within which chaplaincy ought to operate. There are a number of main examples of this reflective literature. They are: *Contact*; the work of Faber, Wilson, McGregor, Gilliat and Beckford, Woodward; and Stoter.

5.2.6. **Contact**

The pastoral studies journal, *Contact*, produced a number of articles in its issue of January of 1966, in the light of recent changes within both the Church and society. These articles ask whether the chaplain is an historical left-over, or a poorly paid

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6 *Contact*, 16. 1966.
social worker, or a waste of money (Contact, 1966 page 2). The articles set an innovative approach that bears the influence of a tradition of pastoral or practical theology started in Birmingham University by R A Lambourne and J H Mathers. The journal asks whether chaplains themselves are able to cope with the changes necessary in their role in the light of the rapid developments both in hospitals and in the Church. Discussing points of comparison with chaplaincy, the editorial argues that the relationships between consultant and GP are also undergoing a process of change, and that there is a division between those who take a scientific attitude towards the conquest of disease and those whose concern is to see the patient as a whole and in his or her context.

Even the structure of this issue of Contact is crucial and as a method of doing pastoral theology it bears the hallmarks of Lambourne's thinking. The opening article presents views of the nature and problems of the hospital as an institution. It is followed by discussions of the contemporary role of the chaplain with some suggestions for future developments. In the discussions about change there is the suggestion that a decline in numbers attached to churches faces chaplains with a particular difficulty in communicating their role. The contexts of both Church and society provide the chaplain with particular challenges. What is significant is the order of reflection: starting with the hospital and only then turning to the chaplain. This collection of essays clearly influenced the work of Michael Wilson in his seminal study to be discussed below.

In 1980 Contact produced a further collection of essays on hospital chaplaincy (Contact, 1980: 4, 69 pages 2-26). Different models of chaplaincy are discussed by Roger Grainger and Stephen Pattison.
David Lyall considers the teaching of pastoral care in hospitals and Christopher Hamel Cooke explores the role of lay visitors in chaplaincy work.

5.2.7 Faber: 'Pastoral Care in the Modern Hospital'

In 1971 SCM Press built upon their list of books exploring the interface between religion and medicine by publishing *Pastoral Care in the Modern Hospital* by Heije Faber, a Dutch lecturer in pastoral psychology. Faber also starts from the hospital, but assesses it, and chaplaincy’s present role, along quite different lines. The central question that Faber addresses in this book is the role of the hospital chaplain. It bridges the categories of reflective and directive literature in so far as it attempts to explain the effects certain illnesses have on patients, with particular emphasis on psychosomatic illnesses, and how the hospital causes particular stresses and strains for the patient. He is concerned how the role of the chaplain functions and how it is understood in the light of what he describes as ‘the progressive secularisation of society’ (Faber, 1971 page viii) with its result that there is little understanding and definition of the chaplain in the modern hospital. Faber declares his bias clearly: he is influenced by a ‘clinical pastoral education’ in clergy awareness, and this is demonstrated throughout the book.7

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7 Clinical Pastoral Education (CPE) is a method of developing personal and professional growth in ministry; a distinctive feature is the suspension of practical experience normally in a hospital setting. CPE has its roots in the United States under the leadership of Cabot (a physician) and Boisen (a congregationalist minister) in the 1920s. Central to CPE is supervision with an accredited person. A typical programme will consist of modules of teaching in the area of pastoral care and theology, the undertaking of a limited amount of pastoral work, an inter-personal group experience and supervision. The core of this supervision is reflection on written verbatim accounts of pastoral conversations. In Britain CPE is not widespread. Two London hospitals (one acute health, St George’s, and the other mental health, the Maudsley) offer courses. There are also supervised hospital placements in Edinburgh University. Ian Ainsworth-Smith (St George’s), John Foskett (formerly of the Maudsley) and David Lyall (Edinburgh) have been key figures in CPE in Britain and this is reflected through their writing. See: Ainsworth-Smith I and Speck P (1992) *Letting Go : Caring for the Dying and Bereaved*, SPCK, London; Foskett J (1985) *Meaning in Madness*, SPCK, London; Foskett J and Lyall D (1988) *Helping the Helpers: Supervision and Pastoral Care*, SPCK, London; Lyall D (1995) *Counselling in the Pastoral and Spiritual Context*, Open University Press, Buckingham.
The book concentrates upon the culture of the hospital as shaping the experience of illness. In Faber’s view, much of the development of the hospital and the response to sickness occurs in a society where structures are imposed and supported along strongly hierarchical lines. The sociological conditions of the modern hospital and the resultant restless atmosphere are well described. In this culture, Faber believes, patients have never been the focus of the hospital system. They are not the focus of the system, and the medical model of care dehumanises them. Objectification and isolation are the hallmarks of the modern hospital, which create abnormal relationships in order to make the patient controllable.

It follows that in the process of hospitalisation there is no security for patients because there is no real location of responsibility for them. Faber provides a careful description of the place of the patient: ‘it is a highly ambivalent atmosphere, at once frightening and fascinating, threatening and reassuring, serving and domineering, saving and wounding’ (Faber, 1971, page 21).

This description has important implications for an understanding of the role of the chaplain in the care of the patient in such an ethos. Faber refuses to move quickly to a sharp definition of that role, rather emphasising the real difficulties of the engagement of the chaplain in the medical process. He comments:

This sense of uncertainty (on the part of the chaplain) is in effect part of the wider problem of the place and identity of the clergy in modern society. It is, however, the considered opinion of those engaged in clinical courses in hospitals that younger clergy find it peculiarly difficult to believe in their pastoral identity in the hospital setting, alongside doctors and nurses. The solution to this will only be found on the one hand in a deeper awareness of one’s pastoral ministry, to which such courses make a significant contribution, and on the other in a more open identification with the hospital. The minister must seek to make himself at home, to enjoy the contact made in the course of the work, and in consequence to take part in the social life of the hospital. He has to succeed

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in striking a balance between distance and identification (Faber, 1971, page 36).

In a striking metaphor Faber compares the minister in hospital with a clown in a circus. He sums up this aspect of the work in the following way:

A character which is slightly anti-social; openness and sympathy in love; a feel for the fringes of human life; a kind of irresponsibility, carelessness and inner freedom; the ability to share suffering; compassion; humour; a great deal of patience and wisdom. And we are to know that these are not experienced as normal human qualities but as a pattern of life of another order, another wavelength (Faber, 1971, page 86).

Faber goes on to look at the tensions of the hospital chaplain's life: the ways in which the chaplain belongs and yet does not belong in the institution; awareness that the chaplain is an amateur amongst experts yet also a professional in his own sphere; and the tension between the necessity of study and training on the one hand, and freedom, originality and creativity on the other. The core of the chaplain's understanding of his or her role within the context of the hospital is best summed up in the following passage:

Much of the minister's work consists of conversations. In these his first task is to enter as fully as he may into the other man's world, to accompany him on an inner exploration. It will hold surprises not only for the minister but also for the other, before they finally stand together in the light of the Gospel. To use an image of Fosdick, the American preacher, a pastoral conversation is like sailing round an island: you make the best landing when you have sailed right round it. In other words, the message of the Gospel will only work when the minister has entered into a real pastoral relationship with the other person. He must have understood him, entered into his world, and he must be with him. Otherwise his conversation will be a more or less authoritarian talking-to from a distance, which is no longer appropriate to present-day structures. I want to emphasise that this understanding of pastoral relationships is not a piece of technical advice based on certain modern insights into the nature of conversations, but in the simple existence of such a relationships there is a partial realisation of the Gospel. The minister in his work represents the one who has fully entered into the world of men and become one with them - the basic meaning of the Incarnation. In the work of the minister there should be that
same movement which we find fully completed in Christ. Our being with the other is a reflection of Christ's saying that he will be with us 'till the end of the world', one could almost say a realisation of it (Faber, 1971, page 109).

5.2.8. Wilson: 'The Hospital - a Place of Truth'

Michael Wilson's *The Hospital - a place of truth*, published in 1971, still stands today as a remarkably comprehensive exploration of the role of the health care chaplain, and has become a standard work on chaplaincy with a wide circulation and influence. Its origins are of interest. In 1966 The Queen Elizabeth Medical Centre contacted the University of Birmingham Institute for the Study of Worship and Religious Architecture for advice on specifications for a hospital chapel. The then Professor of Theology, Gordon Davies, suggested that it would be more fruitful to explore the role of the chaplain, and a working party was established. In October 1967 Wilson joined the working party as a Research Fellow with funding from the Joseph Rowntree Charitable Trust. He undertook this major study with the cooperation of the Department of Social Medicine in the University of Birmingham.9

Wilson makes recommendations about hospital chaplaincy by way of a number of surveys. It puts the exploration of the chaplain into the context of understanding the tasks of the hospital within the wider context of the work of the Church as a community. Wilson, in his introduction, argues that the focus of any hospital

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9 For background information to what might be described as the Birmingham tradition of pastoral theology, see *Explorations in Health and Salvation: a selection of papers* by Bob Lambourne, edited by Michael Wilson, Birmingham, the University of Birmingham Institute for the Study of Worship and Religious Architecture, 1983, reprinted 1995 by Department of Theology.
institution is always people in terms of their situation and destiny. Independently of Faber, he explores the task of the hospital and the meaning of health, and discusses the hospital as a resource of belief. He argues that the hospital is a school for society in which attitudes to illness and health, aging and death, are taught.

He develops an understanding of the dynamic between learning and experience in relation to the kinds of attitudes that shape hospitals and the kind of learning that emerges from illness. This section ends with Wilson's definition of the institution: 'The primary task of the hospital is to enable patients, their families and staff to learn from the experience of illness and death and to build a healthy society' (Wilson, 1971, page 31).

Wilson develops his argument by exploring the meaning of health through a discussion of different models of health at work in a hospital. Wholeness, he argues, in this context, means the whole of life, and death is part of what it means to be human. Illness is positive and tragedy is not something to be overcome but an experience to be understood. From this basis he argues that the Church should be involved in health planning, organisation and delivery. It should also encourage theological thinking about the meaning of health as it is worked out through good and bad structures by disclosing the truth of our life, ourselves and God.

Like Faber, Wilson discusses the hospital as a source of belief about human personhood and society. While acknowledging the achievement of the hospital as an expression of human concern for well-being, he also assesses the institution as a place where problems are solved and which thrives on the objectification of faults in human systems and their correction. He sees hope for the re-shaping of hospitals as he outlines two important current
forces in medicine. They are the development of social medicine and the development of community therapy and mental health.

In the discussion of the primary task of the Church in the hospital, Wilson asks questions about the interrelationship between involved detachment and critical responsibility; that is, how far the Church should be identified with the values and structures of the institution of the hospital. He explores briefly the effects of being a Christian in the workplace of the hospital and asks whether or not a network of Christians affect the work and culture of the hospital. He defines the task of the Church thus: 'to express in its common life the truth that sets men free to be fully human' (Wilson, 1971, page 44). This definition is reached as a result of discussing the meaning of charity within a dynamic of giving. These general purposes then need to be applied to the circumstances of the hospital.

All this thinking bears upon the role of the chaplain. It suggests that the chaplain has to deal with some difficult conflicting expectations of the role. Wilson develops some distinctive ideas and concepts of the role of the health care chaplain: 'his work is a work of prayer and communication in thought, word and deed. His most powerful work is reflective and contemplative ... prayer and work are related' (page 52).

Wilson believes that the chaplain is universal in belonging to all, and the patients appreciate his friendship and the quality of communication with him. There are problems about identification and identity which seem to be resolved in personal terms rather than functional terms. In other words, the success of the health care chaplain depends more upon personal qualities than clarity of role if that is seen as a matter of clearly listable tasks and
procedures which exhaust the content of the role.

In the second section of Wilson's study, the role of the hospital chaplain is explored in further depth and detail. He accepts its difficulty, particularly in relation to the complex culture within which it is located, and discusses also the relationship of the chaplain to the local congregation (an easily neglected aspect). He concludes that it is impossible to define what is the essence of a successful chaplain. In his analysis of surveys of the views of ward staff his conclusion is that 'It depends upon the man.'

Building upon his conclusions, Wilson argues for more ecumenical teamwork within chaplaincy and particularly that chaplaincy departments look at the concept of establishing a hospital chaplaincy teaching unit, where the chaplain is a lecturer in health and human values, an administrator of the team and an initiator of research. This concept is discussed in detail, but undergirding the framework are the following beliefs:

1. the role of the full-time chaplain should be more experimental,
   and
2. the role of the priest is always that of a generalist: 'the environment (the hospital) must not be conceived of in terms of a specialism so much as in terms of a foreign culture' (Wilson, 1971, page 82).

Wilson then asks what chaplains need so that they can be at ease in the hospital culture and warns: 'The role of the counsellor clearly fits comfortably into the expectations of a therapeutic institution. But the chaplain may have changed his model of health based on the Gospel, for the medical model of sanitation, wellness through the eradication of defect.' (Wilson, 1971, page 85).
In a discussion of the nature of religious needs, Wilson highlights the effects of developing secularism in the late 60s and early 70s. He asks what areas of life are vested with religious significance and in an attempt to hold on to the distinctiveness of the role, he concludes: 'The chaplain, therefore, is not primarily someone who steps in to complement care at the point of a ward sister’s weakness, or because he can speak of God and she cannot. He enables staff to deepen the quality of their own patient care, he does not take it out of their own hands' (Wilson, 1971, page 91).

He builds upon this model of the chaplain as theological educator within the institution:

The skill of the chaplain lies in his knowledge and communication of what it means to be fully human: that is to love God and his neighbour as himself in thought, word and deed... His expertise is therefore common property. He too is human and what he learns about being human it is his professional skill to share with others. His self-knowledge is the key to his ability to help others. He is always, therefore, open to learn something from others (Wilson, 1971, page 102).

Again, the core finding of Wilson’s research indicates a large degree of reliance on individual and personal categories - if people like the chaplain as a person, they respond to the possibilities of conversation. This leads Wilson to conclude

The hospital creates particular divisions between sacred and secular, professional and private, formal and informal, giver and receiver; the chaplain will identify himself with both poles in each tension, and try to be himself, the same person in all his roles... the role of the hospital chaplain is an enigma. Essentially an adventurer, he explores the dangerous territory of man’s making and breaking; where every meeting is new and no situation is ever repeated (Wilson, 1971, page 107).

Drawing upon the industrial chaplaincy movement and the work of the William Temple College in Rugby, Wilson argues for the chaplain as an institutional theologian accessing the hospital structures at every possible point of influence, power and planning.
'The chaplain is chaplain to the hospital as an institution. He will sometimes become aware that the hospital itself is a sick structure, promoting the very anxieties about death which society created it to relieve' (Wilson, 1971, page 112).

The study concludes with a discussion of the practical aspects of the role of the chaplain in relation to death and serious illness. In the light of this it explores the relationship between beliefs and buildings as they relate to the kind of chapel necessary for a hospital.

Wilson concludes that the chaplain should be the person who can embody the learning, non-sickness centred and non-objectifying attitudes which all in the hospital ought to have. The chaplain will have many roles, formal and informal, prophet, priest, administrator, counsellor, teacher, healer, judge, servant, but beyond all these, his role is to 'be himself'. He is to be a person, himself: to be the same person within the hospital as without, in his professional life and without it.

The man who makes a consistent attempt to be himself in these different roles, to be truthful in his relationships, will make integrity and truth possible for others, that is, allow them to learn about themselves and others (Wilson, 1971, page 55).

The key word here is 'integrity' which comes from holding the sacred and secular, health and sickness together. It follows from this that the minister of word and sacrament will not try and gain a respectable professional image (Wilson, 1971, page 52), but in the face of a highly professional institution he will remain an amateur, a generalist, one whose work is that of prayer and communication in thought, word and deed.

Wilson’s work gives the impression that the chaplain belongs to a
different order from others in the hospital. He is to present a radical challenge by his life and works to the hospital. Wilson sees for the chaplain a socratic role, a person who being trusted by all, can ask questions from a frame of reference beyond the hospital.

Wilson's chaplain does not compete with the professionals, to 'do' things, to find a role but is rather a generalist. He is a universal man, relating to all equally as people and trying to be himself. He questions the assumptions of the hospital while identifying with its members.

This model is the most comprehensive and persuasive in this evaluation of literature. It affirms the ministry of the chaplain to all in the hospital, has connection with the whole church, the ministry of all Christians, the need to look for health rather than weakness and to question the hospital's assumptions.

There are some criticisms of Wilson position. There is little explicit theology to justify this ministry. There is a danger of this 'alternative' human being standing above and beyond the hospital (like Autton's chaplain), and of losing contact with individuals because of his extraordinary modus vivendi. Finally there is little development of the exploration of what 'being himself' actually means.

This work, while remaining idealistic and theoretical, has shaped practice and thinking. Speck (1988), Woodward (1995) and Stoter (1995) draw on it extensively in their writing. There is also some indication in feedback from chaplains that they have been influenced by this thinking. This will be drawn out and discussed in Chapters Six and Seven.

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The most recent summary of the role of the chaplain is a
dictionary article by Stewart McGregor. He draws upon two main
sources - Faber and Wilson. In this article, McGregor defines
chaplaincy as 'the range of specialised non-parochial ministries
exercised in hospitals', and 'a unit or department staffed by a
chaplain, which provides services of a religious or pastoral nature'

He describes the core task of chaplaincy as providing a supportive,
pastoral or sacramental ministry to patients, so that they are given
the opportunity to speak openly about their feelings in relation to
their illness, injury and hospitalisation: 'Pastoral ministry
demands sensitive listening, perceptive observation, careful
response ... and a capacity to confront ultimate questions of
meaning in such a way that patients may be comforted and may
come to use their experience of illness positively' (McGregor 1987,
page 118).

The article argues that this core function relates to specifically
religious care within the context of a changing hospital with its
development in technology and specialisms. The chaplain is to
develop the tasks of 'ethicist, patient's advocate, psychologist,
resident theologian, adviser, enabler, teacher and interpreter'

McGregor also expounds the task of the chaplain as questioning
the system of the hospital, or calling the churches to help build a
healthy society, both of them more structure-related functions. In

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McGregor T S (1987) *Hospital Chaplaincy* in Campbell A *A Dictionary of Pastoral Care*, SPCK, London. It is perhaps worth noting here that McGregor was a Scot and this study limits its geographical focus to England. In Scotland the NHS pay the Church of Scotland to employ chaplains in hospitals. They are a relatively small group with a strong sense of shared identity and support.

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conclusion he takes the Faber discussion of the role of the clown as he concludes that the chaplain holds a unique place in the life of the hospital: 'In the face of the development of technology the chaplain stands for the common human denominator' (McGregor, page 118).

5.2.10 Beckford and Gilliat

In June of 1996 a research team from the University of Warwick's Department of Sociology published its findings of the Church of England's relationship to other faith communities in a multi-faith society. The project sought to discover how, and to what extent, the Church of England's dominant position in publicly funded chaplaincies (for example, in hospitals and prisons) could permit people of other religious faiths to participate in these aspects of public religion in England. A closely related question was how far the involvement of members of other faith communities in chaplaincies and civic religion contributes towards their sense of participating in the nation's public life. The research was conducted through an extensive survey of publicly funded chaplaincies, which included health care chaplaincies.

The main findings of the report may be summarised in the following way.

The researchers uncovered a variety of views and opinions about relationships between the Church of England and other faith traditions. Despite this diversity of opinion and practice, Church of England clergy remain important as gate-keepers of chaplaincies and civic religion. If anything, the re-organisation of the NHS in the 1990s has augmented their status and their influence over health care chaplaincies. Members of other faiths still rely on

Beckford J A & Gilliat S (1996) "The Church of England and Other Faiths in a Multi-faith Society, Dept. of Sociology University of Warwick. The author of this thesis was part of the steering group for this project. It was funded by the Leverhulme Trust.

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them to provide access to facilities and resources in health care organisations and prisons (Beckford and Gilliat, 1996, page 505). Leading members of other faith communities wished to strengthen their involvement in publicly funded religious activities, although they would also recognise that this is unlikely to lead directly to the political empowerment of the faith community concerned. They claim that having an equal opportunity to participate would symbolically affirm the value of other faiths to this country, provide at least a stepping-stone towards political representation and remind Christians that other faiths are now neighbours rather than strangers.

The Church of England’s facilitation of the limited access which other faiths have to publicly funded chaplaincies and to civic religion in general was initially helpful in creating fresh opportunities, and the role of the Anglican ‘broker’ on behalf of other faith communities continues to be useful in practical terms. There are signs however, that the subject is becoming more challenging - for two reasons: first, because the mounting pressure on resources in health care organisations and prisons makes it increasingly difficult for Anglican chaplains to treat all faith communities in an even-handed fashion; and second, because other faith communities are now large enough and well-enough established in England to feel the need to assert their independence from Anglican patronage or oversight. As a result, the researchers argue, the nature of the relationship between the Church of England and other faiths is likely to change in the future. They conclude that they hope that these findings will provide a new and unique development of policy in this area.

5.2.11 Woodward: ‘Encountering Illness’

In 1995 the present writer attempted to make a contribution to the
literature around health and social care from a chaplaincy perspective with the publication of *Encountering Illness: voices in pastoral and theological perspective*.\textsuperscript{12} The book draws extensively upon his own experience as an acute health care chaplain and asks a range of theological questions about the nature of pastoral care in the light of listening to the wide diversity of experiences in relation to illness. This book demonstrates a commitment to a pastoral response to illness that takes seriously both theology and the complex diversity of experience. The book has had wide circulation amongst health care chaplains and is now used extensively by them as a tool for reflection.\textsuperscript{13}

5.2.12 **Stoter**

The work of David Stoter concludes this section. Stoter is Manager of the Chaplaincy Department and Bereavement Centre at the Queen's Medical Centre in Nottingham. He is also the Chairman of the Council of the National Association for Staff Support in Health Care. He has recently written two books which reflect his long experience as a chaplain.

The first is *Spiritual Aspects of Health Care*\textsuperscript{14} and is aimed mainly at a nursing audience, though he refers to all professional health care staff, including chaplains. It provides a theoretical and practical framework within which spiritual and religious needs can be met by all those working in health care. Stoter argues that chaplains should no longer be regarded as the only professional group who can respond to spiritual and religious needs:

> Spiritual care was, until recently, considered to be mainly the responsibility of the hospital chaplain ... Things are now changing and there is currently a surge of interest in caring for the whole person and looking after their physical, emotional,


\textsuperscript{13} This assertion is based on letters to the author about the work and invitations to address groups of chaplains from across the country.

social and spiritual needs. It is evident, and welcome, that many professionals are realising their need for guidance and help in playing their part in providing spiritual care (Stoter, 1995, page iv).

Stoter argues for an inter-professional approach to meeting spiritual needs within a framework that aims to offer clarity in both definition and process. Stoter develops some of this work in *Staff Support in Health Care* which considers the nature of staff support. He draws on his experience as a chaplain to show how stress and pressure might be minimised and, by implication, suggests that the chaplain may have an important role to play in staff support.

5.2.13 Conclusion

This completes the overview of reflective literature in this area. The next section will summarise the main themes that emerge from an examination of the Hospital Chaplaincy Journal.

5.3 The Hospital Chaplaincy Journal from 1961 to 1997

It is the purpose of this section to summarise the main issues and questions dealt with by the Journal. In the main this section will discuss how chaplains have used the Journal to share with colleagues aspects of their work. Specifically, it will show how the Journal portrays chaplains (especially in the late 1970s and

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16 It has been necessary to limit this Chapter (and thesis) to acute health care chaplaincy. There are however a number of important contributions about the nature of chaplaincy by those chaplains working in the field of mental health. They discuss and reflect on the role of the chaplain with the mentally ill. For a discussion of the mental health chaplain as priest see Autton N (1969) *Pastoral Care of the Mentally Ill*, SPCK London pages 14-23. For an exploration of the place of worship in the pastoral care of the mentally ill, see Grainger R (1979) *Watching for Wings*, DLT London; and (1983) *A Place Like This*, Regency Press, London. Grainger, author of much of the sparse literature on psychiatric chaplaincy, approaches the role from the perspective of functionalist sociology and suggests that the chaplain functions as a licensed anarchist or jester within the hospital structure. Grainger emphasises the independence of the chaplain, being in the hospital but not of it (Grainger, 1979, page 16).

Pattison provides a critique of the individualism and narrow perspective of aspects of the mental health chaplaincy which he regards as being blind to matters of inequality and injustice that engender and perpetuate suffering. He argues for a socially and politically committed pastoral care as a central role for the chaplain in overcoming sin and sorrow. See Pattison S (1994) *Pastoral Care and Liberation Theology*, CUP, Cambridge.

17 The Hospital Chaplain was published from 1961 to 1990 by the Hospital Chaplains’ Fellowship. This journal became The Journal of Health Care Chaplaincy and has been published by the College of Health Care Chaplains from 1992.

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1980s) as adapting to structural and cultural change, particularly in the introduction of management changes.

The main function of this quarterly publication up to around 1991 was to provide a forum in which news could be exchanged, and it has reflected a strong sense of corporate identity that was fostered through local branches of the Hospital Chaplains' Fellowship. The reports it contains give the impression of a network of chaplains engaging with a very wide variety of issues and subjects. There are a number of ongoing conversations with other health care professionals, particularly senior nurses and medical staff, who are invited to meetings to keep chaplains informed about developments in the spheres of health and health care.

But throughout its 36-year history, down to the present, the other main function of the Journal has been to provide chaplains with the opportunity to share their 'on the job' reflections at a deeper level. So in a number of varied articles chaplains address the substance and activity of their work in a variety of areas. There are some core subjects that are addressed throughout the history of the Journal. These are: the sacramental ministry of the chaplain - the Eucharist, anointing and laying-on of hands; the ministry of healing; the nature of suffering; mental illness, stress, burn-out, alcoholism; the psychological effects of illness; the nature of pain; a range of ethical issues; and work amongst the critically ill and dying.

In addition chaplains are kept informed of the latest developments in relevant literature relating to their work through careful and systematic selection of book reviews. Each December issue of the Journal collects together the papers from the Chaplains' Conference held earlier in the June or July of that year. Chaplains
manage at these conferences to secure both senior academics and health care professionals to address a range of issues relevant to their work.

The following subjects and themes have been dealt with in the December editions of the *Hospital Chaplain* : Michael Wilson's research (published as *The Hospital - A Place of Truth*, 1971) in 1972; The Care of the Elderly, 1973; The Bible and Pastoral Care, 1977; Pastoral Care in Times of Crisis, 1974; NHS reorganisation, 1979.

The other significant feature of the journal worth noting here is that throughout the period chaplains continue to ask health care professionals to reflect to them about their own particular concerns. Nurses and doctors appear throughout the pages of the journal informing chaplains of developments in their area of work and particularly making a plea for collaboration and teamwork.

The *Hospital Chaplain* for the period between 1961 and 1975 took the form of a brief newsletter reproduced locally on a parish printing machine. It contained news of clergy moves, sermons, short book reviews and short spiritual reflections on chaplaincy experience.

The most significant feature of the journal lies in the picture that emerges of a group that reflects a degree of reflection and engagement with the organisation within which it is located. There are a number of articles that lay the foundation for developments of thinking and practice in the area of acute health care chaplaincy which will be outlined below.

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Chaplains' Training in Management: Ken Povey, a Regional Officer at the West Midlands Health Authority, raised this question at the Annual Meeting of the Council of the Hospital Chaplains' Fellowship in February 1972. He asked chaplains to think seriously about the development of administration within the Health Service, and in what way their profession might benefit from training in management. He criticised chaplains for not providing clear descriptions of their work and concluded by commenting on the varied degree of their ability to communicate what they were doing. Training in management, he argued, would enable the chaplain to understand more clearly dimensions of the organisational structure and the support of staff at all levels in their work. This position was developed by Alec Phillips, the Regional Training Officer of the North East Metropolitan Region.

In his presentation he offered the following advice:

We are likely to be judged on our performance. In management terms, our performance is determined by our knowledge and skills (or combination of both), in conjunction with motivation. The chaplain's knowledge of people is already recognised but his professional skill has to be linked to his ability to communicate - and the chaplain can only communicate meaningfully when he has a thorough knowledge of the hospital, how it works or fails to work, through its aims, ideals and politics (Povey, 1972, page 15).

Phillips concludes his talk by asking chaplains to analyse more clearly their role and objectives and systematically to engage with reflection on what the hospital expected of its chaplain. If the chaplain means business

1. He must know what his objectives are
2. He must know what his needs are to meet those objectives, and
3. He must realise that management is only a beginning to attaining his objectives.

This marks a significant development in a group of people’s
movement towards a position whereby some of the tools of the Health Service's culture are used to consolidate and develop the place and role of the chaplain in the health care setting (Povey, 1972, page 16).

Throughout the mid to late 70s John Foskett, a psychiatric hospital chaplain, was a significant figure in the development of accreditation within pastoral care and chaplaincy. He consistently argues for an approach to pastoral care that develops a knowledge base which can stand alongside other therapeutic methods and care interventions in the health care process.\(^{10}\)

Throughout the period between 1979 and 1989 the journal demonstrated the chaplains' ability to understand the structural changes that shape the culture of the Health Service. Two references illustrate this. In December 1989 the journal explored the political changes within the re-organisation of the Health Service, helped by long detailed arguments from Simon Jones, a civil servant working in the Department of Health, and David Perry, a District General Manager for the Oxfordshire Health Authority. In their articles both Perry and Jones highlight some of the reasons for the necessity for change within the organisation of the Health Service, and draw out the implications for chaplains.

Simon Jones concludes his talk with the words:

I said earlier that the Department recognised the value of chaplaincy work in the NHS. Those were not idle words. We have had very little correspondence about chaplaincy since the White Paper was published - and I'm not asking you to write in! But one letter we did receive from an MP was answered by the Secretary of State, Mr Clarke, who wrote: 'I fully recognise the value of the role of the hospital chaplain in ministering both to patients and staff.' He went on to say that he was 'sure that hospitals which opt out to become self-governing will similarly value chaplaincy services.' Ministers do not expect chaplains to be treated any different to any other NHS employees (Jones, 1989, page 10).

\(^{10}\) See Hospital Chaplain September 1978. page 5-12

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David Perry offers the following advice to chaplains in the light of political and structural change:

We shall all need not only to respond when asked, but, crucially, to try to so understand what is changing around us that we can anticipate and, in a pro-active way, foresee a need to stress the values of continuity and people and to underline the real purpose of our work.

I doubt very much whether there is one model job description that will fit the role of all the hospital chaplains in the 1990's - just as there is, I suspect, no such model for the nurse or the doctor or the manager. We each, I think, have the duty to better comprehend our own organisation and the changes that are going on, and to offer our own tailored contribution to best serve the needs of our patients and our colleagues.

For today, I will have succeeded if I have struck any chords with the proposition that it is not sufficient for us to consider the alternatives of continuity or change, but to carefully study the vital importance of ensuring that we have continuity and change (Jones, 1989, page 14).

This edition of the journal marks a significant turning point followed up in many of the articles in subsequent issues. From this point chaplains address themselves with both enthusiasm and understanding to the challenge set by Jones and Perry to explain more clearly the nature of chaplaincy in present circumstances.20

It is probable that it was the significant structural changes in the Health Service during 1990 that motivated chaplaincy organisations to establish the newly-formed College of Health Care Chaplains in the early part of 1992. There was a clear call for an organisation which could protect the professional interests of health care chaplains of all denominations and provide a resource in training for the development of business planning, appraisal and quality within chaplaincy. These discussions had an outlet in the July Conference of the College of Health Care Chaplains held in Ripon in 1992. The December edition of the journal includes some very detailed advice offering support to chaplains on writing a

business plan, and thinking practically about the nature of evaluation of quality standards.

Many of these themes were picked up and developed during my own time as Editor of the *Journal of Health Care Chaplaincy* between 1992 and 1996. There was the adoption of a more pro-active policy of commissioning articles from chaplains that explored a variety of areas, including the debate about the closure of major London hospitals; spiritual pain and work with the dying; ethical and theological dilemmas in the NHS reforms; the complexities and challenges facing the modern NHS manager; and a special report reflecting upon issues in relation to the reforms for chaplains.

At the time of writing, the College of Health Care Chaplains in the pages of its Journal has undertaken a debate about the nature of the organisation in relation to the Health Service, and decided that it can best protect chaplains' interests by affiliating the organisation to the Manufacturing, Science and Finance Union. One of the main factors in the affiliation of the college was the perceived need for chaplains to secure professional indemnity insurance in order to safeguard their working practice. The College also argued that affiliation with MSF Union would develop the professional status of health care chaplaincy and give members access to a wider range of services. It may be felt that this development strikes a wholly new note in the subjects attracting the attention of chaplains.

