Record of the Churches and Chaplaincy
Conference held at Scottish Churches
House, Dunblane on 22 January 2008

The Rev Mary Buchanan, Convener of ACTS welcomed all present to the conference and invited all (listed below) to introduce themselves.

Rev Chris Levison – NHS Education Training and Development Officer and Spiritual Care Coordinator
Rev Dorothy Anderson – Ministries Council, Church of Scotland
Rev Iain Telfer – Ministries Council, Church of Scotland and Chaplain, NHS Lothian
Ms Jacqui du Rocher, Roman Catholic Chaplain, Royal Infirmary of Edinburgh
Rev Andrew Graham – Chaplain, Golden Jubilee National Hospital,
Dr Ewen Harley – United Reformed Church
Mr Bill Reid – Methodist Church,
Right Rev Vincent Logan – Roman Catholic Bishop of Dunkeld,
Rev Gillian Munro – Director of Spiritual Care NHS Tayside,
Rev Rona Phillips, United Reformed Church
Rev John Humphreys – United Reformed Church
Very Rev Aldo Canon Angelosanto – Roman Catholic Chaplain NHS Tayside,
Rev Fred Coutts – Head of Spiritual Care NHS Grampian,
Rev Margery Collin – Head of Spiritual Care NHS Forth Valley
Rev Andrew McMillan – Scottish Churches Committee on Healthcare Chaplaincy
Most Rev Dr Idris Jones – Primus of the Scottish Episcopal Church
Mr Hector Mackenzie – Scottish Government, Head of Patient Focus and International Issues
Rev Dr Ian MacRitchie Head of Spiritual Care NHS Highland,
Rev Carol Campbell – Baptist Union of Scotland & Chaplain, Royal Hospital for Sick Children Glasgow
Rev Blair Robertson – Head of Spiritual Care NHS Greater Glasgow and Clyde
Dr Geoff Lachlan, Fair For All, Religion & Belief Project
Rev Bob Devenny – Head of Spiritual Care NHS Lanarkshire
Rev John McMahon – Lead Chaplain, NHS Lothian
Mrs Pamala McDougall – Religious Society of Friends (Quakers)
Sr Rosemary Bayne, Chaplain (Roman Catholic & Generic) NHS Lothian
Mr John Thomson – Ministries Council, Church of Scotland.

2 OPENING WORSHIP

Rev Mary Buchanan led the conference in the opening worship.

3 SCOTTISH GOVERNMENT – DEPARTMENT OF HEALTH AND WELL BEING AND SPIRITUAL CARE

Mr Hector Mackenzie, Head of Patient Focus and International Issues in the Scottish Government, in his introductory remarks, recalled that the attendance of the then Health Minister, Susan Deacon, at a Chaplains’ Conference in May 2000 was the catalyst for change in NHS Scotland’s approach to spiritual care and led to a request
for support and guidance from the then Scottish Executive to the Christian Faith Communities and “a New Partnership.”

It was clear that even with the best NHS care the outcome of some clinical conditions could challenge the fundamental beliefs of patients, their carers and the staff who cared for them. It was clear that the NHS had to better support both the people it served and its staff at these critical times. There was guidance available but it was out of date. Following an initial meeting in February 2001 (to which representatives of all Faith Communities were invited to attend) a group was set up, new guidance prepared, and presented to the NHS Scotland Spirituality and Health and Community Care Conference of November 2001. Out of all of this the HDL was issued in October 2002.

All NHS Boards now have spiritual care policies and all full time chaplains are now employed within local Departments of Spiritual Care. A national Chaplaincy Training and Development Unit has been established in NHS education and the NHS Scotland is now advised by a multi-faith Spiritual Care Development Committee. Substantial progress has occurred and first steps made towards chaplaincy being recognised as a health care profession and a career structure and support systems developed.

The introduction of the Data Protection Act, and particularly its interpretation, has brought problems primarily due to the fact that chaplaincy is excluded from the health care team. NHS Scotland challenged this interpretation given that all full time chaplains are now NHS employees subject to the same duties if confidentiality etc as other members of the clinical team. As a UK Act the Data Protection Act cannot be amended by the Scottish Parliament and there seems little prospect if early amendment by the Westminster Parliament.

