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Should the NHS employ hospital chaplains?



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It is wrong to assume that hospital chaplaincy serves only religiously observant patients and that it is a purely 'spiritual' provision.

Even prior to the current austerity measures, some groups were seeking an abolition of the publicly funded service which it claims serves no purpose for the majority of patients who do not adhere to any faith, and argues that religious institutions should meet the costs if the role of chaplains is to continue.

In my research into end of life issues among Jewish and Muslim communities in the UK, hospital chaplaincy is one of the issues that comes up time and again. I have found that it is wrong to assume that hospital chaplaincy serves only religiously observant patients and that it is a purely 'spiritual' provision.

I have spent a year talking to medical students, Jewish and Muslim families, Christians, religious leaders and doctors based at seven hospitals located between London and Cambridgeshire.

I have discovered that religious diversity within faith communities and institutions makes a system 'privatisation' of chaplaincy unworkable; the argument that religious institutions should pay for their own chaplains is simply not possible in our highly diverse society. Even within specific denominations views can be polarised. The diversity of opinions within the Church of England is well known today but it is repeated in every other Christian denomination, and also in Jewish and Muslim communities. Not all religious denominations possess stable and sizeable institutions with the capacity for funding chaplaincy services. Some branches of Islam, for instance, would have problems funding their own chaplaincy services.

My findings also show that some people who have been less religious during their lifetime (or not religious at all) ask for chaplaincy advice. Increased religiosity towards the end of life is not uncommon. Most of the chaplains interviewed reported that people who described themselves as atheists or non-practicing when admitted to hospital turn commonly seek spiritual guidance as the end of life approaches. A Jewish Chaplain told me that the more religiously observant patients usually have a personal relationship with a faith leader and their families are more familiar with end-of-life; what to arrange, how to pray, how to mourn. This is not always the case for Muslim patients, however since a close relationship with a faith leader is not always as common, particularly among recently arrived immigrants. Muslim relatives are often familiar with the religious rituals involved but tend to be less equipped to deal with the practical administrative requirements which chaplains often assist with.

My research also demonstrated that the provision of the chaplaincy service in the NHS is not one directional but remains an invaluable source of support to medical staff, some of whom seek their own solace from the chaplains. The work of the chaplaincy also helps to improve the quality of service. Many doctors, particularly recently arrived foreign doctors still familiarising themselves with the system, are greatly assisted by chaplains to ensure the delivery of high quality care. Many healthcare professionals also require advice and facts on faith matters in order to treat their patients more appropriately. In instances of shock and extreme trauma, doctors are often unable to communicate effectively with patients and their families quickly enough to facilitate medical intervention but can do so much more swiftly through the medium of a hospital chaplain, saving time.

Perhaps most importantly, Chaplains are accountable to the NHS giving them an obligation of non judgemental care to anyone in need. One Muslim chaplain who had given care to an alcoholic Muslim patient dying of liver failure claimed an imam would have condemned him to hell. Similarly, some of the 10 chaplains I spoke to reported that they had been asked to perform funeral services for unborn babies, something most imams and rabbis would not do.

In other cases, families simply seem to have more trust in chaplains than in medical staff. For example, the children of one older woman who spoke only a little English refused to share news of a very poor prognosis with her. A chaplain was called and succeeded in persuading the family to inform the woman of her condition, thus

facilitating the medical ethics requirement of informed consent. Cases like this seem to be quite common.

As the future of hospital chaplaincy seems to be uncertain, I do not think we should look at hospital chaplaincy as a religious service for religious people. In hospitals the services and care provided by each member of staff are interconnected with that provided by others, so doctors, nurses and chaplains are often part of the same team working together to provide holistic care. Chaplaincy work does not only mean providing spiritual care to patients and their families, it provides vital practical assistance to some doctors and healthcare professionals coping who might otherwise struggle to perform their duties.

Our society is becoming ever more complex; religious and spiritual matters can be intricate issues of our identity and personality, but the ways in which we think of ourselves in religious terms may not always be the same. The divide between what is to be 'religious' and 'non-religious' can be fluid even within the same person. Hospital chaplaincies can offer a remarkable service for people from all backgrounds and respond to these complexities within our society and within ourselves as individuals.

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Many of the opinions included in the research were presented by participants at a symposium bringing together hospital chaplains, religious community leaders, medical doctors and academics, held at St Edmund's College Cambridge in May 2010