5.4 **A Summary of the Main Themes Emerging from this Literature Review.**

5.4.1 **Descriptive Self-understanding:**

What is significant from this literature is the number of conscious

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21 See College of Health Care Chaplains Newsletters 8 - 12.
and applied attempts by chaplains to describe the nature, purpose and function of chaplaincy, both to other colleagues and to the organisations within which they work. Much of the material describes some of the practical situations and issues that face chaplains in a variety of situations of pastoral care. A significant number of chaplains have developed their views about the nature and function of their work by a constant process of self-reflection (for example Autton, 1968; Speck 1988; Stoter, 1995).

5.4.2. The Handbook:

As discussed above, much of the literature both in the shape of books and also within the journal takes the general form of a guide or handbook: it is prescriptive about the framework and the nature of the work - clarifying roles, describing the structures and outlining the range of issues, including theoretical ones, that a chaplain should bear in mind in his or her work.

5.4.3. The Development of Skills and Knowledge:

Much of the literature concerns itself with the professional development of health care chaplaincy as it relates to a distinctive knowledge and skills base. The writing and work of Autton has been especially significant in this respect. The work of Foskett, Longbottom and Hollands from the mid-1980s onwards, leading to the debates about quality and business planning, is key in the shaping of The College of Health Care Chaplains' concern to explain with more clarity what skills they have to offer in the therapeutic process.22

22 It may be significant to note that Foskett and Longbottom were psychiatric chaplains and Hollands began his chaplaincy work in a psychiatric hospital before moving into acute health care. They all exercised an important influence on the Hospital Chaplaincies Council and the College of Health Care Chaplains. Longbottom and Hollands were key influences in the production of the Standards Document (see Appendix 2) There may be some link between their culture of psychiatry and psychotherapy (audit, outcomes, etc.) and their motivation to explain the nature of chaplaincy. The work of Browning should also be noted here. His Chaplaincy Modes in Mental Health published in 1986 by Trent Regional Health Authority helped shape mental health chaplaincy in the light of the changes in the provision of community-based care in mental health.
5.4.4. **The Place of Theology**

There is a much clearer role for faith and explicit theology in some of the literature which pre-dates 1970 (Cox, 1955). The period since then has been marked by a significant fragmentation in theology. There is no agreed agenda and framework to the degree that there was formerly (compare Cox 1955 with Stoter 1995). In the earlier period, there was a strong affirmation of traditional theology, accepting the orthodox schema of the Councils of Nicea and Chalcedon (Trinity and the Person of Christ) as 'given', and then exploring its implications in 'modern' terms. This characterises the approach to chaplaincy in much of the literature from before the mid-70s. It is shown in the sermons and devotional reflections in the *Hospital Chaplain* between 1961 and 1975. Much of the more recent literature feels less assured about the traditional theological bases and, as a result, less agreed about doctrinal agendas for chaplains and for the Church in general. It is possible to sense a turn towards the language of psychology and therapy. Yet the use of theology, particularly in Speck, could still be relatively unsophisticated (Speck, 1988, pages 17-26). It is a matter of hanging thoughts on convenient biblical pegs, either themes or texts, or traditional theological concepts. So Speck takes a theme (for example, Christ as vulnerable, God as entering into suffering, God as resolutely creative), and applies it straightforwardly in the discussion of the nature and role of chaplaincy (Speck, 1988, pages 38-60).

The change in the manner and use of theology simply reflects the growth of a plethora of special stances from which to see the Christian tradition, viewed rather broadly; for example, liberation theology, feminist theology, black theology. These partly coalesce (for example the Gospel is for the 'oppressed' of various kinds - and this is of its essence); they are also in part competitors for attention. Meanwhile the Church's agenda seems increasingly
problem-centred; for example ordaining women, or how to bring long-separated churches together, especially their ministries. None of this makes it easy for a person to feel that there is an agreed (even among Christians) framework of ideas to appeal to and use for working out specialised roles like that of the health care chaplain. This is quite apart from the more applied character of theology brought about by modern social pressures and developments. Pastoral theology itself has become a much more self-aware and technical discipline in recent years. So attention has shifted from a secure base in church theology to a style of reflection which stands within the institutions in which ministry is exercised.

In the exploration of the search for meaning in the roles and functions of the chaplain, it is important to ask what are the resources for their tasks and how the Christian tradition is put to active use. This questioning seems necessary if the activity of health care chaplaincy is to be something more than merely listening and accepting and responding. At the same time it is important to be critical and alert to present needs in drawing upon the resources of the Christian tradition. The question about theology as an integrating discipline that gives life and purpose to the chaplain's role and function will be explored in greater depth in Part Three of the thesis.

5.4.5. The Influence of Psychology Over Theology

There is an interesting comparison to be made between the writings of Autton and Speck. Autton describes pastoral care in hospitals in clear terms. The role of the clergyman is well defined:

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ritual plays a clear part in care, as both instructive and edifying. The tone of Speck's book is different - despite the rather traditional features referred to above: he does not tell chaplains what to do, but invites them to think about what it is most appropriate for them to do. His audience is rather wider than chaplains only. However, what unites the two books is that both Autton and Speck speak from experience (though in the former case at least, some years ago) : they address the subject as chaplains with the authority of experience. Part of the difference may be accounted for by the recent development of human relationship theory and the beginning of fragmentation of theology, as described above. It is important to note that both Speck's and Faber's work is more informed by psychology than theology despite and alongside the former's tendency to rather simplistic appeal to the Bible. Speck uses his understanding of human relationship theory to emphasise the importance of the quality of care and the pastor's need for careful understanding of the patient's position and the nature of illness. For Speck, the carer is self-aware and reflective, as well as being in need of support comparable to that which he or she gives to others. For this purpose Speck makes a clear distinction between the meeting of religious and spiritual needs. While he discusses, briefly, how the chaplain can use ritual and theological symbol to help, the spiritual dimension of pastoral care is viewed in the widest possible context. One question arising out of this position requiring further discussion is whether the chaplain is retreating from previously accepted traditions of theology in favour of acceptance and security within a world that does not understand the nature of religion and its function. The implication is that there is a deference to psychology rather than to theology as forming self-understanding and practice.

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5.4.6. **Health Care Chaplaincy’s Contribution to the Developing Tradition of Pastoral Studies**:

Many of the writers surveyed in the literature review can be regarded as significant figures in the development of pastoral theology. It is clear that the Birmingham tradition of the Diploma of Pastoral Studies was much shaped and influenced by the work of chaplains and the Department’s link with hospitals. Autton, Grainger, Foskett (working in mental health), Speck, Wilson, Pattison and Lyall have all made a significant contribution to pastoral theology during the last two decades.

5.4.7. **The Distinction of Personal and Professional**:

A range of opinions about the activity of pastoral care is found in the literature that has been described. There is a clear tension between an approach that seeks clarity of goals, tasks and skills, along with a system of accreditation and a skills-orientated approach to professionalism, and the view that pastoral care is an *ad hoc*, unpredictable activity emerging from the personality of the chaplain which helps change people’s lives in an intangible and oblique kind of way. Wilson highlights the tension by asking whether people in the hospital context evaluate the chaplain in personal or functional terms. The findings of his surveys indicate that almost invariably the hospital evaluates the individual in personal terms. Many of the debates in the pages of the *Journal of Health Care Chaplaincy* in the 1990s indicate that there has been a significant culture change, whereby the chaplain must stand alongside other professionals, with the business plan indicating what difference their intervention makes in the health care process. Of course chaplains have always had to work with others: but the reforms of the National Health Service have focussed issues around accountability and audit with a new clarity. This issue is a major theme in Chapters Eight and Nine of the thesis.
While the present culture of the National Health Service has demanded that chaplains are able to demonstrate functional clarity, there is an indication that the majority of people continue to evaluate the chaplain personally (Wilson 1971) - that is whether or not he or she is an approachable, engaging, available, visible person. An issue that Speck does not really engage with is the reality that when staff are asked to evaluate the chaplain or describe what the chaplain does, they do so generally in narrow (and understandably) religious language, locating a chaplain's role to situations where specific religious needs are obvious or to crisis situations like death. This point strengthens the personal emphasis found in Wilson (1971 page 55): the chaplain is fundamentally a religious person rather than a religious professional.

5.4.8. The Chaplain as an Interpreter of Cultures and Languages:
The chaplain's function as interpreter is prominent in the literature (Wilson, 1971; Faber, 1971; McGregor, 1988; Woodward, 1995). In the pages of the journal the function of many of the articles is simply to explain what is taking place through, for example, developments in nurse training, the adoption of psychological perspectives on illness, new theological writings on healing, and the promotion of a greater understanding of the political developments within health care. Here there is an inherent tension suggested between the language and world of the chaplain and the language and world of the hospital: the chaplain will feel challenged to understand and assess these matters from his or her own distinctive and in part privileged viewpoint and to relate them to one another, where possible.
5.5 Conclusion

This concludes the literature survey before Chapter Six presents the range of experiences of acute health care chaplains. The core function of the greater part of this literature is that it serves to clarify the role of the acute health care chaplain through the sharing of experience. Almost without exception the writers are chaplains who through description seek to clarify the nature and purpose of chaplaincy work. This is done, understandably, with a wide variety of levels of sophistication and insight. Throughout the literature individuals struggle with the experience of illness and explore appropriate ways of responding. They continue to ask themselves what tools help them to be present in the experience and draw upon other professional colleagues to assist them in that task.

What is also evident from this literature is some awareness of health care chaplaincy’s context. There are indications of chaplains being able to respond to the changing needs of the organisations within which they work and it is particularly interesting to note how chaplains reflect upon Health Service reforms, and the introduction of management. Chaplains write and reflect upon the process of business planning and the ways in which they can present a distinctive body of knowledge and skills which are open to professional audit and outcome measures.

However very little of the literature exhibits any self-awareness about the limitations and biases of the writing. There is little critical self-reflection of the limitations of a chaplain’s perspective on illness and the hospital. Further, there is little evidence of social, anthropological or cultural perspectives on illness and health.  

24 The exception to this is Peter Speck. See Pattison S (1980), Images of Inadequacy: Theoretical Models in Contact 69, pages 6-15.
The predominant paradigm of pastoral care is one of caring for individuals. With the exception of several articles in the *Journal of Health Care Chaplaincy* during the 1990s, there is little thorough exploration of the socio-political factors that shape the experience of health and the culture of hospitals. Illness in the literature is both individualised and privatised.25

Very little of the literature goes far enough to locate the chaplain's role within the context of the institution and structure of the hospital. While the organisation of the hospital is described briefly, individuals and groups clearly need more support in coming to terms with working in an institution and with its structures and systems. Little of it demonstrates any ability to put health care into a broader sociological perspective.

Finally none of the literature described above is research-based. Very few chaplains (with the possible exception of Speck) have appropriated research methods within which to examine the features of the chaplain's role and work. There are some questions to be asked about the ways in which chaplains have adapted to the NHS reforms since 1990 in general and the appropriation of the processes of business planning in particular. Chaplains will speak for themselves on these matters in Chapter Six and the issues are discussed in the third part of this thesis.

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CHAPTER SIX

THE INTERVIEWS

WITH ACUTE HEALTH CARE CHAPLAINS

AND SUPPORTING BACKGROUND JOB ANALYSIS

6.1 PART 1: Background and Personal Information

6.1.1. Introduction

During 1994 and through to 1996 fifteen interviews were conducted with active acute health care chaplains. Each chaplain was given an outline of the research project, together with a list of the questions (see Appendix 1). The questionnaire was tested out on two further chaplains prior to the fifteen interviews, and modified slightly in the light of these two pilot interviews.

It should be noted here that there is no significance of socio-economic variables, for example age or gender on the data generated in this chapter. In Appendix 1 there is a short biographical outline for each chaplain given within the boundaries of confidentiality (see Appendix 1 (c)).

All fifteen interviewees were current whole-time acute unit health care chaplains working in National Health Service Trusts of between 800 and 1600 beds. All interviewees worked within teams of ordained and lay chaplains and thirteen of the fifteen interviewees were team leaders. In the selection of the interviewees attention was given to maintaining a balance with regard to gender, denomination and

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1 This group of 15 are a very small proportion of the 321 whole-time chaplains currently in employment in the Health Service. This number was chosen in the light of advice from supervisors and in comparison with other similar studies (see for example, Borthwick (1998); Pilgrim (1990) and Patton (1990)).
geographical location, but with attention to proportionality where relevant. This spread can be represented as follows:

- **Gender:** 11 men and 4 women
- **Denomination:** 12 Anglican
  - 2 Free Church (1 Baptist and 1 Methodist)
  - 1 Roman Catholic
- **Geography:** 5 chaplains from major Northern cities or conurbations
  - 5 chaplains from Midlands and East Anglian cities
  - The remaining 5 chaplains from London, the South Coast and the South West.
- **Age:** The average age of the interviewees was 49 years, with the breakdown of age groups as follows:
  - Below 40 yrs: 1
  - 40-50yrs: 5
  - 50-60yrs: 9
- **Preparation for Ordination:**
  - 8 of the 15 interviewees had received formal university education
  - 7 of the 15 interviewees had come into their preparation for ordination via another professional training (for example - the police, nursing or teaching)
  - 12 of the 15 were trained in residential colleges of their particular denomination
  - 3 were trained on non-residential training courses.
Experience as a Health Care Chaplain:

The average length of experience was 14 years with the range represented below:

Under 10 years - 4 interviewees
10-20 years - 9 interviewees
Over 20 years - 2 interviewees

Two of the most experienced acute health care chaplains in England were interviewed, one with 23 years' experience and the other with 24 years' experience of working as a health care chaplain.

All those interviewed had other ministerial experience in parishes or congregations but 12 out of the 15 felt that their primary vocation in ministry was to hospital chaplaincy.

6.1.2. Main Theological and Vocational Influences

The coverage of personal and factual information was completed by offering each interviewee an opportunity to reflect upon the main vocational influences on their understanding and practice of ministry. These answers are summarised under the following categories:

(a) People: Ten out of the 15 talked about individuals, who had shaped their sense of what it meant to be a Christian and, by implication, stimulated them to think about full-time Christian ministry. All of these individuals were male priests or ministers with one exception of support and encouragement received from an Anglican religious community.

(b) Places: Three of the chaplains shared their reflections on how their theological training had been challenged and enlivened through an...
attachment to a chaplaincy department in a local hospital; this was for them the point at which their classroom experience of the theory of Christian discipleship was related to the immediate and sometimes raw experience of illness and death. Chaplain B puts it in this way

During my attachment to the parish I got an overwhelming sense that many of the parishioners (including the vicar who was supposed to be training me) were rather bored with religion ... they were going through the motions for the sake of it. Nobody asked questions or especially wanted to change. In comparison, in my hospital attachment I was surrounded by people working together to help and care for those in need. Within this process there were endless questions and especially profound questions about God and the meaning of life. I remember thinking and feeling that this was the place where I wanted to work.

(c) **The Pastoral Factor**
Seven of the chaplains talked about the importance of their theological framework as a guiding set of convictions about God, the individual and salvation, as essentially practical tools to be applied in enabling individuals and communities to make sense of experience. This was expressed in the following ways:

I don't find my theology in books - I discover it in people.  
(Chaplain E)

I used to read a lot and carve out some time to absorb theological material. This became more and more irrelevant and because I couldn't see the direct connection between (for example) what New Testament scholars were saying about the Gospel of Mark and my pastoral work in the hospital. I now believe that my biggest theological resource is the experience gained through listening to people in the hospital ... there is the theology ... there is God!  
(Chaplain D)

(d) **Psychotherapy and Counselling**
Three of the chaplains spoke of the importance of their training in psychotherapy and counselling as main influences on their practice of ministry in the hospital.

I don't buy theological books any more, I buy books written by
psychologists about the nature of human feeling and experience. There is real implicit religion here - I learn more about life and truth in psychology than I do in theology!

(Chaplain M)

Listening, which is a central act of Christian care, is the biggest theological influence on my work, and I have been very supported in that by the counselling training that I've done.

(Chaplain O)

(e) **Particular Texts or Books**

Only five of the chaplains interviewed talked about particular theological books as shaping and guiding their thinking and practice. The work of Michael Wilson was mentioned by two chaplains. The work of John Hick, Jürgen Moltmann, Hans Küng, John MacQuarrie, Jean Vanier and David Jenkins was mentioned in passing, but the content of these authors' works was not shared in any detail whatsoever.

(f) **Spirituality**

Two chaplains preferred to talk about spiritual rather than theological or vocational influences on their understanding and practice of ministry. Chaplain G expressed it in this way:

I'm not an academic ... I don't think people who are in this hospital are particularly interested in thoughts that are unrelated to their experience. I found spirituality books about praying and reflecting on the nature of God most helpful in supporting me in the emotional and spiritual listening and responding that I do here.

(Chaplain G)

Another chaplain spoke about the importance of literature and music as things which enable him to dig deeper into the depth and mystery and meaning of life.
6.2. **PART 2: Reflections on the Nature of Chaplaincy in the Changing National Health Service**

6.2.1. **Motivation**

Interviewees were asked in Question One about the attraction of health care chaplaincy for them in order to build up a picture of their motivation for the work.

6.2.1(i) **Reaction Against Parochial and Congregational Ministry**

Six of the chaplains were attracted to chaplaincy in part because of negative experiences of particular congregations or parishes.

I didn't like the parish ... I couldn't make any sense of the purpose of endless Church Councils and worry over buildings. (Chaplain K)

Put frankly, I found the people who came to church narrow, bigoted, prejudiced and uninterested in religion. After two serious disagreements with senior members in the church I decided to actively look for an appointment outside the system. (Chaplain N)

I had a difficult experience of parish life which made me actively look for work outside the Church. (Chaplain J)

6.2.1(ii) **Personal and Professional Connections with Hospitals**

Chaplain A spoke of their own personal and professional connections with hospitals. One chaplain was married to a nurse and another's sister was a nurse and brother a doctor. These family connections gave each of these chaplains a particular interest in hospital work.

One chaplain had first trained as a nurse then after parochial experience felt that hospital work 'just seemed right' (Chaplain F).

Another chaplain spoke of how comfortable he felt in hospitals because of his previous work in a hospital as a laboratory technician.

Because of my previous experience, the hospital felt to be a
place where things came together. It was a stimulating and energising place to be. (Chaplain G)

Two other chaplains referred to their previous experience of working with other health care professionals in a multi-disciplinary team: one at St Christopher's Hospice in London and the other during clinical pastoral education in the United States of America. This positive experience of working in a particular health care environment was a significant factor in the attraction to a chaplaincy post when it became available.

6.2.1 (iii) Specialisation

Nine of the chaplains focused on aspects of specialisation in ministry as the key factor in their attraction towards chaplaincy. For these chaplains the opportunity to work pastorally with people in need was a key factor in their choice of work.

I was ordained to care for people, and the attraction of chaplaincy for me was the freedom to focus in on actually being alongside people who were in need. (Chaplain H)

I wanted to be on the margins of the Church without being marginalised ... to concentrate on what matters ... real people in a real situation. (Chaplain I)

I wanted to use my pastoral skills in individual, intense, and particular one-to-one work. I have a tremendous sense that the hospital was a place where my skills were and are used. (Chaplain C)

The attraction was the multi-professional bit and the contact with the un-churched ... an opportunity to exercise my particular pastoral skills. (Chaplain M).

Introduction to questions 2, 3 and 4

The aim of these three questions was to allow interviewees to establish a specific sense of what they believed a chaplain ought to
be in relation to his or her own personal skills and characteristics and the specific tasks of the post.

6.2.2 **Essential personal characteristics of a health care chaplain**

(1) **A pastoral heart**: Nine of the interviewees identified the most important personal characteristic of a chaplain to be that of having a concern for, interest in and ability to relate to people. These skills were expressed in a variety of ways:

I think that the most important thing is for a chaplain to have a pastoral heart ... someone who can empathise and identify with people's suffering. (Chaplain A)

When I interview someone for a job in chaplaincy I would be looking for someone who is interested in people and warm towards people and gets on with people. (Chaplain C)

I think empathy with the person with whom you are ministering to, whether it is a patient or even a member of staff, being able to get alongside is key to the success of a chaplain. (Chaplain D)

I suppose to be able to come across that you have time for them ... that you are willing to be around when other people are willing to run away. That you will stick in there with them. (Chaplain H)

Within this broad definition of approach and style 4 chaplains identified the ability to listen as a key factor in the pastoral process of supporting people amongst whom they work:

I think you've got to be a good listener, a characteristic to be still and be alongside quietly and listen to someone who is talking, and listen to what they are saying. Not to interrupt them and not to try and impose your own agenda on them, which is very easy to do if you're not careful. (Chaplain L)

Chaplain M sums up this sense of having a pastoral heart as a key to the role and task of chaplaincy in the following way

I think warmth and approachability. You'll get precisely nowhere if you don't make yourself available, if you don't have some sheer physical human warmth. I think you've actually
got to like people.

6.2.2(ii) **Openness**: Eight interviewees identified openness as a key characteristic. For 5 of these interviewees this quality of openness was linked with the general pastoral approach and warmth of the individual chaplain’s style. This was how openness was defined:

Somebody who is willing to risk being open and to risk being influenced by people who have different faiths or none. That carries a risk ... because it means that you may have to adapt and change one’s own model, so it’s openness I think that’s important. (Chaplain N)

I would define openness as, in part, being happy with one’s vulnerability and impotence. I suppose it is more important to be an authentic human being in your openness rather than a close-up, efficient professional. (Chaplain O)

Part of what openness means is being prepared to put oneself in a vulnerable situation, with a willingness to have one’s theology questioned. (Chaplain K)

6.2.2(iii) **A theology that can connect**: the third characteristic, which 7 of the interviewees identified as important in a chaplain, related to their theological perspective:

I think some sort of theological integrity, and I don’t mean being able to shout truths from a position of security. I mean the chaplain showing some willingness to keep going and some connection between what they do, what they say and what they represent. I would want a chaplain who was someone who could all the time be able to translate the theological and religious language of their training into a language where people are working, and also know when sometimes to say nothing. (Chaplain M)

You’ve got to re-interpret your theology in a way that people understand. It is not acceptable to give neat, off-the-cuff answers. Your theology has got to really relate to people in their experience. (Chaplain K)

I think you’ve got to have a strong faith which can contain doubt and be ready to adapt to change. Being secure in one’s own faith leaves one free to be able to connect with anybody and enable them to sort out their own theological position. (Chaplain H)
I think having a theology of struggling is important. That means not having the answers and being willing to risk being with someone and allowing their concerns to shape your belief. To become a bridge, to be a catalyst for them. (Chaplain D)

Linked with this theology was an ability to assess situations, and wherever possible to give both patients and staff a sense of perspective on their experience.

6.2.2(iv) **Stamina and a sense of humour**: Eleven of the interviewees, as part of their closing remarks, emphasised the importance of stamina and resilience. One of the interviewees, who had had some management training, linked stamina with an ability to prioritise and be well organised; the other interviewees gave the impression that the work of a chaplain was endlessly demanding with infinite need in the place of work and therefore requiring emotional and physical strength. Humour played an important part in over half of the interviewees' view of their ability to cope with many of the demands put upon them.

6.2.3. **Negative personal characteristics in a health care chaplain’s work**

Interviewees were then given the opportunity to explore what personal characteristics might interfere with the work of a health care chaplain. The responses all fall into two main categories. The first concerns the attitude or approach of the individual chaplain. This relates to the second category, the quality of engagement in pastoral care.

6.2.3.(i) **Inflexibility**: Eight of the interviewees mentioned inflexibility as the main personal characteristic most likely to interfere or inhibit chaplains in their work.
An inflexible attitude which expresses itself in rigidities. For example, a kind of spiritual arrogance which says that we have the answers when nobody else has. (Chaplain A)

I think that inflexibility is related to either a lack of awareness or preparedness to ask some fairly searching questions about one's motivation for the job. Perhaps all chaplains should be psychoanalysed. Perhaps sometimes experiences from our past may haunt us and that we need the hospital far more than the hospital needs us. Of course, we all carry baggage ... I just wish more people would be honest about what's in their bag! (Chaplain G)

Of course the job is stressful, and I think that chaplains that take refuge in security (of whatever sort - managerial, psychological, or religious) can become inflexible and unresponsive. This may be related to our willingness to look at our own hurt bits, our shadow side and our incomplete bits. (Chaplain L)

I would define inflexibility as an over-developed feeling of self-sufficiency. I think anyone who thinks they can manage as a chaplain on their own - that they can deal with all that is thrown at them, that they don't need to be supported, that they need no further training and that they are able to get on with anything, are potential disasters. This inflexibility can lead to a profound inability to work with other people. (Chaplain B)

Inflexibility and a narrow-mindedness and an inability to accept how very different people are and how different their needs are. I think this is related to chaplains' attitudes to supervision and training. (Chaplain C)

...recognising that we have got all the answers - being judgmental and making assumptions about what you think a person needs and what they themselves want is a dangerous personal characteristic in many clergy and some chaplains. (Chaplain K)

6.2.3.(ii) **Too much certainty in theological approach**: Six of the interviewees highlighted a chaplain's over-defined theological approach informing his or her pastoral ministry as a significant factor which might hamper their work.

A rigid theology which wasn't flexible. (Chaplain F)

I think being too religious - religiosity in any way shape or
form - thinking you've got the answers, or thinking somehow you've got to justify God or have the answers for people when there aren't any. (Chaplain E)

I don't think we realise what a strange language theology is. Too many chaplains can only speak, as it were, Church language. I don't think that the organised Church realises how very out of touch, not hostile but out of touch, Christian languaged people are. I think more chaplains ought to be critical about theology as a tool for their work. (Chaplain N)

I like to use the term 'a double-glazed view of religion' as summing up a kind of attitude to religion and theology which is destructive. What I mean is the kind of person who has got religion neatly set up, well protected from all the battering of external gales and wind and hail and snow. This kind of person is just going to be unmoved ... incapable of being vulnerable ... there are some glorious inconsistencies about the truth of what we represent, and our theology ought to hold and manage that. (Chaplain J)

Because we live in such a fast-changing society I think there is a desire within a lot of people to find stability and concreteness. Evangelical churches or other groups who desire security and certainty can often provide them. It's my experience that many staff go along that route. For example, doctors often seek religious foundations which are strong and can withstand anything. They are attracted to a kind of religious certainty. I'm afraid that rigidity does not help any of us withstand the tears and the volcanoes that happen in hospital life. Perhaps our role is to help people to understand that life is not as clear cut as some religious commentators would like it to be. (Chaplain D)

6.2.3(iii) **Inability to listen**: Five of the interviewees highlighted the importance of listening and stressed an inability to listen and so to respond to individuals as an important factor in this section.

I think chaplains underestimate the significance and uniqueness of their marginalised listening role. Too few of us really spend time listening gently and sensitively to people. When we feel under threat the tendency is to rush around and be busy. I wish we were more confident in this tool of listening and conscious of our failings in listening. (Chaplain O)

The unwillingness to engage with people where they're at. I think one has to be prepared to listen to people's stories. In a culture that demands we prove the validity of our existence, it's often the quality of listening that goes out the window first for the sake of job security. (Chaplain D)
The real weakness that I see in myself is the fact that a lot of people I listen to I find rather boring. It's terrible resisting yawning as someone is spilling out their story. I wish there was a tablet I could take that would enable me to be more interested in people. Part of the work is to listen, but it's not easy to listen creatively and attentively. (Chaplain H)

6.2.3(iv) Lack of self awareness or professional boredom: Four of the interviewees talked at length in this section about whether or not they had been in chaplaincy for too long in relation to their own ongoing professional creativity, and the potential dangers of 'burn out'.

There is still a lot of guilt among ordained people and the feeling that they've got to hold onto their job, their chaplaincy ... they can't hand over easily, and they can't share, which leads to indications of burn out. I do think there's a lot of cynicism, a lot of carelessness and a lot of bad temper amongst chaplaincy colleagues. I think partly because chaplains think they've had a safe job and now they are in a position of having to justify their existence and be managed by other health care professionals. This is threatening. (Chaplain C)

It's very easy to be lazy in this job. Ten years ago I was left to run things very much as I wanted and no-one especially interfered with my work. I am now in a position of being managed, and although I have to go through the motions of producing business plans and reports, there's nobody around who really checks up what I'm doing and why I'm doing it. I think there are many more people in health care chaplaincy who are burnt out and bored with their jobs than one might imagine. They take refuge in involving themselves in everything else but the ongoing spiritual care of patients and staff. (Chaplain N)

6.2.3(v) Discomfort with being marginalised? : Three interviewees shared their reflections about the paradoxes of being the representative of the Church in the hospital, but feeling ambivalent about what the function of representation means. One chaplain expressed it in this way:

We have to achieve a balance between assuming that because we are a priest that that gives us rights; that people understand who we are and what we represent, and being so unconfident about our role that we apologise for it and pretend
to be something other than we are. Both of these extreme positions result in marginalisation. (Chaplain K)

One interviewee articulated his own need to want to define his role within the hospital as being very different from the traditional role of a priest in a parochial setting.

I think most people experience religion as irrelevant, idiosyncratic and deeply disconnected from their every day concerns and feelings. Many view clergy as irrelevant, and I think my job in the hospital is to present an acceptable face of religion through the quality of my personal contact and my ability to interpret the meaning and truth of the spiritual in a secular context. (Chaplain O)

6.2.4 The tasks of the health care chaplain

Interviewees were asked to articulate the three key tasks of the work of a health care chaplain, and there emerged a remarkable degree of consensus. All 15 interviewees placed at the top of their list spiritual care. There was a significant division over whether chaplains viewed the spiritual support and care of staff as more important than that of patients. The other tasks are listed below in the order of priority placed on them by the 15 interviewees:

1. Spiritual care and support of patients
2. The spiritual care and support of staff
3. Team leader and enabler
4. Education and teaching
5. Change management
6. Representative of the Church

This is how chaplains more clearly defined those core tasks:

- To meet people pastorally and enable them to develop some appropriate religious expression of meaning within their illness.
- To enable people to express their spirituality.
• To be available to those in need.
• To be present for people.
• To keep the chaplaincy profile high through an effective management of the team and its work in the hospital.
• To be a team leader and enabler.
• To explain what chaplaincy is through the management of communication within the team.
• To prove the worth of chaplaincy through the use of management tools, of mission statements, business planning and audit.
• To ask questions and challenge the institution .... to be the conscience of the place.
• To struggle with the institution as you find it.
• To enable the institution to come to terms with change.
• To represent the church in the hospital.
• To be a person of prayer ... the Maker's representative!

6.2.5 Chaplaincy in context: reflections on management and values within the National Health Service

Introduction to Question 5

The aim of the next set of questions was to explore the range of views about how health care chaplaincy was developing and responding to the significant changes in the National Health Service after 1990. This next set of questions was designed to allow chaplains to evaluate chaplaincy within their units and to explore the opportunities and constraints placed upon them, given their present contexts.

6.2.5(i) An Improved National Health Service?: Six of the 15 interviewees began their comments and reflections about the

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National Health Service by affirming that their overwhelming experience of the NHS reforms had been positive. They articulated particular areas of improvement before highlighting some of the difficulties and problems. In all these 6 cases there was a very positive sense that their respective hospitals were supportive of chaplaincy and that the structural and cultural changes that came about as a result of the reforms were creative and provided a positive strengthening of the role of the chaplain within the hospital. The remaining 9 interviewees articulated a range of negative experiences of management and values within the NHS without any reference to the positive benefits.

6.2.5(ii) Improved efficiency in management: Four of the chaplains spoke about the improvement of management of the hospital and the ways in which the introduction of Trust hospitals provided more opportunity for management to shape the culture of the place and the corporate identity of its purpose and life.

I think we’re very fortunate here that we do actually have quite a good management system which has come about since we have become a Trust. I’ve experienced improved communication with this present-day management system. People feel involved. People know what they’re about. There’s an improved pride in the place. (Chaplain G)

I think we have a much more up-front management style which is more looking towards end-results. The up-side is that I think it has actually made us think more clearly; we can’t waffle around saying ‘look what we’ve done’. I don’t think that’s altogether bad. (Chaplain M)

Speaking for our Trust, we have a Chief Executive who has worked very hard at trying to have an open style of management, who has tried to introduce a culture of our visions and values, where we have freedom within a framework, where things are team-orientated, where there should be openness of information and good communications. This is all a very good and positive thing. (Chaplain A)

Two other chaplains again pointed out that the freedom Trusts had as a result of a certain measure of de-centralisation of control and
power allowed Trusts to organise aspects of their work much more effectively and responsibly towards the individual patient. One chaplain referred to the re-designing of the front entrance of the hospital in a way that was much more user-friendly for patients and visitors. Another chaplain related at length how the whole procedure for dealing with out-patients had improved considerably as a result of the NHS reforms.