The HDL is currently being revised and amongst the issues being considered by the Spiritual Care Development Committee are generic chaplaincy, denominational chaplaincy and the place of religious care within the NHS’s wider spiritual care approach.

Many patients nowadays do not profess a faith on admission but later in their stay in hospital, many do. The benefits of spiritual care, including religious care, are available to all and chaplains support the clinical team, helping patients on their journey.

The NHS wants to continue partnership working and continues to look at the issues.

By the end of 2006 all full-time chaplains were in the employment of the NHS. There is now a requirement to consider career structure and support systems.

The NHS wants to continue its partnership working with Scotland’s faith communities while it addresses these issues. The revision of the HDL is an important component of this search to better achieve the aims of providing support to both patients and staff.
Conference acknowledged the resources provided by the Scottish Government to develop spiritual care and chaplaincy, for example the appointment of Chris Levison as Spiritual Care Co-ordinator and Training and Development Officer and the formation of the Spiritual Care Unit. Without the additional funding provided, development would have been much less than it has been. Conference then discussed “part-time and denominational chaplaincy – the future”. Conference accepted that the Data Protection Act is unlikely to be amended quickly but expressed hope that chaplains can be accepted in future as members of the health care team. Conference noted that there remained an important role for part-time chaplains and that work was in progress to allow them to become NHS employees too.

Encouragement was given to those chaplains who wish to be employed by the NHS. It was recognised that they remained the most effective conduit for provision of religious care.

Reference was made the recently published "Multi Faith Resource for Health Care Staff".

There also remained a legitimate task to improve and develop the links between generic or spiritual care chaplaincy and the individual care provided by denominational chaplains.

4 WHAT IS A GENERIC CHAPLAINCY?

Rev Fred Coutts, Head of Spiritual Care NHS Grampian, gave a power point presentation which is summarised in the attached pages of printed slides.

5 WHAT IS A DENOMINATIONAL CHAPLAIN?

The Very Rev Canon Aldo Angelosanto, Roman Catholic Chaplain NHS Tayside began by posing the question – was the denominational description a misnomer?

For him any issues relating to payment of salary and professionalism had been resolved. He was currently working part-time in Ninewells Hospital, Dundee and patients are his main focus. He was present for not only Roman Catholic patients but for all.

He has a duty to meet the sacramental needs of Roman Catholic patients which provide comfort and strength to them.

He observed that illness can isolate and immobilise people.

He believed that religious care and spiritual care are co-centric.

Personally he had experienced rejection on only 3 occasions in 5½ years.
He makes a priority of getting to know the staff. He receives regular out of hours calls. Demand for the priest is common. He is on call 24/7.

He saw the hospital as a microcosm of society and considered it his duty to facilitate the religious needs of non Roman Catholic patients.

He reminded conference that only a priest is authorised by the church to offer the sacraments of the sick and confession. Communion however can be administered by a Eucharistic minister.

He uses the hospital chapel regularly for weekly Sunday services.

To him spirituality transcended the every day. He brings the Christian faith to many.

The Data Protection Act has brought huge problems. Priests are no longer given details of patients on admission. He wondered if the administration process was not working effectively? He would welcome more patient information being made available.

He experienced great joy and satisfaction at being able to work at the “coal-face”.

Nevertheless, for a Roman Catholic priest his first loyalty remained with his church.

6 AN EPISCOPAL (IAN) VIEW

Most Rev Dr Idris Jones, Primus of the Scottish Episcopal Church gave the following presentation:

I think it is only fair to give you a bit of my background before I speak about the Episcopal view - some clarification by the way - I can certainly give an Episcopal view as a bishop, but I suspect it is more the Episcopalian view that is required here. The two are not completely unconnected!

Early in my ministry I felt drawn to hospital chaplaincy. First of all as a Chaplain in a District General hospital ; then As half-time chaplain employed by the NHS in the main Teaching Psychiatric Hospital in Newcastle upon Tyne for five years during which time I was responsible for setting up a Chaplaincy Team, negotiating accommodation and worship space for the chaplaincy and introducing the idea that for many of the long stay patients it was the other patients in the Ward who represented their family and also should have the opportunity to be present at funerals when they occurred.

In addition to this formal, paid, Chaplaincy I have had over the years the experience of acting as Chaplain to Primary Schools (an absolute delight) and secondary schools (not a bundle of joy). These were in varied locations both urban and rural. Finally, I served as a member of the Chaplaincy Team at Dundee University which was an
ecumenical team in which the Chaplains shared completely in the work and also in each others liturgy.

