A QUESTION OF IDENTITY: WHAT DOES IT MEAN FOR CHAPLAINS TO BECOME HEALTHCARE PROFESSIONALS?

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Abstract: What does it mean to be a healthcare chaplain? The recent introduction of the chaplaincy guidelines has taken chaplains into the heart of the healthcare system and ensured that the National Health Service in Scotland has to think about and perhaps re-think the role of chaplaincy and its place within the system of healthcare delivery within Scotland. This presents a challenge not only to the National Health Service but also to chaplaincy. Chaplains will be called to account for who they are and what they do in a way that they have not previously had to. The question of the professional identity of the chaplain is thus crucial. This paper reflects critically on the identity of chaplaincy as a healthcare discipline and offers some reflective comments on the pros and cons of what it might mean for chaplains to develop an identity as "healthcare professionals."

Key words: chaplaincy, professional identity, professionalism, professionalisation, spiritual care.

These are interesting times for chaplains. The recent introduction of the new chaplaincy guidelines has taken chaplaincy into the heart of the healthcare system and ensured that the National Health Service in Scotland has to think about and perhaps re-think the role of chaplaincy and its place within the system of healthcare delivery within Scotland. This is indeed a significant step forward for chaplaincy in Scotland. However, it has also raised an important discussion as to precisely what chaplaincy is and how it fits into our current evidence based healthcare system. How are chaplains to identify themselves and what evidence base will they be required to draw on if they are to "prove" the continuing significance of their work? In this paper I want to raise some issues and ask some questions about the identity of chaplains and the future of chaplaincy. I do so not in any sense to criticise chaplains or the discipline of chaplaincy. Quite the opposite, chaplaincy is a discipline within which I spent some of my most fulfilling working years and it remains dear to my heart. I believe that chaplaincy offers not only a vital healing conduit which is crucial for the sustenance of a genuinely person-centred health care system, but also a powerful prophetic challenge to the church in terms of the way in which it defines and practices ministry. It is for that reason that I think that hard and perhaps awkward questions need to be asked at this stage of the development of chaplaincy.

The changing status and perception of chaplaincy raises some important issues that chaplains must begin to reflect on if they are to retain both their integrity and the authenticity of their place within a constantly changing and often uncertain healthcare system. The points presented below are intended to stimulate debate and to open up what I believe is an important dialogue around the nature and identity of healthcare chaplaincy. In this way I hope my thoughts can play a small part in enabling chaplains to focus in on issues that the new guidelines highlight as important and which in the long run may be crucial to the future of chaplaincy.

What does it mean to be a professional?

It is clear that many healthcare chaplains feel that the direction they should be moving in is towards the development of a professional identity as 'healthcare professionals.' In itself this is not an unworthy goal. If being a professional means that chaplains see the importance of performing their role in a way, which is professional, i.e. informed, knowledgeable and complementary to the other disciplines, then this is something worth striving for. If chaplains are to be taken seriously, it is vital that they are viewed by other professionals as engaging in forms of practice which are relevant, efficient and

credible. In order to achieve this they must be seen to be acting in a manner that is professional in the broader sense of the term. However, if being a professional chaplain means striving to achieve an accredited status that is equivalent to the way that professional status is attributed to other healthcare workers such as doctors and nurses, this raises important questions and potential difficulties.

Professionalism or professionalisation?

What I want to highlight here is the difference between 'professionalism and professionalisation.' It is clear that professionalism is very important. My friend and colleague Alison Elliot suggests that the beginning point of professionalism is "the existence of a system and structure which ensures that chaplains have the resources to do a professional job." It seems clear that the recent guidelines point towards ways in which such a structure could be put in place and sustained within a Scottish healthcare context. Elliot suggests that in order to do a professional job, chaplains require the following:

- *Integrity* – This can be maintained by the provision of some sort of code of conduct such as that which is largely outlined in the chaplaincy guidelines.
- *Autonomy* – The ability to work unsupervised in a way which makes a distinct contribution to the practice of healthcare.
- *Back-up* – Being able to keep up with colleagues in things like giving PowerPoint presentations, efficiency and so forth.
- *Support* – From other chaplains, the church, people who know what chaplains are going through etc.