These six interviewees appear to have responded positively to the opportunity offered by the reforms to communicate the nature of chaplaincy. The introduction of a management culture had provided them with the freedom to begin to think differently about how best to develop chaplaincy and had allowed them access to a greater range of managers to explain the nature of spiritual care. Chaplain F sums this up:

I know that many of my colleagues would disagree, but I feel positive about notions of accountability. I don't feel threatened by the fact that chaplains now are required to explain who they are, what they do and what difference their work makes in the hospital. I think it's absolutely right that chaplains shouldn't be exempt in any way from that process. We all need to be able to define what we do, why we do it, how we do it and how effectively we do it. That's a good discipline for us and for the hospital; big institutions need to know how the money is spent and whether it's being spent effectively.

6.2.5(iii) **Too much change handled badly**: the remaining interviewees gave a very strong impression, backed up with anecdotal evidence, that much of the change that had come about as a result of the reforms had been managed badly. One chaplain made a crucial distinction between structure and culture within his own organisation. He felt that while some structural change was necessary to improve the efficiency and effectiveness of the delivery of health care, this structural change had profoundly re-shaped the
culture of the hospital and that this cultural change was being managed inappropriately. Three of the interviewees clearly resented having to be managed and accountable to another individual (in these 3 cases, to someone of another profession from the chaplain and a good deal younger). These 3 individuals asked not to be quoted at length about their feelings towards management, fearful of the possible consequences of their criticisms and feelings.

6.2.5(iv) **Poor management**: These comments reflect this position.

I feel, overall, desperately sorry for those who are in management, even those in senior management, because of the sense of vulnerability and job insecurity. Our hospital has undergone three major reorganisations in the last 2½ years, and what I can't be clear about is whether the difficulties that have inevitably emerged as a result of these re-organisations, are due to the impossibility of achieving such change within constraints, or just poor management. I suspect it's a rather complex mixture of the two. Whilst expressing sympathy for the tasks of managers, I find the quality of their work very questionable. One example would be constant poor communication. (Chaplain G)

I genuinely don't understand why it was necessary to increase the number of managers working in our hospital. Many people within the organisation were promoted to these posts, and to my mind without appropriate training or support. While I feel sorry for them - some are frightened because they're afraid of their own jobs - there is a general culture of incompetence about, and I resent having to be subject to their inefficiency. Two examples of that. First, I think the amount of paper that I now have to deal with has doubled, and I'm not clear what end this bureaucracy serves. An example of inefficiency within the system is that only last week I was summoned to the Magistrates' Court because I hadn't paid my Community Charge. It was part of the package that the hospital would pay it. I kept passing on the final reminders for this bill until finally I was summoned to Court because of the system's inability to pay the bill. I dread to think what else is happening within the financial system! (Chaplain I)

Until the hospital became a Trust I was left alone. I did the job and I got on with it. I think that I did all the things that were expected of me and lots more. Nobody interfered with me. Suddenly we've got management and I've got to be in that. I
find that quite restricting. I don’t see the point of it. And I find the fact of this management structure being imposed upon me quite difficult to handle.

(Chaplain C)

6.2.5(v) **A change in values**: Seven of the interviewees reflected on the change in values of their hospitals, shaped by an emphasis on financial accountability.

Money now seems to be the God. It’s always been around, of course, but it’s now the trigger that sparks everything off; the questions are asked ‘What happens now about money, where does the money come from? How are we going to finance this? Do we need to finance this?’ One practical thing that I think has resulted in this concern for finance is the early discharge of patients. In an attempt to use beds more cost-effectively, I do think that many patients are discharged far too early, and in some cases return still needing attention and treatment. I think also that the emphasis on financial effectiveness has caused much more stress amongst staff. (Chaplain D)

The provision of health care is strictly controlled by the pounds and pence. I think this is affecting how people see their work and has a knock-on effect in relation to the quality of care. For example, there are lots of areas where decisions are made about the care of patients, and these decisions are being made by people who have no notion of what it is like to look after sick people. Financial concern is not related to the process of care. (Chaplain B)

The personal values thing is that I find that a lot of the management are unhappy about certain things, the external pressures, the external restraints that they have in order to balance the books. (Chaplain A)

The kind of erosion of the spiritual, personal values, human values, because of the strong market forces which bear upon the way people think and respond. The terrible cost is that people are so devalued by the whole system. You see this now in an attitude whereby they do not want to give as much as they did over and above what they’re paid for. I have to accept that an institution dedicated to healing and wholeness can create so much sickness amongst its work force, and I think that the concern about money is the key element in this picture. (Chaplain E)

**Introduction to questions 6 to 15**

Questions 6 - 15 were designed to enable each chaplain to articulate
a variety of dimensions of the work of an acute health care chaplain. Chaplains were asked to reflect upon the positive and negative factors which contribute to their ability to perform within each hospital trust. They were also asked to reflect upon the place of chaplaincy within their organisation and to share an impression of what challenges and possibilities were present for chaplaincy in the future.

6.2.6 What do you think prevents you from performing the tasks of health care chaplaincy within your unit?

6.2.6(i) Too much freedom? Five of the interviewees felt that there was very little within their hospital that prevented them from performing the roles and functions of chaplaincy.

I come and go as I please ... no-one is breathing down my neck and no-one (as yet) has asked me to make any account for how I spend my time. It's perfectly possible to shut my office door and sleep for the afternoon without being bothered. This is a constant worry to me; my freedom is an indication of how little my organisation values what I do. Or perhaps no-one quite understands the role and has the time and space to learn from me about what I do. (Chaplain N)

Very little prevents me from doing my work. Our Chief Executive says about me .. I pay the chaplain to be an optimist. I think he means by that I don't really get in the way and that our work is a tremendous asset to the morale of the community here. In practical terms no-one much interferes with my day-to-day work. (Chaplain J)

The chaplaincy here is given a lot of freedom. We get very little interference from management. We prepare once a year the business plan which never gets any critical reflection back, and I have a vague feeling that senior management feel that we do a good job. (Chaplain H)

I wouldn't say that we get any interference from management and I have to say that we are very well supported in this hospital. Both the Chairman and the Director of Nursing Services are church people, and that seems to help the general feeling that we are doing a good job and expresses itself.
6.2.6(ii) **Bureaucracy and management**: Nine of the interviewees spoke about the significant burden of bureaucracy as a factor which prevented them from spending as much time as they would like in and around the hospital. 4 of these interviewees related this increased bureaucracy to the NHS reforms.

Bureaucracy - meetings - form-filling - the lot, if I want to I can go in on a Monday morning and not see a single patient. I can sit at my desk ... and read the nonsense that comes through the internal mail. I think when I first began in the Health Service my bin got emptied maybe once a week; it has to be emptied now two or three times a day, and I'm not exaggerating. (Chaplain I)

Without a doubt there's too much admin. I now have a lot more administration which feels quite useless and irrelevant to my pastoral work. Just tons of paper really (Chaplain K)

At the back of my mind I have a sense that the main task for chaplaincy is about being visible around the wards, and listening to patients and staff. I feel that the demands of management constantly get in the way of this. We are now, as a chaplaincy team, much more involved with a higher profile in management than when I first came. Our manager likes to meet with us often, and we have to prepare agendas, budgets, letters, all sorts of documents for her, and that can take a lot of time that might - and I'm not saying that we would - spend in the wards. (Chaplain C)

6.2.6(iii) **Working relationships - confusion or hostility about the perceptions of role**: Five of the interviewees articulated the attitude of staff as a significant factor preventing them from performing the tasks of chaplaincy in the unit. Two of these chaplains shared some reflections upon what they perceived to be prejudice against religion based on some kind of experience of, or agenda, on the part of a staff member.

Working relationships can get in the way. ....You can have someone in charge of a ward who is personally hostile to chaplaincy. Though you get in when you have to, if patients send for you, you feel that only the most determined patients get through if they want to see a chaplain. But if you go in
casually, then I have had the experience of being questioned by nursing staff as to what one is doing. I think some feel threatened and others just don't like religion! (Chaplain C)

I feel that my role as a chaplain is surrounded by tremendous variation of expectation. Some understand what I do and are keen to involve me in the planning of a care package for patients. Many others seem to want to describe me as the acceptable side of religion, and I've overheard staff saying to patients .. 'why not have a word with chaplain: don't worry, he's not like a vicar, he's not really religious! (Chaplain G)

I think that difficulties emerge when I feel that I'm cast in a narrowly ecclesiastical role. I wouldn't actually want to dodge the role of the priest because I think there are times when people consciously or unconsciously want a priest; someone who represents something and can do something which on the face of it will make things better. But I think we're always saying that the chaplaincy role brings with it a cluster of other things. I think our role with staff sometimes is pivotal, both in relation to the role of pre-counselling and pre-evangelism. What I mean is that we are sometimes hanging on with a toe-hold to people's perceptions of what we might be about and what we represent. I sometimes think our main function is to suggest that this organisation called the Church, and the gospel that it stands for, might just have a human face. If we've done that then we've done something. This is where role confusion helps, because we're able to help with the diversity and complexity of people's expectations. We need also to be demonstrating that Christians can think creatively and compassionately (Chaplain M)

Sometimes people are hostile to chaplaincy because of their own beliefs or their philosophy on life. They can be very anti-chaplains because maybe they are a lapsed something-or-other, and they feel guilty about it and they've decided to ridicule it and make it not worthwhile. There are a small minority of people for whom my presence in any area of the hospital irritates. (Chaplain H)

6.2.6(iv) Communication: Four chaplains spoke of the difficulty of communication within large and changing organisations. This point relates to the nature of the organisation rather than the particular work of chaplaincy. These interviewees felt that it was sometimes impossible to know what was going on at a number of levels within the organisations. This relates to an earlier point about there being
too much change badly handled. (see page 164)

I think that change has become difficult, because there have been so many changes of personnel, changes of wards, changes of policy and changes of style. Change is all worked very well if we are the ones who are innovating it. The trouble is that the change seems to be happening to us and we have very little power over it. The biggest change is the turnover of staff. I seem to be invited to more farewell do's than anything else at the moment, and that can be frustrating, particularly when you've spent a lot of time building up a good relationship with a nurse or a manager. (Chaplain H)

The whole process of networking has become much more complex. I think there's a difficulty for me as the chaplaincy leader to manage structural communication. There are in our Trust six directorates, each doing its own thing. The old pyramid style of management was actually much more easy to work with. Even a flat style of management would be easier, but having five upright structures - it's just impossible to interface with. Amidst all this management change the notion of spiritual care takes a very low priority in some directorates, and I don't feel that I have a method of dealing with a very wide range of managers which puts chaplaincy firmly within their approach and thinking. (Chaplain D)

6.2.7 Exploring other negative elements in chaplaincy work

Interviewees were given an opportunity to articulate particular negative experiences or incidents which were felt to be especially significant.

6.2.7(1) Making a difference in a large organisation: Five of the chaplains reflected further upon the problems of getting things done within a large and complex hospital organisation. There was an underlying sense that it was very difficult to make any kind of difference in shaping and influencing the life and work of the hospital.

I feel very alone a lot of the time and really quite alienated from a proper sense of shared purpose. Perhaps I've been here too long (17 years), or perhaps I'm just getting too old to be flexible and adaptable. I do find myself siding with other colleagues in the hospital when they express their deeper needs at being able to make any difference to an organisation which seems to be dominated by a concern for contracts,
management and money. (Chaplain O)

I have a constant frustration of feeling rather like Charlie Brown - when he says 'you can't fight City Hall'. Sometimes you do feel that whatever and however many memos you send, however many doors you knock, I think the frustration of wondering whose responsibility it is and who can action this is a constant negative factor. For example, everybody in the organisation has a measure of unease about the fact that dead bodies are transported around the hospital on very obvious trolleys. I speak to people and I write to people, and they agree 'yes they are terrible, but no-one seems to be able to sort it out and action a new set of trolleys. (Chaplain G)

I feel that I am a natural problem-solver and that my ability and patience to solve problems in this environment is tested to the full. For example, it took me two years to sort out problems with the mortuary. I don't fully understand why the organisation doesn't work as creatively as it might. Perhaps it's unrealistic to expect change to happen quickly over a particular issue, given the size and nature of the place. (Chaplain A)

6.2.7(ii) Relationships with the medical staff: Three interviewees spoke at considerable length about the overwhelming negative factor for their work being both the dominance of doctors within the hospital culture and their own personal relationships with medical staff.

I think that some of the consultant staff, particularly .... after 11 years I'm still like a bit of shit on their shoes. They don't speak, they don't look at you, they keep their heads down. I've worked very hard at an approach which supports their sense of power and control, yet gently asks questions about other human dimensions of care. I've thought about it a lot and I think it's to do somehow with them seeing me as the 'mopper up' of their failures. Even on wards where I've got on well with some of the consultant staff and been used by them, I'm greeted by a paediatric consultant saying 'what's wrong D, is there anything I should know when you're on the ward? When I was there he was looking around for who was dying and wanted to know about it. My presence, for doctors, is often seen in wholly negative ways. Even consultants that have used you with patients, once they've finished using you, still don't really want to talk to you very much. I find that extremely hard." (Chaplain D)

I'm genuinely appalled at the kind of power that doctors have in this acute unit setting. Much of this goes unchallenged. While I admire the huge gains achieved within medicine over the last 20-30 years, somehow we seem to have lost the human
dimension. Science and objectivity are much more important than art and subjectivity, and it is the kind of medical dominance that I find most difficult to deal with. (Chaplain M)

6.2.7(iii) **Audit and outcome**: Three chaplains talked about the difficulties surrounding the move to measure the effectiveness of services within an acute setting.

I do struggle with how my outcomes are measured and how I am to audit what I do. I'm not a haematologist that takes blood and analyses it, or a speech therapist who says 'because of my work now this patient can do this or that'. Much of my work is intangible and doesn't fit easily into the present culture of audit. (Chaplain G)

6.2.7(iv) **Burn-out**: Two of the chaplains spoke at very considerable length about their feeling burnt out in post. There was a general feeling that the constant exposure to acute illness and death had left its mark upon the ability to change and adapt. Both talked about a constant feeling of tiredness, and at getting involved in things outside of the hospital, for example, diocesan education and administration, and National Hospital Chaplaincy’s Council work, as a way of coping with the pressures and difficulties of chaplaincy work. Both chaplains asked not to be quoted in this section, and felt confident enough that they were in touch with their feelings of burn-out to work them through to a positive conclusion.

6.2.8 **Articulating the sources of strain and tension within health care chaplaincy**

Five of the interviewees felt that at this stage in the interview they had said enough about the problems and difficulties relating to their work and wished to proceed with specific issues of conflict. The remaining 10 interviewees expressed an overwhelming consensus about the sources of strain and tension. These fall into two
categories: the first relates to the constant exposure to acute illness and death, and the second relates to perceptions about the confusion between spiritual care and religious care.

6.2.8(1) **The cost of working with acute illness and death:** Eight of the interviewees spoke at length about how costly working with acute illness and death was; two particular quotations illuminate this area of strain and tension:

You can’t be working with people who are sick and not feel strain and tension, can you? My heart always sinks when my bleep goes off and I see that the number is paediatrics. I think that I can cope reasonably well with premature babies, even little babies, but children who have developed a personality and all of whom seem to look incredibly beautiful and face illness and death, really do give me enormous tension and strain. Last week a 3 year-old boy had a fit and was brought in brain-dead. You can imagine the trauma that the parents experienced. It was doubly difficult for me because his brother had done precisely the same 18 months ago, and I was very involved in that situation. I really did feel that I had absolutely nothing to give or nothing to say. I could see no logic in it, but only feel the desperate tragedy. Having to face experiences like that sometimes two or three or more in the day, takes its toll. (Chaplain B)

I find work in intensive care especially challenging and difficult. We have the regional burns unit here and there’s a constant number of patients coping with very horrific accidents. I remember two months back having one death there each day for about 10 days, and getting very involved with the family of a 21 year-old who had been involved in a car accident, and because he was young and fit and healthy, took three weeks to die. I moved between coping with each of these particular deaths and going to his bedside to watch the horrendous sight of his body rotting away. The smell was horrendous and the physical and mental pain quite unbelievable. I remember going away one evening and thinking to myself that it was quite unhealthy to be around all this intense feeling and physical suffering when my bleep went and I was called into the burns unit again by a plastic surgeon who was treating an 18 month old child injured in a house fire. He said over the phone ‘there’s nothing we can do, will you please come down to the unit’. Every fibre of my being wanted to say no. (Chaplain H)

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After relating a similar sense of strain and pressure from the constant exposure to failed liver transplants, one chaplain commented

I don’t really think that chaplains share the questions about coping with illness with as much honesty and openness as they might. There is a cost to care and all of us have our coping mechanisms which often, I think, in the long run, take us away from the patients into a kind of security gained through another role. Some become national figures in chaplaincy and enjoy going around talking about how to do the job (whilst running away from it themselves), others make a cult of being the manager and some escape into teaching. This isn’t bad – perhaps it’s all necessary, but I long for a bit more honesty about the costs of care. (Chaplain O)

6.2.8 (ii) **Role confusion**: Two chaplains in this section mentioned the difficulty experienced through staff and patients wanting to confine and define the role of the health care chaplain in narrow religious terms. They spoke about the sense, from among those who defined it narrowly, that the chaplain’s role was simply about supporting those who had explicitly Christian faith and wanted support especially during the process of death. From this perspective there was a constant challenge to educate staff and others about the role of chaplaincy in non-directive listening and support.

6.2.9 **Exploring conflict**

In question 9 chaplains were asked about the points at which they experienced particular conflict within their units and to express this through a particular example.

6.2.9(i) **Managing conflict**: Three of the interviewees expressed the feeling that wherever possible they either managed or, in one case, avoided any conflict within their work.

I don’t feel I have any conflict in my work. It's quite simple, but then that's my style, I think. I see chaplaincy as focussing
people on what they can be doing and supporting them in what's possible. In this sense I guess I work as a problem-solver and a reconciler. I really have very little conflict. (Chaplain A)

I don't like conflict at all and so I try to avoid it. I think I probably change my behaviour when I see it coming. I try to work round it, which is not a bad thing because I don't manage conflict very easily. I suppose I find it difficult to take such a 'hands-off' approach to many of the recent redundancies within the Trust, which do seem quite cruel and brutal. I don't think the Trust know how to handle them. I sometimes get pieces to pick up, and at one level I ought to challenge the organisation about its activity in this area, but I don't. (Chaplain C)

6.2.9(ii) **Conflict through acting as an advocate for staff**: Seven of the interviewees related particular examples of the conflict that they have experienced with senior management as a result of chaplaincy's involvement in staff support. Such conflict arose from taking up a particular case of an individual or staff group and thereby challenging the institution to think about its behaviour. One interviewee talked at length about his concern for the domestic staff and their wages when the catering and cleaning contracts went out for competitive tender. Another interviewee talked at some length about her concern for how a directorate manager was treating staff and made a formal complaint to the Chief Executive about his behaviour. This resulted directly in an investigation which led to the manager's suspension (the chaplain wanted the details of this case of conflict to be kept confidential).

Other chaplains comment:

Consultants earlier this year decided to take part in a television programme which was exploring how awful the situation was in the NHS - how dire it was and how it was in crisis. They were not actually into a management bash, they were saying: Here is a well-run hospital but there are problems. They asked me to join them to reflect upon issues about staff morale, which I did. I do feel it's part of a chaplain's role to speak for those who cannot easily speak for
themselves. I felt it was important to share with others how staff can easily become demoralised and devalued in a place where people are too busy changing to care. I got a mild wrist slap from the hospital for speaking out; it was mild, but a reminder to me about how easily people can feel threatened. (Chaplain M)

Perhaps fighting the corner of members of staff who I feel are being unfairly treated sometimes, I get irritated (and express this) with management when they refuse to get out of their offices and to wander around to see what's going on. There's a lot of conversation about the sense of corporate identity which in practice is meaningless. Many of the problems that are around staff advocacy are really about inappropriate or inadequate communication. (Chaplain B)

6.2.9(iii) **Conflict over resources** : Four of the chaplains spoke about conflict over the resourcing issue within their own departments. One interviewee was finding it difficult to appoint to a vacant post within his team. Two interviewees were experiencing difficulties about secretarial support for their departments. Another interviewee, working alone, had been battling with the Trust about support for his heavy 'on call' commitments. This left him feeling very devalued and, as a result of the lack of support from management on this issue, he was considering leaving his Trust.

6.2.9(iv) **The management process** : Two interviewees spoke about the local and national politicisation of health and the frustration experienced as a result of working in a very complex organisation.

I feel frustration more than conflict. I suppose it's partly to do with whether or not I feel that I am being listened to in the organisation .. whether my being here makes any difference. I'm endlessly frustrated about issues involving value judgments where advice has been sought and given, and I thought agreed, but then you find another management process has become involved and what one thought or perceived was quite a creative or open and honest discussion, appears now to have been totally ignored. My Chief Executive wants me to exercise a role as the conscience of the organisation, but in practice my experience is that nobody takes any notice of what I say. Of course they do sometimes, but it's very de-energising and frustrating. (Chaplain D)
I have frustration between what they (both politicians and managers) perceive is happening in the Health Service and what is really happening. You hear people from the Health Authority on the television announcing that some initiative is happening, but this does not square up with what's happening at grass roots level. At one level I wish that everybody involved in the NHS had the experience of being a patient, and from that perspective to explore the credibility gap between what they believe is happening and what is actually happening. I'm particularly scandalised by the ways in which my Trust seems to be able to get around the figures around cancelled operations. Different language is used, and often people are not put on a waiting list so that figures can be manipulated.

(Chaplain C)

6.2.9(v) **Project 2000**: One chaplain spoke about the importance of his role in education of both doctors and nurses and the difficulties encountered. His particular example of conflict emerged out of the introduction of the Project 2000 course. As a result of developments in nurse education he found himself without a role and felt that this lack of contact with student nurses would have a significant effect upon the effectiveness of the working practice of a chaplain at ward level in due course.

6.2.10 **Articulating the positive and energising dimensions of acute health care chaplaincy**

Question 10 asked chaplains to reflect upon the positive dimensions of their work.

6.2.10(i) **The support and affirmation of colleagues within the Trust:** Thirteen of the interviewees articulated as one of the most positive dimensions of their chaplaincy work the positive support and affirmation that they receive from staff at all levels within the organisation, despite the problems already described. For the majority of interviewees articulating this point, this support and affirmation was directly related to the explicit sense that many staff understood the importance of both the chaplain's work and what the
chaplain represents. For others, the encouragement and affirmation came from working alongside other professions, and the shared sense of purpose and collegiality that developed from that collaboration.

In this secular world where organised religion is on the decline, I am constantly surprised and encouraged by the wide-ranging awareness of people. In a tangible sense, for the majority of my time I have a feeling that staff understand my presence and work. I've never been in a job where I have had so much positive and encouraging feedback. In almost every area of the hospital I feel that I have the confidence and trust of staff, and that they are willing to introduce me to other people and support chaplaincy. The majority of these staff would have very little to do with the organised Church, and some have had negative experiences of it, but the key factor in the positive dimension of my pastoral work is an open, trusting, human relationship, where people feel they can experience a quality of care and support. It is not, of course, one way. I in my turn feel very supported and listened to by colleagues and patients. (Chaplain C)

I am profoundly moved by the encouragement, the affirmation, and the affection of fellow NHS staff. It expresses itself in so many different kinds of ways. I remember having been called in to deal with the aftermath of a house fire in which people had been killed and there were some survivors. One ambulance paramedic, hearing me coming into the Accident and Emergency Department, looked out of the ambulance as I was walking in, having parked the bike. "J, you always turn up for us ... who turns up for you?" It's moments like that ... human contact that gives you the strength to go that extra mile. (Chaplain J)

Despite all of the recent upheaval around the NHS reforms and all the challenges to the notions of care (in relation to financial efficiency and effectiveness), I'm constantly surprised and encouraged at how important a whole number of staff and managers feel spirituality is. Nursing staff appreciate that patients need space to explore the meaning of their illness, and the best kind of managers realise that any community should be talking about values and its spirituality if it is to be adapting and caring and responsive. So many different people say to me that I'm important, and that I represent something which is impossible to quantify or purchase. (Chaplain F)
I think that the positive things are that I have had very good support from managers that I can relate to easily, and who have an understanding of chaplaincy. This exists at all levels including the Health Authority level. In my area there has been an increased interest in chaplaincy and this has expressed itself through more appointments coming on board. (Chaplain A)

What surprises me is that even the people who don’t really understand what the chaplain is up to, seem to think that the chaplaincy is a good idea. Now obviously, some of the health care professionals as individuals may have hang-ups about the Church or about religion, for various reasons, but even those, if they exist, don’t seem to use that as a stick to beat the chaplaincy with if anything goes wrong. It’s the feeling that people generally think that you are a good thing, not you personally, but what you represent - that what you stand for is a good thing. (Chaplain E)

6.2.10(ii) **Working in a team**: Five of the interviewees felt that working collaboratively in a team of chaplains was a significant factor in both their feeling personally supported and the work of chaplaincy getting done.

I talked earlier about the work being incredibly stressful. I get an enormous amount of support from the team itself. I have been very fortunate in having a good Free Church colleague - having someone that one can rely on. We have developed a system of trained volunteers who work with the paid chaplains in covering the hospital and being available to support and listen. (Chaplain D)

While I know that there are frustrations in being part of a team - it is the group that I’ve most come to value because it helps and supports me working things out. The volunteers are a key element in our profile in the hospital. They enable wards to be covered and people to be aware of our work and presence. (Chaplain G)

6.2.10(iii) **Freedom**: Four chaplains reflected on the surprise that they all felt at having so much freedom within their jobs - even in spite of the introduction of management controls and audit.

It is impossible to plan your day. One is constantly interrupted by a wonderful mixture of requests and
opportunities that emerge from bumping into people. As one gets better known in the hospital then the bleep is constantly going off with staff in a number of areas asking you to listen or support. My freedom is the greatest luxury and one of the greatest demands. (Chaplain B)

Sometimes I wonder if I've got too much freedom?! I think we sometimes underestimate this freedom. I know that we have our pressures and we have our deadlines, but there's still a great deal of freedom. I think that one of the privileges of the job is that if it is 3pm and you feel lousy you can sit in your office and have a sleep or go home. I can't think of another member of staff within the hospital who has this amount of freedom. (Chaplain M)

The freedom of being part of the institution yet not, and able to go anywhere within in. Having this unique position which possibly a lot of people don't understand - but if you can live with that it doesn't really matter too much. The freedom and the marginalisation are key to what keeps me here and energise. (Chaplain E)

I think the freedom that I've had to meet almost anybody in the hospital and build up and develop a range of links and contacts has meant that quite literally I feel part of the fabric of this place. There is a sense in which one of the things that energises my life is the sense that I'm indispensable; that people need me. When somebody learned that I was leaving last week she came up and said to me 'but you are part of the fabric, you're like one of the bricks, you can't leave, the whole place will fall down!' Obviously it will not, it will continue. But I do think that that's a lovely feeling - to be seen as part of the place. (Chaplain O)

6.2.10(iv) The courage of patients: Two chaplains spoke about the privilege of being such an intimate part of patients' struggle with illness and death. One interview summarises this sense of privilege:

I never cease to be amazed at how people, going through the most difficult of circumstances, cope with what life deals them. It's the courage of the human spirit that continues to uphold and stimulate and enliven one's positive feeling about the creative heart and mind. (Chaplain G)

6.2.11. Exploring staff expectations

In question 11 interviewees were asked how important they felt the chaplain was in the eyes of other staff. Thirteen of the 15
interviewees gave the impression of a very variable picture across their units. One chaplain said categorically that the majority of staff in the hospital felt that the chaplain was an important part of the institution, and one further chaplain felt that at present the chaplain was not currently at all important to staff.

In the majority of reflections on the variable nature of how important the chaplain is, a number of key factors emerged as significant. These were:

6.2.11(i) **Personal and professional contact**: for 8 of the interviewees the importance of the chaplain and the regard in which the chaplain was held by staff related to their seeing the chaplain in action, especially in a crisis situation. It was felt that staff who understood and affirmed the role of the chaplain had seen the chaplain at work, and knew from first-hand experience the difference that the chaplain’s intervention had made.

6.2.11(ii) **Involvement in education and training**: Five of the interviewees related this question to their involvement in education and training. Many of the difficulties around the understanding of chaplaincies' role had been overcome by their participating in medical and nursing training, and especially in the induction programmes of all staff into the hospitals.

6.2.11(iii) **Visible presence**: Four of the interviewees felt that the key factor in the staff appreciating the importance of the chaplain related to the chaplain's ability to be visibly present throughout the hospital.

6.2.12 **Working relationships within the trust**
Interviewees were asked who they worked most closely with in the institution. Every single chaplain mentioned the nursing staff as the key professional group with whom chaplaincy most closely collaborated. Many interviewees reflected upon the significance of good working relationships with nurses at ward level as the critical factor in the function of pastoral care to staff and patients. 2 of the interviewees mentioned collaboration with their own chaplaincy team members, and this was felt to be important for those chaplains who were team leaders. One interviewee felt that his line manager was also important in the day-to-day work of chaplaincy. 5 of the interviewees referred to their hope of being able to work more closely with the medical staff.

6.2.13 Where do you find yourself in shared consensus within the hospital?
Chaplains were asked in this question to give an impression of the areas of work where they felt chaplaincy worked most creatively in shared consensus with the unit.

6.2.13(1) Support in managing crises in critical areas of the hospital
Six of the interviewees referred to their role of working with staff in particular areas of the hospital. These areas included Accident and Emergency and the Intensive Care Unit, but in four interviews they also relate to the role of the chaplain on the Maternity Unit in cases of neo-natal death. Chaplains spoke about how their work in these areas gave them a tremendous sense of working together for the patient in that crisis.

I think that the most significant thing that I've done during my time here which is very widely appreciated by the hospital, is sorting out the whole protocol for the disposal of non-viable foetuses. This worked at a number of different levels. Firstly, I did a lot of work around their own feelings and reflections.
about working with bereavement and loss within the Maternity Unit, and second, we produced a service in the context of which parents could begin to express some of what they were feeling in relation to their loss and bereavement. This practical problem-solving gave the hospital a lot of good publicity, but most significantly for me it enabled a group of professionals to work through this together, and come to a solution which took seriously the support of staff and parents around loss. (Chaplain B)

I suppose I feel that I am working most closely with the organisation when I am somehow needed. The staff I work most closely with in shared consensus are the Intensive Care Unit staff. I run a staff support group for them, but also spend a significant amount of the day on the unit, picking up any needs there may be there amongst patients and their families. (Chaplain O)

There are certain units in which I feel I definitely have a role, like palliative care, the Hospice, the Burns Unit, Intensive Care and the Maternity Unit. In the area of neo-natal bereavement one feels that one is viewed as part of the whole package, and one knows that chaplaincy will be routinely offered to everybody. In this way one feels part of the team. There have been particular incidents like when I had to baptise a baby on delivery. One arrives, the obstetrician is delivering the child, the paediatrician is waiting with the incubator, and I am in the middle baptising the baby. The response from all the staff changes after an incident like that, and you find you get more used in the future. It is a turning point, there's a different kind of acknowledgement. (Chaplain E)

6.2.13(ii) **Staff support**: Six of the interviewees felt that the area which was most appreciated and acknowledged within their own Trust was the role of the chaplain as a pastoral support for staff.

While I've been here I have created a staff support and a listening network, so that staff have access to a resource to enable them to reflect on difficult personal or professional experiences. The hospital now looks to the chaplaincy department to be the lead in this provision for staff support, and I feel that it has locked us into the structure of the hospital, and made our role more secure. (Chaplain D)

Without any doubt I feel myself to be most in consensus collaboration with our unit in the area of staff support. It has been our success in facilitating and providing such a service that has given the chaplaincy such a secure and high profile. 

*Chapter Six. page 185*
Put another way, we don’t now have to look for things to respond to, the hospital comes to us.