Apart from my ministry experience I also worked as a non-medical psychotherapist with two different health boards under the direct management of consultant psychiatrists to whom I was answerable.

As Chaplain in Newcastle my line manager was the Sector Administrator as they were called in those days and above him the Senior Administrator with frequent liaison with the male Matron - who was called by a number I seem to remember. Now I think that this was a significant experience especially in terms of the development we now see taking place in Spiritual care. It did me no harm at all to be answerable as a professional within a professional structure to someone who was not just a non-cleric, but actually a non-Christian either. It did not impede my work or leave me feeling unsupported or mis-understood.

Part of my involvement came about I should say because of a parish system in England where whoever happened to be Parish Minister got the job. I realised that my training incumbent really preferred not to have to have anything to do with the hospital and I have, since I became bishop, never expected anyone to act as chaplain unless they felt they had a genuine call to do so. Chaplaincy carried out reluctantly or plain badly is better ended and left alone.

I wanted to give you this context of my ministry not in any sense to claim any particular expertise - I never actually did Clinical Pastoral Education in the UK though I did study some modules in the United States where I worked for three months as full time chaplain in an Episcopalian Hospital.

So I am not an expert, but do have some experience and I would have to say that in the middle of presentations about what in the Anglican world are being called Fresh Expressions; more familiar to us in Scotland as Church without Walls; one fact seems to have been overlooked - that Chaplaincy - Industrial, Educational, Health, Retail, Prison whatever has been doing it for years.

Now an Episcopalian view: in Scotland there is a widely differing distribution of membership according to region. The reasons for this are historical and need not concern us - but the fact is that whereas broadly speaking in the South West Episcopalians account for perhaps 1.5% of the population in the area around Aberdeen and further North it can be up to 5% at least. So when it comes to trying to visit members of congregations who may be in hospital, the task is a different one depending on which region you happen to be located for in ministry in the SEC.

For many years we have laboured with a number of difficulties that come from being a minority. First of all when someone is being clerked, if they are ever asked about "religion" not a lot of folk have either the patience (with a "c") or the knowledge to have a clue about Episcopalian. Are you Catholic is the usual follow up - if not, then by definition you must be the other lot. Now it is possible for an Episcopalian according to their back ground to describe themselves with total accuracy as a Protestant Catholic - or as a Catholic Protestant. Our tradition is precisely about living
and worshipping with elements of both and finding it a fruitful experience. But try that on in a busy hospital ward. Our identity is not recognised on the whole. In any case one ought to say if asked what religion - “Christian” - but that often merits the question “Are you trying to be funny?” Still it is an irritation under which we labour.

Another difficulty (and it may well be our responsibility) is that because of this mixed background the Sacramental nature of our ministry is overlooked. Episcopalians may request access to a Priest for Sacramental Confession (which only a Priest can do in our tradition). They might also seek the ministry of laying on of hands, or anointing with Chrism - again usually but not exclusively a ministry of the ordained. And they might also wish to receive communion either from a Priest or from a Eucharistic minister. Any non ordained person sharing in these ministries will have received authorisation from myself as Bishop and will have received some training and been through a process of selection prior to receiving authorisation. So when there is special pleading on the grounds of recognising the expectation of sacramental ministry this should include provision for Episcopalians who desire it.

Referral is for us, as for everyone else an area in which difficulties can lie and I see that Chris Levison is going to say something about this later.

Respect of the individual is a priority, that is clear, and so however frustrating it can be, I think we have to accept that if someone requires to be visited by a denominational chaplain they have to make that clear - and we have to tell our congregations that this is what they must do. Then we rely on the integrity of nursing staff to make the request - but since chaplains are part of the whole team this should not be impossible to achieve. It is also a matter of record that sometimes members of our congregations actively do not wish to be visited and in any case the changing nature of hospital care means that whilst a chaplain can be available a visiting cleric may not get into to visit until the patient has actually been discharged.

It is up to the family I would maintain to keep the minister informed where possible. The situation is different in different cultures - in the Mid West USA for example a Pastoral Care department would regularly received a commendation for a member of a particular congregation - whilst on being clerked a patient would respond not just with denomination but the church they attended - and would be asked Would you like your pastor to visit? Not a lot of folk in today’s Scotland could identify a congregation to which they belonged I suspect.