To Elliot's list we might add one further dimension of professionalism which is:

- *Respect* both for oneself and for the dignity, autonomy and personhood of the other, 'the other' being understood as both patients and fellow healthcare workers.

At this level, becoming a professional is vital for any chaplain and a central dimension of good practice. This would seem to be a wise and worthy goal for chaplaincy.

Professionalisation

However, if becoming a professional means the professionalisation of chaplaincy, that is, developing chaplaincy in line with other healthcare professions such as nursing or medicine, then other questions have to be raised and answered. Before we can decide whether or not this might be a good or a bad thing we need to reflect clearly on what it might mean to become a 'healthcare professional' in this second sense of the term We might describe the five primary components necessary for a discipline to have professional status as:

1. A body of knowledge that supports and underpins their practice.
2. A code of professional ethics.
3. An occupational organisation controlling the profession.
4. Substantial intellectual and practical training.
5. Provision of a specialised skill or service.

Let us take each of these dimensions in turn.

1. A body of knowledge which support and underpins their practice.

The Cambridge dictionary defines a professional as *a person who has the type of job that needs a high level of education and training, e.g. health professionals. This education provides the professional with the necessary body of literature that underpins and sustains its practices* (Cambridge online). At first glance one might think that chaplains clearly meet this criteria. Full time chaplains are normally ordained ministers who are educated to the level of university education and sometimes to postgraduate level. However, a deeper reflection reveals a potential problem. Historically chaplains have been ordained Christian ministers who do specific training within the field of Christian theology in order to attain their status as ordained ministers of word and sacrament. This being so, the body of literature which has traditionally underpinned their practice has been the Christian biblical and theological tradition. However, it appears that some chaplains do not want to have their practical and theoretical resources limited to Christian scripture and tradition (Barcley 2003). Rather they want to be seen in more generic terms as 'spiritual carers,' who are able to cater for the spiritual needs of *all* people of all faiths and none. Becoming a spiritual carer in this sense is not in itself problematic insofar as chaplains within a secular healthcare context are called to care for all

whom they encounter and not simply those with an expressed religious commitment. Current research would support the suggestion that all human beings have spiritual needs if spirituality is defined in broad terms which include but are not necessarily defined by religion (Newberg and Aquili 2202) (Hay 1994). Some manifest these needs through religious structures, but many express them in varied ways which do not include religion or even a concept of a deity. If this is so, becoming a 'spiritual carer' in this generic sense is an important dimension of the chaplain's role; spiritual needs need to be catered for and chaplains are a group of people charged with the responsibility of caring for this dimension of human beings.

However, in distancing themselves from the Christian tradition as its primary body of *professional* knowledge, it becomes unclear what body of knowledge actually underpins the practice of chaplaincy. Is it psychology, counselling, psychotherapy? If so what is it that makes the difference between a counsellor trained in these disciplines with an interest in spirituality and a professional chaplain? Could we not just get rid of chaplains and employ spiritually oriented counsellors at less cost? These, I suspect are the types of questions that, in the long term, managers and accountants may well begin to ask. Chaplains will more and more be called to offer an account of what it is that makes them unique and indispensable? Do chaplains have answers to such questions that can justify their existence and status as healthcare professionals?

Now it might be argued that chaplains use their training and experience in the Christian tradition and indeed their personal faith position as a crucial beginning point for the spiritual caring that they deliver. It is their motivation as Christian ministers which moves them to provide spiritual care to *all* people. If this is so, then chaplains need to articulate much more clearly what this actually means in terms of identity and practice and explain the implications and *professional* relevance of such an approach within a secular healthcare system. Chaplains, as a body, need to be clear where they stand on this foundational issue.