(Chaplain A)

6.2.13(iii) **Counselling and therapeutic support**: Two of the chaplains felt that the skill that was most used by people within the Trust was their competence in psychological and counselling support. This particular skill was used for intensive staff support, but also has been drawn upon to facilitate support groups and responses to particular local and international problems. The two chaplains who spoke about their interest in this area had both been responsible for co-ordinating the hospital’s preparation and response to the Gulf War crisis, and the possibility of their Trust handling a large number of casualties and fatalities.

6.2.13(iv) **The conscience of the organisation**: the same two chaplains felt that this role of reflecting back to the organisation key elements of concern enables them to play the role of community facilitator and builder.

I have a strong sense that the notion of being the conscience of the organisation is a significant part of what the Chief Executive and others want from me. When I got back from holiday, my line manager said, ‘It’s good to have you back’. I pressed him on why he felt this, and he said, ‘it’s good to have you around .. you often say the things that everybody else is thinking but not prepared to say, and you challenge us.’

(Chaplain F)

6.2.14 **Who values you least within the organisation?**

In the final two questions, interviewees were given the opportunity to explore the individuals or groups within the organisation who might not value the presence and role of chaplaincy. In this question, 8 of the 15 interviewees considered and discussed their inability to answer this question accurately though earlier some had complained
about consultants. They simply had no sense of who in the organisation might not value their presence and role.

Three of the interviewees felt that individuals or groups who had least ordinary contact with chaplaincy would be those who would least value them - which might be expected. 3 further interviewees felt that it was the medical staff who chiefly refused to engage with issues around spiritual and pastoral care, and thereby failed to appreciate the role of the chaplain. Two further interviewees reflected on the high turnover of patients and staff as a significant factor in keeping the profile of the chaplaincy (as a continuing factor) high within the hospital, and thereby contributing to a sense of appreciation and value.

I think the ones who value us do see what we bring. As a senior Sister said once, 'you don't see the patients after you've been, we do, and we see the good you've done, the difference you've made'. I suspect that the ones who don't value us are the ones that we actually threaten, and that is particularly true of medical staff. Others who don't value us don't see us, and that is impossible to remedy given the size of this organisation. (Chaplain H)

There are still some who don't really understand the role. I think it is inevitable that there are some doctors who perhaps don't fully appreciate what the role of the chaplain is. Many health care professionals know that there are some needs that they cannot meet, but some doctors feel you might be the one that comes along and reminds them that they've failed. You might be a reminder of the limitations of acute care.

(Chaplain K)

6.3 PART 3: CONCLUDING QUESTIONS

In this final section chaplains were given the opportunity to offer any reflections on aspects of health care chaplaincy which had not been given sufficient attention within the questions, and to share reflections on the process of the interview.
All 15 interviewees reflected back with differing emphasis on how glad they were to have participated in the research. Four of the interviewees thought that the process had enabled them to make some significant comments about the role of chaplaincy within their units, and their own personal and professional connections with their present work.

9 of the interviewees used this section to ask questions about the future of chaplaincy, and 4 others chose to emphasise points made in the earlier part of their interviews. The main areas are categorised below:

6.3.1 **Education, training and research**

For 8 of the interviewees questions around education, training and research were key and critical. For 3 of them the key issue was what kind of educational preparation there should be for work in health care chaplaincy. For 4 of the chaplains in this group, concern was expressed about professional standards and the ways in which chaplains engaged in continuing ministerial education and development. For 2 of the chaplains there was concern about the failure of health care chaplaincy to develop any research base. The following quotations reflect these concerns:

I'm very concerned about chaplains and their education. We need to think much more clearly about what qualifies an individual to be a chaplain and how chaplains, once in post, grow and develop. Do we need management training? Should we all train as psychotherapists? What would a document which attempted to define and measure spiritual need and pain look like? (Chaplain A)

I still don't think that there is sufficient attention paid to in-service training and development. There isn't enough critical reflection on the nature of chaplaincy and what models of chaplaincy are appropriate in today's National Health Service. Do chaplains represent the Church? What is the relationship of sector ministry (chaplaincy) to the wider church? Do
chaplains see themselves as counsellors? How is this evaluated and measured? (Chaplain C)

Any literature search within Britain would point to very few chaplains critically evaluating and reflecting upon their work. The quality of thinking and reflection within chaplaincy and on chaplaincy is very poor. (Chaplain O)

6.3.2 **The challenges and opportunities of working in a multicultural environment**

Four of the chaplains felt that chaplaincy needed to look at its response to the reality of living in a world where other faith traditions had an important part to play, both within British society and in its institutions. Two of the chaplains felt that Christians could no longer claim to have a monopoly on public chaplaincies in hospitals, and that some of the racial and ethnic prejudice to be found amongst Christian groups needed to be challenged through a much more open and generous dialogue with other faith traditions, with a view to enabling them to play a fuller part in the life of hospitals.

6.3.3 **Audit**

Four chaplains felt that the issue of audit was a critical factor in the future survival of chaplaincy.

As the National Health Service becomes more strapped for cash, then I think it unlikely that organisations will want to pay for something which cannot be measured. (Chaplain O)

I suppose this point is related to audit between chaplaincies. I don't think that we are very good about drawing on the experience of others, and sharing models of good practice. There's a certain amount of professional jealousy about, and this doesn't help chaplains to have a broader perspective which can contain a sense of the strengths and weaknesses of each chaplaincy department, as they relate to the wider scene. (Chaplain K)
6.3.4 **A stage in one's ministerial career, or a job for life?**

Three of the chaplains reflected on whether they themselves (and others) should view health care chaplaincy as a lifelong commitment and career, or simply a stage in one's ministry. One chaplain, felt burnt out and needing to move. Another chaplain felt that no individual chaplain should be in post for any longer than 8-10 years. Another chaplain expressed it in this way:

I don't think we take seriously enough the question of strain and burn-out. I've often wondered 'How long can you be a chaplain? Is there a point when you shouldn't be a chaplain any longer, when you are burnt out?' I have a sense after 16 years in post that I've done all that I can, and I'm glad to be moving on. The problem is how do we know when we've reached the limit - when it might be desirable to have a break or sabbatical? (Chaplain D)

6.3.5 **Moral and theological reflection**

Finally, two interviewees spoke about the urgent need for chaplaincy to secure an adequate theological and moral base from which to offer a critique about government health policy and ethical trends in modern medicine.

This will be considered further in Chapters 6 and 7.

6.4 **Supplementary material to the interviews**

There follows supplementary material which completes the data section. This material includes an analysis of current chaplaincy literature and business plans; an analysis of how chaplains spend their time within a sample working week and an analysis of chaplaincy job descriptions.
6.5 An analysis of chaplaincy literature and business plans

6.5.1 Introduction

Each of the interviewees was asked to supply examples of how his or her department communicated the nature of chaplaincy to the health care organisation. This literature included cards and leaflets distributed to all patients on admittance; cards and leaflets held in patients' lockers throughout the ward areas; poster and information on notice boards in hospitals and information held for staff within each unit or ward. All 15 interviewees provided a range of literature falling into the above categories.

In addition 5 of the 15 interviewees provided examples of business plans and annual reports which give very clear indication of how particular chaplaincy departments communicate their work within the health care organisation.

The purpose of this Appendix is to extract from this literature the major chaplain roles and to evaluate these roles by prioritising them, on the evidence of the literature provided by each of the chaplaincy departments. This list represents chaplains' perceived priorities.

1. To help patients cope with fears and anxieties resulting from illness.
2. To be present with patients and/or family in time of crisis as a
witness of God's love and concern.

3. To help hospital employees with their personal and work problems.

4. To be an informal resource for staff wanting to reflect on work matters.

5. To be an advocate for staff in the hospital.

6. To manage the resources and personnel of the chaplaincy team, both paid chaplains and volunteers.

7. To administer the Sacraments to patients upon request.

8. To attempt wherever possible to ensure that each patient is visited by someone within the chaplaincy team at least once while hospitalised.

9. To provide worship services within the hospital.

10. To pray privately for individual patients.

11. To pray with individual patients.

12. To help patients with their own efforts to pray.

13. To help the patient face death.

14. To comfort the patient's relatives at the time of serious illness or death.

15. To counsel patients on ethical issues (rightness or wrongness of actions or attitudes).

16. To visit patients the night before an operation.

17. To handle patients' questions and complaints about the hospital administration, doctors or nurses.

18. To be a resource for doctors or nurses on ethical issues.

19. To consult with doctors and nurses as part of a team working for total patient care.

20. To conduct lectures or classes for medical or nursing students on subjects of pastoral or ethical concern.

21. To confront hospital administration when policies or practice seem inconsistent or problematical.
**SUMMARY**

**Items making up the six major chaplaincy roles**

<table>
<thead>
<tr>
<th>Chaplain role</th>
<th>Item No.</th>
<th>Role Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pastoral Care</td>
<td>8</td>
<td>To attempt wherever possible to ensure that each patient is visited by someone from the Chaplaincy team at least once while hospitalised.</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>To visit patients the night before an operation.</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>To counsel patients on ethical issues (rightness or wrongness of actions or attitudes).</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>To be an informal resource for staff wanting to talk things through.</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>To be an advocate for staff in the hospital.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>To help hospital employees with their personal and work problems.</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>To handle the patients' questions and complaints about the hospital administration, doctors or nurses</td>
</tr>
<tr>
<td>Comforter</td>
<td>1</td>
<td>To help patients cope with fears and anxieties resulting from illness.</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>To help the patient face death.</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>To comfort the patient's relatives at the time of serious illness or death.</td>
</tr>
<tr>
<td>Manager/Admin.</td>
<td>6</td>
<td>To manage the resources and personnel of the chaplaincy team, both paid chaplains and volunteers.</td>
</tr>
<tr>
<td>Liturgist</td>
<td>7</td>
<td>To administer the Sacraments to patients upon request.</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>To provide religious worship services within the hospital.</td>
</tr>
<tr>
<td>Witness</td>
<td>2</td>
<td>To be present with patients and/or family in time of crisis as a witness of God's love and concern.</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>To pray privately for individual patients.</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>To pray with individual patients.</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>To help patients with their own efforts to pray.</td>
</tr>
<tr>
<td>Resource person</td>
<td>18</td>
<td>To be a resource for doctors or nurses on ethical issues.</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>To conduct lectures or classes for medical or nursing students on subjects of pastoral or ethical concern.</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>To consult with doctors and nurses as part of a team working for total patient care.</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>To confront hospital administration when policies or practice seem unjust or unethical.</td>
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</tbody>
</table>
6.6. **An analysis of how chaplains spend their time within a sample working week**

6.6.1 **Introduction**

All of the interviewees were asked if they would be prepared to fill in two weeks' sample time-sheet, spread over the period of a couple of months, in order to give an impression of how time was spent during their working week. Interviewees were given the freedom to choose the week, but were asked to avoid untypical weeks which would give a false impression of the use of time with specific roles and functions.

The results are summarised below. It is important to note here that these results support chaplains' descriptions of how they spend their time.

Nine of the 15 interviewees responded. It is also important to note that all 9 of these interviewees worked at least ten hours more than their contracted 37½ hours per week, and 2 of the interviewees reported that they consistently worked at least 50 hours per week, and sometimes up to 60 hours per week within the hospital. The majority of those who responded were team leaders.
6.7. An analysis of acute health care chaplaincy - Job Descriptions

6.7.1 Introduction

It is the purpose of this Appendix to present further documentary evidence in order to build up a composite picture of the range of tasks and roles that Trusts expect Health Care Chaplains to perform in the course of their work.

This summary of Job Descriptions was achieved by securing eleven job packs of Chaplaincy posts advertised during the months of December 1997 and January 1998.

This Appendix represents a summary of Acute Chaplaincy posts from the following NHS Trusts:

- Nottingham City Hospital
- Leeds Royal Infirmary
- Chelsea and Westminster Health Care
- Preston Acute Hospitals
- Portsmouth Hospital Trust
- Milton Keynes General
- The Leicestershire Royal Infirmary
- Oldham
- Southmead Health Services
- The Central Sheffield University Hospitals Trust

6.7.2 Job Arrangements and Accountability

Title of Post: Four of the eleven posts were Chaplaincy Team Leaders. Two of these posts were described as Head of Chaplaincy Services and the other two as Chaplaincy Manager/Senior Chaplain. Two of the eleven posts were whole-time Chaplain’s posts within established
teams and described as whole-time hospital Chaplain. The remaining five posts were Chaplain's Assistants and referred to as Whole-time Chaplain's Assistant. Only two out of the eleven posts were advertised ecumenically and therefore open to candidates from the Free Churches and Roman Catholic Church. The remaining nine were all advertised as Anglican posts including the four Team Leader's posts.

**Location:** Nine of the eleven posts were located on one Acute Hospital site and two were located across two or more Acute sites.

**Accountability:** The two whole-time Chaplains and five whole-time Chaplain's Assistants were accountable to the Chaplaincy Team Leader or the Head of Chaplaincy Services. Five of the eleven posts were ultimately responsible to the Director of Nursing and Quality and the remaining six were located within the non-clinical services (or therapy services) group. This group included Occupational Therapy, Physiotherapy, Speech Therapy, Chiropody, Social Work, Clinical Psychology, Medical Illustration and Dietetics.

**Denominational Accreditation:** All posts were required to be accredited by their own denomination through holding the Bishop's License or having the nomination of their respective denominational authority.

**Liaison:** All eleven job descriptions referred to the Chaplain's responsibility for liaison with all members of staff throughout the NHS Trust. Particular reference was made in eight of the job descriptions to liaison with medical, nursing and managerial staff. In a further six job descriptions, reference was made to chaplains of
other denominations, churches in the locality of the NHS Trust and other faith communities.

6.7.3 **Job Summary**

All job descriptions contained a job summary and the list below highlights the core features common to all of the posts advertised.

a) The provision of spiritual care  
b) The provision of pastoral care  
c) The provision of religious care  

These three core elements in the job summary were applied both to the care of staff and to that of patients and their relatives.

The core element shared by all job descriptions for Chaplaincy Team Leaders was the managerial function of the co-ordination of the Chaplaincy Team. The Chaplaincy Team Leader was the principal point of reference for religious and ecumenical matters within the Trust.

6.7.4 **Main Duties and Responsibilities**

In the analysis of the main duties and responsibilities described in the job descriptions it is clear that all job descriptions followed a standard template provided by the Hospital Chaplaincies Council (see Appendix B). There is little variation in the framework laid down by the Hospital Chaplaincies Council and only two of the job descriptions depart significantly from this template. The main duties and responsibilities are listed below:

<table>
<thead>
<tr>
<th>Chaplaincy Role</th>
<th>Role Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pastoral Care</td>
<td>To make provision for the spiritual needs of patients, staff and students within the NHS Trust.</td>
</tr>
<tr>
<td>Religious Care</td>
<td></td>
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<tr>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>To visit patients and staff in the wards and departments regularly, and, when requested, to give special ministrations to seriously ill or dying patient.</td>
<td></td>
</tr>
<tr>
<td>To provide counselling interventions to patients, relatives and staff as a response to expressed/identified pastoral and spiritual needs, particularly in the area of bereavement.</td>
<td></td>
</tr>
<tr>
<td>To be an available resource along with other departments and groups for staff support.</td>
<td></td>
</tr>
<tr>
<td>To conduct worship in a style that is accessible to patients from all Christian traditions.</td>
<td></td>
</tr>
<tr>
<td>To provide regular services in Chapel and elsewhere in the Trust; bedside ministrations (prayer, communion, anointing etc.); baptism of infants; and occasional services, for example, funerals and annual Trust services.</td>
<td></td>
</tr>
<tr>
<td>To provide information and facilitate appropriate contact with representatives of the non-Christian faith communities.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Liaison &amp; Network Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td>To co-operate with all members of staff in the awareness of and response to spiritual needs.</td>
</tr>
<tr>
<td>To co-operate with medical, nursing and management staff, wherever possible, in departmental meetings.</td>
</tr>
<tr>
<td>To be available to parish priests and ministers</td>
</tr>
</tbody>
</table>
in order to consult with them on pastoral care of their people when in hospital, and to receive information from those priests and ministers, always remembering the rules of confidentiality by which every NHS employee is bound.

To develop effective relationships with leaders of other faiths and community representatives in order to establish a network of support for patients and staff.

To co-operate with all Chaplains within the department in order to build up and develop an effective Chaplaincy team.

Manager To manage the resources and personnel of the Chaplaincy Team, both paid Chaplains and volunteers.

To ensure the effective running of the hospital Chapel as a resource available to both Christians and individuals and groups of other faith traditions.

Training & Education To support and develop good practice in palliative care and the care of bereaved families through involvement in the staff training programme and, where requested, in de-briefing staff.

To participate in staff induction so that staff understand the nature and functions of Chaplaincy.

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To participate in the education programmes for nurses and medical students.

Self-Development

To attend to personal and spiritual development by quiet days and other means.

Participation in departmental appraisal processes.

6.7.5 **Person Specification**

All eleven job descriptions included a person specification which highlighted essential and desirable person specification criteria. There was considerable consensus between all job descriptions, again suggesting that the Hospital Chaplaincies Council's template was followed closely.

**Qualifications and Other Requirements.**

i) To be ordained within the Church of England or other denomination for between 3-5 years.

ii) To be eligible to be licensed to officiate by the Bishop of the diocese or other denominational authority.

iii) To have good communication/inter-personal skills.

iv) To have ethical, theological and pastoral insight.

v) To provide some evidence of personal growth or faith.

vi) To have skills in teaching and training.

vii) To have skills in management.

viii) To have some knowledge of other denominations and faiths.

ix) To have some experience of or interest in Hospital Chaplaincy.

x) To have some training in listening skills and offering Christian Counsel.
xi) To have a working knowledge of the NHS and relevant parts of the Patients' Charter.

xii) To have a wide interpretation of spirituality and an unthreatening approach to patients.

xiii) To be able to deal with own and others’ stress.

xiv) To have the ability to lead public worship with a sympathetic understanding of patients’ needs.

xv) To have knowledge of other faith issues.

xvi) To have a commitment to working in a team.

xvii) To have a commitment to working ecumenically.

All job descriptions note that the successful candidate should be able to show him/herself as flexible, responsible and sensitive and open to further training to develop these particular skills and requirements.

Job Arrangements:
All eleven post holders were expected to work a minimum of 38 hours per week plus on-call responsibilities. All salaries were within the professional and technical Witley Council (a Chaplains’ scale for whole-time Chaplains and whole-time Chaplains’ assistants). All potential employees were required to comply with particular local Trust job arrangements in connection with Equal Opportunities, Health and Safety at Work, Smoking, Data Protection and Confidential Information Policies.

6.8 Conclusion
This completes the section of data. We turn now to the conclusions and discussions in the light of the framework articulated in Part One and this data in Part Two.
PART THREE

CONCLUSIONS

AND

DISCUSSION
CHAPTER SEVEN

INTERPRETING THE DATA

THE FUNCTIONS AND MODELS
OF ACUTE HEALTH CARE CHAPLAINCY

7.1 Introduction

It is the purpose of this chapter to summarise and draw out the main features of acute health care chaplaincy from the history, literature and experience provided in Part Two of the thesis. These features will be interpreted within the context of the framework outlined in Chapters Two and Three. In this chapter we shall discuss the material dealing with how chaplains understand what they do and why they do it. The material that deals with the contextualisation of chaplaincy within the National Health Service will be discussed in Chapter Eight, with specific reference to the impact of the NHS reforms on chaplaincy, a subject that chaplains address in their interviews. These conclusions and discussions emerge from the whole range of material both in Parts One and Two of the thesis.

The present chapter falls into a number of parts. First, the main features of the data will be summarised and drawn out. Second, comments will be offered in the light of these features and the material contained elsewhere (Chapter Four, history; Chapter Five, literature; Chapter Six and the Appendices), particularly the summary of how chaplains spend their time, the analysis of chaplaincy business plans and literature and the summary of the analysis of chaplaincy job descriptions.
7.2. The main features of the data

7.2.1. The creation and nurturing of relationships as the core of acute care chaplaincy

Within the body of data there is consistent need felt by chaplains to describe the nature and content of their work. The majority of chaplaincy literature (particularly the articles contained within the *Hospital Chaplain* and the *Journal of Health Care Chaplaincy*) consists of a description of the nature of pastoral care and the range of relationships. Chaplains feel a need to tell their story and come to some critical agreement about the shape and content of pastoral care and its role within the context of acute health care. The heart of this is the creation and nurturing of pastoral relationships. The focus of the practice of pastoral care will be discussed in greater detail in sections 7.3. and 7.4.

7.2.2. The development of chaplains as a group with an identity that holds recognition and worth

The history of health care chaplaincy is the story of how a particular group within the National Health Service has grown and developed. This is demonstrated most obviously through the increase in numbers of chaplains. It is particularly important to note that despite some considerable organisational insecurity following the NHS reforms of 1990, the total number of new whole-time posts in England and Wales has risen steadily - an increase of 77 between 1994 and 1996, bringing the overall U.K. total to 350.1 While it has not been part of this research to ascertain why there has been this steady increase in the numbers of health care chaplains, one possible conclusion is that a recognition of the worth of the health care

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1 Hospital Chaplaincies Council Annual Report 1996 (General Synod of the Church of England GS 1245). p.2
chaplain accounts for this increase. This might be an area for further research.

The development of health care chaplaincy has been due, in part, to the proactive and 'political' role of the Anglican body, the Hospital Chaplaincies Council of the General Synod of the Church of England. They have initiated some significant working parties and reports for the National Health Service, and this has managed to keep the issue of the hospital chaplain on the wider agenda, and served to articulate and explain the nature of the role of the health care chaplain. The Tunbridge Report (1974) and negotiations over pay and conditions with the Department of Health (1990-1992) are examples of this work. In addition, in July 1996 the Health Service Journal produced an eight-page in-depth evaluation of hospital chaplaincy.² In late 1996 the National Association of Health Authorities and Trusts launched, at Church House, Westminster, a report entitled Spiritual Care in the NHS - a guide for purchasers and providers.³ Both of these professional publications gave a high priority to the provision of good quality chaplaincy for NHS patients and staff. While the cognitive seldom change anything, however it would seem reasonable to conclude that these publications had some positive influence in advocacy for chaplaincy within health care Trusts (Hoschild, 1983).

In 1994, in consultation with all other churches and chaplaincy organisations, a joint 'national consultation' was planned for 1997 by the Hospital Chaplaincies Council. The Council aimed to learn from Government what future expectations were for chaplaincy in

order that they might better plan, organise, prepare and train chaplains for the work in the NHS in the 21st Century. This consultation took place on the 20th and 21st of October 1997, and at the time of writing this thesis the final report was in preparation for publication.

7.2.3 The development of training for chaplains

The annual hospital chaplains' conference, that has taken place every year in July since 1961, is a symbol of the importance attached, by some at least, to a chaplain's personal and professional development through reflection and training. The work of Autton and Wilson is particularly significant in encouraging and challenging chaplains to stand back from their work for the purposes of critical reflection (Wilson, 1971; Autton, 1968, 1982).

In 1996 the Revd Malcolm Masterman was appointed by the CHCC and HCC to the post of hospital/health care chaplaincy training and development officer. This post was a consolidation of the aspects of training work done by a number of chaplaincy organisations (the Hospital Chaplaincies Council, the College of Health Care Chaplains, the Health Care Chaplaincy Board of the Free Church Federal Council and working in co-operation with the Roman Catholic Church). Masterman's main duties are to reflect upon the content of the health care chaplaincy standards document (Appendix 2) ; to co-ordinate, develop and implement introductory training, in-

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*The report is likely to reiterate the present Government's support for the provision of spiritual and religious care to patients in hospital but to suggest that this provision ought to demonstrate its quality by attempting to address the balance between the Christian ownership of this provision and the work of other faith communities. It follows, therefore, that in principle, the provision of chaplaincy in the future ought to happen on a multi-cultural and multi-faith basis (personal correspondence between the author and a member of this consultation used with permission).
service training, specialist interest and development courses in line with current NHS systems, and to organise the annual study training course. In the year 1997 the training officer organised two introductory training courses for acute chaplains (attended by 50 people), and two introductory training courses for mental health chaplains (attended by 40 chaplains). Specialist courses included in-service training in the areas of confidentiality and ethnic needs (12 attendees); children's spirituality (60 attendees); management and budget training (16 attendees); medical ethics (16 attendees), and palliative care (60 attendees). This is an indication of some measure of commitment to training and in-service development. The numbers taking up these courses remain a small proportion of chaplains.

More specifically in February 1998 the University of Leeds' School of Health Care Studies and the Department of Theology and Religious Studies of Leeds University have jointly established an M.A. in Health Care Chaplaincy. The course runs over a two-year period and is part-time. The objective is to enable chaplains to investigate and reflect upon issues which relate to their practice: for example, the history and theology of health care chaplaincy; the contribution of chaplaincy to pastoral care; issues of ethical concern in the health care environment; the management of health care services and the relationship between the chaplaincy service and the overall management of health care services; the examination of the role of the health care chaplain in a multi-faith context. At the time of writing this course has 11 participants. Also the University of Wales in Cardiff is planning to establish a Master's Course in Sector Chaplaincy. Again, these are indications of some attempt to develop a knowledge and skills base. A fuller discussion of how chaplains have been shaped by the context of the National Health Service is Chapter 7. page 207
We turn now to a brief summary of the evidence presented in Chapter Six.

7.2.4 The chaplain’s motivation and nurture

Theological Influences: chaplains are people who have some training in the tradition and practices of their faith community. They are not, by their own admission, theoreticians or academics whose work is primarily guided by a systematic ideology or set of reference texts. They describe their theological influences as informal and personal, shaped, for example, by attraction and admiration of a particular place or person. For chaplains the purpose of developing expertise through professional training (for example in psychotherapy and counselling) is to enable a more responsive and creative pastoral response to those who are living with illness. The role of spirituality as supporting and inspiring creative practice is affirmed as an important influence; overall, a picture emerges of a group who have a strong preference for learning through action and whose theological influences are implicit rather than explicit. Unlike many of the parish clergy, chaplains are rarely people with an ‘up front’ doctrinal or scriptural theology at the front of their minds (Francis and Francis, 1998).

Motivation: when articulating the reasons or motivations for the choice of health care chaplaincy rather than ‘mainstream’ parochial or congregational work, three key motivating factors emerged. Over a third of the chaplains interviewed chose health care work because they had had negative experiences of parochial or congregational work. The choice for chaplaincy was, therefore, a reaction against parochial work. Further, the majority of those interviewed expressed...
the desire to specialise particularly in the area of pastoral work, and this had been encouraged by positive experiences of both the hospital as an institution and personal links with hospital chaplains during training.

7.2.5 **Skills, characteristics and tasks of the chaplain**

**Skills and characteristics:** It is significant to note that almost without exception, when asked to reflect upon the skills and characteristics necessary for any health care chaplain, chaplains evaluated the chaplain in personal and not professional terms. In other words, the quality of the chaplain as a person was viewed to be more important than the possession of particular professional skills. A concern for and interest in people, personal openness and warmth, with stamina and a sense of humour, were all important characteristics. Chaplains felt that inflexibility and too much certainty in any particular theological approach (or narrowly religious approach) would prevent a chaplain from being able to connect with the people and situations in their work. It was felt necessary to be able to relate theology to experience, rather than possess any particular theoretical approach to theology, and also to have an ability to cope with being both misunderstood and on the margins of the life of any health care institution. Further, a candid self-awareness led a third of those interviewed to discuss at some length the issue of 'burn-out' (see 6.2.7(iv) pages 172-174), including two of the chaplains who expressed their own personal concern about their own 'burn-out' (Coates, 1989).

**Tasks:** The following roles were articulated as the key elements within the work, in order of priority:
• spiritual carer of patients and staff
• team leader and enabler of other workers within the chaplaincy team
• educator and teacher
• manager of change
• representative of the Church.

There is a clear consensus from this area that the core activity of chaplains is to provide pastoral care to both patients and staff and that other tasks should enable and support that work.

7.2.6 Disabling factors in chaplaincy work

Role confusion: in the discussion about what prevents chaplains from performing their work within the hospital and other negative factors, the most common issue was that of role confusion. Chaplains felt that they had to battle constantly with misunderstandings over who they are and what they do or, indeed, with some measure of hostility about their representing the Church within the hospital.

Bureaucracy and management: a significant minority (6 out of the 15 interviewees) felt that the increase in bureaucracy and management as a result of the NHS reforms did not enable them to be more creative or participative in pastoral work. The issue of communication and making a difference in a large organisation was also part of this critique of the changes in the organisation and structure of hospitals.

Excessive freedom: as a contrast to the issue of control and bureaucracy, one third of the interviewees articulated their concern that there was little effective control which shaped their work within
Trusts. This freedom, perceived partly as lack of interest in their work, stands in sharp contrast to issues of control through management.

Four of the 15 chaplains felt some measure of difficulty in working with doctors as co-equal partners in the delivery of health. Audit and outcome: a majority of chaplains expressed some concern about how far their work could be easily measured through appropriate audit and outcome measures. This was expressed through some unease about the usability of the health care chaplaincy’s standards document (Appendix 2).

Working with illness and death: again, a majority of chaplains articulated the negative effects of constant exposure to illness and death. This is a key point in relation to supervision and burn out (chaplains articulate the issue in Chapter Six, page 173 and it is discussed in Chapter Nine, page 271).

7.2.7 Positive and energising dimensions of chaplaincy
The majority of chaplains articulated how positive they felt about the work and reflected upon the high degree of job satisfaction within their own work and roles. This satisfaction was related to a sense of achievement through the giving of the pastoral support to patients and staff; the variety within the work; support gained from chaplaincy colleagues and other staff.

7.2.8 Working collaboratively within the hospital
The majority of chaplains viewed nurses as their main allies within the hospital and the professional group with which they most closely worked. This would back up their affirmation of direct pastoral work
with patients and staff as the core function of chaplaincy. Nurses were seen as being in the key position to facilitate this work.

Amongst other areas of work within the hospital, chaplains articulated especially their input into critical areas of the hospital (accident and emergency; intensive care and neo-natal units), staff support and work with the community or institution of the hospital as areas where they felt chaplaincy worked most creatively.

7.2.9 Conclusions

In the light of the interpretation of the data above, there are a number of key topics which impinge upon the study of the role of the health care chaplain. These might be summarised as follows:

(a) a significant element of role anxiety and confusion caused by the marginalisation of the Church and clergy in general, and the difficulties of locating the work of the chaplain within the context of acute care.

(b) the tensions and paradoxes that emerge from the relationship between the chaplain as a person and the culture of professionalism, promoted both within chaplaincy in particular and in health care in general. There is some real measure of conflict and disagreement about whether the chaplain ought to be seen and evaluated in personal or professional terms - particularly as professionalism is established through a set of measurable standards. The tension between whether a chaplain's personal warmth is more important than the measurability of the outcomes of his or her pastoral intervention remains a critical issue for chaplains in this thesis.

(c) a minority of interviewees who specifically articulated their own sense of burn-out. Other chaplains gave voice to concerns about
their ability to maintain their motivation for acute health work.

(d) it is important to balance any negative reflections and perceptions with a positive sense that chaplains maintain a visible and faithful presence around illness, and attempt to offer pastoral care to the highest possible standards within their given ability, awarding the chaplain a considerable level of personal satisfaction and vocational fulfilment. This care takes a number of shapes and will be discussed in 7.3 and 7.4.

7.3. Chaplaincy and the practice of pastoral care

Before discussing in some detail the roles, functions and models of health care chaplaincy, it is necessary in this section to highlight some issues in relation to pastoral care and chaplaincy. We have seen above that the essence of the activity of the health care chaplain is focussed on the practice of pastoral care. This activity has been described in the following way, ‘to enable individuals and groups in a health care setting to respond to spiritual and emotional need, and to the experiences of life and death, illness and injury, in the context of a faith or a belief system’.

An analysis of the chaplaincy literature supplied by the 15 interviewees, and summarised in chapter 6, indicates that chaplains define themselves and their work in relation to being an available and responsive resource around spiritual care. In the light of this material and the other findings of parts of this thesis, we can lay out essential aspects of the nature of pastoral care from a chaplaincy perspective.

6 Health Care Chaplaincy Standards (1993) see Appendix 2 for the outworking of this core mission statement through a system of standards.
7.3.1 **Pastoral care is a shared activity.** Clearly chaplains co-operate with others in the process of listening and supporting. It is important to recognise here that a significant number of chaplaincy departments (10 out of the 15 examples) work with lay volunteers. These are usually drawn from local churches and trained by the chaplaincy departments. Their work is to visit areas of the hospital and report back about problems and referrals to part-time and whole-time members of the chaplaincy team.

