The Dignifying Practice of Hospital Chaplaincy

Contents:

Introduction and context of my Placement 2

Dignity 4

Autonomy 7

Respect 9

Empowerment 16

Communication 18

Evaluation 19

Bibliography 21

The NHS commits itself to providing essential support for all individuals at all times. Simon Stevens Chief Executive of NHS England comments on the need for spiritual care that: “At its best, our National Health Service is there when we need it, at the most profound moments in our lives. At the birth of our children. At the death of our loved ones. And at every stage in between- as we grapple with hope, fear, loneliness and compassion-some of the most fundamental elements of the human spirit” (Swift et al, 2015, p5). This recognition of the need to care for the human spirit through pastoral support has led the NHS to establish chaplaincy departments across its hospitals with the view to conceive high quality healthcare as looking after the whole person, not just their medical needs. Due to the challenges, time-constraints and pressures faced by medical professionals, Chaplains are required to help meet this gap in support. In order to develop and build upon my understanding of a Chaplains role in the healthcare setting, I have completed a placement over the past year, working alongside the Christian Chaplains based at Leeds Teaching Hospital which supplies treatment to around one million people a year (The Leeds Teaching Hospitals, 2020).

In this position, I have accompanied, participated in and observed visits to patients who have referred themselves to the service or who have been referred by their faith leader, relatives or healthcare team. We visit both long and short-term patients and spend time with them in conversation to establish if they have any specific spiritual needs, such as receiving communion, or whether they would value a regular chaplaincy visit. Moreover, I have accompanied volunteers who have a designated ward and so see all the individuals on the ward and offer support. Beginning my placement, I sought to understand the relationship between Christian theology and beliefs and how this is practically implemented in the Hospital Chaplains role. This required me to be conscious of the behaviour and attitude of the Chaplains towards patients in order to understand how their faith was lived out in this role. The conversations I observed with patients highlighted to me that patients often feel an altered sense of self when in hospital, because they are in a vulnerable state and have lost some of their normal routine and relationships, so often feel that they are treated less individually. On observing interactions Chaplains have with patients, I have identified the care they provide for each individuals’ needs as consequently functioning primarily to restore and promote their dignity whilst in a vulnerable state.

Therefore, my thematic focus of this report will be on dignity in Chaplaincy practice and I will draw on examples and reflections from my time on placement to illustrate why and how I believe Chaplaincy to be an essential, dignifying support service. Chaplains themselves are practical theologians because as Forrester highlights, it is the discipline “which is primarily concerned with the interaction of belief and behaviour.” (1983, p455). The academic basis of this report will draw on pastoral theology, chaplaincy studies and theological anthropology, in order to relate the Christian belief in inherent dignity with Chaplains’ practical application of this in the hospital context.

The writing style I have developed which links this academic literature with reflections from my placement experience, is respectful of patient’s privacy and stems from my viewpoint as an observer. This is because I am aware of the ethical issues that can be encountered when writing about the experiences of others, who are both vulnerable and not participants in research. Establishing my writing style was challenging to begin with as I wanted to give an accurate depiction of the ways Chaplains support patients but not breach ethical standards. Consequently, the proceeding discourse ensures the anonymity of patients and Chaplains by using examples which are generalised and reoccurring themes and comments, not specific to one individual.

Before proceeding with my discussion, I would like to address my scholarly position in regards to religion. As a practicing Christian, I have found my position on placement to be of great value because I have been able to locate and understand the intricacies and links between Christian beliefs and actions which might not have been identified by outsider scholars. Moreover, it allowed me to participate in conversations of faith with common ground. This leads me to take a reflexive standpoint in line with Pearson (2002) whose approach is described by Knott to propose: “whatever its difficulties the both/and position of the insider scholar is productive, the reflexive nature of its stance giving it the edge over outsider scholarship.” (Knott, 2010, p269) Having spent a significant amount of time as an inpatient myself, I am also an ‘insider’ to the patients’ experience, knowing the emotions and thoughts patients experience in hospital, as well the way varying ways Healthcare Professionals treat us. These personal experiences are relevant because they enable me to offer a unique perspective being an observer, religious and patient, which further enriches my reflections from placement and those noted in academic literature on the subject of feeling dignified.

For the purpose of this report, I will be drawing on Griffin-Heslin’s (2005, p254) model of dignity which defines dignity as comprising of four key elements: autonomy, respect, empowerment and communication. Whilst Griffin-Heslin’s paper was written primarily for the use of healthcare staff, I believe it is applicable in the chaplaincy context because it demonstrates situations in which patient’s dignity can be compromised in hospital and points us to guidance of what changes can be made for this sense of dignity to be restored and supported.  In paying attention to these four elements in treatment towards patients, their dignity is upheld, promoted and respected. To clearly lay out the way dignity is central, I will be structuring my report under these four subsections with theological support, and address them one at a time to help build a picture of how the practice and behaviour of chaplains can be specifically linked to each and consequently restore dignity.