2. A code of professional ethics; 3. an occupational organisation controlling the profession; 4. Substantial intellectual and practical training

Let me take these three points together. These three dimensions of the professional role appear to be relatively uncontroversial, at least in principle. Chaplaincy is a discipline which is deeply implicated in issues of value and meaning. Its daily encounters with people on an intimate and deeply trusted level combined with the primary task of caring for the person's spirituality, a dimension of experience which is inherently caught up in systems of meaning and belief, means that ethics and moral principle provide some of the implicit grammar of chaplaincy. A code of ethics would enable the development of ethical standards and assumptions that would provide important guidance for chaplains as they wrestle within the complex ethical environment of the healthcare system. Such a code of ethics is vital not only to enable chaplains to practice ethically, but also to ensure that patients are protected from potential abuse or malpractice.

Similarly having a unified occupational professional body which oversees the profession is a vital dimension in terms of setting boundaries, establishing professional qualifications and training, dealing with disciplinary issues, setting standards and so forth. However, even here some critical thinking may be required. Take for example the issue of training and dedicated chaplaincy qualifications. All of the healthcare professions, medicine, nursing, social work, occupational therapy etc, have specific courses with particular qualifications which it is necessary to acquire before a person can practice within any given area. For chaplains to become healthcare professionals in the way that the other healthcare disciplines understand this term, a similar dedicated training qualification will have to be developed. Presumably, if it were to hold any credibility, the chaplaincy qualification, the nature of which would be decided by the organising body, would have to be at a similar level to that of other healthcare professions.

All of this is fine, but it raises two important questions. Firstly, will everybody have to do this qualification? For example, will a chaplain who has been in post for a substantial length of time be forced to do this qualification if he or she is to continue prac-

tising? This would of course be the case with the training qualifications attached to the other healthcare professionals. Alternatively, would such a qualification only be compulsory for those coming in fresh to chaplaincy? If so, would there be real credibility in running a two tier chaplaincy training system wherein some are trained professionals and others are not, the newest chaplains being healthcare professionals, in the narrow/technical sense, and the more experienced not? Also, if such training was to become a significant dimension of being a healthcare chaplain, and if it is ultimately made compulsory by whatever means of delivery, are we happy to live with the fact that some people, for a number of reasons, may find themselves unable to gain the qualification and therefore not considered fit to practice? Have we reflected on the pastoral implications of such a situation? These are not simply questions for chaplaincy educators to reflect on, they are questions which any organising body with responsibility for certification *must* think about very carefully. I would suggest that issues such as this need to be thought about now rather than catching chaplains off guard in the future when the issue may raise itself in a much more intense and negative form.

5. Provision of a specialised skill or service

Healthcare professionals are called upon to provide a specialised skill or service. But what is that skill or service? Chaplains claim to be experts in spiritual care. It is this claim that provides them with the right to claim to have a specialised skill and to provide a unique service within a healthcare context. In a questionnaire prepared for a recent conference on chaplaincy in Crieff, Rev. Iain Barclay (2003) asked chaplains what they thought were the main skills that chaplains had to offer to people in terms of spiritual care. The main skills highlighted by chaplains were:

- Being with the patient
- Showing empathy
- Listening
- Treating them as whole people
- Loitering with intent/Hanging out

Each of these highlighted points is of course vital for holistic, genuinely person-centred care. However, one is still left with the question of what it is that makes these skills 'specialised?' With the exception of loitering with intent, could not any of the caring professions claim these as central to their practice and professional identity? In the same study chaplains described their role as relating to the provision of "a professional expert resource?" If chaplains are not really adding anything new then why would they be seen as "a professional expert resource?" If I were a nurse with twenty years experience, why would I need a chaplain to teach me these things? Now it may of course be that the sample on which this study was based was skewed or unrepresentative. Alternatively, it could be that chaplains need to seriously reflect on the precise nature of the specialised skills they have to offer and the uniqueness of the service they seek to provide. In an evidence-based healthcare culture such reflection may become crucial for long-term survival.