I am aware of some exciting and truly Christian stories coming out of the developing world of Health Care Chaplaincies - I know that it is not all sweetness and light particularly where there is a community base to the care being given - but examples of what can be achieved by the Q.E. in Birmingham for example with a team of lay chaplains drawn from all the churches and able to give total cover to the hospital and on the whole finding a welcome from the patients to whom they are available for spiritual care ranging from a short chat, to a chapel visit, to receiving communion or whatever is asked for.
I could go on because there are so many fascinating areas to be explored- but I have said enough I think

Just to summarise. I don't see any problem at all in a priest in my tradition being answerable through line-management to a manager in the Trust.

Not all priests make good chaplains

Training and authorisation are very important indeed.
We cannot expect that people know what we are about, what we can offer or what the different faiths / denominations expect. The task lies with us to find a way to give that information and actually alongside their general training to beware of stereotyping people with labels. If it is unacceptable to speak any longer about “the stomach in bed 3” then it is also unacceptable to speak about the “religious nut” or to assume anyone can be fitted into a pigeon-hole of faith.

7 GROUP DISCUSSIONS (1)

The conference was dispersed into smaller discussion groups to consider the issues raised by the four speakers.

8 ACCOUNTABILITY (TO THE NHS, CHURCH, DEPARTMENT HEADS, LINE MANGERS, PATIENTS) AND DATA PROTECTION

Rev Chris Levison, NHS Education Training and Development Officer and Spiritual Care Co-ordinator gave the following presentation:

One interesting development has been the European Network of Healthcare Chaplains.
Last consultation 24 countries, realisation that there are 24 different ways in which Chaplaincy is organised.
East Europeans sent by church delighted that they are able to be open as Christian priests, ministers and pastors. West Europeans are often trying to be available for all and developing research and language which is far from traditionally religious. Some places the churches are supported through general taxation, others totally voluntary. Some places chaplaincy is generically blessed by all churches e.g. Netherlands, other places it is uni-denominational like Italy. In some countries chaplains are clergy and spend just a little of their week in a hospital, in others they are often whole time and are part of the health service. In England and Southern Ireland chaplains have been employees of the health service for a number of years but authorized by their church authorities. In some countries there is little or no training for chaplains, in others like Germany, unless you have done Clinical Pastoral Education you are not allowed onto the wards. Some countries like France have separate catholic and protestant chaplaincy services; in others like Finland the service is ecumenical.
To whom are chaplains accountable? And to whom should they be? Is not a simple question to answer.

In Scotland there is a shift of emphasis taking place to which there have been differing reactions.

The concept of chaplaincy has been around for a long time. The word chaplain comes from “caplan” the word for a cloak. The traditional story tells of St Martin of Tours who, when confronted by a beggar in wintertime, tore his cloak, his caplan, in two giving one half to the beggar and keeping the other half. This is sometimes used as a good picture of empathy rather than just sympathy, whereby the giver is not totally self sacrificing but maintains the ability to help and to care. Churches and religious orders began hospitals to care for pilgrims and travellers. The patient pathway of the modern era rings many bells. After the start of the NHS there were a number of chaplains, churchmen who worked in hospitals. Churches appointed part time denominational chaplains to look after their people in hospital. Many of these chaplains did a superb job, exercising great individual gifts and leadership and many represented their church or denomination in the best of ways.

As churchgoing has declined, and as the multi faith nature of society has grown to become more recognised, there has been a recognition that spiritual care remains an important part of care for the whole person. Chaplains found that they were spending a lot of time with people who had lost that close church allegiance and experience. Spiritual care came to represent or include aspects which were not particularly or necessarily those of a religion. The need to search for meaning, the need to be affirmed, to be creative, to be listened to. An increasing evidence base began to show that not only was religion generally good for your health and well being but a sense of value, of meaning, of self awareness and spiritual care also helped enormously in the whole healing process. Staff could be and already were part of this care. In short spiritual care is coming to be seen as a responsibility of every healthcare professional and not only those who are clergy. Some public health experts have suggested that care for the human spirit, the search for meaning and significance is one of the most important areas needing to be faced in a population where depression is coming to be the major health challenge facing our society.