Chaplaincy support serves people from all backgrounds and those of faith and none. This is due to the view that every human has a spirit and mind that can benefit from emotional and pastoral support. Leeds Chaplaincy services mission statement reads: “Naturally many people have ritual and sacraments requirements as they belong to a faith community, however the hopes and fears, worries and aspirations of every human person mean each individual has spiritual and pastoral needs” (The Leeds Teaching Hospitals, 2020).The purpose of the service is to be present with any person who requires support; this rests on the belief that irrespective of faith all individuals should be treated with respect and affirmed as dignified persons.

The Chaplain Christopher Swift, in his NHS guidance for spiritual support writes: “Across the NHS there are many patients and service-users unable to exercise their religion or belief without support. An effective chaplaincy department is the most reliable way to ensure that the freedoms guaranteed by the European Convention on Human Rights are observed and promoted” (2015, p14). This illustrates the role of Chaplains as upholding rights to practice of religion but also to be advocates for other rights, including dignity and freedom which are at the core of human rights discourse. However, the need for the maintenance of this right to freedom and dignity is prevalent in the Christian Tradition and so I will now expand on the theological basis for our right to dignity and later address how Chaplains behaviour reflects this.

The Universal Declaration on Human Rights article one states: “All humans are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.” (UN General Assembly, 1948). The theological view I will be supporting is not founded on the ideas of capacities which qualify our personhood, but has an ontological basis meaning that because we exist at the same species we are equal persons. Bayer described how some traditional Christian views define personhood as constituting of “certain qualities, ‘merits'’”, which can lead to the view of people with different abilities to reason or function at a normative level as less human or even be termed as “wrongful life” . (2004, p279). This conception is problematic in the hospital context where individuals often lose capacities and is condemned by Disabled and Access theologians such as Block (2002), who proposes that Jesus’ ministry was inclusive and accessible, reflecting his care for all of humanity by welcoming those with reduced capacities and disabilities. Therefore, I argue that Jesus’ approach shows that he affirms them as equal persons and so possessing dignity too. Consequently, I support Bayer’s argument that dignity is: “attributed to him or her-bestowed, given on loan- by the One who promises and gives himself unconditionally to humankind: namely, God. Thus, my dignity as a human being is attributed to me “without any merit or worthiness on my part” (2004, p279). This theological anthropological view of being related to by God, not capacities, as the defining factor of our possession of dignity and need for care and respect thereof, originates from the description of God throughout scripture as “almighty, creator of heaven and earth, as merciful father who “remembers us as he remembered Noah (Gen 8:1).” (Bayer,2004, p283) Furthermore, Gods care for humanity is demonstrated in that our identity constitutes of being related to and so having access to Him who loves us: “God created humankind in his image” (Genesis 1:27). Conceiving dignity as a gift given by God, necessarily means that “it cannot be taken away from me by any other human being” (Bayer, 2004, p279).  Thus far, I have summarised why theologically, all individuals possess dignity and so should be treated equally and respectfully.

Spiritual care compliments the medical care offered in order that each individual's wellbeing and needs are met. NHS Education for Scotland based on WHO research recognise that spiritual support aids the recovery process, therefore, the NHS should endorse spiritual services: “If we can recapture and maintain the reality of therapeutic relationships within healthcare, if we can integrate the needs of the human spirit in the care offered, there will be enormous gains in the short and long term, outcomes and satisfaction of both patients and staff.” (2009, p13). In acknowledging the utility of spiritual support for patients, the NHS tends to the needs of the whole person where this can sometimes be indirectly and unintentionally neglected in the clinical setting. I would like to highlight here that my report is not a critique of the healthcare systems treatment of patients, but it does address that some professionals’ attitudes towards patients can be detrimental to their sense of self and so I will include instances where Chaplaincy can support individuals’ emotional and spiritual wellbeing where healthcare professionals cannot. Griffin-Heslin (2005, p256) described how there are a multitude of unavoidable factors such as time pressure and the volume of patients a healthcare professional is responsible for, that can lead to patients’ respect, dignity or freedom being compromised and people feel they are not receiving sufficient attention or care which can contribute to developing a negative self-image.

During my time on placement, I have frequently observed that patients feel they experience this treatment that depersonalises them. When patients enter hospital, they are in a state of vulnerability and most patients become dependent on members of staff to support them in activities and actions which they would usually manage themselves such as washing and dressing. This in itself contributes to changes in self-image and worth because independence and the ability to have control of their circumstances is lost.

Having established the importance of maintaining dignity in these range of views, I will now draw on the work of Griffin-Heslin in discussing the first element of dignity, autonomy, and how this is supported in the Chaplaincy role.

Autonomy

Autonomy and respect for it, are central to ensuring patients feel dignified because their physical state and treatment by others give way to this being negatively impacted. Key components of autonomy are: independence, freedom of choice, making decisions and possession of rights and needs. (Griffin-Heslin, 2005, p254). There are a multitude of manners by which Chaplains respect and encourage autonomy which begins with their intention when meeting a patient. NHS Education for Scotland (2009, p6) comments that: “Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires”. When Chaplains briefed me before visiting patients, they referenced the idea that they do not go with ‘an agenda’ when meeting someone, they go to be compassionately present with the individual and allow them to lead the conversation. Whipp supports the idea that presence is the starting point from which a supportive relationship can be built as chaplaincy support functions by: “bringing the felt presence of covenantal love into the lives of suffering people through compassionate action and above all, pastoral presence.” (2013, p78). In giving patients the opportunity to freely speak, their pastoral and spiritual needs can be identified in what they choose to converse about and it is the role of the chaplain to listen and address those needs. By Chaplains embracing the listening role they return some control to the patient when they feel out of control. This may appear to be a minor element, but when individuals have little independence, this can be liberating because the Chaplain is engaging and responding to the individual based on their wishes.