Evidence based chaplaincy

In a healthcare system which has a tendency to favour technical solutions over and against the significance of persons, chaplains have the potential to fulfil a crucial role in reminding all of the disciplines of hidden dimensions of care which are crucial for holistic healing. And yet, as I have suggested what spiritual care actually means is not at all clear. Combine this lack of clarity with the difficulty of having to *prove* the worth of chaplaincy to management and accountants and we have another tricky problem. I recently attended a conference on spirituality and healthcare at Harvard University in Boston. It was fascinating to see where the Americans were on the issues I am trying to highlight. Spirituality is in some ways more embedded within certain dimensions of their healthcare system than our own. However, that brings with it its own difficulties. One chaplain gave an interesting example that will help to illustrate the difficulty. In outlining the specific competencies that make a professional healthcare chaplain he took great pains to point out that "no one should pray with patients except chaplains. You see, prayer is a professional competency for chaplains…a mark of our identity." Now we have to ask ourselves if this is a paradigm of the direction we want to go as we try to establish the meaning of 'professional' within chaplaincy. Do we simply want to try and squeeze the uniqueness of chaplaincy into a mould in which it simply will not fit? How will we gauge the measure of our practice? Do we want spiritual disciplines to become competences that are judged in the same way as giving an injection or drawing blood? How do we gauge our

worth within an evidence based culture that demands forms of evidence which simply may not be available to or appropriate for chaplains?

Buckets and waterfalls

Let me try and illustrate the difficulties in assessing and understanding the meaning of spiritual care within a healthcare context that has a radically different way of looking at the world. I will borrow an analogy used by Marc Cobb at a recent meeting on spiritual care in Edinburgh. Imagine yourself walking through a deep, dense wood. You are surrounded by beautiful, luscious foliage; the constantly changing aromas of the rich shrubbery makes your head swirl. Suddenly you reach a clearing. Right in the centre of the clearing is a beautiful stream headed up by a magnificent waterfall. You stand and watch in awe at the mystery and wonder of the waterfall. Multiple rainbows dance across the glistening surface of the water. The sound of the water, the taste of the spray the sight of the magnificence and power of the waterfall touches you in inexpressible places and brings you into contact with a dimension of experience which you can't quite articulate, but which you feel deeply and meaningfully. Eventually, your gaze of wonder begins to change as your curious side clicks into action: "What is this thing called a waterfall?" What is it made of?" "Why does it have such an effect on me?" So, you pick up a bucket and scoop up some of the water from the falls. You look into the bucket, but something has changed. The water is of course technically the same substance in each setting: H2O. It remains a vital constituent in your life; you need it to live and without it you will perish. Yet, something has been lost in the movement from waterfall to bucket. In your attempts to break it down, analyse and explain what it really is, the mystery and awe of the waterfall has been left behind. Which is more real? The mystery of the crashing waterfall or the still waters of the bucket?

I think this word picture reveals an important dimension which sits at the heart of the current debate over the role of the chaplain within a professional, evidence based, scientifically driven healthcare system. On the one hand, chaplains are called to be spiritual healers and carers. They are called to mediate and care for a person's spirituality: that dimension of humanness which is unquantifiable, mysterious, individual and unique. On the other hand, they are called to justify their existence within a healthcare context which places great emphasis on that which is quantifiable, generalizable and universally applicable. The distinction between the waterfall and the still waters of the bucket symbolises the difficulties that chaplains are faced with when they begin to consider their role the healthcare system. In terms of professional development and chaplain's long-term role within the healthcare system this tension requires to be reflected on sensitively and thoughtfully in order that the uniqueness of chaplaincy can be fully recognised and effectively and meaningfully worked out.

Square pegs in round holes

The truth is that in significant ways chaplaincy does not fit within the standard model of the health professional…and that is a very good thing! Chaplaincy is a unique discipline with a unique role within the healthcare system and it has to establish itself on its own terms. Chaplaincy is a prophetic discipline which challenges many things within the healthcare system and forces it to begin the process of lateral thinking. One of its challenges may be to begin to redefine the meaning of 'health professional' and expand the boundaries of precisely what evidence base should underpin the practice of chaplains. In a system which is inherently death denying chaplaincy calls us to notice that death and illness may have meaning beyond the understandable but ultimately unrealistic desire to avoid both. Chaplains are called to enable the system to redefine health and healing in ways which will enable it to realise that illness has meaning beyond the technical language of pathology and that healing and health relate as much to the restoration of that meaning as they do to the elimination of suffering and pain, a goal which in reality will never be achieved. Chaplaincy is the critical voice that makes holism possible.