There is also a recognition that other health care professionals share in the process of listening and supporting. There is an increasing interest on the part of nurses in spiritual care, and a number of research projects in this area are being undertaken by them.²

7.3.2 **Pastoral care is a distinguishable activity.** Some work has been done by chaplains describing how pastoral care can be distinguished from other activities and its outcomes monitored and audited (Health Care Chaplaincy Standards 1993; Stoter, 1995; Woodward, 1997). There is some indication from other health care professionals that they appreciate the role and function of pastoral care within the process of delivering health care (Davis and Fallowfield, 1991 chapters 18 and 19).

² An example of a Christian nurse who has set up a small business venture to promote spiritual care in the NHS is Veronica Cuthbert. Her business VPC, health-care consultancy, has facilitated a number of training events within the North-West Regional Authority following the work of Karen Zander who is the principal for the Centre for Case Management in Boston, USA. Zander’s most recent publication *Managing Outcomes Through Collaborative Care* (1995), American Hospital Association, argues for an inter-professional approach to spiritual care and a research base which can co-ordinate the measuring of outcomes of pastoral care. Other American examples of this research are Vandecreek L (1995) *Spiritual Needs and Pastoral Services: readings in research*, Journal of Pastoral Care Publications, Oregon; Saudide J and McKenny G Editors (1994) *Theological Analyses of the Clinical Encounter*, Kluwer Academic Publications Dordrecht. Some work has been done by the author with Birmingham Health Authority, see Woodward J (1997) *Developing Standards for Spiritual, Religious and Cultural Care* - privately circulated.
Pastoral care is a specialised activity. In the promotion of professionalism (or more accurately described from a sociological perspective as professionalisation strategies) amongst health care chaplains, there is a widespread assumption that pastoral care is a specialised activity demanding particular skills and training. This is reflected in the concerns both of the training officer (see above: 7.2.3) of the Hospital Chaplaincies Council and some of the work of the College of Health Care Chaplains in the promotion of the health care standards document (Appendix 2).

Some health care chaplains have drawn upon the disciplines of counselling and psychotherapy in the promotion of a distinctive role of empathy within the processes of care, others have drawn upon their theological training which equipped them to be a resource for wisdom about the provision of religious, spiritual and cultural care. Chaplaincy's role in the provision of religious and spiritual care is affirmed both by the National Association of Health Authorities and Trusts' publication *Spiritual Care in the NHS* (1996), and by the early indications from the findings of the report of the multi-faith joint national consultation organised by the Hospital Chaplaincies Council (October 1997, see 7.2.2.). Some chaplains have taken a lead role in teaching and education around spiritual care through their links with medical and nurse education.

Pastoral care is a time-consuming activity. This places particular demands upon the health care chaplain. This has been a specific argument in the development and resourcing of health care chaplains - that is, for an increase in their numbers, borne out in the figures since the establishment of Trusts - and in the discussion of issues of professional indemnity and insurance (hence the desire of the College
The roles, functions and models of health care chaplaincy

The question then becomes, can we establish a model of the role of health care chaplaincy?

7.4.1 What model of chaplaincy?

In drawing together the strands in Part Two of the thesis and the Appendices, the following model of chaplaincy that emerges might best be described in the following way: chaplaincy is a ministry of encounter, connection and inter-relationship. The locus for this ministry is in the relationships of patient to illness, staff to patient, patient to family, but also of relationships within staff, families and the hospital community. Hospital chaplains stand at the place of meeting, and the meeting of most significance may not always be the encounter of the individual with health, but relationships among staff, and particularly the encounter of the staff with the organisation. This may be why, in part, the numbers of chaplains has increased in recent years - because as persons they facilitate meeting or good encounter within the organisation at times of stress and disconnection and re-organisation. In this sense chaplains help to make the bonds of peace or to foster community - albeit often only provisional community.

The model represented below, while seeing the patient as the focus of all that the hospital stands for, does not necessarily view the patient as the heart of the totality of a chaplain’s ministry. The chaplain is located at the point of contact, whether it be with staff, family or patients, and whether between group and group or within a
particular group. The chaplain may also be a catalyst for certain kinds of problematic situations relating to illness that arise for particular groups, for example, doctors or nurses - whose own attitudes may depend on personal factors concerning illness, vulnerability or even death.\(^8\)

A model of chaplaincy: a ministry of encounter, connection and inter-relationship

This model visualises the realities of encounter, connection and inter-relationship with which the chaplain engages. It could also be described as a model of *in-betweenness*, which will be discussed at further length below. Its weakness is that in its two-dimensional and static form it does not fully conceptualise the inter-relationships between the patient, the patient's family and friends, the staff, the community and institution of the hospital and the wider social context within which the hospital is placed. All these five dimensions interact with each other in a unique and dynamic way.


*Chapter 7. page 217*
The Patient. Chaplains have articulated that the focus of their work is the delivery of spiritual care to the patient; much of their time is spent in a variety of activities intended to facilitate the delivery of this care. Some chaplains, for example, might spend very little time in a working week seeing patients, but enable a whole number of other voluntary workers within the team to maintain direct chaplaincy to patient contact. Despite this, in the analysis of the time-sheets, it is clear that over 32% of the chaplain's working week (on average) is spent in patient contact (see Chapter Six, 6.6.).

Chaplains see as their priority the task of ensuring that patients have the appropriate support they need around illness. From this perspective, chaplains see illness as a critical time that serves to confront those that undergo or who work with it, with mortality and with their own vulnerability (Speck, 1988, chapter 2). Illness may lead to a radical re-evaluation of the direction of life, of work, relationships and belief. In this re-evaluation, religious faith and practice may support some people through illness and the chaplain is called upon to fulfil these needs. For others with no religious faith, the task of the chaplain is to find some personal link and common ground within which support can be offered and new meaning and purpose explored (see Chapter Six). Chaplains draw a distinction between religious and spiritual needs (Stoter, 1995, chapters 1 and 2): so they aim to meet spiritual needs (for meaning, purpose, direction, etc.), which may include religious needs where appropriate, and enable patients, within the context of a supportive relationship, to reflect on their illness and on how this experience may lead to a greater sense of integration and wholeness.
This encounter is random, unpredictable, and infinitely variable. It may have elements of formality (ritual, religious worship, psychotherapeutic or counselling techniques), or, more usually, it is informal with the chaplain meeting the patient at the bedside and engaging in supportive listening.

The patient's family, carers and friends. It is often the case that the patient's family or friends are in the best position to offer support to the individual and often they themselves may need some opportunity to reflect upon what is happening to their loved one, and how best to discover they can deal with any distress in order to be empowered to participate in their loved one's care. Often chaplains are called in to support families when a patient is critically ill or dying. This need accounts for a majority of 'call-outs' of chaplains, especially out of normal working hours (Speck, 1988, chapter 5; and supplementary material in Chapter Six).

Professional health care workers. This particular area of work has increased in its significance and, as the analysis of time sheets shows, takes up a significant proportion of a chaplain's time (32%). A number of factors may account for it. The first is that the average stay of patients in acute care has decreased (Harrison and Prentice, 1996) and so staff become the group to whom it is easier for the chaplain to offer some continuity of care and contact. The second factor is the significant amount of stress that staff have experienced as a result of organisational changes within the National Health Service since the 1990 reforms (see Appendix 4 and Lee-Potter, 1997). Chaplains comment that when staff feel supported and motivated, they are more likely to be able to deliver the best possible attention and care to patients (Stoter, 1995; Speck, 1988; Woodward 1995).
has been noted that while chaplains seem to work most closely with nurses, it is also evident that they relate to a wide variety of staff across the hospital. These might include porters, cleaners, physiotherapists, doctors, managers, social workers and pharmacists.

The community and institution of the hospital. The fourth element that chaplains connect with and encounter is the organisation or structures that make up the community of the hospital. This aspect of connection is complex and multi-dimensional. It may mean formal engagement with the institution of the hospital through regular meetings with the Chief Executive or other senior managers or Trust Board members, in order to feed back perceptions about aspects of hospital life. This 'feedback' may mean challenging and confronting the way decisions are made, or reflecting back to those with responsibility and power, the effects of decisions and changes on the life of the hospital. This was summed up when one chaplain said that his Chief Executive regarded him as 'the conscience of the organisation'. Some chaplains have shown much insight in relation to many of the key effects of the NHS reforms and established their role as bridge builders and community builders. Two chaplains interviewed for this thesis are on their local Community Health Councils; for others this work is clearly done on an informal basis as the community of the hospital is encountered on the corridors, at ward level or in the hospital canteen. This aspect of the chaplain's work is discussed in greater length in Chapter Eight.

The wider context of the hospital. The fifth and final dimension of chaplaincy work - and it is significantly under-represented in chaplains' evidence - concerns the wider social context of the hospital.
Chaplains are representatives of the Church - though some choose to distance themselves from their parish colleagues. The churches, as the largest voluntary organisation in the country, have significant links in the community. There is little indication however, in Chapter Six that chaplains work effectively as ambassadors for the hospital within the community or, indeed, by encouraging the community to take some responsibility for the life and work of the hospital within it.  

The diagram below (the 'zone' of ministry) is a further way of representing the inter-locking and overlapping areas of a chaplain's work. The triangle connects the chaplain with the spheres of work. The patient is at the centre (central circle) and the hospital, the family, the health care worker and social context or background all connect with the patient. The chaplain's presence in all these zones or areas fosters 'in-betweenness' (discussed in 7.5)

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9 One chaplain during a tour of the hospital indicated to the author his involvement in the Hospital League of Friends and the annual hospital fête. He commented, in passing, that he felt this involvement was due, in part, to the fact that he was one of the hospital's longest serving staff (he had worked in the same hospital for nearly 24 years).  

Chapter 7. page 221
There follows a number of descriptions of the modes and roles of chaplaincy. These roles are based on the models of chaplaincy described above and based on how chaplaincy has described its work in Part Two of the thesis.

(a) **The chaplain as interpreter or explainer**: coming into hospital as a patient is for most an event which raises a series of unfamiliar and perhaps uncomfortable experiences. Individuals have to cope with their loss of control and giving over power to experts in an environment very different from their usual one (Davis and Fallowfield, 1991). Fundamental concepts of security and hope for the future bear upon the person's world of meaning and truth. The chaplain is amongst those who can listen to and interpret these experiences. The issue of language is fundamental here. While some people may have the language with which to express these experiences, often individuals may have difficulty in understanding and conceptualising what is happening to them. Thus, patients, staff and relatives may be searching for some form of meaning for their experiences, but doing so without any available framework of language or reference (Speck, 1988; Frank, 1995). A whole host of undigested and, at times, unhelpful theological concepts, Bible stories from childhood and other truisms may surface, and the chaplain may be in a position to construct both a language and a possible interpretation. Ideally such interpretation will emerge not only between two or more people (perhaps chaplain, patient and friends), but also by the interplay of the various aspects of a person's struggle to come to terms with what is happening around and within him or her (Bailey, 1997; Gersie, 1997).
This explains, in part, why chaplains have felt it necessary, as we have seen, to make a sharp distinction between religious and spiritual needs. For people without formal religious needs there are questions of direction, purpose and meaning (spiritual needs) and so there may be a need for space within which doubts and fears can be acknowledged and insecurities and meanings around illness articulated and interpreted. The chaplain has a role in developing theological understanding (both explicit in relation to religious needs, and implicit in relation to spiritual needs) of what it means to be human in the light of the meaning of health, healing and suffering (see Appendix 2).

(b) The chaplain as a listener to the voice of suffering: one of the key and distinctive roles of the health care chaplain is as a person who can attend to the profound experiences of suffering. The voices that articulate these experiences may differ widely depending upon the context, and may go beyond the actual patient. It may be the pain of parents coming to terms with a stillbirth, or the anxiety of children watching their father wait for a cardiac operation. Chaplains have emphasised that this is the silent work done at the bedside (Autton, 1982; Stoter, 1996). It is a ministry of presence and listening (see Chapter Six 6.2.3 (iii) page 159).

(c) The chaplain as intercessor: whilst some of the chaplains in Chapter Six play down the significance of their role as an overt religious representative, it is clear that many still see prayer as a part of their role and function. In the majority of hospital chapels that were visited during the process of interviewing, a significant feature of the use of the chapel was a request book for prayer. Often chaplains are asked 'will you pray for me?' This request, and the use
of the book, reflect the image of the chaplain as a representative of God, and also the perception that the chaplain can forge a meaningful link (or a different kind of solidarity) between the human and the divine. It is, of course, impossible to know what people think and patient perceptions of the role of the chaplain is an area for further research.

(d) The chaplain as intermediary: the chaplain may often join with others in trying to draw people closer together, particularly if family relationships are strained or have broken down. The chaplain may also operate at the level of being an advocate for the patient. Often, if the patient is severely disempowered in the health care process, questions and views will need to be represented to other members of staff. At a basic level, chaplains may support the patient in the formal process of complaint (Stoter, 1995, Chapter Fifteen).

Many health care chaplains today realise that the majority of the population neither attend church on a regular basis nor have had any experience of a pastoral ministry from a church or faith community (see the overview of Secularisation in Chapter Three, 3.7., pages 55 -62). Some chaplains feel here that it is part of their role to promote and present a positive view of the Church through the relationships they make and the work that they do. This often involves the breaking down of stereotypes and correcting misinformation, or talking through past negative experiences. In this regard, the chaplain can also act as an intermediary or bridge between local churches and individuals or groups (Wilson, 1971). One of the chaplains spoke at some length about his plan to work this out through a practical focus, for example, in relieving the isolation of the elderly and providing a supportive network for those
whose process of rehabilitation requires support.

Chaplains may also be able to operate as neutrals in an institution that is so often divided into the doctors, the nurses, the managers, the nursing auxiliaries, etc. Thus the possibility arises of mediating between groups without being seen as attached to any. One chaplain, again in giving the author a tour of his hospital, said he took as his guide in relating to staff, the rule that he assumes an equality with whomever he is speaking.

(e) The chaplain as critical voice: the effect of the NHS reforms on chaplaincy will be discussed in Chapter Eight. At this point comment is made on how some chaplains have felt it necessary to express criticism about some of the current trends in health care.

There are some presuppositions on the part of chaplains at work here. One is that chaplains are in a unique and privileged position. Chaplains believe that part of their uniqueness lies in their ability, unlike other members of staff, to visit every unit in the hospital. They are able to meet and talk to such a wide range of patients, relatives and staff, and to come into contact with all professions, trades and occupations at work, so that at any time they may be familiar with the issues of concern throughout the hospital. It may follow therefore that a chaplain might be expected to have a distinctive overview or a special insight into the institution. From this perspective some chaplains take their role as critical voice, as someone who can feed back to the institution areas of concern, very seriously indeed. The ability and preparedness to perform this role may well depend upon the level of personal and professional security that chaplains feel within their own health care institution.
(f) The chaplain as manager: with improved structures of accountability, many chaplaincy departments have been required to become more accountable for what they do within the hospital. For a number of the interviewees their role as a team leader or a manager was emphasised. This includes the management of a chaplaincy team, some of whom may be paid and others voluntary; managing a budget; writing policies and business plans; organising 'on call' rotas; evaluating work performances; and giving feedback on issues related to chaplaincy within the hospital. These issues may include: how best to respond to the spiritual and religious needs of other faith communities, work in relation to death and bereavement, and to the managing of staff groups during a critical period of change (Stoter, 1997; Beckford and Gilliat, 1996).

(g) The chaplain as hospital ethicist: a small number of chaplains referred to their role as a resource person in ethical decision-making. In the two incidents related by interviewees (see pages ??) this role related directly to enabling or empowering the patient to decide about options for treatment. In another incident the resource related to a care team deciding with a family whether to withdraw treatment. It is interesting to note here that while Christian theology is only one influence in the framework of ethics and has a less influential role than formerly, in some contexts the hospital chaplain is still seen as a resource person in a process of decision-making (Speck, 1988, chapter 7). In fact, though the whole subject of medical ethics has only developed substantially in recent decades, Christian ethicists, including some chaplains, have made notable contributions (Verhey and Lammers, 1993; Autton, 1983; Campbell and Higgs, 1982; Thompson, Melia and Boyd, 1994).
The chaplain as peripatetic teacher: this role relates in part to the role of chaplain as hospital ethicist. For some staff it is clear that the chaplain is seen as having particular expertise which can be shared in formal and informal sessions. These areas of expertise include ethics; the nature of religious, spiritual and cultural care; understanding patients from other faith traditions; death and dying and pastoral care. Many chaplains in large teaching hospitals have exercised a role in the education of nurses, though this has changed with the introduction of Project 2000 and the concentration of nurse teaching within university settings. Some other chaplains have a role within the medical school and sometimes student chaplains play a role in this area (see example of interview in Appendix One and Legood, 1998). Other chaplains have a role on specialist English National Board nursing post registration courses. For two of the interviewees the changing profile of chaplaincy in relation to education was a serious threat to their work. Other chaplaincy departments have acted as a resource for the training of theological students in ministry. This has ranged from taking students on placement to setting up a series of lectures at theological colleges or on part-time ministerial training courses.

The chaplain and lay ministry: As we have seen, many of the interviewees have managed to sustain their contact and profile with patients and staff throughout the hospital by employing volunteer lay chaplains.

The chaplain as practical theologian: all chaplains interviewed for this thesis in particular, and indeed all chaplains employed in the Health Service, have some training in the tradition and practices of their faith community. As such they are individuals who might be...
expected to foster 'in-betweenness' (see below - 7.5) or inter-weave in highly complex sets of ways in response to situations, individuals, contacts and institutional frameworks. They are in a position to therefore nurture the faith development and meaning searches of others.

In doing this, chaplains are individuals who 'represent', evoke, suggest and stand for the value of religious and spiritual levels of meaning, and even of truth. Part of their implicit function as a practical theologian is to be a listener, interpreter, and mediator - some of the key models described above. In this chaplains can be seen as at the cutting edge, of making theology for new circumstances, and so critically re-shaping the tradition. This fits in with the liberal theological stance of many of the interviewees and with the needs of the hospital setting (Woodward, 1989, 1995).

A brief summary of their theology might be:

- a belief in Christ who is present, alongside, vulnerable, at risk, and wishing to learn as well as to offer possibilities of hope and meaning through the encounter.

- a belief in God as a creator who sees value, potential, meaning, in each life, and with an equality and a sense of justice, that is, a God who 'attends' to persons with equal concern and focus, irrespective of apparent worth, status or claim.

- a belief in a God who accepts, renews and conveys the possibility of new beginnings. Some chaplains experience being a presence through whom the other hears and senses forgiveness, and who offers some resolution of the inarticulate feelings of guilt, self-blame, impotence and self-rejection.
7.5. **Exploring marginality and 'in-betweenness'**

These reflections emerge from a rapidly changing and diverse situation. It is clear that some health care chaplaincy is eager to generate standards and communicate clearly its purpose in what has, to some, been previously an ill-defined field. What then emerges, in part, is a sense of chaplains who are in search of an identity and some element of institutional security from which both to understand and possibly to explore the effects of modernity and modernisation on religion in general, and therefore their role in particular. Chaplains want their role to be understood. They want to exercise some influence in their hospitals. Perhaps then it is inevitable that one of the challenges and problems of the health care chaplain today within the context of a professional existence is that chaplaincy is still in search of itself. This needs to be set against the feeling that retaining an element of amateurishness is part of the chaplain's secret and usefulness (compare with the role of the ward orderly or cleaner who is often found easy to relate to for the same reasons).

By contrast, within the process of hospitalisation and the structures that surround and control the experience of the delivery of health care, tasks and functions are very clearly defined. This is a regimented and often hierarchical structure where there is clarity of lines both between professions and within professions. It is not surprising that the question of how the chaplain fits into this clearly demarcated process will continue to be both challenging and problematical. Perhaps there is a constant need to define and re-define the profession as the context changes and needs vary. The chaplain therefore inhabits an uncomfortable and difficult situation.

As we have seen, chaplains live between a number of spheres of
importance and of professional groups. One could even say that they live between a number of cultures: for example, the Church, medicine, management, therapeutic and nursing. They are employees of the National Health Service and so will receive some of their boundaries and expectations from the hospital: in the assigning of roles and missions and in the attempt to gain some measure of institutional security, where the primary master (the Trust manager) will influence, and even seek to determine, the ways in which chaplains both think and act. They are also representatives of the Church. The boundaries relating to this second side, with its own particular language and conventions, are not always intelligible to other health care workers. And the particular pressures of the National Health Service and any particular health care Trust will not be immediately understandable to the Church.

It follows that the institutional position of the chaplain is not a neat one, and in order to perform the functions and tasks of pastoral care within the hospital a number of tools will be needed. These tools will include some anthropology, psychology and management skill as well as the normal ministerial training in theology and pastoral care. This approach understands that a whole range of factors will bear upon meanings of illness in a hospital and that the chaplain is required to be flexible in both thinking and practice. The hospital acts therefore as a kind of threshold which transforms a number of traditions and produces a religious world of meanings, all of its own, if largely divorced from the world of the Church. This hospital world is attractive and energising for some chaplains; for others it is complex, de-valuing and confusing. One significant thread throughout Chapter Six is the sheer level of insecurity that chaplains feel about who they are and what they do. This experience of anxiety.
and insecurity will be explored below.

This thesis is about health care chaplains - who they are, what they do, where they work and how they reflect upon what they do. It has shown that despite a growth in numbers and some measure of increase in professional competency, hospital chaplains remain in some ways an enigma to themselves, the Churches and the health care world. They are for some perplexing, and for others inexplicable. However, what has emerged is that part of the success of the development of health care chaplaincy lies in the particular strength of the personal characteristics of the individual chaplain. It seems that chaplains are seeking individual personal identity and survival rather than a tradition or corporate identity through (for example) the College of Health Care Chaplains. They are often admired as men and women; sometimes as acceptable faces of religion and at other times as people who have listened and supported with a huge amount of sensitivity and skill. It follows then that while the role and functions of the chaplain may be enigmatic, their personal characteristics are not. Chaplains are appreciated for their personal warmth, approachability and readiness to support staff. These characteristics are both valued and affirmed. (During the author's visits to interviewees, it was significant that chaplains were well-known in their places of work and they were greeted with warmth and affection).

It is therefore very difficult and perhaps not desirable to define too closely the present state of the art (a significant term) of hospital chaplaincy. Part of the reason for this is that hospital chaplaincy is a ministry of dialogue and of the exchange of ideas and feelings. It is always on the move; always changing, partial, informal and always
passing by and through. However, the constant feature, in addition to the strength of the personal characteristics of the chaplain, is readiness and skill in listening to the voices of suffering. This assertion is based on the evidence presented in Chapter Six when chaplains reflect on dimensions of their work (see pages 180 and 182-184). It is also backed up by the analysis of how chaplains spend their time in Chapter Six - 34% of the working week is given over to contact with patients. This is the unique function of the hospital chaplain that some understand and value, though others mistrust. While it is relevant to have in mind the future of health care, as expanding technology clashes with constraining finances, there is a consistency of engagement with suffering and of handling suffering creatively which puts the chaplain in a unique and distinctive position as institutions and systems change. In embracing a philosophy of the human ecology - that is the understanding and care of human beings as whole persons in the light of their relationships to God, to themselves, their families and the society in which they live - the chaplain continues to be a resource for the processes by which we live with our suffering.

7.5.1 A ministry of paradox in a place of paradox: context and identity

A picture emerges of a chaplain holding together a range of contradictions and tensions. This may explain in part how insecure chaplains largely feel. It is true that they are at the sharp end of some profoundly painful and difficult human experiences with a product that few consciously want or think they need, and indeed one that chaplains themselves are often not sure about, or do not know how to express very confidently. It is true that many of the chaplains, at least, are all too aware of this problem. Some are able
to express the idea that in their own personal embracing of conflicting ideas or responses they point to a larger truth. This is the meaning of a paradox, and such paradoxes express themselves in all kinds of ways in the health care organisation. Human beings in illness often have to cope with paradoxical feelings and thoughts. There are profound paradoxes in both the crisis of illness and the process of hospitalisation. If the chaplain can share them, so much the better, for few others are likely to see it as their place to do so.

Part of the difficulty may lie in wondering where the authority of the chaplain comes from and what sort of animal he or she is exactly. Here there are real difficulties for the chaplain, because what happens between the chaplain and the patient will be determined not by rule of thumb but by the needs, motivation and availability of the patient and the skills, sensitivity and availability of the chaplain. Both the chaplain and the patient are free in principle to ignore one another. It may be difficult to establish meaningful contact where needs can be understood and responded to. Part of this difficulty may lie in the chaplain's unease about aspects of his or her role, or the patient's misunderstanding of or uncertainty at why the chaplain is present at the bedside (see Chapter Six, 6.2.3(v) page 162 and 6.2.6(iii) pages 170-171). While the particular structures of a health care institution make a very variable provision for chaplaincy, the ability of the chaplain to be available for patients may be severely limited by chaplaincy resources in the face of bed numbers and the turnover of patients.

What does emerge from this ministry is the countless times when the chaplain is able to comfort and support the patient through particular periods of crisis. So, as the activity analysis shows in Chapter 7. page 233
Appendix 5, over a third of the chaplain's time is spent at ward level meeting patients. It is within this meeting that the chaplain comforts and sustains patients as he or she discern the particular personal experience and how best to respond to it. Implicit in this approach and model of care is that the spiritual needs are directly related to physical needs. In other words, if people feel understood, and find some element of purpose and meaning in their suffering, then they may be better placed to profit from their experience of illness and at least handle it with courage. As the voices of illness pose particular questions for the patient, the chaplain may be for some a symbol of a living force. As the chaplain enters into the struggle, discerning the questions and listening to the story, then the journey towards integration and hope is or can be a shared one and a mutual one. Put another way, hospitals do not create paradoxes and mysteries, they merely focus them, and part of the creativity of the chaplain is to share in that rich moment of truth.

7.5.2 The chaplain: between worlds?
The gist of what has been said may be put by exploring in a little further detail how far a chaplain has a dual identity and what kinds of tensions might arise from this walking between different worlds, for example health care and religion, or between the two monolithic structures of the Church and the hospital. Each world or structure has its own domain and demands an assumption and a mission. There are points of both support and conflict. To varying degrees and in varying circumstances the chaplain will give allegiance to either Church or hospital. But moving between the two worlds can and does create tension. Like many tensions it is never fully resolved and perhaps never should be.
7.5.3. **The context of the hospital**

The context of the hospital fosters a sense of 'in-betweenness'. It is true that the boundaries of the parish, especially in so far as it virtually equates with the congregation, are much easier and clearer, in that it is a sphere where the ministry of the priest is accepted and there is minimal role confusion.\(^{10}\) By contrast, in the hospital the chaplain feels little primacy. Here there is no reverence or favour and it can be an altogether lonelier world. As we have noted, in a setting where tasks are so carefully delineated and precisely measured, the chaplain may easily feel out of place. The chaplain does not have unilateral access to patients. Access is shared with others and others make most of the crucial decisions. Who does what to whom and when needs to be defined and scheduled. Generally, medical tests and the requirements of medical or nursing staff must take precedence over other contacts during the hospital stay.

The chaplain's 'congregation' therefore is varied and represents a broad spectrum of faith and no faith. In traditional Christian terms, it is not a 'congregation', a 'worshipping community' (as it is often put) at all. In this way the hospital chaplain is both nobody's pastor and everybody's pastor. It is not surprising therefore that questions of validation and authority are significant for the chaplain. The chaplain has no claim upon the patient and can assume no authority. In an acute hospital setting, patients come for medical care and not for pastoral care. In this sense the doctor is the 'priest' whom the patient installs and imbues with authority. Rarely is the chaplain seen as a factor in the crucial process of diagnosis, tests, treatments, plans, length of hospitalisation, prognosis, pain control,

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\(^{10}\) The nature of parishes is changing. As a unit it is equally multi-cultural - the parish priest (like anybody) is between cultures. It is a matter in the hospital of being officially beholden to two bodies. See Ecclestone G (1988) *The Parish Church?*, Mowbray, London, and Greenwood R (1996) *Practising Community: The Task of the Local Church*, SPCK, London.

Chapter 7. page 235
diet, medications and discharge. As medical technology develops and the average length of stay is reduced, it will become increasingly difficult for those health care personnel who are not directly involved in the process listed above, to have sufficient time and space to develop a meaningful pastoral and supportive relationship with the patient. The chaplain is unable to presume on any religious motivation in patients, and cannot assume that the traditional faith resources and religious rituals will be welcome or significant to any more than a few patients. Part of the challenge and the difficulty is that much time is needed to acquire a feel for the religious needs and meanings of each patient, and this time factor is crucial especially in the light of the reducing length of stay. The agenda therefore of the chaplain/patient relationship is uniquely open. It follows that the chaplain mostly comes to the bedside empty-handed, without any specialised equipment or narrowly focused task. Of course, for some Roman Catholic chaplains, the administration of the Sacraments is their primary task.

The other main experience of chaplains concerns their freedom. The chaplain has freedom of access to all places within the hospital and more particularly the chaplain/patient encounter has wide freedom of expression. This sharing in a critical interim of a patient’s life could be characterised as extemporaneous, informal, casual and conversational. This approach and style are in very sharp contrast with the culture of the National Health Service. It is no wonder then that the chaplain is an enigma and that many questions surround the relevance of the chaplain. The chaplain is in the hospital but not quite of the hospital. The chaplain is an ‘in-between’ figure and therefore there will always be tension with the assumptions, values and perspectives of the hospital.

Chapter 7. page 236
Some of the chaplains discussed the role of further training beyond their general preparation for ministry. In this connection a number of intellectual strands are apparent in chaplains' reflections about the nature of their work.

The first is theological liberalism. It is interesting to note that there are very few Evangelicals within health care chaplaincy. In their desire for a theology which is flexible and open, chaplains seem usually to be people who react against authoritarian and dogmatic religion. This theological approach is optimistic about human nature, social in its outlook, and its liberalism emphasises the intellectual authority of experience.

The second strand might be characterised as philosophic pragmatism; in the sense of an experiential and empirical method of learning, based more upon function than theory. Chaplains learn by doing rather than theorising. If psychology has influenced this pragmatism, then it is likely to be clinical in its approach and inductive; that is, it is based on cases and its goal is to increase functional competence. For the chaplains who assent to this kind of pragmatism, professionalism and skills-based outcomes become important factors in the development of the chaplaincy service.

In relation to this it is a very interesting feature of many of the responses from the interviewees that theology is not put forward as a significant tool for the work. Many of them reflect an absence of confidence about the traditional modes of theology and how it relates to or engages with the actual realities of experience. This may be partly related to the character of the normal theological scene and of
theological training. These seem to be dominated by the quest for abstract truth and by historical matters, and are often weak on hermeneutics of a kind that facilitates application in the pastoral sphere. It is important to ask then whether cognitive theology helps chaplains to engage with the culture of the National Health Service or could possibly do so. Chaplains were invited to reflect on theological influences on their work but few responded in any detail (see Chapter Six 6.1.2. pages 150-151). Does it help these individuals and groups to understand their 'worlds'? If not, then action might well be preferred to thinking, as providing more effective results for the chaplain's work. Pastoral or practical theology may more appropriately be described as reflection on doing the job, while the exploring of abstract and 'timeless' ideas and of historical sources is an unaffordable luxury that does not produce results. Put another way, theology seems incapable of engaging with the way the chaplain actually acts, thinks and works. It would, however, be unrealistic to expect theology (or any other theory) to bind people together.

This may prompt searching questions about the nature of theology as a language of truth. What kind of language of meaning is theology in the context of health care? If it is a specialised, obscure language that hospitals (like the secular world in general) are incapable of understanding, then the chaplain is bound to acquire another language, an alternative form of communication. In the walking between worlds, security may even be found with the culture of the Health Service, where there is little or no sympathy for religion and its languages. Here medical and managerial languages are the predominant models of expression and the repositories of values. It may follow that chaplains are likely to want to understand, appropriate and use the tools and languages of management (for Chapter 7. page 238
example) to secure their place in the organisation. To whom do chaplains belong, and is it possible or desirable to nurture distinctiveness (whatever that may mean) or detachment from the dominant culture in which they live? Perhaps investment in management or therapeutic or psychological language is more rewarding than the customary language of even pastoral theology. In the hands of a skilled chaplain these secular languages could be vehicles of Christian-based values and perspectives - a way of bridging cultures and worlds. It may not be unconnected, at a different level, with the 'theological liberalism' of many chaplains that hospital chaplaincy is virtually a monopoly of the established Church. Even with 'congregationalising' tendencies in recent years, Anglican parish clergy (from whom chaplains are largely recruited) retain a sense of ministry to the community as a whole. Clergy of other communions, especially Roman Catholics, are likely to have, initially at least, a less comprehensive sense of the chaplains' sphere and to think largely in terms of ministry to those of their own flock.