Surprisingly, I have found that the majority of conversations with patients are not centred around religion but frequently discuss everyday topics such as family, television or hobbies. Whilst these things might not seem meaningful matters to discuss, they reflect the individual's desire to have a distraction and feel more normal because they are spoken to and treated personally, like a friend and not focusing on the health condition. From my own experience, I have found that a distraction can be helpful because your mind can take a break from the worries and emotions you are experiencing, but in some cases having a listening ear is valuable because you have opportunity to voice those emotions. Therefore, I maintain that both ways of engaging in conversation are beneficial, in offering a form of escapism or release from your thoughts and feelings and so the Chaplains careful attention in recognising what the individuals needs are, is the best manner of supporting patients pastorally. Conversations about family and hobbies also creates an opportunity to develop a relationship of trust because the Chaplains shows interest in what is important to the patients and knows the person not based on their health but on their personality. I did not expect that we would often leave a visit not knowing what health issues the patient had, but this exemplifies the Chaplains’ approach which is grounded in the person’s identity primarily.

Moreover, whilst they are professionals, I have found that chaplains ensure to portray a friendly and relatable demeanour by engaging with the interests of the individual, showing the patient that they are easy to talk to which is vital in developing an honest and trusting relationship. Participating in apparently small talk, helps restore a sense of normality for patients but demonstrates the chaplains care for them as a whole person. Furthermore, beginning conversations by getting to know the individual, creates a relaxed and open environment which I have seen lead to more deep and meaningful conversations later on. Whipp writes that: “For the experienced pastor, the social niceties of what is called “small talk” work to pave the way for latter “soul talk” as the ground is laid for deeper trust and availability” (2013, p132). So the patient has the choice of what to discuss, but by ensuring to establish a trustworthy and compassionate presence as a chaplain, individuals may feel more comfortable to reveal their worries and thoughts. The characteristic of meetings with patients are of multi-dimensional support because discussion can comprise of laughter, comfort and emotional vulnerability.

From observing patients’ responses to visits, it is clear they find value in the visit and how they are treated and uplifted by chaplains because genuine gratitude is expressed by both non-religious and religious patients. I propose, that this demonstrates that some restoration of their sense of self-worth and feeling dignified occurs, and that spiritual support is valuable for non-religious people as well. Griffin-Heslin, drawing on Mairis (1994), argues that: “If dignity is maintained a sense of empowerment and a positive self-image may exist” (Griffin-Heslin, 2005, p255). Moreover, Marin et al (2015, p22), conducted independent research as well as drawing on previous large studies, which highlighted that meeting spiritual needs through chaplaincy visits, improves patients’ satisfaction with their hospital care and should, therefore, be a more recognised and promoted service. The results of Marin et al’s study, leads me to argue that the needs of the human spirit are not being met adequately within the healthcare setting, so to improve the satisfaction and spiritual health of patients, Chaplaincy support should be further integrated into the care patients receive.[[1]](#footnote-1) Offering chaplaincy services more, would demonstrate respect for the individuals’ spiritual needs, which supports their dignity as I will now discuss.

Respect

Underscoring the recognition of autonomy lies great respect for the individual and their inherent dignity. Respect and autonomy are inextricably linked, Jacobs (2001, p26) supports this, writing: “respect and dignity are two concepts that can be explained simultaneously”, because in recognising that we are all equal in worth and possession of dignity, we should behave so as to preserve the dignity of others. However, this respectful attitude towards patients does not always happen. In visits with patients, Chaplains often hear patients’ opinions on the way they are being treated, and Chaplains themselves are aware of behaviour which affects patients' feeling of autonomy. Examples of things Chaplains observe include: professionals speaking about patients in their presence but not addressing them and lack of good communication between professionals and patients resulting in patients experiencing anxiety around test results, what treatment they are receiving and not being forewarned of procedures they are going for. I can testify to this issue from my own experience as an inpatient in hospital and that lack of communication, also contributes to emotions of feeling out of control, forgotten and that you are not involved in decisions centred around your own wellbeing. All these emotions and situations can result in persons feeling undignified because their dignity is not respected.

It is possible to conclude from patients’ reflections on their experience, that they become an object as opposed to a subject of care. Although there are healthcare professionals who will be attentive to patient’s dignity and be respectful thereof, minor actions and attitudes of some healthcare professionals could have a greater negative effect on the individuals, considering that they will most likely be in a physically and subsequently, emotionally vulnerable state. Cobb (2012) on writing of the value of transdisciplinary care, also details how patients struggle with feeling a loss of identity and self-worth because the way they are treated and addressed is less about them as a person. He describes: “It is a common experience of people seeking healthcare and treatment that they feel compartmentalized. Many types of healthcare fragment the whole to achieve technical or operational efficacy” (2012, p94). Moreover, in describing an anonymised patient he writes: “His experience so far had been one in which healthcare professionals had been interested in parts of his life, or more accurately elements of his failing biology. Two years of this refractory process has left him struggling to maintain his sense of personhood and humanity.” (2012, p94). It is evident here, that not addressing the individual as a whole and equal can negatively affect their perception of themselves and dignity. The consensus of responses and reflections in Chaplain-patient interactions I have observed, leads me to support the line of thought I have proposed, because conversations around being treated less individually, with reasoned beliefs and not merely a bed number have been recurring themes. Having identified these resulting effects, Chaplains have the unique opportunity to spend time hearing the concerns of patients and reassuring them that they are heard as well as having conversations which help to begin rebuilding their self-worth and personhood.