Intuitive based chaplaincy

In a context which demands empirical evidence based on the methodologies of science and empiricism, chaplaincy is called to reclaim the significance of such "hidden" dimensions of the healing process as they are revealed in such things as narrative and intuition. Most of what chaplains do relates to the listening to and the telling of stories. Stories reveal a form of knowledge that is not only grasped with the mind but also with the heart. Stories demand interpretation, intuition, imagination, all gifts which are

fundamental to chaplaincy when people are practicing well. As in their day to day encounters with human pain, suffering and joy, chaplains struggle to understand the human spirit and to translate that into understandable forms of spiritual practice which can enhance the healing process within the structure of the National Health Service, they are called to reclaim the significance of intuition and empathetic imagination as a legitimate dimensions of professional practice; intuition which reaches into the depths of the experience of suffering people not to *explain* their illness, but to try passionately to *understand* the meaning of what people are going through and to draw on the spiritual traditions to enable forms of deep healing which include but are not defined by particular religions. Such a practice of intuitive, narrative based chaplaincy when it is embodied and worked out may offer a beginning point for the establishment of an identity of chaplaincy that retains its integrity without losing its relevance (Greenhalgh 1999). But, chaplains need to be sure and confident of who they are and how they fit in before they can effectively challenge anything.

Catalytic chaplaincy

Chaplaincy is a catalyst which has the potential to transform the way in which we do healthcare within Scotland and beyond. This is an important point. A catalyst changes things not so much by what it *does* as by what it *is*. A catalyst only changes things by being itself. If a catalyst becomes something other than itself it cannot function and there can be no change. That is why the questions surrounding the professional identity of chaplains that I have tried to highlight in this paper are of such importance. Chaplains can transform healthcare practices only if they are certain of who they are and are confident enough to act accordingly. If chaplains are unsure about who and what they are, or unclear about the uniqueness and specific value that they bring to healthcare practices in Scotland, nothing will change and they may well find themselves swallowed up by cheaper alternatives.

Conclusion

My intention within this paper has been to try and raise some critical issues for chaplains as they seek to establish their enduring identity amongst the various healthcare professions. A vital dimension of this process is the necessity for chaplains to be very clear and confident about their identity. Chaplains need to think clearly about what it is that gives them the right to claim a unique place within the healthcare system and to work through the critical tension between professionalism and professionalisation. Chaplaincy holds great relevance for the practice of contemporary health care. As I have tried to point out, it deals with a dimension which is vital for holistic healing, but highly problematic to "prove" in the way that the other healthcare disciplines seek to prove the worth of their practises. However, this relevance could quickly dissipate if chaplains, in their quest for credibility and a professional status simply copy from the other professions and don't reflect on the uniqueness of their own discipline and its relationship to other healthcare professionals. Reductionism is alive and well within the healthcare system and it would be all too easy simply to reduce chaplaincy to within the boundaries of the "acceptable," "credible" disciplines such as psychology or counselling and forget about the uniqueness of the human spirit and the chaplains firm calling to offer care of the spirit. The suggestion that chaplains are catalysts for transformative healthcare practices is crucial. To lose that dimension of the chaplaincy role is to risk losing a vital dimension of the process of healing from the National Health Service in Scotland. I hope that as people pick up on, reject and develop the questions and suggestions that I have made that we can begin to open a dialogue that will take seriously an issue which has vital implications for chaplaincy now and in the future. The stakes are too high for us not to take the time now to reflect on the future.

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References

CAMBRIDGE ONLINE *Cambridge online dictionaries*: http://dictionary.cambridge.org/

BARCLAY I. 2003 *Shaping Chaplaincy*. Chaplaincy for Tomorrow Conference March 2003. Church of Scotland, National Mission, Edinburgh.

NEWBERG A., AQUILI E. 2002 *Why God Won't Go Away: Brain Science and the Biology of Belief*. Ballantine Books, USA.

HAY D. 1994 *The Biology of God: What is the current status of Hardy's hypothesis?*, International Journal of the Psychology of Religion 4(1) 1-23.
GREENHALGH T. 1999 *Narrative based medicine in an evidence based world*. BMJ 318: 323 – 325.

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