All professions within the Health Service have or are undergoing a process of change and reorientation. Some would argue that nursing practice has been transformed over the past twenty years (Bradshaw, 1994), and few doctors today are not conscious of the financial implications of their practice (Calman, 1998). Chaplains are in the process of asking themselves seriously about how they want to shape and market the business they are in. It is apparent that some of the interviewees have been successful in promoting their service, while others struggle. Success is related, in part, to the understanding of their 'products' that chaplains display when their managers ask searching questions during their appraisal or in the production of a business plan - and the confidence they can bring to the process.
In an organisation where accountability has become more important, chaplains have to 'deliver' within the context of organisations that work under rigorous financial constraints, where survival is the name of the game and few posts are secure. The perceptions about levels of job security, given financial cut-backs and other changes, are clearly reflected itself in the chaplain's discourse. It follows that it will be an ongoing task of the chaplain's distinctive and specialised training to ask how pastoral theology can engage with a positive vision of a resource that can stand amongst other services and be useful in ways that are effective in and may even transform the process by which health is organised and delivered. Of course it may turn out that Christian values and perspectives are so at variance with the official ones, that there is no future for chaplains!

These questions again are ultimately issues of identity, relationship and the communication of action. These three dimensions belong together in dynamic interaction and will vary, as the interviewees demonstrate, according the context and the resources available.

7.5.5 The conflicting perspectives of medicine and religion

In an age of scientific medicine, suffering remains a religious issue (though it is also a medical, psychological, social and human issue), and expresses itself as patients ask the following questions:

- What have I done to bring this about?
- What does it mean?
- Why did it happen?
- Where is God in all this?
- What must I do?
- How can I adapt my life to this predicament?

Chapter 7. page 240
Early hospitals offered more spiritual comfort than physical relief because this was the best that they could do given the state of medical knowledge and the strength of the Christian culture that gave rise to them, with its emphasis on the ultimate dimension of human existence (Pelling and Smith, 1991). With the developments in modern medicine and the promotion of the medical model of health as the absence of disease, death is still often viewed as a failure and matters like judgment and salvation have no place at all. There often seems a mismatch between the tradition from which the idea and practice of chaplaincy derive and a culture that asks them to quantify their contribution in strictly this-worldly terms.

Part of the contribution emerges from the chaplains’ perspectives on health which will always be broader than those of medicine. From their understanding and appreciation of the social model, with its broader grasp of the factors that shape health and life, they are likely to view illness theologically as an interaction between the biological - psychological - social - mental - spiritual forces within persons. In other words, illness is multi-dimensional and the response to illness needs therefore to be multi-dimensional. This is often not possible within the narrow confines of an acute hospital. It is not always easy to empower patients to be active participants in health, or to resource an inter-disciplinary and interactive approach to healing which takes seriously the many dimensions of health and wholeness. However, in many sectors beyond acute care the importance of pastoral care has won a place of relevance and respect and even of

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centrality. This is particularly seen in many of the developments of community and social care, and often in the context of the Hospice Movement.

The chaplains therefore find themselves to be easily enmeshed in conflict, for their role is not to explain, cure or eliminate disease. It is only to engage with the sufferer in the suffering, and to embrace it with sensitive pastoral care.
8.1 Introduction
Chaplains are shaped by their context and, during the period in which this study was carried out, particularly by the organisational and managerial changes in the National Health Service. It is the purpose of this chapter to explore how these recent changes have impacted and will impact upon chaplaincy.¹

8.2 Chaplains' reflections on their context
One third of those interviewed felt that recent NHS reforms (post-1990) had improved the operational and strategic work of their health care Trust. This group of five interviewees highlighted a number of features of this improvement. The most important of these was a greater efficiency in management: there was a sense that the hospital was working better. One chaplain highlighted the improvement in the treatment of outpatients and another a significant change in communications, whereby many more members of the hospital staff had better access to information. Chaplains also indicated positive notions of accountability. They perceived the decentralisation of control as providing real opportunities to improve the way chaplaincy was communicated within the Trust.

Two of the interviewees felt that the changes had provided chaplains with particular opportunities to develop the service, including the resourcing of departments (see 6.2.5(i) page 162).

However, two-thirds of the interviewees felt that there had been considerable negative effects on their health care Trusts as a result of the changes.\(^2\) Amongst these interviewees there was widespread criticism of managers within the Health Service. Whilst sympathising with the relative job insecurity amongst managers, six of the interviewees felt that the process of change had been handled badly. Three chaplains who gave specific criticism of individual managers were so anxious about the force of their criticism that they asked specifically not to be quoted about their feelings towards management, fearful of the possible consequences (see 6.2.5(ii) page 163). One interviewee felt that managers were insufficiently trained for their work and that while there had been an increase in bureaucracy and paperwork, general communication had not improved see 6.2.5(iv) pages 164-165). One further interviewee felt constrained (for the first time in his hospital chaplaincy ministry) by being managed and being held to account for what he was doing and why (see Chaplain C pages 159-160).

Seven of the interviewees reflected on the change in values of their hospitals, shaped by the emphasis on financial accountability. There was a perception that the introduction of an ‘internal market’ had resulted in an erosion of spiritual, personal and human values. It was felt that the management of resources had become the key

\(^2\) Whilst not wishing to invalidate the reflections and perceptions around change, it is important to note that four of the interviewees who reflected on these negative effects had also felt that they themselves were showing signs of burn-out. These honest reflections about motivation and work are bound to shape how an individual deals with any change.
outcome within the health care Trust (see 6.2.5(v) pages 165-166).

Other chaplains complained of the increase in bureaucracy and management tasks for them as chaplaincy team leaders and three chaplains talked about the difficulties and anxieties around the move to measure the effectiveness of chaplaincy within an acute setting (see 6.2.6(iii) pages 168-169).

Finally, a number of chaplains reflected upon the difficulties of working in an organisation where there was so strong a medical dominance within the culture (see 6.2.6(iii) pages 168-169).³

8.3. Chaplaincy in the NHS reforms

The NHS and Community Care Act (1990) established the principles of an internal market or 'managed' market, with a division between purchasing authorities and provider units (Ham, 1995). The reforms arose in part as a response to the chronic funding problems facing the NHS, but also as an attempt to improve the efficiency of services and establish a shift from Health Service administration, or consensus management, to general management. This was a process initiated by the Griffiths Reforms of 1984 (Ham, 1994, 1995; Cox, 1991; Strong & Robinson, 1991; Klein, 1993).

The effect on chaplaincy emphasised the need to operate within a competitive market-place. Trusts were now competing with each other for business, and, like other health care professionals, chaplains had to recognise that the hospitals worked now within a

³ It is significant to note here that the interviews that took place after 1994 reflected some of what the Bishop of Birmingham had said to the British Medical Association in July of that year (see Appendix 7). In my analysis of those interviews included in that Appendix a significant number of chaplains wrote to back up the perception that since the 1990 reforms, the National Health Service had become too dominated by finance and effective management of resources.
market system. There was a responsibility to demonstrate value for money through the introduction of quality measures, such as clinical audit, and to respond to local needs (Brooks, 1995).

In the early period leading up to the reforms, some anxiety was expressed by chaplains about whether managers might want to continue to purchase their services. As general managers had authority to determine the nature of service provision, and as financial constraints within the new scheme meant cost-efficiency and patient need demanded that services were prioritised, these anxieties around the likely effects of the rationalisation of services for chaplaincy seemed well-founded. However, fears for chaplaincy itself were unrealised. In fact the number of chaplaincy posts increased significantly as many Trusts took the opportunity to strengthen and develop the role of the chaplain within their hospitals. A number of factors may account for the increase though it needs further research and testing. These include: the introduction of the Patients' Charter and the statutory obligation of Trusts to provide for the spiritual care of patients; the Christian commitment of non-executive Trust board members and their desire to support the work of chaplaincy; the good repute and persuasiveness of individual chaplains through their appropriation of business planning to fund more chaplaincy; the decentralisation of

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4 There was considerable discussion in the Council of the College of Health Care Chaplains about how best to support chaplains in their work following the 1990 NHS reforms. This culminated in the CHCC Annual Conference in July 1992 exploring 'Chaplaincy and Professional Development' (see The Journal of Health Care Chaplaincy December 1992, pages 5-27 for a report of this conference). Representatives from purchasing organisations addressed the subject of chaplaincy from a purchasing perspective and a Director of Quality gave practical advice to chaplains about developing quality statements. Chaplains worked together in groups to write business plans and discussed what further skills were needed for chaplaincy work in the light of the standards document (see Appendix 2). This was the first occasion that chaplains had seen a copy of this document. The author ended this conference by exploring theological dimensions of accountability ('Where is God in all this - to whom are hospital chaplains accountable?') Journal of Health Care Chaplaincy, December 1992, pages 21-26).
control, allowing more freedom around decision-making within Trusts and thus releasing resources for chaplaincy where local factors were powerful.

8.4 **The impact of management on chaplaincy**

In order to improve efficiency, the internal market was designed to establish a competitive market-place with an emphasis on cost-effectiveness, quality of treatment and increased responsiveness to patient needs (Ham, 1995; Maynard, 1993). Quality standards were introduced and covered such areas as waiting times, patient satisfaction and a statutory requirement to subject clinical practices to clinical audit (Ham, 1994).

The emphasis on quality issues, accountability to purchasers and clinical effectiveness became key factors which shaped the early concerns of the establishment of the College of Health Care Chaplains in 1992 and is reflected in many of the articles contained in the *Journal of Health Care Chaplaincy* during this period (see footnote 4 in this chapter). These two developments indicate that chaplaincy worked hard to define clearly what it aimed to do and how its interventions might be audited (see Health Care Chaplaincy Standards document in Appendix 2).

The introduction of general management, following the *Griffiths Report* (1983) secured for managers the authority to operate across professional boundaries. These powers were extended in the reforms of the 1990s with a large degree of autonomy for Trusts (Ham, 1995; Strong & Robinson, 1991).

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5 This was an NHS management enquiry report in 1983 chaired by Sir Roy Griffiths who was Management Director of the Sainsbury's food chain.
The impact of these developments has been referred to by chaplains. For some of them it was their first experience of being made accountable to any individual or process within an organisation. Chaplaincy was accountable and managers were required to justify chaplaincy practice. As we have seen, some chaplains perceived this as a threat to their departmental autonomy. However there is no indication that managers exercising power in relation to need for cost-efficiency within existing financial limits brought about a reduction of chaplaincy services within NHS Trusts.

8.5 Quality assurance, audit and chaplaincy

The Hospital Chaplaincies Council and subsequently the College of Health Care Chaplains viewed the growing emphasis on quality of care measured through audit as an opportunity to demonstrate its worth (see comment by Chaplain F on page 178). This was the motivation behind the eventual production of the Health Care Chaplaincy Standards document (see Appendix 2), but also lay behind the efforts of individual chaplains to act as a resource to Trusts in enabling them to respond to the requirements laid down in the Patients’ Charter about spiritual care. Some chaplains played a part in working with purchasing authorities in the shaping of audit

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6 It was not part of the original research plan to gather evidence about where chaplaincy was managed within each of the 15 health care Trusts. 10 of the 15 interviewees were contacted by telephone during June 1998 to ascertain how they were managed within their Trust. 6 of the interviewees reported that they were managed within therapeutic services (alongside physiotherapists, chiropodists, speech therapists, occupational therapists) and 4 were managed within support services (alongside personnel, porters, cleaners).

7 This should be compared with a similar study of podiatry where the author argues that the introduction of the NHS reforms resulted in a contraction of podiatry services (Borthwick A, 1998. page 284).

8 The chaplain who has done most research in this area is Seye Olumide, an African working at first in Bradford and now in London. His thesis Towards a non-racist fulfilment of the 1948 Health Act’s recommendations about spiritual care for all patients and staff in the NHS hospitals in the UK (University of Bradford unpublished M.Sc. thesis 1993) played an important part in shaping Beckford and Gilliat’s work (The Church of England and other Faiths in a Multi-faith Society, Department of Sociology, The University of Warwick, 1996).
questions relating to the provision of spiritual and religious care.\textsuperscript{9}

However, it is significant to note here that apart from this limited range of responses, very little further work has been done in the auditing of the standards set out in Appendix 2. While there is a widespread agreement about the necessity for audit, it has given some chaplains cause for concern and led some to argue that their work is not clearly measurable (see 6.2.7(iii) pages 171-172). Very little research work has been done on the outcomes of the chaplains’ interventions or, indeed, about the role of religion and spirituality in the patients’ coping mechanisms around illness.\textsuperscript{10}

8.6. **Medical dominance in the National Health Service**

A number of writers have discussed medical dominance in the culture of the NHS and its effects on the basic human aspects of care.\textsuperscript{11} Chaplains have reflected on their relationship with doctors in their hospitals (see 6.2.7(ii) page 171) and the need for pastoral care to correct the imbalance between the technical process of medicine and basic human aspects of care (Speck 1988, chapter 1; Woodward 1994, chapter 7; Bragan 1996, chapter 6; Bruggen 1997). Sometimes, it is asserted, hospitals do not seem to be places dedicated to human health and wellbeing, but instead like places


\textsuperscript{10} Some research is planned in this area by the Lincoln Theological Institute for the Study of Religion and Society in the University of Sheffield. This subject is addressed by American authors (Vandecreek, 1995; Verhey and Lammers, 1993) and in passing in Sampson C (1982) *The Neglected Ethic: Cultural and Religious Factors in the Care of Patients*, McGraw-Hill, London and Rees D (1997) *Death and Bereavement: The Psychological, Religious and Cultural Factors*, Whurr, London.

dedicated to medical technical excellence.\textsuperscript{12} This shapes and influences the work of all those in the hospital who do belong to this dominant group.

This medical dominance has been noted in Chapter Three in relation to the sociology of professions. Many have become more critical of medical power (Johnson, 1977; Illich, 1976) and while it is not necessary to address those debates here it is important to note medical dominance as it shapes the chaplain’s experience of marginalisation in the hospital. Clearly contemporary medicine occupies a prominent place in society as a whole (Jones, 1994, chapter 11; Perkin, 1989, chapter 8). It is highly technical, orientated towards cure, dismissive of the non-empirical and very much focused on centralised medical facilities. It has little time for finding ‘meaning’ in illness and suffering, preferring to eliminate these things instead (Wilson, 1971, 1975). This needs to be contrasted with Christianity in general, and chaplaincy in particular. Christianity is one religious option amongst many in a secularised society (Habgood 1983). Its values may seem arbitrary and arcane to many doctors. Generally speaking, it is not technical in its operations, it concentrates on the well-being of people in society and it takes the realm of the spirit seriously. At the same time, what it has to offer in practical terms is often not very apparent to medical practitioners who have to meet immediate demands.\textsuperscript{13}


This general background bears upon how and why chaplains may view their role within the hospital as marginal to the medical enterprise.

8.7. **The changing nature of acute care**

Work has been done on the changing nature of both the acute hospital and acute care. This section is necessarily a brief overview, in part, to acknowledge that the context of acute care does shape chaplaincy. It is retrospective and does not take into account the impact of the new Labour Government's health policy. This is related, in part, to the recent NHS reforms and the development of a primary-led health care service.¹⁴

The future of health services will necessarily also be influenced by changes both in the economy and in society (Butcher, 1995). Some of the relevant factors are the opportunities available for paid employment, the evolution of new patterns of work, changes in the family and resources available for public expenditure (Jones, 1994, chapter 1). The trend towards smaller families and more childless couples means that elderly people are less likely to have family to turn to for support. The greater mobility of parents and children reduces the capability of family members to care for one another, as may the increase in the divorce rate and changing patterns in social networks and relationships (Jones, 1994; Bennet and Ferlie 1991; Butcher, 1995).

At the same time improved living standards and higher personal incomes among those in employment may create a demand for paid carers in the community (Harrison and Prentice, 1996; Marks, 1992). The service of carers may be purchased privately or publicly depending upon political decisions about the future of health services. Associated with this, the public is likely to have increasing expectations of health services as a consequence of higher standards of living and awareness of technological advances. The consumer movement may become a more significant influence for change, and patients may demand a bigger voice in decision making. This will add to the pressure on those responsible for service provision (Jones, 1994; Hughes and Gordon, 1992). Against this background there are a number of general implications that will impact upon the changing shape and culture of the acute hospital.

8.7.1 Self-care and care in the home

The greater availability of over-the-counter diagnostic kits and of diagnosis which can be carried out at a distance will put more emphasis on self-care and care in the home. At the same time the development of less invasive surgery and new forms of medical treatment, will enable care to be provided on a day-patient and out-patient basis. The need for care in the home by families, relatives, friends and paid carers is therefore likely to increase, thereby stimulating demand for community nursing and other services. As the whole role of hospitals changes, a higher proportion of nurses is likely to be working in the community, alongside GPs and other staff. The future of community health services, primary health care and related services provided by Local Authorities and other agencies, needs to be considered in the context of developments in the acute sector (Stocking, 1992; Marks, 1991).
8.7.2 General Practitioners

With improved knowledge and technology much medical investigation and treatment that formerly required the facilities of a general hospital will be available locally. GPs will have available a wider range of diagnostic tests, and will be able to initiate the appropriate treatment without reference to hospital services. In the same way that care for diabetics has moved from hospitals to general practices, similar care for other chronic illnesses will be increasingly possible. This could result in turn in greater specialisation among GPs with doctors working together in group practices, each taking an interest in a particular area of work with support from other members of the primary care team (Harrison and Prentice, 1996, Chapter Nine).

Greater knowledge of genetic predisposition to illness creates opportunities for specifically targeted health promotion activities. Primary care is the natural base for these activities. It is likely that GPs will take on more responsibility for screening their patients for risks, and will work in co-ordination with other staff to promote healthier lifestyles. The pace at which GPs assume greater responsibility for the health of their patients, may depend as much on the financial incentives available as on the development of appropriate technology. Also important will be the provision of continuing education to inform GPs and other staff about the potential of new technology (Packwood, Keen and Buxton, 1991).

8.7.3 Hospitals

Hospitals in the future are likely to be very different from now. The
move from secondary care into primary care is already taking place, with the result that the need for beds is declining as greater use is made of day surgery and day investigation facilities, and as more emphasis is placed upon care by GPs, self-care and care in the home. A core of intensively used beds, grouped to provide maximum flexibility, will remain, with appropriate support from other departments and laboratories. Economies of scale are likely to dictate that laboratories will serve much larger population than current small departments do. As the number of beds and the need for beds decline, hospitals are likely to serve larger populations in order to justify the critical mass of facilities required to maintain a satisfactory service. This trend will be reinforced by a stronger emphasis on quality assurance and clinical audit, coupled with consumer pressure for higher standards. Increasing research evidence indicating that better results are obtained in hospitals where staff are experienced in treating specific conditions is likely to result in greater specialisation within the medical profession. The emergence of regional specialist centres may be at the expense of district based services. A loss of accessibility may be the price to be paid for higher quality care (Harrison and Prentice, 1996, Chapter 11).

8.7.4 The Future
It is likely that the nature of the acute hospital will continue to develop and change in the next decade or so. The trend is that general hospitals of the future will provide fewer beds and will use these beds intensively. Wherever possible the average length of stay will be reduced to an absolute minimum, greater specialisation will
occur and patients may have to travel further for treatment. There will be much less clearly defined boundaries between primary and secondary care, with more care offered in the community.

Important and difficult ethical questions may arise from these developments, for example in relation to genetic engineering. It may be that many of these questions will have to be resolved outside of the health care system by politicians or lawyers.

There is much uncertainty surrounding many of these developments with, for example, much depending on changes in mortality and morbidity, demographic trends, and decisions about the future of the NHS. Whilst technology creates a strong pressure for change, these factors are also important.

8.8. Chaplaincy and a primary-led health care service

The publication of the Labour Government's White Paper *The New NHS: Modern. Dependable* in December 1997 marked a movement away from a hospital-based service towards more care being delivered in the community. It marks an attempt to ensure that decisions about health care are taken as close to patients as possible.\(^\text{15}\)

We have noted changes in acute care, particularly developments in clinical practice, short lengths of stay in hospital, the provision of more care and treatment in the community and people's developing interest in their own health needs. It is not possible at this stage to make concrete conclusions about the implications for chaplaincy

\(^{15}\) At the time of writing this movement is still being evaluated and discussed. For a summary of the issues in this area see: Pietroni P (1996) *A Primary Care-led NHS: Trick or Treat*, University of Westminster Press, London; *Statement on a Primary Care-led NHS* (1996), Royal College of General Practitioners and Gillam S (1994) *Community Orientated Primary Care*, King's Fund, London.
except to suggest that it is probable that there may be less resources for acute care in future years (Harrison and Prentice, 1996; Ham, 1992) and that the continued effort to reduce the length of stay makes it difficult for chaplains to develop and sustain meaningful pastoral relationships with the patient and thereby influence the process of rehabilitation and indeed of death.

Mental health care chaplains have responded creatively to the move from hospital to community-based care (Browning, 1986). Acute chaplains need to explore the practical implications of the present and future changes on models of chaplaincy. There is no indication of that work taking place at the present moment. It may be that there will be increased emphasis on the role of chaplains in relation to the structures and staff of hospitals and in teaching and ethical consultancy.

8.9 Conclusions

This concludes a summary and overview of the implications of recent organisational change in the NHS on chaplaincy. We have noted that the introduction of the NHS reforms in 1990 has forced chaplaincy into a greater degree of accountability. Some chaplains have used this process of change to develop their work and others have found it threatening and demotivating. It may be the case that chaplaincy (in terms of increased numbers of appointments) has peaked in strength and influence during the 1990's and that the next decade will mark a period of steady decline. Further, the medical and managerial dominance continues to pose challenges to how chaplaincy can influence the shape of health care and strengthen the

16 I have discussed this at further length in ‘Healthy Living Centres: The Churches: a resource for health and wholeness’ Crucible, April/May 1998, pages 68-77.
role of pastoral care in the hospital. Some chaplains have attempted to demonstrate effectiveness by using business planning and quality assurance. Finally we note that the changing nature of acute care through the development of primary care challenges chaplains to reflect on their models of care and relationships in the community and churches. It is important to note here that there is no evidence to suggest that acute chaplains are planning for the future in the light of the changing nature of acute care.
CHAPTER NINE

THE CONCLUSIONS

9.1 Introduction

It is the purpose of this final chapter to draw together the main conclusions of this thesis. In the process of reflection, it will make clear where the main strengths and weaknesses of acute health care chaplaincy lie in the light of the data and thereby give some indication of the challenges and opportunities that lie ahead for chaplains and chaplaincy.

The chapter will summarise the picture that is generated in the data contained in the over-view of chaplaincy history, literature and interviews. It will summarise the main influences on how the chaplain reflects upon his or her role in acute care. In the light of this summary the chapter will explore specific areas for further work by chaplains. The two main areas of suggested development are the implications of working in a primary-led health care service and what the agenda of chaplaincy training and thinking might be in the light of this piece of research. Finally, the chapter will conclude by examining the weaknesses of this present work and suggesting possible future areas of research about chaplaincy.

This thesis has explored how health care chaplains have understood and managed their roles, especially during the early part of the 1990's, partly as a result of the reforms of the National Health Service. Chaplains have expressed a measure of tension and anxiety about both their role and function throughout their interviews and some measure of concern about the structural changes in the NHS. There are indications that chaplains cope with these tensions both within their role and in Christian belief.
by underplaying the distinctive theological element in their identity and role in favour of involvement with society and the culture of the NHS.

This study has located these findings within a sociological framework in order to understand the nature of professions. This framework also goes some way to account for why chaplains may experience a sense of marginalisation and how chaplains have responded to changes in health care.

The neo-Durkheimian framework (Chapter 3, pages 42 ff) which emphasises professionalisation as a process by which professions acquire necessary characteristics, is demonstrated in the attempts by chaplaincy to acquire and regulate a skills and outcome approach to its work (see Appendix 2). A major issue for chaplains is how others understand their role thereby offering some measure of security. The neo-Weberian framework (Chapter 3, pages 44 ff) expands on two notions; those of social closure and professional dominance. Chaplains are affected by medical dominance within which the chaplain experiences marginalisation of role and identity. In the light of the developing nature of the multi-faith nature of society there is an ongoing debate about how far the distinctiveness of Christian chaplaincy ought to be maintained within this context.

It has also become clear that the NHS reforms have forced chaplains to become more accountable. Some chaplains have secured and developed their position in the light of these changes and others have clearly struggled to respond creatively. It is not possible to achieve a complete picture of how chaplains use their theological knowledge within their work because this is an evolving and diverse situation. Chaplains handle the
relationships between their professional and religious identity in various ways.

This identity is further shaped by secularization as religion has declined and thereby has led to a marginalisation of the identity and role of the clergy in today's society.

9.2 **The key influences on the chaplain**

There are three main influences on how the chaplain reflects upon his or her role in acute care.

The first derives from the setting within which any health care professional has to operate. The setting of work always interacts with the worker, especially in large institutions where context can profoundly shape the worker's attitudes, including their understanding of their individual task within the overall institutional goal. So, for example, in modern hospitals the nature and cost of the technology and the knowledge and skills required to understand and operate it presses strongly towards treating the illness and not the patient (Calman, 1998; Jones, 1994; Bradshaw, 1994). Chaplains are caught up in this and in the resulting tension because it is closely linked with perceptions about the necessity for financial accountability (see Chapter 6 page 168) and efficiency and the changing boundaries between primary and secondary care (see Chapter Eight, 8.7 and 8.8 pages 251-255). The National Health Service was originally intended to free patients from the suffering and deprivation resulting from illness and so was focussed on the individual. This was done regardless of cost, but at a time when levels of understanding and competence meant that medicine was simpler and therefore cheaper (Webster, 1998; Prentice and Harrison, 1996). The changes in medicine in general and acute care in particular have

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produced a level of anxiety amongst most health care professionals (Cox 1991; Saks 1995). Chaplains are not immune from this and, indeed, have felt themselves to be marginal because of aspects of the way care is both conceptualised and delivered (see Chapter Six page 164-167).

The second key influence that has become evident in this thesis concerns the issue of professionalism. This thesis has demonstrated that there has been an attempt to engage in strategies of professionalisation, particularly by the College of Health Care Chaplains. However an examination of the history and literature of chaplaincy has shown that some chaplains have developed a belief in professionalism less for its own sake than as an ongoing part of the necessity of defending and explaining their role to other health care professionals within the hospital (Wilson 1971; Speck 1988; Woodward 1995; Stoter 1995). Clearly these strategies have been successful if the criterion of measuring success is the steady increase in number of appointments.

There are, however, positive and negative dimensions to this. The positive dimension concerns the dedication of chaplains to enlarging the possibility of doing something for the good of the other; in effect by 'going deep', enabling knowledge or skill in a limited area to be highly developed and then put into general use. Chaplains' authority and influence emerge from their ability to be present in some of the most profound of human experiences (see 6.2.13 page 184). They engage with and manage uncertainty. The positive aspect is also apparent as chaplains show they can adapt their capacity to 'go deep' to changes in the system and role of the hospital (discussed briefly in Chapter Eight).
In what sense clergy are professionals alongside others in the Health Service is a continuing debate. In what sense they will be able to demonstrate how their interventions shape and influence the health care process remains to be seen. It is a matter of conjecture, for example, how chaplains might respond to any centralised desire to monitor and accredit pastoral work in hospitals. This would result in profound changes in the selection and training of chaplains. At present there is no system for monitoring or evaluating chaplains or the pastoral care they provide. They are present in the hospital by virtue of their ordination only - and because they have always been there. Some have responded by taking part in further training, others prefer to remain distanced from any attempt to regulate their work.

The issue of how far and in what respects the clergy in general should be regarded as professional in the light of the summary of the sociological literature in this area is discussed in Chapter Three (see 3.8.3 page 72 ff), but in the case of chaplains in a hospital there are strong structural and other pressures for them to be regarded as such. They look for organisational security as they attempt to explain the nature of chaplaincy. This thesis has demonstrated that chaplains can and do earn regard as professionals because this is how hospitals are constrained to see them and to demand that they work within their institutions. However, the strength of the chaplain comes from being in certain important respects on the margins - as (it may be suggested) clown or as artist. Chaplains and clergy could be seen as left over from a pre-rational traditional society. This is why they seem non-rationalistic. They are pre-rational in sociological terms. Chaplains stand not over against the institution, but obliquely alongside others in the hospital. This critical distance can enable them to reflect on the corporate dimensions of the health care.

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institution (see, for example, the ways in which chaplains have reflected on the NHS reforms 6.2 pages 164-169). It enables them to offer staff an impartiality and a style of critical detachment within which they can feel listened to and supported. It can provide the critical distance and neutrality within which to be an advocate for patients and others within the institution and even, in certain circumstances, for the institution itself in relation to some of its functionaries. In this sense, their odd kind of professionalism (if it merits that term), is the very condition of their usefulness.

The third influence in a chaplain's self-understanding is secularisation and the general marginalisation of the clerical role. The general force of secularisation is to make religion, and so chaplains, redundant. However, the context of medicine, especially in acute hospitals, on the edge of life and death, wholeness and fragmentation, exerts a pressure which makes people unwilling to expel religion from the institution. This thesis suggests that chaplains continue to have the ability to be relevant when many of the forces of modernity seek to banish them to irrelevancy. Some may feel embarrassment at religion in general and, by implication, at what the chaplain stands for, and may see it as a personal service to individuals by their choice. There is a pressure, likely to be significant in the ongoing funding of the National Health Service, that will force chaplains constantly to justify their position. It is likely to be argued that chaplaincy may be funded if it can be shown to make a contribution to the working of the hospital despite its theoretical oddity. Shrinking financial provision will accentuate internal competition for reduced sums of available money. As a non-revenue producing department with a lack of clarity about its work outcomes, chaplaincy will find itself at a distinct

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disadvantage. It remains surprising that these pressures have not so far made themselves felt.

In this curious period of expanding technology and competition for resources, it is a complex business for health managers to balance care, quality, and affordability. It is probable that the best they can do is to negotiate the most advantageous trade-offs between these aims. Within this process chaplaincy would do well, in the light of this research, to think more rigorously about its nature, role, functions and outcomes.

These influences have led to a widespread diversity of both the provision of chaplaincy (some hospitals employ more chaplains than others) and in the ways chaplains work. The 1990's have given chaplains a different range of threats and opportunities which have led to a range of models of chaplaincy (see Chapter Seven, pages 203-208). Some chaplains have maintained their links with their church community and others have concentrated on developing expertise and security within the health care institution (chaplain as teacher, manager of change, staff support resource, etc.01). The conclusions presented in Part Three of this thesis offer an overview or summary of the main themes and findings of the data. It is not possible to define one model for chaplains. They are, in part, reactive and involve themselves in many diverse aspects of work (see the diagrams in Chapter Seven pages 219 and 221).

This concludes our overview of the key influences that bear upon the role of the chaplain. Some of these influences will be picked up and discussed at further length below.
Beyond anxiety and confusion about role and identity

One of the abiding impressions from the data in this thesis is that of the mild anxiety and self-preoccupation which chaplains give voice to when they reflect upon their role and identity. The chaplains who are heard in Chapter Six are constantly asking the question: ‘What do people think of us?’ (see 6.2.6(iii) page 170 and 6.2.7(ii) page 173). Not one of the interviewees in Chapter Six reflected on how far their own anxiety was shared by other groups working in the National Health Service. In a way chaplains, of all groups in the Health Service, might be expected to rise above these anxieties. The problems of self-identity and their management are crucial to the formation of a minister’s integrity. As Rayner has pointed out, all work involves a mastery of anxieties as well as of skills, and, for such self-knowledge, the mastery of feelings of love and sexuality, aggression and power, success and failure, are essential in order not to bruise those with whom the minister works by inflicting either anxiety or insecurity (Rayner, 1978 page 121). Such knowledge and skill will often only come out of the confrontation of experiences, and for a chaplain these can be theological and spiritual as well as purely experiential. By encountering others’ life stories, the recipient’s life story should be altered, even transformed, and he or she may be challenged to find the meaning and depth of life once more, regardless of where it may lead (Gersie, 1997; McLeod, 1997).