The importance of respecting and empathising with patients for chaplains and healthcare staff is connected with acknowledging the concept of shared humanity. Griffin-Heslin, argues with support from Walsh and Kowanko (2002), that “Nurses recognised the importance of shared humanity in order to empathise with patients” (Griffin-Heslin, 2005, p253). Griffin-Heslin (2005) concludes that this is a key component of high-quality nursing care and, therefore, needed to uphold patients’ dignity. Being able to relate to patients because of shared humanity develops greater empathy, despite not being a patient there are elements of being vulnerable which resonate with us which could include emotions, thoughts and worries. Theological discourse offers valuable insights into this concept of shared humanity which highlights how and why we can relate to others in challenging circumstances. This returns us to the belief that humans are given life which is inherently sacred and warrants dignity because it is gifted by God, in whose Image man is created. Humanity as a species are equal in this identity because of their shared state of being, Bayer (2004, p279) writing on the Christian view argues: “Indeed amongst all fellow creatures; he or she will recognise precisely as fellow humans those who share the same ontological status.”. Furthermore, he elaborates that this ontological status is defined by the fact that we are all fundamentally dependent in alike ways because we are all “in need of food, clothing, housing, of help in sickness and in captivity.” (2004, p279-280). This highlights that whether we are in a state of vulnerability such as the patients in hospital or not, we are nevertheless all dependent and subsequently have the capacity to resonate and empathise with other humans.

Part of resonating with others and tapping into this shared humanity is participating in the apparently light-hearted conversations I addressed earlier, because they demonstrate relatability and approachability because Chaplains view themselves as equals in their identity in God and their dependency. Nurses and other healthcare professionals also do this effectively when they chat to patients whilst assisting them, discussing their family or hobbies. However, for Chaplains, connecting with this shared humanity is shown through respectful treatment of patients and can go beyond the surface to enable deeper conversations, about emotions and struggles patients are having. In situations like this, it is essential that dignity is continually affirmed and individuals feel they are treated equally and respectfully because they have trusted and opened up to Chaplains.

Christian Chaplains I have spoken with have all addressed how they feel called to the role and to be with the sick. This call is an extension into this setting of the Christian call to compassion and empathy towards those who are in a state of vulnerability such as sickness, bereavement, and poverty that we read of in scripture. This theme reoccurs throughout scripture but Matthew 25:31-46 clearly lays out the relationship between loving others, especially those on the margins, and loving God. For loving and serving God is evident in the way we serve and love others: “Then he will answer them, ‘Truly I tell you, just as you did not do it to one of the least of these, you did not do it to me.’” (Matthew 25:45). Chaplaincy is a form of active response in ministry to this call to action and love towards those in need. Slater (2015, p89) supports this writing: “In offering this ministry, Chaplains fulfil in an intentional and representative way the discipleship to which all Christians are called in order to contribute to human and social flourishing.” Service and respect for all humankind should be at the centre of Christian behaviour towards others and as Slater (2015) commented, is beneficial in promoting flourishing for individuals and their community. The visits made by Chaplains assist this flourishing in the wellbeing of patients who need the pastoral and emotional support to be uplifted and affirmed in their worth and identity again.

The pastoral needs of patients vary greatly, so Chaplains take the approach of ‘meeting the need’ which arises and enables the most effective care, showing support and respect for the patient in whatever they require. As Whipp (2013, p110) writes: “The presence of the pastor represents profound respect for the whole person; his prayerful concern does not diminish his humanity by reducing his attention to a narrow compartment of issues which are labelled as ‘spiritual’ or ‘religious’.” Vital to ensuring mindful practice is introducing what your role as a Chaplain is to the patient. Normally, I have seen Chaplains communicate that they have just come for a chat and see if there is anything the patient needs or would like specific help with. From there, the patient has the opportunity and control to express their wishes for example, help with receiving communion or having a regular visitor. They also have the opportunity to request or decline extra support without being judged for their answer because the concern of the chaplain is what is best for that particular individual. Moreover, I have seen and Chaplains have also reported that even the people who are strong in faith do not always want specifically spiritual support. This exemplifies that the needs of patients of faith and not can vary and the emotional and pastoral needs of the patients can require more tending to. In addition, Cobb (2012) describes the need to treat individuals as a whole with a multitude of spiritual, emotional and pastoral needs as a Chaplains which transcends simply offering the opportunity to receive or participate in rituals. He argues “For example, it may be relatively easy to identify the needs of a patient to perform Salat (the ritual dimension) and to organize facilities for this to happen, however, if this is the only dimension we grasp then this neglects the interrelated dimensions and disregards the wider meaning and expressions of spirituality for that person” (2012, p96).

