

WHY THE NHS NEEDS CHAPLAINS

The Context

NHS chaplains are healthcare professionals who, recognised and supported by their respective faith communities, are uniquely qualified and trained to deliver spiritual and religious care to patients, clients and staff.

The World Health Organisation understands spirituality as, *'an integrating component, holding together the physical, psychological and social components [of a person's life]. It is often perceived as being concerned with meaning and purpose and, for those nearing the end of life, this is commonly associated with a need for forgiveness, reconciliation and affirmation of worth'*.¹ Spiritual care addresses these needs. Religious care addresses the needs of those whose spirituality is, to a greater or lesser extent, associated with a defined system of belief and practice, shared 'in community' with others.

It is incumbent upon the NHS to address all the healthcare requirements of patients and clients. In hospital, hospice or other in-patient or residential settings this means attempting to meet a full range of needs: medical, nursing, social, environmental, psychological and spiritual. Consequently, the NHS undertakes to provide patients with care which encompasses good nutrition, a safe and therapeutic environment and time and space for enjoying social and emotional support from friends and family. This is done in recognition that these can contribute to positive healthcare outcomes. Spiritual and religious needs are no less significant, particularly in times of acute stress or when individuals and families face challenges associated with major or terminal illnesses. There is no defensible rationale for separating spiritual and religious care from other aspects of healthcare. This is recognised by the Department of Health: *'all services, including spiritual ones, should be delivered appropriately to service users and NHS staff'*². This principle is reflected in many NHS Trust spiritual care policies: *'The NHS is committed to holistic care. This means that physical, mental, social, spiritual and religious needs should be*

¹ WHO Technical Report Series. Geneva 1990; (No.804): pp 50-51

² NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff : London 2003 p3

*acknowledged and met. Today health care professionals recognise that these needs cannot be viewed in isolation because they make up the whole person. Therefore the multi disciplinary team should work together to ensure these needs are met.'*³

Correctly, delivery of spiritual care is seen as being the responsibility of all professionals in a multi-disciplinary healthcare team, but on the grounds of care, efficiency and human rights, it is essential that chaplains play a central frontline role in ensuring that appropriate spiritual and religious care is extended to all patients, clients and staff.

Care

Many individuals, as patients in hospital, experience an increased awareness of their spiritual needs. This awareness may not have been anticipated, taking many people, religious and non-religious alike, by surprise. It is imperative that such needs are met. In situations where a terminal illness is present and palliative care is paramount, meeting spiritual needs may acquire a particular intensity. In such circumstances, offering optimal spiritual care is a priority and to deny such care would amount to dereliction of duty on behalf of the NHS. In addition, it would add to whatever suffering a patient might be experiencing; clearly, the very opposite of good healthcare practice. Providing its patients with optimal spiritual care, as part of a comprehensive care plan, is primarily the responsibility of the NHS, not of any other organisation. In practice, this means that each NHS Trust must make adequate provision for spiritual care for all its patients and clients. Similarly, NHS staff members who may be traumatised, exhausted or who may simply require spiritual support ought, reasonably, to expect that their employers will provide them with the care they need.

The provision of spiritual care cannot, however, be completely divorced from the provision of religious care. While it is true that many people may wish to have their spiritual needs addressed in a non-religious manner, it is also true that for many people, their spiritual needs can only be properly addressed through the medium of religion. It would be entirely inappropriate for anyone to dictate to another person how his or her spiritual needs ought to be met. It would be

³ *Harrowgate NHS Trust Spiritual Care Policy*, Harrowgate 2004, p1

just as indefensible to suggest that spiritual needs ought always to be met in a non-religious way as it would be to suggest that all spiritual needs ought to be met in a religious way. There is simply no escaping the fact that each year hundreds of thousands of people who are in hospitals, hospices or other residential facilities require religious care in order for their spiritual needs to be met. This care may take the form of receiving a sacrament, being prayed for by someone who has a trusted position within their faith community or listening while scriptures are read. It will also, in many cases, involve wider spiritual care practices such as empathetic listening or spiritual counselling. In times of need and distress, for both patients and their families, it is essential that the correct and most appropriate form of spiritual care is given and this, in many cases, will involve religious care-giving. It is incumbent upon the NHS to ensure that such care is given.