In the way they express themselves within the context of this thesis, some chaplains seem not to have much to stand for, and in some respects, not to be all that professional. This may be to do with them as individuals, their training, the Church’s situation now in society, the National Health Service as a place and context of work, or a range of other factors. Certainly, as has been indicated, a significant minority of those interviewed...
admitted to some level of burn-out (see 6.3.4 pages 187-188). It may be that the chaplain’s position is, currently, impossibly odd - for reasons beyond anyone’s control or remedy. This may account for the frank expression of their sense of vulnerability. It is the implication of this study that chaplains need to manage both their anxiety and the confusion around their role and identity more creatively; to acknowledge the dilemmas and work through them with an awareness of what can be changed in order to give a clearer sense of purpose, and of what remains fixed about the context of health care, though causing such difficulty and challenge. This may be facilitated through training, research and supervision (see below, 9.6).

9.4 Management, medicine and the market

Chaplains do demonstrate in this study some ability to respond to change and adapt their work in the light of evolving structures. It is interesting to note how many have become knowledgeable and skilled in the management of their departments through the setting of mission statements, outcome targets and the formulation of budgets and business plans. Following the 1990 reforms, some have seized opportunities to develop their service and to communicate the nature of health care chaplaincy in relation to both managers and government (see 6.2.10 pages 179-182).

Others have expressed considerable reserve and doubt about many of the aspects of change and reflect with a certain amount of insight on their organisations during this critical period of change. While there is a certain amount of sympathy for the need for change, there is an overall sense that in the 1990s it was implemented too quickly (see page 166). Chaplains feel that innovation is often led by bad practice and carried out by over-
stressed managers because of the speed of their deadline and performance targets (see pages 166-167). A number of practical and organisational difficulties follow from this. These relate partly to how far patients feel valued and also to the problems of getting anything done in a complex and bureaucratic organisation. There seems also to be a good deal of misunderstanding between professionals and not least between managers and doctors, with chaplains sometimes feeling rather helplessly involved in the cross-fire.

Perhaps one of the roles of the health care chaplain is to explore further how they can be a resource for building and developing the context of the hospital as a community where people experience job satisfaction and work at understanding one another and the objectives of the place, and where those in power work at valuing staff at all levels. There is a move by chaplains in this direction in the significant recognition by them of their role in staff support. There still remain questions about how far chaplains use the insight and wisdom gained from working with staff to build and develop healthy work contexts, and how far such a role can or should be formalised (see 6.2.13 pages 184).

There is also another critical area linked with these reflections on the context of health care. This is to do with the role of values in change. The result of the move away from central bureaucracy to the introduction of the market (see page 162), and its resultant emphasis on the local and individual rather than the collective, has been that the values of public services have changed and are still changing. The values people adopt indicate the kind of structures and organisations that develop, and staff at all levels bear witness to their experience that health organisations have come to behave in a different kind of way. Perhaps there is a role
for the chaplain to enable an organisation to be more explicit about the values that are chosen, and how these values operate at all levels of individual and corporate existence. These areas of concern range from the treatment of porters and cleaners to the explicit process of rationing in health care (New and Le Grand, 1996). The chaplain is in a relatively good and strong position to facilitate and empower debate about the critical roles of values in health care. The chaplain’s place in the organisation gives him or her a unique opportunity to engage in constructive and systematic evaluation of the systems and organisations within which he or she works. In other words, the chaplain can facilitate asking how comprehensiveness, quality of access to service, choice for the user, and the costs of these services relate to each other. It is a matter of thinking through how people can be empowered to engage in corporate and public debate about the values that people want and need from health care. This debate could involve both patients, potential users from the community and staff at all levels of a hospital. In this dimension, the chaplain acts in a pastoral and ethical role, with the explicitly Christian remaining hidden or perhaps implicit.

This section has argued that one of the purposes of chaplaincy is to promote alternatives. This will require both freedom and courage on the part of chaplains to act according to a different vision and with a different perception of reality from most of those around them. In other words it requires a prophetic vision combined with a social and political awareness that can encourage debate and change (Pattison, 1982, 1994). This, perhaps ironically, requires chaplains to be more at ease with their marginality. Chaplains might be described as liminal people. They are in between; and the freedom, or potential freedom, this position imparts, gives them the possibility of
relating to and interpreting reality in all kinds of creative ways. Chaplains as liminal people can be subversive and influential as they are in touch with so many dimensions of the life of the hospital, not least, of course the patients' encounter with illness. Again, this may require a re-appraisal of present models of training and supervision, and might need to be supported through an ongoing structure of research and development.

9.5 **Building alliances between primary and secondary care**

It has been noted in Chapter Eight that the boundaries between secondary and primary care are shifting, a development which will affect the future of acute hospitals in general and the role of the acute health care chaplain in particular (Chapter Eight pages 253-255). There are some further important reasons why, in the light of these changes, acute health care chaplains would do well to examine not just their practice but also their theological principles in relation to health in order to broaden perspectives on the subject today. These open up a wider dimension that concerns us all.

There is an inter-connectedness between human beings and their environment. Hospital institutions are likely to employ a fairly narrow model of health and disease that can often fail to explore and respond to the reality of this wider inter-connectedness. Health and disease are social processes with moral, ethical and spiritual aspects. If society is to pay due attention to these processes and dimensions in considering how best to promote well-being in the community, then the chaplain must make further creative links between secondary and primary care in exploring what it means to be human and to have health in and through one's place in the community. The chaplain, as priest of the Church that belongs in society at large as well as employee of
the hospital, is a symbol of this wider perspective.

A number of factors already been noted have a bearing upon the changing boundaries between primary and secondary care. They might be summarised as follows. Hospitals will become more cost-conscious and are likely to want to exploit their expertise more intensively. Some may well become narrower in the scope of the medical services provided and they may be fewer in number. It is argued that those that will survive will become parts of coalitions and networks, making it difficult for the local hospital to retain its unique identity and mission as a general resource (Chapter Eight pages 251-253).

Hospitals will care for fewer in-patients and for briefer periods of time. This has already happened and will continue. Some have predicted that in-patient admissions will be cut by one-third. The national average length of stay has shortened consistently over the past decade. As part of this change hospitals will be even more focussed on physical matters. It may be that there will be little reward for doing a more humane job or for addressing quality of life issues. It may follow that concentration will be on the healing of the body, and as a result health care will be narrowly defined. It is possible that more services will be offered by agencies outside the hospital. There will be an increase in day-case surgery and more of the diagnostic tests may be done prior to admission. Finally, more care will be taken into the community and into the home, and families will be drawn on to assist in providing part of the care (Chapter Seven pages 219).

It will be necessary therefore for chaplains to explore different ways of working within this changing context. It may be a way forward to work between the hospital and home context.

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concentrating on fewer patients in greater depth, as has happened with some mental health care chaplaincy (Browning 1986). It may also be an option for chaplains to broaden their base of services within the hospital, developing work in out-patient facilities rather than in short-stay ward areas. It is likely that the role of the chaplain with the staff will increase, and some may feel that they have a particular contribution to make to education or administration. Work with the elderly, which will develop and increase in the future, could be an area of development, as could work with particular specialised units such as transplant or oncology services. As long-term care moves out of the acute hospital more and more to nursing homes and residential care, chaplaincy might consider how transitions are managed and how palliative care in long-term care could benefit from links between the hospital chaplain and other clergy or congregations. It is significant to note that none of the chaplains interviewed or any recent chaplaincy literature address these radical changes which health care is undergoing and their implications for the role of chaplains.

In this perspective the chaplain can no longer define himself or herself in a narrow context divorced from wider congregational and church life. The chaplain may have to look to developing wider networks with the churches as part of this development in their role. Key in this broadening base of chaplains as health care changes, is the financial factor. With the decline in all mainstream churches it is unlikely that churches would pay for chaplaincy in hospitals at its present level. If the National Health Service chose not to employ full-time chaplains, then the chaplain of tomorrow may have to raise funds for the work and sell his or her services. It is possible that parishes may want to buy into the resources that chaplains could offer, as might other

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voluntary organisations. These services could include counselling, consultation, crisis intervention work, education, staff support and lay training.

To discuss these changes in this broad and generalised way might suggest that, despite the present signs of hope in the present increase of chaplaincy posts, there may appear to be little long-term future for hospital chaplaincy. However, the history of chaplaincy demonstrates that it has been, to date, flexible enough to adapt to many changing needs. Demands to adapt and change are compelling and chaplains will need to face new boundaries and limits. Like their patients in relation to their illnesses, chaplains must contend with a changing self-image, and in this process they will be forced to face new struggles, new limits and new challenges.

9.6 **Training, research and development**

There are a number of critical areas for attention and development which may be necessary to ensure the ongoing security and development of chaplaincy in the acute sector. These are issues primarily for a chaplain’s personal and professional development through training and supervision.

While some initiatives have been taken at national level, there continue to be very few chaplains engaged in continued ministerial education, or any systematic educational programme which provides them with opportunities to reflect upon their work. In this they are unlike most of their professional peers in the NHS. As has been mentioned and discussed before, the only accreditation necessary for entry into chaplaincy continues to be ordination within a particular denomination. It is surprising that a system of clinical pastoral education or accreditation in
pastoral care within hospital chaplaincy has not been introduced to provide a clearer framework of reference within which the roles, functions and identities of the chaplain can be explored and discussed. Such courses as exist are both small-scale and optional.

Continued scarcity of chaplaincy literature is a serious weakness in the chaplains' ability to communicate clearly the nature of their work and how they contribute to the health care process. This thesis has shown that in some presently critical areas chaplaincy has made some significant contributions to the life of hospitals. These areas include the enabling role of the chaplain in empowering the institution to respond to the needs of individuals of other cultures and faith communities (Beckford and Gilliat 1996); development of systems for staff support (Stoter 1997); education and training in ethics, spiritual care, death and bereavement; support and use of volunteers from the wider community; the development of an appropriate system for handling death and bereavement; and the ongoing support of senior health care professionals in a changing and demanding organisational culture (Stoter 1997). In all these ways chaplaincy can claim to meet the most stringent tests of usefulness that may be applied in the changing life of the NHS as it is at present.

More intimately, the chaplain's strength relates to his or her constant presence in and around all areas of the hospital in general and through the participating in the experience of illness in particular. This thesis has demonstrated how chaplains are present in illness supporting, listening and affirming individuals at a very wide variety of points and stages in the process. Chaplains need much more systematic support in articulating some of the opportunities and dilemmas of their work. Some
Chaplains are isolated because they receive so little systematic feedback from others in their hospitals - an almost inevitable effect of their 'oddity'. The best motivated chaplains are those who work within teams and the most creative chaplaincy literature emerges from the work that is done by a chaplaincy department, co-operating with others in the hospital to communicate the nature and purpose of the chaplain's work (see Chapter Six, 6.5; the work of Stoter is particularly innovative in this area). For these chaplains, the oddity is mitigated and understood as a result of being shared; it can even be a source of confidence. Chaplains need to develop systems which can enable them to be confident in what they do well, and in how their intervention makes a difference to the experience of health and well-being. They also need support to improve their profile in their Trusts by securing critical and positive feedback about their role and work. Chaplains, through supervision and other methods, need to bridge the gap between perceptions and the reality of what they do, why they do it and how they do it. Some of the role anxiety demonstrated in this thesis emerges from 'burn-out', which is, in part, related to a lack of support and of preparedness of chaplains to be critically self-aware. Often they seem over-conscious (or wrongly conscious) of their 'oddity' in the institution; though it is equally true that others (often senior members of the hospital) do little to help chaplains feel valued or understood as professionals alongside themselves. This can be true, for different reasons, of believers and non-believers alike.

Another major weakness of chaplaincy at present is the lack of a commitment to research. As the pressure increases on professionals to justify their work, it is imperative that chaplains develop a research base which can explore the nature and practice of spiritual, religious and cultural care. There is widespread
recognition that patients suffer spiritual distress, and a growing nursing literature that bears testimony to the reality of such distress. Chaplains are in a unique position to facilitate and share in this research as a basis for establishing the need for spiritual care of patients and for furthering the institution's commitment to rehabilitation. It may also be the case that chaplains could shape and change the hospital's perceptions of their role through systematic audits of the expectations that staff have of chaplaincy, thereby providing information on which to plan for how they might want to work within any particular hospital.

9.7 Where is God in all this? Lines of accountability

A final critical area of concern in this study is the question of accountability. We have noted how chaplains have responded to change in the often uncritical appropriation of the tools of management: performance review, business plans, audit, quality initiatives, objectives, change, management and organisational missions.

It is significant to note the relative absence, in the chaplains' responses, of a theological critique of this process. There is an embracing of the language of the health care business without any theological critique. Very few of the interviewees spoke openly about God, or provided any substantial indication of how they used their theological training or indeed any but the most general beliefs, in their work.

At the heart of ministry lies a conviction about the nature and person of God. The minister is a vocational professional in the sense that one of the undergirding questions motivating work and
perspective is ‘What does God want of me?’ A combination of personality, experience and context leaves the individual or group with a variety of understandings and perceptions of God. These perceptions or models of God give rise to a variety of patterns of belief. It is significant to note therefore, that within the discourse and reflections by chaplains there is very little reference to conceptions of God, and no explicit exploration of either the patterns of belief or the models of pastoral practice that follow from these theological understandings. It is as if the fundamental knowledge base of theology, which would make health care chaplaincy distinctive, is a useless tool in the attempt to move the ministry of the health care chaplain to an acceptable professional base within the Health Service. Perhaps in a desire for security, the chaplain prefers to adopt and appropriate many of the cultural norms prevalent within the organisation of health care itself.

All the same, this model of adoption emerges through reflection on how chaplains work within the Health Service, and is reflected in the ways in which they have taken on many aspects of the new culture (and in some cases used it to explain and promote the service). While not mentioned explicitly by any of the chaplains this is a reflection of working in environments where there is a greater degree of control than clergy usually experience; though, despite this, many chaplains continue to experience significant amounts of freedom, with many in the hospital failing to understand their role and work, and so perhaps by-passing them, warily. In the light of this understanding of professionalism, how does the Christian belief that God is to be found especially in the vulnerable, marginalised and weak impinge upon the ideas of accountability prevalent within the health care organisation? Of course chaplains are inheritors of a long and
complicated history of the relationship of faith to culture. In the present social setting, it may be that a positive view needs to be taken of the prevailing secularity; and it is within the context of the hospital as a secular institution that the chaplain has to work out his or her Christian obedience to the Gospel, making all kinds of acts of faith in the transforming power of Christ. There is a theological basis for working with the culture, as 'given' by the Creator. There is a need to state a belief in God as not confined to the religious sphere or embattled against non-Christian structures, but as involved in all parts of his creation. This is an incarnational frame of belief. As such, it involves of course the hope of transformation and perfection of what is given. In this context the need to be professional and the negotiation of freedom in controlling the content of chaplaincy work seem significant, but there are certain dangers in the ethos of professionalism. There may be some uncertainty or confusion about what 'professional' means in this discussion. For chaplains it is partly to do with being efficient and co-operative in relation to the hospital structures, and this understanding is to be encouraged; but it cannot stand alone. The issue is in part about a chaplain's sense of identity and role within the hospital. There will of course be some chaplains who hold the structures and value systems at arm's length while they continue their activity. This approach is defective.

An understanding of professionalism which does need to be questioned is a narrow attitude and approach which sees efficiency as lying in achieving specific tasks and goals, rather than in maintaining a broad objective of articulating, questioning, and sustaining moral and religious values. There should be an appreciation of this broad view of the chaplain's role by the hospital; an acceptance that chaplains are paid to be a
presence within the community, promoting values and hopes, and offering care that sustains healing. Theologically, the hospital could be understood as an anonymous Christian community by virtue of its healing task. The role of the chaplain would involve being a person who asks questions of the institution about its deeper assumptions; questions of meaning and purpose. As we have already suggested, the chaplain can be a resource in shaping priorities on various assumptions regarding God, healing, disease, health and wholeness.

Health care chaplaincy has no option but to organise and develop a professional approach to its key tasks and roles, but there are dangers. It has been our major conclusion of this thesis that the role in the organisation is often an ambiguous and ambivalent one. There is a need to get the chaplain's feet under the organisational table but often to remain on the edges and margins, and risk feeling impotent as a result. In the light of this, refuge may be taken in clear tasks and roles in order to cope with the feelings of threat and insecurity: the chaplain as academic; the chaplain as manager; the chaplain as therapist. Perhaps a chaplain needs to be critically reflective about where self-validation comes from. It will not necessarily come from the attempt to be professional in the narrow sense. In the debate about clarity in relation to roles and tasks, what is the role for the intangible, the immeasurable and the transcendent?

One of the areas within which there is a major theological crisis is in the chaplain's critique of the culture of which he or she is a part. The chaplain seems reluctant to take on the role of saboteur, mole or whistle-blower. There was little questioning by the interviewees of an assumption of the implicit goodness of the organisation and culture. In this sense chaplains have
understandably become institutionalised. Their loyalty is with the hospital that pays them. There is discomfort in asking, 'With whom or to whom do chaplains need to belong?' The role of prophet is an almost impossible one to fulfil when the chaplain depends upon the hospital for validation and security.

This is fundamentally a theological issue. Put in the form of a question it may be formulated thus: 'Does the chaplains' experience in the Health Service and in society lead them to believe that the fabric of society and of its institutions is alerting and promoting people to care for their neighbours and share with their neighbours?' From this perspective it is essential to ask questions about how far the organisation and delivery of health care guards, cherishes and promotes essential human health and well-being within society.

9.8 The chaplain as practical theologian

Implicit in the discussion above is the value and worth of theology as a tool for the chaplain. As we have noted, it is significant that the chaplains lacked any confidence or skill in the articulation of a theology for their work.

While recognising that in today's world individuals will search for their own meaning and are fairly distrustful of institutions (Ward, 1998), the chaplain continues to be in a unique role in being able to offer the possibility that strands of theology may enable individuals and communities to make sense of their experience. The chaplain has training in the tradition and practices of the faith community, and, because of his or her position in the health care institution, can interweave a sense of the value and purpose of what is happening at any given time. In doing this the
chaplain is someone who still to a degree represents or evokes the abiding value of religious and spiritual levels of meaning - perhaps even of truth. Thus the chaplain can be a listener, interpreter and mediator. In this the chaplain has the opportunity to allow theology to be a more creative force in the world of health self-understanding, of its methods, processes and ends. Within the chaplain's experience and critical self-reflection, there can be profound creativity in developing a theology which can embrace life in all its complexity and mystery. This is what some of the chaplains asserted in what they called 'flexibility' or 'openness' (see Chapter Six, pages 155-158).

9.9 Weaknesses of this research and areas for future work

While this research has attempted a comprehensive overview of much of the chaplaincy literature and history, it has not been possible to give a detailed account of what chaplaincy looked like (say) in 1950, 1960, 1970 or 1980. It is recognised that the picture and conclusions about chaplaincy are generalised and that sometimes there is an over-emphasis on the structures at the expense of how chaplaincy operates on a day to day basis. Further, it has not been possible to ascertain how the chaplaincy literature has shaped practice. There are some indications that there is a tenuous relationship between chaplaincy literature and practice. Chaplains tend towards a pragmatism which is not shaped by the cognitive.

This research is not comprehensive. It gives a small indication of how a number of chaplains (though representative and articulating a large degree of consensus in their views) understand their role around the year 1997. These findings may need to be checked out against a more comprehensive survey of chaplaincy.
The research does not explore what the impact of chaplaincy is on patients and staff. It largely accepts that chaplains do what they say they do. Further work needs to be done on the impact of the pastoral care of the chaplain on the patient, the staff and the wider community of the hospital.

Certainly the potential re-alignment of emphasis in health care away from a market philosophy towards primary care will bring new challenges and opportunities to chaplaincy following the 1997 General Election, and this is a critical area to be researched in order to explore what the future role of the chaplain may be.

9.10 Conclusions

In a post-modern world clergy are not absent. They may be misunderstood but they still stand as valid representative figures. In NHS Trusts chaplains are present living with paradox and tension; engaging with marginalisation and disempowerment and lack of communication. They are key people able to be both present in and possible transformers of the experience of illness in relation to staff, patients and their families and friends.

Though this thesis has been concerned with the realities of the work of a particular group of workers in the NHS, it has made use of a number of disciplines and, because chaplains are the group in question, pastoral theology, while not prominent or explicit, has been in the background throughout. It is appropriate therefore to conclude by noting that however much the current challenges and difficulties in chaplaincy arise from present-day circumstances in England and its health service, they may be seen as implicit to the very vocation of the Christian and the role of the Christian in society, and even in the structure of the
Christian faith itself from the start. That is, to use the trite formula, the Christian is essentially in the world and not of it - always a kind of misfit. In Augustine's metaphor, the Christian inhabits the earthly city but tends towards the city of God. Further, the reflections of St Paul made the experience of loss and curtailment, not regrettable but essential as the measure of success and triumph. Behind this, of course, lay the pattern of Jesus himself where death was the gate of life and its necessary condition. So for St Paul weakness was the necessary condition of strength (see especially 2 Corinthians 4: 7-18; 6: 1-10; 12:9-10). In St Paul's view this pattern characterises the apostle especially, and it has become part of the Christian tradition expressed in the Christian leader's life and work - including chaplains. It is perhaps significant to note how little the responses in Chapter Six grasp this principle, which may be seen as close to the heart of the Christian minister's 'true professionalism', visible not only in real life but sometimes vividly in fictional priests like Chesterton's Father Brown. Rose Macaulay expresses this in The Towers of Trebizond when Aunt Dot says 'Other clergymen ... are so odd compared with ours'. The narrator in the novel reflects on this

I could see she was remembering the whole strange world of clergymen; Mullahs, Buddhists, Orthodox, Copts, Romans, Old Catholics, Anglicans, Lutherans, Presbyterians, Rabbis, and of course they are all odd (my emphasis), for they uphold strange creeds and rites and that is what they are for (Macaulay, 1956, page 64).

It is perhaps then inevitable that chaplains are odd, but this is perhaps where their strength lies, in their liminality. Their marginal position allows them to listen, to interpret and to share meanings, activities which in essence are liberating and transforming. Hospitals may well be poorer places without them.
APPENDIX ONE

(a) Semi-structured Interview Questions to Acute Health Care Chaplains

(b) Example of an Interview Transcript

(c) Biographical Information about each chaplain
QUESTIONNAIRE

Part One
Personal Information

1. What is your denominational affiliation?

2. What was your age last birthday?

3. In what year were you ordained to the ministry?

4. How many years in all have your served as a health care chaplain?

5. Have you had any other kind of ecclesiastical appointments since ordination?

Part Two
Your View of Chaplaincy

1. What was the attraction of health care chaplaincy for you?

2. What do you consider the two or three personal characteristics most essential to a person's success as a health care chaplain?

3. Is there any personal characteristic which you feel would be most likely to interfere with a person's success as a health care chaplain?
4. In order of their importance, what do you consider are the three most important tasks of the health care chaplain?

5. Have you any reflections on personal values and management styles within the NHS?

6. What do you think prevents you from performing the tasks of health care chaplaincy within your unit?

7. Are there any negative factors in your work which you wish to discuss?

8. What are the sources of strain or tension for you as a health care chaplain?

9. Where do you find yourself most in conflict with your unit?

10. Are there any positive factors in your work which you wish to discuss?

11. How important do you think the chaplain is in the eyes of other members of staff?

12. Who do you work most closely with in the organisation?

13. Where do you find yourself in shared consensus within the hospital?

14. Who values you least within the organisation?

15. Do you think there is a reason for this?
Part Three

Concluding Questions

1. In concluding this discussion is there any aspect of health care chaplaincy which you feel has not been given sufficient attention here? If yes, which?

2. Have you any other comments to make on the evaluation of this research?
Example of a full interview
26th November 1996

(answers in italics)

Part One

1. What's your denominational affiliation?
   
   Church of England

2. And your age last birthday?
   
   55

3. In what year were you ordained to the ministry?
   
   Deacon in 1966, priest in 1967

4. Just to give a kind of perspective of your experience, can you give me a brief run-down of your Crockfords?
   
   Certainly. I did a parish job in London diocese between 1966 and '69. I did a whole-time pastoral care training in the United States between 1969-71 at (then it was Theological School) Divinity School, Harvard, and then the Chaplain Residency Programme in Massachusetts General Hospital. I came back to England in 1971 and between '71-'73 I was half-time in a curacy in a parish and half-time doing further chaplaincy training by directing a branch of the Samaritans and working with the director of pastoral care and counselling in this diocese. In 1973 I came to St George's hospital where I've been ever since.

5. Good. Thank you. So you've served as a health care chaplain for 23 years, and did you do any other job before you were ordained?
   
   Apart from working in a camping and sports shop for a gap year of 18mths, and whilst I was in training being an officer in the Territorial Army - No.
Just to round off the personal information - Could you give me a brief resumé of the kind of health care institution that St George's is, and the second paragraph will be where chaplaincy fits into that - what kind of team you’ve got?

Yes. St George’s Hospital is a 1000 bed hospital basically. St George’s Health Care Trust consists of the site of St George’s Hospital which is the whole range of specialities, except radiotherapy. Atkinson Warley Hospital, which is our neurosurgical and neurological unit at Wimbledon about 4 miles away, but the bodywork hospital which is a 120 bed care of the elderly unit in Battersea about 3 miles away. The chaplaincy is 2 whole-time chaplains, a half-time chaplaincy appointment which is at present we are hoping to upgrade to a whole-time appointment, with a bid for another whole-time appointment - that’s from the Anglican point of view. There is a Catholic chaplain half paid by the hospital, half paid by the diocese. A one-session Free Church chaplain. A number of pastoral assistants attached voluntarily to the chaplaincy, 2 lay Readers attached to the chaplaincy, and close links with local faith groups, especially the local mosque, and the Imam from there does one session.

Part Two

Part two is a series of questions as you have seen. The first one is to try and get a sense of what the attraction of chaplaincy was for you.

1. What keeps you with it. Was there something particular happened, someone you met, a particular experience that made you feel that pastoral care and health care chaplaincy was really where you should be?

I had this dilemma when I was a theological student of feeling certainly called to deal with a ministry, by no means sure that I was actually called to be parish priest. When I was a theological student at Westcot House we used to go and chat with the local hospitals, doing all sorts of crude things like wheeling pianos around in our cassocks, which I
wouldn’t do now. On one occasion I was rung from the hospital and asked to go and pray with a patient who was dying, who I had actually visited that morning, and had actually got through, and I was quite amazed that anybody should summon a mere theological student to this particular ministry. It provoked lots of thinking, that this was a ministry that I thoroughly enjoyed, got very enthusiastic about, even for a while toyed with the idea of double qualifying and doing medicine as well. I was advised, and I think rightly, not to do that, because it would just be a long time training to no purpose, you would still have to decide what you did, so I was ordained knowing that of course I would do my parish job, but that was not where I really would finish up. My training vicar was really incredibly indulgent and gave me a charge to go and ‘cut my teeth’ at the local hospital, which I did, but I knew all the way through that a chaplaincy was where I was heading. I think what interested me was the multi-professional bit, the contact with the unchurched. I’ve always been a better pastor I think, to the non-unchurched, and I think the pre-counselling, pre-evangelism bit always I found very attractive.

Just related to that in terms of what shaped your theological thinking. Are you able to isolate at this stage any of the main theological influences on you? Either in relation to individuals or particular experiences, or indeed any particular desert island theological books that seem to be a source of inspiration that shape your thinking and feeling and action.

Well of course, I date myself - I was at Cambridge in the early 60’s, and therefore I was seared by ‘Honest to God’ and the debate that followed it. Fascinated by the writings of Harry Williams who began to make those links between depth psychology analysis and religious belief. The people who really seared into me and still gave me a vision were Harvey Cox - ‘The Secular City’, Paul Van Buren - ‘The Secular
Meaning of the Gospel'. I think that was a slightly overoptimistic vision, but what it gave me very clearly was a view that if you’re going to be a good pastor, the secular isn’t your enemy. It was a view that actually the enemy of the Gospel is the sacral not the secular. I think it always gave me a vision which of course then people especially like the alter writings of John Robinson, and anything that David Jenkins wrote, really gets one’s thinking going, and I suppose in the background Bonhoeffer and all the stuff which he wrote incomplete, tantalising but never properly fulfilled. But it’s said that if you want to see the things worked out look for them at work in the secular world. It was that that got me onto the idea of being bilingual, understanding the language of the religious tradition, but also understanding another language, as it were, from ‘secular tradition’ which is a useful one to be able to understand.

2. What do you consider to be the two or three personal characteristics which you look for in a chaplain?

I think warmth and approachability. You’ll get precisely nowhere if you don’t make yourself available, if you don’t have some sheer physical human warmth in the old fashioned stuff. I think you’ve actually got to like people. I think also some sort of theological integrity, and I don’t mean being able to shout truths from a house top, I mean the person showing some willingness to keep going, that praxis between what they do, what they say and what they represent. That’s what I would look for. Somebody who could work under crisis, who would survive having lots of projections attached to them, especially in a crisis, like God, Devil, lover hated object - whatever, and being able to work with those. I would certainly look for somebody who could all the time be able to translate the theological and religious language of their training into the language where people are working, and also know when sometime to say nothing.
3. What are the things that are most likely to get in the way of a chaplain's ability to get on and do the job?

I think it's when the chaplain can only speak, as it were, church language. I don't think the organised church realises just how very out of touch, not hostile, but out of touch Christian language people are: so somebody who thought they were bringing God or the church to the people I think would be lost. I think the job is stressful, and therefore somebody who would show no willingness to look at their own hurt bits, their own shadow side, their own incomplete bits. And also somebody who would be the stereotype priest - the worst stereotype in a hospital would either behave like the vicar claiming rights, or so put down their role and be so apologetic and would be marginalised.

4. The next question is really what you feel the essence of the job is in relation to tasks. What are the two or three most important tasks of the chaplain.

A presence in the hospital which isn't conflicting with the other presences, but it actually represents something else. A chaplain must be visible but his job is never to say look at me, it is always to say look through me. I think by our presence, what we say and what we don't say, by the interest we have we are actually modelling a way of thinking that people might say we take people's present experience of pain, joy, struggle, or whatever, absolutely seriously but at least provide the opportunity to look beyond it if you want theological language, to think about it in transcendent terms. In terms of the task I would divide I think in three ways. I certainly see it as a responsibility to patients, but being a good old Church of England person, I would say that my responsibility as a priest of the Church of England is not just to the church, not just to the gathered congregation; it is some responsibility to represent the spiritual for the unchurched, and that would be patients' visitors. When we look at our time, we reckon half our time are contact times with the staff, the other half are with patients.
and relatives, establishing a presence that will sometimes be a human presence, sometimes being built round prayer, sacrament, sometimes a counselling presence, sometimes all those things running together.

Is the education teaching element significant in relation to your experience and skill?
Yes, I do a lot of teaching formally and informally, both in the medical school and the college of Health Studies. If the areas of, for example, the inter-relationship between religion, culture and spirituality, which of course is right where a lot of the Patients' Charter stuff is, so it's at the cutting edge. Certainly in the area of ethics and the whole business of grief and loss. How as a hospital we can have some practical procedures which we can use.

5. Have you any reflections on what I'm calling personal values and management styles within the NHS? How does the culture feel to you today?
I think we have a much more up front management style, which is much more looking at end points and results. The up side is that I think it has actually made us think more clearly, we can't waffle around saying 'look what good we've done'. I don't think that's altogether bad. What is interesting is that when we were audited by the Kings Fund, rather dreading that audit, we came out with a very very high score from the Kings Fund.

That was the Chaplaincy Department?
What I think the down side is that there are so many managers who are locked into a system of achievements and targets and everything else, we can be so locked onto efficiency that we lose the ability to care for people. I think that all the evidence is that in a workforce that has been submitted to change over many years, what you can ask of it becomes more and more limited. A lot of our job, I think, is supporting
managers who have to make the most horrendous decisions. Our purchasing Health Authority is £14m overspent. My own view is that it is facile to get that onto a manager bash. I suspect that more and more we are seeing people being asked to do the impossible - on those terms it can't be done. But round that it often means that management style people are trapped into a fairly abrasive style, often seen as uncaring by the people they manage, but I think in many ways they are all victims of the system.

So you wouldn't necessarily have any negative things to say about the system?

Somebody has got to be honest about it. It is expensive and we may not be able to afford everything that is claimed. I think the politicians must just be honest about it and that's the bottom line.