The recognition of these variable needs, allows for the most effective and appropriate care and demonstrates that to show respect for patients best, Chaplains are careful not to presume patient’s preferences, wishes, or abilities, be they religious or not. A clear example of how Chaplains attitudes seek not to make their own assessment of patients’ needs, can be seen in the respectful and non-patronising treatment of those who struggle with speaking or communicating. I have observed interactions on visits with people who cannot speak or communicate due to their health, which have been really meaningful and natural. This is down to the initiative of the chaplain in using whiteboards and pictures which has enabled patients to write and express what they want to speak about and respond to chaplain’s questions. This requires a lot of patience as it can take a long time for people to write down but I have observed it to be uplifting for the patients because they have someone with sufficient time to listen and respond to them and so still find immense value in a visit. This is one instance where spiritual care services can be seen to be very important because unlike healthcare professionals, who have lots of patients who all require medical care, the Chaplains are able to spend lots of time one-to-one with each patient. Visits do not have a time constraint so Chaplains stay for as long as the patient needs or would like. [[2]](#footnote-2)

In providing Chaplaincy services, the NHS ensures that people can have conversations and human contact and support with others, without taking time away from the healthcare professionals whose role is centred around medical support and treatment. Furthermore, as Cobb (2012) noted, the method to ensure patients personhood, self-worth and dignity is preserved and promoted, is through treatment of the individual as a whole which is not attainable through the care of healthcare professionals alone and so transdisciplinary teamwork is beneficial for promoting the wellbeing of individuals. Chaplains hold expertise in spiritual and pastoral care but Cobb argues that their expertise also includes general skills in personal and emotional care which makes them incredibly valuable in the Hospital context because their vocation “is expressed in the reflective and rigorous discipline of pastoral care, a practice adept at border work and located at thresholds and transition, or places that contain the possibility of transcendence” (2012, p96).  In supporting individuals in a wide array of ways they become advocates for the individual as a whole.

Whipp (2013) agrees that the role of Chaplains pastorally, is to pay attention to the whole individual in their vulnerability and be empathetic to their needs as highlighted in the Matthew 25 text, I addressed earlier. She writes (2013, p111): “In a society which tends to dehumanize us all by losing sight of the vulnerable individuals on the edge of society (cf. Matt 25:31-46) or, more subtly, losing touch with the ineffable qualities of human wholeness which are essential to preserving the ‘soul’ (cf. Mark 8:30) pastors pay attention to what is being lost.” To care for the wellbeing and locating areas of the individual's emotional or spiritual health which needs help and encouragement, Chaplains can seek to be present and of support in ways which prevent the loss of or restore the sense of self-worth and meaning in the individual. Meeting these needs means that specific, individualised care is provided over generalized which leads to more appropriate and respectful treatment of the unique needs of the patients and so high respect for and affirmation of their dignity. In the NHS funding chaplaincy services, they address the needs of the whole person by individuals who have the time and skills do this.

Having identified and elaborated on the role of the Chaplain as supporting the dignity of patients in many not specifically religious ways, I would now like to address the ways they care for and preserve the dignity of those who do desire religious support. In providing ritual or religious support the right to religious freedom and practice identified in UDHR are maintained. I have seen that patients who ask for prayer are always offered to be prayed for at the bedside or to be prayed for in the chapel by the Chaplains. This is not presumptuous of patients’ wishes and gives them the opportunity to express whether they wish to engage in prayer or be comforted in the knowledge that others are praying for them throughout their stay. Moreover, on attending the morning and lunchtime services in the chapel, I have noticed that the chaplains always pray for the individuals who have put a prayer request on the payer tree or in the box outside the chaplaincy. By ensuring to do this, Chaplains continually lift up the worries and concerns of the human spirit reflected in these prayers, respectfully, whatever they may be and are faithful to caring for patients’ pastorally and spiritually by meeting this need. In situations where worship or rites are included, chaplains are proactive in seeking to make the space feel more personal and private so that the individual can feel best respected in their wishes to participate in something sacred. This is usually carried out by drawing the curtains around the bed to maintain privacy which is an essential element identified by Griffin-Heslin (2005, p254) as essential for respect and dignity. Moreover, the Chaplain usually mentions to the patient that closing their eyes and remaining in a short time of silence to begin, is helpful in centring themselves and focusing in preparation to receive communion and be less distracted by the noise and busyness around them. These are a few simple but effective ways of imitating a sense of a sacred space and personal participation and practice of faith which are respectful of the individual's beliefs.

Furthermore, it could be perceived that individuals may not be able to participate in their usual rituals such as communion, if they have compromised physical capacities like the ability to eat. However, as I observed on a visit with the Catholic Chaplain spiritual communion is offered which does not require one to eat or drink the elements of bread and wine but instead hold them in your hands. The chaplain offers a prayer in this time which addresses that the person cannot physically consume the elements but their desire to participate is there and that they now receive it spiritually despite not being unable to receive sacramental communion. Spiritual communion is used for multiple different circumstances where individuals cannot attend or receive sacramental communion and the following prayer is usually said by the individual as per Catholic Church tradition, although the Anglican Church also practice spiritual communion.[[3]](#footnote-3)

“My Jesus, I believe that You are present in the Most Holy Sacrament. I love You above all things, and I desire to receive You into my soul.