The guidance which was produced in Scotland on spiritual and religious care, which after consultation became an official health department document has been one of the most significant of its type. It follows much of the recent thinking of the WHO which acknowledges that spiritual need is part of a persons health need. All people have a right to spiritual care if they wish it, all staff are part of this team, chaplains are the specialist spiritual care providers, staff need to be valued and cared for if they are expected to provide this quality of care for others.

The health service now understands the necessity of providing this kind of care quite explicitly if it is to maintain the integrity of this understanding. So, how does it do this? By buying in the expertise of the churches and saying “over to you” or by taking a greater level of responsibility and asking for partnership and relationship with faith communities and belief groups as it seeks to develop this programme.
The health service, through its spiritual care committees, and through the employment of more chaplains, through its reliance on general taxation and through a requirement to be non discriminatory, is developing an equality and diversity approach. Each person has an equal right to having their total health needs met and these include spiritual and religious; but as people have different needs it has to be an approach which is appropriate to the differing needs which people exhibit.

Who should employ chaplains, who is responsible for their training, to whom is a chaplain accountable? There has been variety and no standard method in the past. Some, a few, employed chaplains directly, (Highland, Borders) some have been employed through the Church of Scotland (C of S) Board of National Mission but almost entirely funded by the NHS. Some have been appointed by their bishop alongside parish responsibilities, some by the local presbytery. The standard of the service has varied and much has depended on the skill and theological understanding of the individual and the direction of the denomination or church.

One chaplain who will remain nameless used to object regularly to his management. He had allegiance to a bishop, was appointed by a board of the C of S, was expected to write an annual report to a presbytery of the C of S, was accountable for day to day work to his lead chaplain and also to a line manager who was not a chaplain. For life and doctrine he was under the discipline of bishop and diocese.

Since the advent of spiritual care policies in each health board and the development of spiritual care committees, it is clear that the NHS Boards have become places where responsibility lies. They are not authorities in ecclesiastical matters or even on comparative religion, but they are representatives, and they have a clear responsibility to serve the spiritual and religious needs of the patients and the staff.

The boards and their committees have clear responsibilities and they also require to listen and learn from the faith communities with whom they deal. They have to provide a service which to the best of their ability looks after the needs of all. It is important that access is given for those who wish it, by the representatives of the faith community of their choice. It is also important that those who do not have a living connection with a faith community, have an equal access to the care which is appropriate for them at the time. Many people who have ceased to have an active relationship with a faith community or congregation, when faced with serious illness, find strength comfort and support from someone who can recognise and respond appropriately to a faith or beliefs which have never been articulated or openly expressed.

I’m going to look at the question of accountability under the headings I began with.

To the church. Chaplains are expected to be in good standing with their faith community or belief group. This means different things in different contexts. If a chaplain is a minister, priest, lay person, pastor or leader of a group, then he/she is expected to retain that status and remain in good standing. I am expected to attend
presbytery, maintain a lifestyle which is in accordance with church teaching, and not act or espouse doctrines or ideas which would be offensive to those of my faith community.
My church however does not know a lot about chaplaincy which is ecumenical, generic, and facilitates the spiritual care of people from widely differing contexts. Nor does the church know about the structure of the NHS, the Knowledge and Skills framework, the PFPI and Equality committees, the evidence base and training needs of chaplains or spiritual care facilitators.

“In good standing” is a non technical relationship. This is because different faith communities have differing ways of “authorising” or accrediting their leaders. If a chaplain fell foul of his or her faith authorities – in a way which did not automatically render them inappropriate as a chaplain. This would be a difficult decision for an employing health board.

To the NHS. The NHS has policies in place in order to protect the public and have a good standard of service. Chaplains are responsible for maintaining such policies. In addition there are employment policies, professional continuous training needs and many other protocols in a secular service which are there in order to provide a service which is equitable for all and of the highest quality possible. Health professionals have competencies and standards and particular skills. It is necessary that all members of a health care team have such aspects to their work so that they will be understood and well utilised by colleagues. If spiritual care is an integral part of health care, a health service without this would be seriously incapacitated. The NHS therefore has both a responsibility and a right to hold those within its practice to account. The Board and its executives are ultimately responsible to the health department and the government for the service and so rightly the employees are accountable to the board and its chief executive.