While faith communities will be willing to cooperate with NHS Trusts in delivering such care, it still remains the responsibility of the NHS to see that every patient is properly cared for. Given the large numbers of people who, each year, require spiritual or religious care, NHS chaplains are uniquely able to meet these needs. **Chaplains are trained and qualified as healthcare professionals and they enjoy the confidence of their faith communities; as NHS employees they are also available, as part of a multi-disciplinary team, to provide the cover and care required in hospitals, hospices and other settings.**

Effectiveness

A moment's reflection will suggest that not only are NHS chaplains best equipped and placed to provide spiritual and religious care, but they are also the only practicable means by which adequate spiritual and religious care can be delivered within the NHS. While other members of a multi-disciplinary team may contribute directly or indirectly to spiritual care, it is unrealistic to propose that they can take full responsibility for delivering such care. Time, energy and expertise are required in providing spiritual care. Other members of the healthcare team are likely to be fully employed in delivering their particular area of expertise and while this ought to incorporate spiritual and religious sensitivity, that is not the same as delivering spiritual or

religious care. Spiritual care is not simply an ‘add-on’, any more than nursing care is an ‘add-on’ to medical care or occupational therapy is an ‘add-on’ to psychological services.

In publishing the results of a 2010 survey⁴, the RCN has acknowledged that many patients are ‘*missing out on important spiritual care*’ with only 5% of nurses feeling that they could always meet the spiritual needs of patients. Ninety percent of nurses surveyed believed that ‘*providing spiritual care improves the overall quality of nursing care, and the vast majority (83%) believe spirituality is a fundamental aspect of nursing, even for patients with no religious beliefs*’. **The importance of the chaplain’s role, as part of a multi-disciplinary healthcare team working alongside nurses, could hardly be better illustrated.**

The idea that generic ‘spiritual care-givers’ might be trained and utilised by the NHS is fraught with difficulties. In the first instance, to train and equip such ‘spiritual care-givers’ would require the deployment of new resources. Such resources would not merely require financing, but would also have to cover areas such as training, monitoring and management. It would not be viable simply to transfer chaplaincy resources to a new ‘spiritual-care service’, since spiritual care will not, in and of itself, address the needs of those whose spiritual care must be approached through the medium of religious care. For these people, (and there are hundreds of thousands of them each year), chaplains remain the only realistic means by which the NHS can deliver spiritual care. To put it bluntly, if a patient’s spiritual needs can only be adequately met through religious care, then it is essential that someone qualified, trained and recognised in providing that care from within the individual’s faith community, is at hand to provide the care needed. Christians need Christian spiritual and religious care-givers, Muslims need Muslim care-givers, and so on. A Christian, for example, who requires the comfort and strength gained from receiving Holy Communion cannot have his or her needs addressed by a generic ‘spiritual care-giver’ who may or may not be a Christian and who may or may not believe in God. **Such a care-giver may well be able to deliver spiritual care to a non-religious patient, but he or she will not be able to provide comprehensive spiritual care to a religious person.**

⁴ http://www.rcn.org.uk/newsevents/press_releases/uk/patients_missing_out_on_spiritual_care,_say_nurses

NHS chaplains are qualified, trained and equipped to deliver both spiritual and religious care. This means that a chaplain can provide appropriate spiritual care to a non-religious patient as well as comprehensive spiritual and religious care to a patient from within his or her faith community. As NHS chaplaincy is, rightly, multi-faith in its composition, NHS chaplains are able to provide full spiritual care to all who desire it. This is by far the most efficient and cost-effective way in which the NHS can meet its obligation to provide holistic care to all who require its services.

It may be objected by some, that spiritual care for religious people ought to be the responsibility of their faith communities; their priest, minister, imam or rabbi, for example, ought to visit them in hospital and take care of their needs. While it is true that many local ‘clergy’ will make every effort to continue to provide some pastoral care to members of their congregations who are in hospital, this does not remove from the NHS its obligation to provide appropriate spiritual care. Patients’ friends and families often bring them food, but that does not remove the NHS’s obligation to provide good nutrition for people in hospital. Similarly, no other area of care is off-loaded or even delegated to professional volunteers to deliver. GPs are not asked to continue to see their clients while they are in hospital care, community pharmacists are not contacted to provide drugs and community nurses are not asked to do ward rounds. The reason for this is straightforward: these professionals already have a full workload and simply cannot ‘double-up’. Equally, the responsibility for providing care for a patient in hospital lies with the relevant NHS Trust, not with community-based services. To go further than this and to suggest that other professionals ought to be responsible for providing care on a voluntary basis, would be, rightly, met with gales of derision, and yet, some people suggest that this ought to be the relationship between the NHS and faith communities. Again, it is worth emphasising that most faith communities will do their best to continue to provide some ongoing pastoral care, but this will very seldom come close to meeting the spiritual needs of religious people in hospitals, hospices and other residential facilities.

If the NHS were to attempt to train and employ ‘spiritual care-givers’ and then to enter into a plethora of locally contracted agreements with various faith communities the provision of spiritual care in the NHS would disappear into a maze of administrative chaos with the patient

losing out on spiritual care, the Trust losing out financially and the NHS becoming more rather than less complex administratively.