Since I cannot at this moment receive You sacramentally, come at least spiritually into my heart. I embrace You as if You were already there and unite myself wholly to You. Never permit me to be separated from You. Amen.” (ThoughtCo, 2020).

In providing this opportunity, Chaplains provide a sense of normality in the spiritual routine for those whose physical capacities have reduced and ensures that patients identity and self-worth is not diminished. This is a key example of the way Chaplains support and empower individuals in their practice of faith, which as Griffin-Heslin recognises, upholds patients’ dignity in helping them to develop a positive self-image. Attitudes and acts which empower patients stretch beyond these examples, and I will now move to highlight further areas where this occurs in chaplaincy practice.

Empowerment

Vital aspects of empowerment in my chosen model are: “Feeling important and valuable in relation to others, self-esteem, self-worth”. (Griffin-Heslin, 05, p254). The attitude towards patients that Chaplains have, of maintaining their inherent dignity and treating them as made in the Image of God, affirms their self-worth and value in the way they lovingly care for whatever needs they have, acknowledging their shared humanity. This empathetic and encouraging attitude, means that Chaplains help to develop perseverance and strength in patients, which is a desirable attitude in scripture: “Each of us must please our neighbor for the good purpose of building up the neighbor.” (Romans 15:2). However, the primary way in which Chaplains can help to empower and affirm individuals in their identity is by being present and reassuring people in the knowledge that they are not journeying alone, but the Chaplain is there to go through the highs and lows of life in hospital with them. This is practically living out the biblical call to sympathy that is well summarized in Romans 12:15 “Rejoice with those who rejoice; weep with those who weep” (Romans 12:15). Having identified how Chaplains build trusting and approachable relationships with patients throughout this report through their attitude, I argue that this enables an environment for honesty in the patient and allows the Chaplains to be compassionate companions in the patients’ journey to recovery, discharge or in palliative care. Whipp comments that this conception of the role which is of journeying together removes models which can be unhelpful to the patient’s view of themselves as argued by Feminist scholars which concentrate on the relationship being between ‘one-caring’ and the ‘one cared for’ (2013, p8). Obviously the Chaplains is providing care, but incorporating the view that the patient and chaplain are learning and growing together through the process of recovery or long-term treatment strengthens the intimacy between the two which can lead to more effective care and greater understanding of the patient’s experience.

As NHS Scotland identifies, there is a need to meet and respect the individual’s spiritual needs and beliefs of patients because this can “make a crucial difference not only to their ability to recover from, but their very understanding of health and illness” (2009, p13). The companionship of the Chaplain and the skills they possess can aid to more effective recovery because as Raffay et al (2016, p2) supports: “Chaplains can work with service users and carers to bud resilience. Resilience and spirituality have numerous links including finding meaning in life and having a sense of hope.” Core elements to the process of recovery and included in the ‘Recovery Model’ are purpose, meaning and hope and this being essential to good recovery, therefore spiritual care can be of great assistance to this for the non-religious and religious (Raffay et al, 2016, p2). Moreover, as Reilly, further agrees: “Traditional spiritual practices such as the development of empathy and compassion are being shown to be vital ingredients, even pre-requisites in effective healthcare-in the cared and cared for they build wellness and happiness. Effective healthcare must now (re)take into account these values.” (2005, p xi).

Imperative to this idea of companionship and growth however, is the need for continuity of relationship. On placement, I have seen that returning and long-term patients usually receive support from the same Chaplain. This removes the burden from the patient feeling that they need to explain and familiarise themselves with someone new regularly, because they already see a wide variety of healthcare professionals and so having a consistent visitor is valuable in building and maintaining that supportive and trusting relationship. This way, Chaplains are aware of the situation, personality and concerns of the individual which is useful in empowering and enabling them to feel dignified because they feel valued in the eyes of the Chaplain who they trust and know. I have witnessed this to be comforting and reassuring for patients and it also enables Chaplains to encourage and remind people of the progress they have seen them make since they have been seeing them. I have found it uplifting and encouraging as a patient, when others have identified the progress I have made which I often haven’t noticed myself (because time appears to pass more slowly in hospital) so when others notice your progress, it demonstrates their care and interest in you. The encouraging and attentive attitude of the Chaplain in this way, further contributes to building a greater sense of self-worth in that person as they feel heard, noticed and valued.

Additional ways I have seen Chaplains accompany patients throughout their time in hospital are by being present in other treatments or therapies, such as music therapy, which whilst being a companion role embodies this idea of journeying together. In acknowledging progress and through discussion helping to grow resilience and hope, patients are helped to look forward to the future and what things they can enjoy on discharge. Amidst this process Chaplains ensure to enquire into the individuals support network, so that on return home the patients do not feel that they are abandoned or unsupported, especially for those who do not have loved ones nearby. The Chaplain assists, if needed, with helping locate community support in the form of a vicar or someone in the community who can visit and continuing in helping to empower the individual in the knowledge that they are still valued and cared for in return because the recovery process normally continues at home once leaving hospital. Finally, on the topic of empowerment, in the context of conversations about faith, I have observed Chaplains use scripture which is in itself empowering in reminding the individual of God’s concern for them and their identity and worth that can be found in Him. A core text used was Psalm 103 which focuses on God's fatherly love for his people and his continued presence and faithfulness in care for them. These examples show the value of relevant and encouraging words in Chaplaincy practice for patient dignity, however, their value also resides in the positive way in which Chaplains communicate them, which I will move on to discuss now.