To Department Heads. Chaplaincy has been excessively individualistic in the past. It has varied from place to place and chaplain to chaplain. The level of training, the competence of care, the content of teaching about spiritual care has varied too much. Staff have not known what service is provided because different people in one establishment have provided a different service. The establishment of departments with dept heads enables the chaplains from different backgrounds, to work as a team and to provide a service which has a logic and a consistency. It enables a level of training to be established, team meetings and the opportunity to use people’s strengths and complimentary skills in order to enhance the whole service. Some denominations are less used to having a management structure. A structure can be very inclusive and does not need inherently to become authoritative. Team members are accountable to a department head. This benefits the service, encourages people to work together and enhances the understanding of the service without making everyone work in exactly the same way.

To a line manager. The HDL said that there should be a lead manager for spiritual care in each board. This is the NHS way of doing things. This person does not need to be theological but has a responsibility to ensure that the department of spiritual and
religious care is being properly managed, financed, a supported within the structure of the board and the health service. Line managers are important as they form a strong part of the link with the rest of the service. It is enormously important that such a person is supportive of the spiritual care service. Everyone in the NHS has a line manager.

**To the Team.** Chaplaincy team members are accountable to the rest of the chaplaincy team. They share on call, they, are jointly responsibility for building up the respect and good relationships which enable much spiritual care to take place. They provide back up for each other, they should be exemplars of team working especially if they wish to work alongside other members of the health care team. Chaplains require the support of the team especially when dealing with costly and difficult situations.

**To a Professional Association**
All chaplains are invited to be members of an appropriate professional association. In Scotland there are three such groups: the College of Healthcare Chaplains, (Scottish branch of a UK association – closely linked with the Amicus Trade Union), The Scottish Association of Chaplains in Healthcare, SACH, and the Association of Hospice and Palliative Care Chaplains. These three associations are working quite closely together and have a jointly approved Code of Conduct for chaplains which their members are expected to adhere to. It is increasingly asked by employers that chaplains should belong to one of these organisations as this is a further form of accreditation with a disciplinary code attached. These three associations also share the aspiration that chaplains might some time in the future become members of a registered healthcare profession. To be so registered would be a further type of professional accountability.

**Chaplains are accountable to patients.** The needs of the patient come first, and last and in the middle. Patients have a right to be cared for well and in the best way which is possible and practical. They also have the right to be left alone if that is what they wish. There needs to be some way in which feedback from patients upholds and justifies the work of a chaplain. Unlike a congregation, patients can usually not vote with their feet and not attend. The work of spiritual care can have a profound effect on the person to whom it is directed. This is a huge responsibility. Patients can tell very quickly if a chaplain is really interested in what they are saying. Patients’ opinions will differ, every intervention will not be a success, however there must remain a sensitivity which in general manages to contact and communicate with people. A chaplain is not running in the popularity stakes, but if he or she is disliked or gives reasons for being unwelcome or unacceptable to many people, it is unlikely that they will be successful and helpful in their work. (One person specification for a job advert suggested that the chaplain had to have a pleasing smile – I don’t know how many human rights it broke, but on behalf of the league of people with black and broken front teeth – I object – or maybe I don’t.)

**Chaplains are accountable to God** unless they are non believers, in which case, I think, they are still accountable to God. One of the reasons why ministers and priests
and pastors have not been well supervised in the past is because supervision has seemed secular and if God is your master, who needs a secular supervisor? However clinical or pastoral supervision from a trained person is another kind of accountability. Spiritual direction may be the religious term but chaplains, like others in pastoral situations need to reflect on their practice and be both challenged and supported as they have both their failures and their successes. Being accountable to God does not imply an avoidance of human accountability but rather an acknowledgement that a human face can help us in that more ultimate accountability. The one at its best models the other.

Chaplains, thus have and will continue to have multiple lines of accountability. However the trend is increasingly towards direct employment by the health service as it is towards the chaplain with the right skills, training and experience, rather than a chaplain of a certain denomination because they don’t have one of these. A health board will want also to have their chaplaincy team reflect the religious / spiritual make up of the population being served and so there will be compromises for the sake of the competency of the service. The essential rights are those of the patients and their need to be cared for in a holistic way, rather than those of the faith community. There is no need for there to be any conflict between these two rights as they should be in harmony.

Data Protection

Data Protection and Chaplains in NHS Scotland

What is the Problem? And – is there a solution?