Human Rights

Article 9 of The European Convention on Human Rights⁵, enshrined in The Human Rights Act (1998), states:

*'Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to **manifest his religion or belief, in worship, teaching, practice and observance** (author's emphasis).*

Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.'

As a signatory to The European Convention on Human Rights and The Universal Declaration of Human Rights the UK government and its agents have obligations to respect, to protect and to promote these rights. Article 2 of The Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms⁶ states:

*' Each State has a prime responsibility and duty to protect, promote and implement all human rights and fundamental freedoms, inter alia, **by adopting such steps as may be necessary to create all conditions necessary in the social, economic, political and other fields, as well as the legal guarantees required to ensure that all persons under its jurisdiction, individually and in***

⁵ Council of Europe, The European Convention on Human Rights, Rome, 4 November 1950

⁶ United Nations, General Assembly resolution 53/144, 8th March 1999

association with others, are able to enjoy all those rights and freedoms in practice (author's emphasis).

Each State shall adopt such legislative, administrative and other steps as may be necessary to ensure that the rights and freedoms referred to in the present Declaration are effectively guaranteed'.

This requires the NHS not only to allow freedom of religious belief and practice, but also to take all reasonable steps to promote such freedoms, enabling patients, clients and staff to express and to practise their beliefs. Of course, these rights have to be set beside other rights such as the rights associated with privacy; freedom to practise one's religious beliefs does not mean that other people can be subjected to an invasion of their privacy or that they can be pressured in any way to participate in the religious practices of others. Nonetheless, the NHS has an obligation to promote rights associated with religious belief and practice.

For many people in hospitals or hospices, religious practice cannot be merely a private affair, conducted in isolation from others in their faith community. In particular, when individuals are unable, because of illness, to practise their beliefs unaided, it is essential that appropriate spiritual and religious help is at hand. There are many religious practices that are core elements of belief that patients may need assistance to perform. Many patients may be too ill to pray or to read their scriptures. They may wish to participate in key rituals associated with their religion; rituals that require the presence and participation of qualified and trained religious 'leaders'. The NHS has an obligation to respect, to protect and to promote such rights.

In order to meet its legal obligations the NHS must ensure that all appropriate and practicable steps are taken to facilitate religious beliefs and practices. This cannot be done by merely stating that patients are permitted to make arrangements for members of their faith communities to visit them and to perform various religious functions. This may, indeed, demonstrate a respect for article 9 of the European Convention but it falls well short of promoting the rights contained in that article.

This is not merely a theoretical point. Huge numbers of patients are treated by the NHS each year and it is instructive to look at some NHS statistics⁷ to underline reasons why the NHS can fulfil its human rights obligations only if it continues to provide chaplaincy services.

In 2009/10, there were 14,537,712 hospital admissions in England. An analysis of the 'Picker Inpatients surveys' between 2007 and 2009⁸, indicates that, on average, 22% of patients identified belief as 'an issue' while in hospital, 17.7% of patients wished to practise their religion, 2.1% reported that their beliefs were not fully respected and 2.9% were not able to practise their religion as they had wished. Using the 2009/10 NHS statistics, this translates into absolute figures of 3,198,297 patients for whom belief was 'an issue', 2,573,175 patients who wished to practise their religion while in hospital, 305,291 patients who reported that their beliefs were not fully respected and 421,594 patients who were not able to practise their religion as they had wished.

This hospital 'population' was served by some five hundred 'whole-time-equivalent' chaplains who made approximately one million patient-visits between them. Given that many patients required more than one visit it is not difficult to see why, out of the two and a half million people who wished to practise their religion while in hospital, well over four hundred thousand were not able to do so. Chaplains also attend to the needs of critically ill patients and neonates who were not surveyed as well as to families and staff. Many serve on ethical committees or manage bereavement or other services. **Given this workload, it is fair to say that the NHS may be precariously close to failing to fulfil its human rights obligations. If chaplaincy services were to be eroded, it may only be a matter of time before a Trust finds itself facing a legal challenge from a patient whose spiritual or religious needs were not met because of inadequate chaplaincy provision.**

⁷ <http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics--hes>

⁸ Clayton, A, *Religious need in the NHS in England: The contribution of Picker Inpatient Surveys*, (unpublished) September 2010

Five hundred whole-time-equivalent chaplains is a tiny number compared with the 140,897 doctors, 417,164 nurses and 44,661 managers employed in a National Health Service workforce that totals almost one and a half million.

In the interests of patient care, efficiency and human rights, the NHS could utilise more rather than fewer chaplains. It is, therefore, to be hoped that government policy will reflect this and that Trusts will do all that they can, even in challenging circumstances, to ensure that the spiritual and religious needs of patients, clients and staff are met through adequately resourced chaplaincy services.

|Does the NHS need chaplains? Clearly, the answer is ‘yes’.

Brendan McCarthy 14th March 2011