6. What do you think prevents you from performing the tasks of health care chaplaincy within your unit?

I think sometimes the problem is the difference in vision between people of different traditions may view chaplaincy. I think it's quite clear that our Catholic colleagues see themselves as having much more ministry mainly to patients to start with their denomination. It's quite difficult to get to look together at what are the wider institutional and organisational issues, and also I don't think have especially realised that we have come to see chaplaincy as ultra-specialist, but for which you do need training, still smidgens of feelings from the Catholic point of view that you dump clergy that can't hack it elsewhere into chaplaincy. I think the difficulties about that are that we're sort of confined by a narrow ecclesiasticism. I don't feel constrained in any way about whether every C.of E. patient is seen. The change as I see it has been to care. The Patients' Charter picks that up very clearly, and teasing out religion and spirituality and culture as being three things that are related by not coterminus. But we've had endless incidents here where
pointing out that a proper understanding of those enhances care, a failure to understand them can finish us up in difficulties.

Some of the health care staff understand chaplaincies role and some don't. Some expect you to be 'the vicar'.

*I think that is the difficulty when I feel I'm cast in a narrowly ecclesiastical role. I wouldn't actually want to dodge the role of the priest because I think there are times when people consciously or unconsciously want a priest, somebody who represents something and can do something which will make it better. But I think we're always saying that the chaplaincy role brings with it a cluster of other things. I think our role with staff sometimes, I get back to the role of pre-counselling, pre-evangelism. We are sometimes hanging on with a toehold to people's perceptions of what we might be about, what we represent. I sometimes think our main function is to suggest that this organisation called the Church, and the Gospel that it stands for, might just have a human face. If we've done that, then we've done something.*

7. Are there any other negative factors over and above this role confusion.

*I don't think role confusion is always bad- it's sometimes quite challenging and creative. I don't see confusion as always bad. It keeps you thinking. It does mean that between us we take on roles that might be seen as 'non chaplaincy' for example, I'm a senior member of the Hospital Research Ethics Committee, I chair a complaints monitoring group, I chair a Fertility Ethics Committee and counsellor for the Conception Unit. I see those as very important add-ons to the chaplaincy because its the way of working with the organisation and using skills we have. And also demonstrating that Christians can think creatively and compassionately but don't have to be a soft touch.*
8. What are the sources of strain or tension for you?

I don't think conflict is the right term - consultants earlier this year decided to take part in a television programme which was really saying how awful the situation was in the NHS, how dire it was and how it was teetering on the edge. They weren’t actually into a management bash, they were saying here is a well-run hospital - they asked me to join them to say the effects on staff morale and the organisation. I got ever such a mild wrist slap from the press and publicity department, but no more than that, and equally making it clear that they weren’t into gagging. Perhaps I should have told them what I was going to do, but it was really no more that a wrist slap and I don’t see that so much a clash of personalities as any organisation coping with conflict.

9. Where do you find yourself most in conflict with the unit?

I think it's sometimes knowing that there are lots of areas you ought to be covering more fully than you are and knowing that you're prioritising these other areas out. It is sometimes the feeling that I would like to work much more as a team, especially with people of other traditions, who don’t look at it that way, and we have had tensions when we have had people foisted on us from other traditions who, it seems to me, their organisations or churches haven’t taken responsibility for. The positive side of that is that when I’ve had those problems, the organisation has been tremendously supportive. I think the tension is sometimes when you have a huge turnover of staff and a bit of the hospital which you think know about you and what you’re doing, you realise that the staff have changed positions so you have to begin the re-educational process. That’s common to many chaplains.

10. Are there any positive factors in your work which you wish to discuss?

No, I think I’ve discussed these.
11. How important do you think the chaplain is in the eyes of other members of staff?
I certainly think the hospital would have a 'use it or lose it' philosophy and would say that it didn't have a chaplaincy something would be lost. There is a presence there which is used differently but which certainly seems to be valued.

12. Who do you work most closely with in the organisation?
With senior nursing staff, with our line manager who is an ally and support. The Service Centre manager who is a senior physiotherapist who is nothing but supportive. I think I know the people if push comes to shove would stand with us, but it hasn't been an issue. We've been very hard pushed on our request for another chaplaincy post, but I have to say no harder than any other department claiming money would be. I would want it no other way. The thing that irritates me most is people saying 'well, you'll have a parish one day', Bishops and Archdeacons sometimes saying 'isn't the hospital your parish' and I shake my head and say 'no', because I'm right out of the way of thinking parish. I think in terms of sector, we are a department of the hospital and we will stand or fall by what we can deliver to the organisation.

13. Where do find yourself in shared consensus within the hospital?
We work well together around staff support. I spend more and more time listening to staff. We also do some important work in education and in 'crisis' areas.

14. Who values you least within the organisation?
I would think the departments where we are known least. Some of the out-patient departments who wouldn't have much clue of what we do. I think the advantage of being around for a while is that some things are built on street credibility, word of mouth.
15. Do you think there is a reason for this?
   
   No - I just don't know. You cannot be everywhere!

**Part Three**

1. In concluding this discussion, is there any aspect of health care chaplaincy which you feel is not being given sufficient attention, given the fact that in broad terms the study is simply trying to reflect on people's sense of the role in a modern health care institution. Are there gaps ...?

   No, I think we need more planning to be certain what we will be looking at as patient advocacy. How the chaplain is in the organisation but not directly part of its hierarchy. How they might be in a position to act as the patients' advocate. I think that bit certainly needs exploring. I think we've worked it out here of how the institution shares some responsibility for the continuing education of the chaplain. I, as you can imagine, have had one or two agonisings while I've been here as to why I should be here so long, and I realised that in some terms I've really become quite fussy, but also thinking there is an analogy of the church works through its vicar who moves through a living every 5 or 7 years life, or the hospital might work and say the consultant who comes when they are 30’ish and who might well stay in post and develop. And that is rather the model where I had a particularly traumatic interview about six years ago when I went to our then chief nurse, who said that's a model you can work with. The job I'm doing now isn't the same as it was 10 years ago ...

   Because you're growing and changing ...

   And so the job changes round you.

I think that's very good where people manage to keep themselves fit. I've had a couple of interviews where I've thought ... he's got stuck.
They don't know where they are going or seem to have any perspective. Do you want me to say more?

*I don't think you need to. I think that's the value of doing some things with critical distance.\*

One of the difficulties I think about the College is that the people who get on the trains to Council meetings on the whole it's therapy for them. They want to feel important.

*Everything isn't all sweetness and light, basically if we don't feel our organisations / institutions are hostile - there may be the odd hot spot. but that's living. I don't feel as one chap who'd been in post as long as I was, always treated his organisation as a hostile place to be overcome. I think the whole thing is a bit like a marriage, you click each other on and you know you might change together but you're not going to reform each other. What happens after a while is that with virtually every consultant can use their first name.*

2. Finally, have you any other comments or reflections to make?

*I feel in a way very very lucky because I think what I may have done in chaplaincy I am much more conscious of chaplaincy has done for me. It's been the most superb place to minister because you are able to keep some sort of vision in mind, that here's a secular organisation where you can claim no privileges, where people all the time will throw up questions at you and not let you get away with ecclesiastical answers, and just keep you stimulated. I don't know that I would have been able to stay in ministry as long as I have had there not been this superb place.*
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<th>Denomination</th>
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APPENDIX TWO

Health Care Chaplaincy Standards (SAILS)

A Map of Standards
Health Care Chaplaincy Standards (SAILS)  A Map of Standards
APPENDIX THREE

(a) A Suggested Outline of Lay Training for Sick Visiting

(b) A Suggested Plan for a Three Months’ Residential Clinical Training Programme
A suggested Outline of Lay Training for Sick Visiting

Course outline of lectures and seminars

TERM 1
1. Introducing the course
2. The Sick visitor and his/her role
3. Techniques of pastoral counselling
4. Principle of a counselling relationship
5. Dynamics of the pastoral conversation
6. Conducting a hospital/home visit
7. Practical guidelines for visiting the sick
8. Writing verbatim reports and keeping records
9. Pastoral theology and pastoral care
10. Understanding human behaviour

TERM 2
11. The crisis of illness and hospitalisation
12. The crisis of dying
13. The crisis of grief
14. The crisis of guilt
15. The hospital/home environment and routine
16. The role of the hospital chaplain/parish priest
17. Ministering to relatives
18. Worship and the sacraments in hospital
19. The use of prayer
20. The ministry of healing

TERM 3
21. Ministering to medical and surgical patients
22. Ministering to paediatric and maternity patients
23. Ministering to coronary care and intensive care patients
24. Ministering to neuro-surgical patients
25. Ministering to renal dialysis and cancer patients
26. Ministering to geriatric patients
27. Ministering to psychiatric patients
28. The problem of pain and the theology of suffering
29. Ethical dilemmas (e.g. abortion, sterilisation)
30. Ethical dilemmas (cont’d) e.g. euthanasia, prolongation of life etc.

Appendix 3 page 300
A suggested outline plan for a three months' residential clinical training programme

1. Introduction / Orientations:
   - Group building exercises
   - Expectations of course
   - Sociology of health care
   - The health team
   - Future developments in health care

2. Counselling: both theory and practice, using:
   - Cases
   - Simulation
   - Video
   - Real world

3. Role:
   - Role theory
   - Perceived by chaplains
   - Expectations of patients and staff (tape recordings)
   - Analysis of difference

4. Cultural Differences:
   - The socio/economic/religious difference of other races
   - Other faiths

5. Community Support:
   - What components? e.g. Social workers
     General practitioners
   - Functions? Health Visitors
     Community nurses
   - How to mobilise? Voluntary organisations
     Relatives
     neighbours
     Church congregations
     Church organisations

6. Ethical Problems:
   - Abortion
   - Sterilisation
   - Resuscitations
   - Transplants
   - Confidentiality
   - Purpose: Information / Education
     Attitude exchange
     Difficulty of judgmental roles
     Individual counselling

Appendix 3 page 301
7. **Sociology and Psychology of Illness:**
- Sick role
- Stigma
- Psychosomatic illness
- Psychology of pain - Thresholds, Attitudes, Projection
- Psychology of care / self-help
- Institutionalisation
- Aggression - victim behaviour (simulation), reasons for aggression
- Control of others' aggression

8. **Theology of Suffering and Pain:**
- Sin and sickness
- Evil and a God of love
- Salvation
- Psychology of pain
- Theology of suffering

9. **Worship:**
- Location - structure
  - Chapels
  - Wards
  - Dual purpose buildings
- Form - Ceremonial
  - Interdenominational
  - Broadcasting
- Patient / Staff involvement in administration and worship
- Chapel furniture
- Composition of congregation - sermon content/style
- Religious continuity in community
- Practical problems / issues

10. **Ministry of Healing:**
- What is healing?
- Healing and wholeness
- Prayer and sacrament
- Caring community
- Health

11. **Care of Dying:**
- Terminal illness
- Personal attitudes
- Where to die - hospital/hospice/home?
- To tell or not to tell?
- Does the patient know?
- Staff attitudes - nursing the dying child, identifying with patient
- Family reaction
- Chaplain's ministry

*Appendix 3 page 302*
12. Care of Bereaved:

- Grief
  - Psychological
  - Physical
  - Normal vs abnormal reaction
- Loss
  - Practical
  - House
  - Finance
  - Social
- Spiritual
- Caring organisations
- Funerals
  - Interment / Cremation
- Funeral directors

Experimental learning methods to be used throughout the course.
Close counselling support is a major requirement of course members.
The emphasis throughout the training is on patient care.
APPENDIX FOUR

An Analysis of Chaplaincy Literature and Business Plans
'What can a bishop say to the members of a professional organisation like the BMA? As far as health is concerned, you are the experts. In your world I am only - but is the word 'only' quite right? - only a layman, a patient (potential if not actual), a consumer (if you like that language), a more or less adequately informed member of the general public. I am without your professional expertise. So what can I say on the basis of what I do know as a theologian, or in virtue of my authority as a pastor and as a minister of the Gospel?

Ethics, I suppose, is the area where you and I most obviously impinge on each other. Now when people talk about the ethics of medicine, they are usually talking about the kind of ethical questions that arise in relation to particular medical procedures – most obviously in connection with birth, reproduction and death.

But there is another area of ethical concern which concerns me today: not medical ethics in the usual sense, but the ethics of social and political policy as they impinge on health and medicine. It is a part of the individualism of our age to suppose that moral questions only arise when we are talking about the lives or decisions of individual people. But there are also moral questions to be asked, and moral principles to be stated, about social and political issues – in this case about the availability and use of resources, about the way priorities are settled and decisions are made, about the health or disease of institutions.
'I the LORD am your healer', it said in our first Bible reading (Exodus 16:26). What does that say about our notion of health? What does it mean to speak of the Lord God as our healer, as the source of all human health and well-being, physical, mental, and spiritual?

In the New Testament the restoration of physical health is often linked (surprisingly to our ears) with forgiveness, with the restoration of broken relationships. That gives a perspective on health which is essentially social. It reminds us that the health and welfare of the individual cannot be separated from that of the community or society to which the individual belongs. And there is a further dimension. The link between health and the forgiveness of sins reminds us that no view of human health is complete which does not reckon with our relationship with God. We are created for life with God and with one another. Without God we are lost, and without one another we are lost. Any smaller view of what we are does not do justice to our human dignity or destiny.

What this means is that any discussion of what is good for the health of the individual cannot be properly discussed without reference to what is good for society, nor the good of society without reference to the good of individuals.

Let us take this a bit further. The Christian faith declares that human beings are made in the image of God who has revealed himself to us as a Trinity of Persons – the Father, the Son, and the Holy Spirit. Interpersonal relations therefore have a sacred quality, because they reflect the life of heaven: they reflect the life of God. This has social and political consequences. Life in society is to be considered not as a mere convenience for individuals who may need it or want it. No, life lived in society, life lived in relationship with other people, is what gives to human existence on earth its true dignity as a taste or likeness of heaven.
The category of the personal is primary. Of course we need institutions and structures. Once more than two or three people start living together, we need rules and conventions. But their purpose is to serve persons, and to serve their common good. Just as the sabbath was made for man and not man for the sabbath, so with everything else. Governments, laws, political programmes, markets, administrative structures – none of them is sacred, none of them is of ultimate importance. In a properly ordered world, they exist to serve us, not we to serve them. People must always come first. So the dignity of persons and the quality of interpersonal relationships must always claim precedence over the needs of institutions or causes or programmes. As soon as we start treating people not as ends but as means or instruments, we in fact start rotting the foundations of a healthy society.

And there is something else. The God in whose image we are made is good. So as human beings we find our fulfilment by sharing and showing those godlike qualities of goodness, justice, truth, compassion and mercy – all of them virtues which presuppose regard for other persons, and all of which require other persons for their exercise. You cannot be good or just or compassionate all on your own. To live a moral life, to live a godlike life, to live a truly human life, we need other people.

The structures in which we live, whether they are small and comparatively simple like the family (but was there ever a simple family?) or whether they are large and complex like the NHS, have an inescapably moral dimension. Whether we like it or not, structures and institutions embody some kind of moral values, both in the way they are ordered and in the way they are run. Some families have rules and habits which help people to flourish. Others do not. And it is the same with large institutions.
These things do not just happen. It is not impersonal forces which shape and determine the ways that institutions are structured and managed. They are the products and instruments of persons accepting responsibility, making decisions, exercising power (or failing to do so) – all of it in accord with some idea of what is right and good, and all of it with an effect on other people. In the end we are all of us answerable to God for the exercise of the responsibilities and the use of the power which we have been given.

Now what about the institution which concerns all of us here, either as practitioners or as consumers, customers or patients – the National Health Service? The very fact that words like 'customers' and 'consumers' should even come into my head shows how far we have travelled in recent years. You hardly need me to tell you anything either about the achievements of the NHS in the past forty-six years or about the symptoms of its present crisis. Its achievements were related to social and political ideals which were avowedly moral: health care for all, and equality of access for all. The NHS has promoted and embodied a culture of generous service and unstinting care which continues to astonish those who receive it.

But in a constantly changing society, no institution is invulnerable to change. Change is inescapable, even if seldom comfortable. You know, far better than I do, the facts and questions that have to be faced. There are questions about resources – both how much of the national cake is to be allotted to health and how, once allotted, it is to be apportioned; questions posed by demographic change, or by changes in medical science and practice; questions about priorities – the claims of research and the claims of the routine, the claims of the elderly and the claims of the young, the claims of acute medicine and the claims of primary care; questions about the relationship between issues of mental and physical health and issues of unemployment, bad housing and poverty; questions
about governance and accountability. One way or another, these questions must be addressed and choices have to be made. There is no dispute about that, or about the fact that every one of these choices has a moral dimension.

Change is inevitable, but not every kind of change is inevitable or desirable. It is no exaggeration (I speak as an observer) to say that the current wave of reforms in the National Health Service – and who would dare to say that it is the last? – is proving deeply distressing to people who have a commitment to public service, who see their profession as a calling, who care profoundly for the quality of the service they have been trained to deliver, and who observe the human consequences of what is happening around them. I well remember meeting a member of Mrs Thatcher's Cabinet, one of the wets, in the early Eighties, when the policies of high interest rates and non-intervention were destroying industry and jobs on all sides. 'I don't pretend to understand monetarism,' he said over the dinner table, 'but I see the effects.'

Well, it is like that now: we see the effects – effects which are symptoms of a system in distress. We have seen the hasty imposition of major change without adequate consultation or trial. Important facts about human behaviour have been ignored, such as that people do not function well if they sense that their professional expertise is being ignored, impugned or denigrated. The very speed of change itself has produced stress and distress in those involved in it. Hospital chaplains have spoken to me about the state of grief in the institutions where they work, of men and women who, after giving years of devoted professional service, find themselves losing heart. But if people who have given years of care to others feel themselves the victims of non-care and accordingly show symptoms of distress, what does that say about the health of an institution whose ostensible purpose is the promotion of mental and physical health and well-being?
Judged not only by theory but also by effect, perhaps the most obviously questionable aspect of the reforms is the introduction of the language and habits of the market into what is properly understood as a service. The culture of competition has set doctor against doctor, hospital against hospital, colleague against colleague. Priorities and policies come to be determined not on the basis of human need, but in accord with the accounting policies, themselves a human construct, of the NHS. These do not in fact reckon with all the costs. It may, to take a hypothetical instance, be cheaper for the South Birmingham Health Authority (which is where we happen to be) to buy certain services from hospitals in other districts, but who reckons up the costs of travel and inconvenience to patients and their families?

This illustrates one of the most distressing defects of the market model. Despite all the rhetoric about patient choice, the patient is in fact not the purchaser. The purchaser is the District Health Authority or the fund-holding practitioner. The patient is reduced to the status of a unit of consumption and exchange. That, in the Christian view, must be wrong, because it is treating people as means and instruments instead of ends.

Of course there are aspects of the NHS which are properly treated as a business, and of course there is the necessity at all times for financial responsibility and accountability. But still the business model won't do, above all because of the culture it breeds. One has only to stop for a moment and ask, 'Who is competing with whom for what? And who is supposed to be making a profit out of it?' to realise how inappropriate and therefore dysfunctional it is. It is dysfunctional because it excludes and distorts. It replaces what should be co-operation with competition, and it excludes from its reckoning precious elements which in fact help to give to the service its distinctive quality.
Perhaps there are some practitioners who are simply in it for the money. That is not my experience. The practitioners I know, of whatever profession, are fulfilling a vocation, they are offering a service of love and duty to their fellow men and women, and there is no price which you can put on those things. The basic point is this: you cannot buy a gift. And yet it is those gifts of attention, care and compassion which make all the difference to what it is all about, which is health and well-being.

The basic issue can be put like this. Think of yourselves. Do you, in the end, see yourselves as having a commodity to sell or a service to offer? For whose sake are you in it?

It is time to be positive. What do we need? First of all, we need to re-establish a publicly shared consensus on our purpose and objectives, a consensus which must have an avowedly moral basis. Necessary elements, from a Christian point of view, will include the continued acceptance by public authority of its duty to ensure adequate and proper provision for the health care of the nation as a whole; equality of access for all; dignity of treatment for all; and a particular care for the weak, the vulnerable and all who are structurally disadvantaged from fighting for their own interests. What we are talking about here is the institutional expression of the virtues of justice and compassion.

Next, if policies are to be developed on the basis of a shared understanding of purpose and culture, there is a need for public discussion in which the facts of change and of financial choice and constraint are openly faced and acknowledged. Politicians and practitioners need to take the public into their confidence. Also, throughout the whole process of the discussion, formation and execution of policy, there needs to be a proper recognition and acceptance of roles, responsibilities and competence. We need both to recognise other people's responsibilities, and to accept and not to abdicate from our own.
Thus politicians have a proper responsibility, which needs to be recognised, for the determination of policy and the allocation of resources. Politicians also need to accept their duty to help to form and lead public opinion and not to hide behind what they read in the newspapers or in their post bag. They should not shy away from telling people what it costs to run a decent public service.

Administrators and managers also have a responsibility – their responsibility for enabling others to deliver the service as effectively as possible. Nobody is helped if the task of administration is despised or denigrated.

Then again, there are the professionals like yourselves. Doctors, on the whole, are not trained in administration, and clinicians tend to look at the effects of policies on individuals rather than at the social and financial constraints which have led to those policies. So there is a need to acknowledge the competence of others. But we also need to accept the responsibility for naming and speaking of the things which we do know about. When a respected and compassionate practitioner tells me that there is human need in the community which he and his colleagues are not being allowed to meet, I listen to him, and so should the politicians and administrators – because in the end it is human need that counts. The famous bottom line is to be found not in the published accounts but in the human consequences.

You as practitioners have a right to ask politicians to attend to the things which you say on the ground of your professional integrity. You also have a duty, of which I am sure you are sharply aware, of not confusing professional integrity with sectional interest. Your professional integrity is in fact something you hold in trust on behalf of society as a whole. It carries with it a duty of free and open speech, not so much for your own sake as for the sake of the society you serve. That is because you are not
doctors for your own sake, but for other people's sake.

I have one last point to make. Christians know that in this world we can never build perfection, only more or less imperfect approximations. We do the best we can, and we recognise the best that others can do, even when we know that it can never be perfect and that even the best can always go wrong. But we also know that nothing that is good, however imperfect, will ever be wasted.
MEETING THE CHALLENGES OF CHANGE
IN THE NATIONAL HEALTH SERVICE

1 Background

1.1 This report is an analysis of the nature and range of responses to the Bishop of Birmingham's sermon delivered to the British Medical Association on Sunday 3 July 1994. The report will represent and describe the range of issues, questions and impressions that were stimulated by the sermon. Comment and interpretation will be kept to a minimum.

1.2 The report represents a summary of 467 letters received by the Bishop and they are divided into 4 sections. Section A are letters of general support; Section B letters of support from clergy; Section C letters of support from the medical professions, and Section D letters critical of the sermon. Sections A to C include 423 letters and Section D 44 letters.

Section A: Letters of general support

2. The overall impression from this group of letters is one of a sense of deep concern about some of the current trends and changes within the Health Service. While there were a minority of letters (16) that specifically expressed support because they interpreted the sermon as a direct attack on government policy, the majority of correspondents gave voice to a wide range of personal experience of the Health Service to back up several of the assertions in the sermon.
2.1 Who listens to our concern?

A number of correspondents were glad that a public figure had spoken out on their behalf. There was a widespread expression of alienation and disempowerment within the social and political context of the organisation and delivery of health.

It is impossible for the opinions of ordinary people like ourselves to be expressed.

So many of us feel powerless and fearful about what is happening.

I feel you speak for so many who feel helpless and concerned to change what is amiss within the Service.

You have voiced what all ordinary users of the Service know to be true.

2.2 Values undergirding the Health Service

A number of correspondents expressed their belief that the values undergirding the organisation and delivery of the Health Service had radically changed to the detriment of both those who deliver and those who receive care. Many letters articulated this belief on the basis of their perception that the Service had become too dominated by concern for money and efficiency within the market economy in the Health Service.

The business culture of this new Health Service has destroyed the caring philosophy that so many of us were committed to.

There is a sense of destruction of the Service where money and contracts seem to be the only thing that matter.

I can't quite help but think that the philosophy of competition is wrong and that there are profound conflicts between the interests of people set against money and savings.

The only concern is about reducing costs.

I am dismayed at the performance related mentality that I heard about while I was a patient in my hospital.

Where are the caring values in the Health Service amidst this talk about waiting lists and improved efficiency?

What are the values and priorities that are being imposed on the Service?
2.3 **Management Style**

A number of concerns were raised about the style of management as they affected questions of finance, communication and redundancy. Several of the letters complained about the quality of treatment received in hospitals and especially about how their complaints were handled by hospital managers. Significant amongst these letters of general support was the perception that employees in the Health Service were not allowed to speak out and express their concern.

I sense a 'get them out before they speak' attitude.

My neighbour who is a nurse feels that she has got to shut up or get out of the Service. Surely there is another alternative to these two extremes?

Nursing staff are now often on short term contracts - a device to keep them uncomplaining and compliant.

Can hospital staff speak out about their experiences?

2.4 **Experiences of Care**

Some correspondents went so far as to describe their experience of care in the light of their impressions and perceptions about the present state of the Health Service. These are quotations from correspondents who have been hospitalised and are reflecting upon that experience.

Instead of feeling like a person with a severe ankle injury I felt as though my disembodied ankle was being shunted through a minimum service route.

We now feel like a commodity sold on a conveyor belt.

I felt as though my husband had suffered because of careless offhand treatment by the nursing staff who seemed to be worn down and de-energised.

2.5 A number of other concerns were expressed by this section of correspondents. The two most significant areas were the care of the elderly and of the mentally ill. There were a significant number
of letters from older people expressing concern about how they would be cared for in their infirmity and old age.

Other correspondents wondered whether there was a political agenda within the Service to privatise Health Care. This was a perception based upon the impression that there was a two-tier Service with GP fundholding patients receiving more favourable treatment.

Section B: Letters of support from clergy

3. This section of letters included a significant number from hospital chaplains and reflect that their position gives them a unique and privileged access to every unit and area of staff within the hospital. The expression, therefore, of their concerns is made with particular power and authority. The concerns raised from this group of correspondents include:

i) the government's willingness to introduce policies without trial or testing;

ii) the costs of management reorganisation and recruitment;

iii) the decline in morale of NHS staff in the face of change and uncertainty;

iv) the staff reviews and consequent alteration of the balance between trained and untrained, qualified and unqualified staff;

v) the injustices that have become apparent as market forces favour one group at the expense of another;

vi) the priority given to economic considerations; 'cost matters more than care' was the current refrain;

vii) reduction in in-patient beds and the closure of hospitals.

A number of quotations illustrate and expand the points highlighted above:

Appendix 4 page 316
It is tragic that vocational responsible care is being thrown out of the window and millions wasted in bureaucracy.

A mass of feelings of anger, despair and powerlessness at what is happening.

This whole thing is more evil than I think any of us realise.

We need to highlight the hardships of auxiliary staff and duty nurses... all shunted about like bits of machinery - and GPs who have been forced to abandon principles and high ideals of practice in favour of bargaining and competition.

Any evidence of real concern for patients or to be seen to be concerned that their views about the quality of service matter are difficult to find.

We need to address the sheer trauma of change and manage it.

These views, on the whole, were expressed responsibly and moderately. A number of hospital chaplains spoke of the positive dimensions of change and their understandable appreciation that there were good aspects to the establishment of Trusts. The overwhelming impression and perception from this group was that it was too early for a final judgment, that some of the changes should be given a chance to work, but that there was a continual need for conversation, critique and evaluation.

Section C: Letters of support from the medical profession.

4. This section of the correspondence represented a significant vindication of the sermon from a very wide range of doctors. Letters were received from some very senior clinicians working both in the hospital context and in the community. They represented geographical locations throughout the country and build upon and develop the areas of concern described above. While some of the letters indicated an inability to appreciate and accommodate change (there was a good deal of regret about the passing of a rosy ideal past), there was an overwhelming sense
that the reforms resulted in the undermining of medical autonomy and professionalism within the Service. Some correspondents wrote anonymously, fearful that their expression of concern might lead to recrimination. This expresses a typical concern; 'there is serious fear amongst NHS employees... that any endeavour by them to reveal the true state of affairs is likely to lead to dismissal'. It is interesting to note that many of the perceptions described here are in sharp contrast with rhetoric within the Service about consumer choice, patient voices and a commitment to quality among professionals working together for the patient.

4.1 Managing change?

Many nurses and doctors spoke about their feeling ground down by the changes with a significant sense of loss at the breakdown of hospitals and teams.

I feel that care is delivered in spite of the NHS not because of it.

Staff are working in deplorable conditions with little support to engage creatively with the challenges of change.

The reforms have had a disastrous effect on the medical profession in my GP practice.

The NHS is in a sad state with a huge amount of stress and demoralised staff - I don't know a manager in my hospital who cares about this issue, or one that is competent to do anything about it.

The morale is low on my ward and this must reflect on patient care.

There is a constant battle to maintain the ethos of the Service and the commitment of doctors and nurses.

Here are very many, as myself, who feel bruised and hurt from what they see... most of us are unable to make free comment.
4.2 Standards of care

It is the perception amongst this particular group of correspondents that the government reforms have so affected and reshaped the culture of the Service that the incalculable human aspect of the work is not valued in the way that it was. This, it is believed, has affected the quality of care. This is particularly something that doctors and nurses feel undermines their sense of professionalism and service.

I am faced with the impossibility of providing the right kind of care to my patients and so I am accepting voluntary redundancy after thirty years nursing.

I am struggling to understand what my vocation means in the light of the present culture of the market in my hospital.

I am finding it increasingly difficult to live with with the way in which people are valued in my hospital.

Many of the changes are finance related they’re not patient related - the rhetoric about efficiency and waiting lists is not an everyday reality on my ward.

So many good people in the Service have retired because they no longer feel they can live with the standard and quality of care both in GP work and hospital work.

4.3 Conflicts in values

Those working in the medical profession back up the perceptions expressed in Sections A and B as they write about how the values underpinning the service appear to have changed. What is clear is that the sermon gave articulation to this point and many of those working in the medical profession found it supportive and encouraging. These correspondents write with a good deal of understanding and subtlety in their thinking and practice. Many affirm the importance of an appropriate use of public money and, wherever possible, providing an environment where the patient is cared for to the best possible standards. However, it is clear that the present value system, as perceived, is not supportive of this desire.
It is clear to us that the quality of medical practice and care is of little concern, and only the balance sheet counts in the present value system.

I wish that managers would be more prepared to be critically self-reflective about dilemmas and difficulties in the present system.

The belief that having a competitive environment with its consequent emphasis on economics and greater efficiency creates a context within which health is promoted is a nonsense.

I long for a constructive and creative debate between people of different values and beliefs about the philosophy of health within this country today.

Caring and support have been taken over by contracts and finance.

Parts of the system are hellish and immoral in their implementation.

The creation of a market is artificial and the rhetoric alienating.

I am depressed because my life is dominated by financial structures and overblown bureaucracy.

The accent now is on how to balance the books and the mismanagement, lack of communication and co-ordination has to be experienced at the grass roots level to be really understood.

Other major areas of concern expressed by the medical profession include GP fundholding, care of the elderly and the mentally ill in relation to care in the community.

**Section D: Letters of critical reflection**

5. While the number of letters in this section was relatively small, there are some significant and important criticisms of the assertions made in the sermon that require careful attention.

5.1 Many of the letters critical of the sermon were not concerned with the substances of the text (many of the correspondents had not in fact read the whole text) but were an expression of the familiar
concern that the Church should not involve itself in comment on politics. On the other hand, several of the correspondents were critical that the Bishop had addressed his comments to such a group as the British Medical Association and was not as challenging to doctors as he might have been.

5.2 Some of the correspondents were able to put their reflections into historical perspective and argue that it was entirely appropriate to be sensitive to the issue of using public money responsibly, effectively and efficiently. This was part of the importance of the general public needing to understand and appreciate the cost of health and of facing the community with the harsh economic realities of a world with limited budgets and increasing demand on services.

5.3 Two of the correspondents explained the reforms in a positive and creative light affirming the widespread involvement of staff in the decisions about service priorities and the management of resources. In addition, they argued, the reforms have given people information and choice which has resulted in efficiency in reduced waiting lists and improved services.

What is clear is that there are important issues that need to continue to be worked at. These include: the relationship between structure and culture within the Service; the management of change within the Service; the framework within which power is understood and exercised; and especially what ideological commitments have driven the change in relation to the customer, the consumer and the market.
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