ENHCC May 2022 Presentation Paper

Chaplains in Palliative Care: proving our worth and standing our ground.

Introduction

Patient quote: ' Hmm, I'm a lifelong atheist so how come I'm talking to a chaplain?'

This patient had been in active naval service during Falkland's war and had carried a trauma of those times through his life. When faced with his imminent death, he said he chose deliberately to talk to a person of faith about this. Something about the language of forgiveness was important to him even though he sat very lightly to any belief. So he chose the chaplain, and his experience moved from being a heavy daily burden to pick up and carry, changed to becoming something he could share with his family and put aside as something he didn't need to carry on a daily basis. Equally, where chaplaincy is based on a more secular model, it is the case that the terminology of our profession draws people to talk about the deeper things of life that matter when life is coming to an end.

The thought behind this patient's words may sound familiar for a patient, family and staff member to express, even in these days of inclusivity. People are not always sure who we are and what they think we are standing for or going to do. 'I'm not ready for your black cloak and scythe yet!'. Yet we know the breadth of the way we talk about and practice spiritual care is very wide. We will, I'm sure, agree that modern healthcare chaplaincy should have no religious agenda, chaplains are trained, skilled individuals from a breadth of backgrounds whose focus is to provide high quality spiritual care as part of a holistic model of care so well known in palliative care particularly. What is often a factor is the way in which our colleagues present the concept of spiritual care and 'seeing a chaplain' on admission or first conversations with new patients.

The frustration continues that after 60 plus years of palliative care in its modern form evolving and taking shape, being accepted as a discipline and component of the whole package of care, the conversations about the value, purpose and cost of this care still surfaces with consequences.

Why are posts being lost and chaplains not replaced?

Why is there a lingering apprehension, even suspicion , about chaplaincy as part of the wider MDT team?

Is the name a hindrance?

Basically, how do we maintain a presence that we know, and patients experience, as valuable and essential especially at the end of life when, as a doctor said recently,

'I have about 25 drugs to offer a patient, you have so much more'.

It feels as if we live on a continual edge of needing to prove the value of spiritual care and having the physical presence of a trained skilled professional in an organisation to lead on this area of care for patients and families.

Are we constantly going to be at the whim of 'who's in charge' and their positive or negative approach to our profession? Even if we strive to embed policy and practice into the organisation's ethos and strategy, there are still egs of job loss and marginalisation? What do we do?

1. Embed the concept of spiritual care in the organisation

This is a true challenge for many healthcare chaplains facing apprehension, even suspicion, about our motive, agenda and value. Part of the UK experience recently is that air time is given to those who abhor the existence of chaplaincy in healthcare and raise a constant voice of challenge to 'get us gone'. Thankfully, this is a minority view but as recent Census information will indicate, people identifying as 'non-religious' will increase dramatically this time and healthcare chaplaincy's future will be reviewed as a result.

There will those in managerial roles who will bring their own prejudices to the place of spiritual care in the organisation. 'People are less religious therefore…' Deliberate missing of the point that NHSS Spiritual Care Matters makes so well:

'We live in a multi cultural world where religious labels are too often used …our differences are part of an enriching diversity of our humanity…spiritual care in NHS must be inclusive and accepting of human difference..spiritual care is the very essence of (NHS) their work.

Wright 2005 states Spirituality is part of health , not peripheral but core and central to it.

We know the facts and efficacy of spiritual care so have to find ways of meeting resistance with resilience, apathy with determination, to embed the value of spiritual care within our healthcare settings.

Question: Who are we to our organisations? How are we perceived?

2. Collect evidence

In 2004, first drafts of Standards for Chaplains in Palliative Care began to emerge, and with it, the idea that chaplains made the move to become recognised as healthcare professionals. This was followed by, in UK, Spiritual and Religious Care Core Competencies, Code of Conduct and eventually accreditation by the Professional Standards Authority. Against this background, however, was a mixed picture of experience of practice and acceptance of this professionalism? Essentially, there was a dawning of the need to provide evidence for the value and purpose of spiritual care and those who lead the way in providing this.

Obviously research, case study work etc has blossomed but essentially this evidence collection begins in the organisations we work for, recording our interventions for the MDT to see and witness what we do. Writing in patient's notes should be starting point of our record of practice. Remember times of scribbling on bits of paper knowing contribution will never see light of day, now replaced with understanding of importance that our interventions are recorded, usually electronically, as part of patient care. There has been some ambivalence on behalf of chaplains to do this and resistance of organisations to allow it but it is the core of our proof.

National NHS guidelines specifically requires that there is 'clear documentation in patient's notes of all key professionals involved in their care' so I'm interested that some organisations and some chaplains baulk against this when evidence is then available to demonstrate what we do, how often and how.

Question: What is your experience and practice?

Conclusion

Entitled this paper ‘Proving our worth and standing our ground’ specifically because it feels as if we are still needing to do this, even in places where spiritual care is given credence, and chaplains enjoy acceptance and trust.

There will be many examples to share. One from my own organisation is around the future refurbishment, including reducing size of chapel/quiet room. On practical level, we need to be access this with patient bed on times and current plans will ‘look lovely’ but have disregarded this fact. No discussion, consultation and I consider myself in a good position in terms of acceptance.

There is a sense that we all have to demonstrate that we fulfil our roles and can quantify and qualify our work, but is it the case that chaplains feel this more acutely than other healthcare professionals?

And how easy is it for us to stand our ground and what does that mean for you? For me, it’s about being that voice that doesn’t allow a person’s spiritual health and well being to get overlooked? A recent example is of a patient in severe pain and distress, our recently appointed doctor had not factored in at all spiritual care until I suggested some intervention. We will recognise that situation at times, and don’t need to apologise for speaking up and out for spiritual care. We know it helps, we know the benefits of addressing spiritual issues and, for a patient, being accompanied by a specialist in the field, and by staff members who avail themselves of training in this area.

Baroness Ilora Finlay kindly wrote the preface to the book edited by myself and Bob Whorton (2017 Jessica Kingsely Press), ‘Chaplaincy in Palliative Care’ and says:

It is the chaplain, by being there and listening, who can facilitate the shaping of thinking and perceiving, provide some security through their very presence and allow the person to find their own hope and way forwards as they face their passing out of this life.’

Adds that the future will needs chaplaincy more than ever but will put far great demands on the person who dedicates their life to this work thanks the role of a chaplain in the past. ‘

Other references.

AHPCC Guidelines for Employers and Managers 2013

NHS Scotland Palliative Care Guidelines 2020

NHS 2015 Chaplaincy Guidelines: promoting excellence in pastoral, spiritual can religious care

UKBHC Code of Conduct 2010 revised 2014

UKBHC Standards 2009

Marie Curie Competencies in Specialist Pallaitive Care 2004