Communication

Griffin-Heslin (2005, p254) described that communication’s role in preserving dignity is related to: “comfort, verbal and non-verbal communication” and explaining. Swift (2015, p25) argues that: “Poor communication skills, pastoral insensitivity; or a failure to identify essential elements of the patient's belief system may all create potentially serious risks for both the patients and the organization.” Attention must be paid, therefore, to how and what Chaplains communicating so as to uphold patients’ dignity and have a positive impact on their experience. When I first went on placement, chaplains stressed the importance of good, open body language because it shows the patient that you are listening and that your full attention is on them. This required: maintaining eye contact, not fiddling with anything, staying still and not sitting hunched over. In addition, it is important to pay attention to the patient's body language because if they are visibly in more pain or looking tired it is important to not overstay your visit and respect their needs for rest and to come again at another time if they so wish. When speaking with patients, Chaplains conscientiously try to be greater listeners than speakers and so their words are responsive to the individual and seek to not be patronising but all the while communicate love and gentleness. Whipp supports this commenting on aptness of Chaplains words: “She learns that a suitable phrase will restore calm; a gentle word-play will send out ripples of delight; a perceptive analogy will evoke deep echoes of healing truth.” (2013, p138).

Moreover, Chaplains gentle and respectful manner of speaking means that on visits to patients who can hear but are not able to respond at all, they continue to chat to them as any other individual and let them know they are there and say a prayer for tem if that was requested. Chaplains adapt their conversation if patients can nod or blink in response by using closed questions which means that they can still engage in conversation and not presume patients' needs. Methods such as these ensure that all patients can receive and engage in a variety of forms with spiritual care and feel respected in the way they are approached and spoken to despite their perhaps limited communication abilities. The final thing Chaplains make sure to do is communicate with the patient to let them know when they will next visit, if they would like one, this means that patients know when to expect them and are aware they are not forgotten. In this thematic discussion and reflection on dignity, I have emphasised the importance of the Chaplaincy role in the hospital context and indicated how this was revealed through my placement experience. In order to address the implication and outcomes of this, I will now move on to a section evaluating my placement.

Evaluation

Having witnessed the value and efficacy of the dignifying service of Chaplaincy in supporting all individuals pastorally and spiritually through distraction or comfort, and consequently improving self-worth and wellbeing, my recommendations are linked with facilitating the services’ further integration into the NHS in order to improve patients’ whole health.

The first difficulty I noticed, which hinders peoples’ desire to receive support, is the language used to describe Chaplaincy and Spiritual services because individuals already have pre-conceived ideas associated with this. Whilst for some who are religious, asking for Chaplaincy support may feel natural and comfortable, I have noticed that those who are not religious often do not feel it is a service appropriate or useful for them because they do not have a faith, which means they can miss out on the universal value of Chaplaincy I have argued for. There is a challenge in communicating the role of chaplaincy as accessible for all, whilst not using language that is so vague its meaning is diminished. This issue touches on a much larger debate on the role of Religion and services like Chaplaincy in the public sphere. With media often representing peoples’ faith with terms such as ‘evangelical Christian’, ‘religious’ or ‘spiritual’, they produce an image of faith as exclusive, which does not contribute to people feeling welcomed if they do not resonate with the same terms. When I have visited patients on a ward round who have not been referred for a visit, they have often begun with disclosing their status as not a ‘churchgoer’ or ‘religious’, highlighting their misconception that Chaplaincy or spiritual care is exclusively for the religious. In addition, I have seen that some healthcare staff are more welcoming of Chaplains presence on ward than others. In order to assist the increased integration of chaplaincy support into healthcare treatment, and enable all people to receive the benefits in recovery and wellbeing by feeling dignified, this understanding needs to be broken down. I would like to acknowledge here, that I do not claim dignity to be central only to the practice of Christian Chaplains but my experience was working alongside them and so my report is specific to this.

I propose a key method of changing pre-conceptions, is by educating staff in the role of Chaplaincy and increasing patient awareness through further research specifically into the benefits of it for short-term, non-palliative and non-religious patients in the UK context because these areas have been addressed less. In developing a greater body of UK specific evidence for its efficacy and utility for patients in differing circumstances, statistics and conclusion of reports can be used in brochures for patients and educational materials for staff. This would help them to understand how Chaplaincy can support them and the importance of spiritual care in health, wellbeing and recovery. This would likely persuade more individuals to be open to receiving support because the role of chaplains becomes more clear and the positive outcomes further evidenced.

My report identifies that gaps in support for patients’ pastoral needs exist and that Chaplaincy helps meet this through addressing the needs of the whole person and restoring dignity. A valuable topic for future research would address the Holistic model of healthcare and whether, despite requiring large re-structuring, this could be a feasible healthcare framework in the future for the NHS. This model is dignifying by addressing the person as a whole with many needs which can be supported through different holistic therapies and services, such as Chaplaincy, alongside the medical to contribute to long-term health (2012).

After completing placement, my perception of what a Chaplain’s role entails has changed. Moving away from my earlier more spiritual conception and towards an understanding of their role of being present, active listeners who are responsive to each human’s needs. This further highlights my point that we all carry preconceptions around the ‘spiritual’ which need to be changed so that we can all reap the benefits of Chaplaincy support if the need arose, because despite being an insider in many ways, I had misconceptions of what a Chaplains role entailed, and now recognise the intricacies of their attitude to be restorative, empowering and dignifying.

In establishing the implications of and reflections on my placement, it is clear that the Chaplaincy service in Hospitals is crucial. However, the Chaplains’ role fundamentally revolves around the respectful and dignifying treatment of all individuals, support that is not overtly spiritual or religious but about the human.

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Bibliography

Bayer, O., 2004. Self-creation? On the dignity of human beings. *Modern Theology,* 20(2), pp. 275-290.

Block, J.W., 2002. *Copious Hosting: A Theology of Access for People with Disabilities.* New York: Continuum.

Cobb, M., 2012. Transdisciplinary approaches to spiritual care: A chaplain's approach. *Progress in Palliative Care,* 20(2), pp. 94-97.

Forrester, D., 1983. Practical Theology. In: A. Richardson & J. Bowden, eds. *A New Dictionary of Theology.* London: SCM Press, pp. 455-456.

Griffin-Heslin, V. L., 2005. An analysis of the concept dignity. *Accident and Emergency Nursing,* 13(4), pp. 251-257.

Holy Bible, *New Revised Standard Version*

Jacobs, B. B., 2001. Respect for Human Dignity: A Central Phenomenon to Philosophically Unite Nursing Theory and Practice through Consilience of Knowledge. *Advances in Nursing Science,* 24(1), pp. 17-35.

Knott, K., 2010. Insider/Outsider Perspectives. In: J. R. Hinnells, ed. *The Routledge companion to the study of religion.* Abingdon: Routledge, pp. 259-273.

Mairis, E. D., 1994. Concept clarification in professional practice--dignity. *Journal of Advanced Nursing,* 19(5), pp. 947-953.

Marin, D. B. et al., 2015. Relationship Between Chaplain Visits and Patient. *Journal of Health Care Chaplaincy,* 21(1), pp. 14-24.

NHS Education For Scotlans., 2009. *Spiritual Care Matters: An Introductory resource for all NHSScotland Staff,* Edinburgh: NHS Education for Scotland.

Pearson, J., 2002. 'Going Native in reverse': the insider as researcher in British Wicca. In: E. Arweck & M. Stringer, eds. *Theorising Faith: The Insider/Outsider Problem in the Study of Ritual.* Birmingham: Birmingham University Press, pp. 97-113.

Raffay, J., Wood, E. & Todd, A., 2016. Service user views of spiritual and pastoral care (chaplaincy) in NHS mental health services: a co-produced constructivist grounded theory investigation. *BMC Psychiatry,* 16(200), pp. 1-11.

Reilly, D., 2005. Foreword. In: S. G. Wright, ed. *Reflections on Spirituality and Health.* London: Whurr, pp. ix-xii.

Slater, V., 2015. *Chaplaincy Ministry and the Mission of the Church.* London: SCM Press.

Swift, C., Chaplaincy Leaders Forum., National Equality and Health Inequalities Team., NHS England., 2015. *NHS England NHS Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual & Religious Care*.

ThoughtCo., 2020. *An Act of Spiritual Communion.* [Online]
Available at: https://www.learnreligions.com/an-act-of-spiritual-communion-a-daily-catholic-prayer-542748
[Accessed 2020 July 1].

The Leeds Teaching Hospitals., 2020. *Chaplaincy Services.* [Online]
Available at: https://www.leedsth.nhs.uk/a-z-of-services/chaplaincy-services/
[Accessed 24 June 2020].

The Leeds Teaching Hospitals., 2020. *Leeds Teaching Hospitals NHS Trust Overview.* [Online]
Available at: https://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=1373
[Accessed 24 June 2020].

The United Nations General Assembly., 1948. *The Universal Declaration of Human Rights.* Paris, General Assembly Resolution 217 A.

Walsh, K. & Kowanko, I., 2002. Nurses' and patients' perceptions of dignity. *International Journal of Nursing Practice,* 8(3), pp. 143-151.

Whipp, M., 2013. *SCM Studyguide to Pastoral Theology.* 2nd ed. London: SCM Press.

1. Increased integration of non-medical services, such as Chaplaincy, would require complex structural reform in the NHS which I cannot discuss in this essay, but favours the ‘Holistic’ model of healthcare, Cobb (2012) and I support, seeking to care for the needs of the whole person which would support their dignity. [↑](#footnote-ref-1)
2. The practicalities of this cannot be discussed at length here, however, I propose that the role of volunteers is key to enabling this. [↑](#footnote-ref-2)
3. Further discussion on the theology and role of spiritual communion is beyond the scope of this essay but would be an interesting research topic. [↑](#footnote-ref-3)