The implementation of the Data Protection Act 1998 has had considerable effect on the work and, in particular, the access for chaplains and faith community visitors to patients. Until recently it was not uncommon for there to be a book at the reception desk of a hospital, which, on enquiry, would be given to any member of the clergy for their perusal and information. That information would then be used to plan a pattern of visitation, either to members of their congregation or to people living in their parish area.

The Act makes it clear that such sensitive information is a private matter for individuals and should only be shared with others with their informed consent. With regard to the NHS it is recognised that it is good practice to have information about a patient in order to care for them and give them the medical treatment they need. Health Professionals are thus exempt from the provisions of the Act and may have access to the information they need without this explicit informed consent. Chaplains, because they are not a registered health care profession, and because they are not, according to the UK Commissioner for Data Protection, “part of the medical team”, are not exempt. So, unless a patient gives their informed consent to it happening, a chaplain has no right to know either that they are in hospital or what, if any, religious faith they may profess nor whether they would wish to share any sort of spiritual
need. This information is of course no longer available to visiting clergy or pastoral groups.

The recording of a patient’s religious or spiritual need is notoriously inefficient and often either does not happen or is full of mistakes. There are many reasons for this such as the need to explain, a, what services the department of spiritual care offers through its chaplains and b, what is the broad nature of spiritual need, which is both impractical and unrealistic at the time of admission. Such needs change rapidly during a spell in hospital and so the admission process alone will never manage to do this adequately.

The World Health Organisation and recent policy statements of the Scottish Executive Health Department are in complete agreement on the need to understand healthcare needs in a broad framework i.e. physical, psychological, social and spiritual, and that any view of health which omits any of these aspects is seriously deficient. It seems logical that chaplains, who are increasingly employees of the health service, should be understood as members of the healthcare team, and therefore have the exemption rights of their colleagues in the multi professional team. If spiritual need (the need for affirmation, love, forgiveness, help in the search for meaning) is an integral part of health, then it is difficult to see why the practitioner specialists in this area are denied the information they sometimes need to facilitate the appropriate spiritual or religious care.

The denial of this information can and has led to a poorer spiritual care service in certain instances. This was not the intention of the Act or the legislature but it is the effect. Many people’s spiritual needs have not been picked up and met, (E.g. there are reports of Roman Catholic patients not being given the last rites because no one had either asked or passed on the information, Jewish visitors can not find their people to visit because they can no longer see the patient lists.) While it is important to guard the privacy of people and to understand that they have a right not to be imposed upon where it is not wanted, it would seem that the sledgehammer of the law has covered a greater area than the nut of malpractice it was intended to avert.

Chaplains have not only a professional code which prevents them from either passing on information without consent, or from imposing their beliefs on patients, and an ethical code which guarantees a degree of confidentiality. They have the same constraints or more, than other health care professions with information they are given. It is strange that they are almost singled out in not being given exemption.

Visiting clergy or recognised faith community pastors are in one sense members of the public (the NHS cannot vouch for them) and so it is even less likely that they will be given information without explicit consent. It might be possible for them to be accredited and to agree to a code of confidentiality – but for the present even that would not suffice.

I am in agreement that in the past information was too available and that it is important to protect a patient’s privacy. However the legislation and its
interpretation has taken this too far causing at times a reduction in care. Considerable lobbying has taken place throughout the UK and questions have been asked in Westminster. (Data Protection law is UK Law). Submissions have been made by several individuals and church representatives, chaplains associations and the national Spiritual Care Development Committee, which is multi faith and has the main denominations all represented on it. I have attended meetings along with a senior servant in the SEHD to explain our point of view to the UK Commissioner’s deputy who has responsibility for this. One member of the Scottish Parliament (Helen Eadie) has hosted meetings about this following representations by some of her constituents. To all submissions the reply has been – “sorry but this is the law and we do not intend to change it”. Unless the Commissioner and the legal minds alter their opinion there seems to be little that can be achieved. The best ways forward would seem to be on several fronts:

- That members of faith communities be told clearly that if they wish religious or spiritual care they have a right to it, but they have to ask for it either from the department of spiritual care (usually the chaplain) or make sure that their own faith community representative has been informed.
- That chaplains become a registered healthcare profession. This is being worked on by Chaplaincy associations but they are meeting some resistance. It will take time.
- That there should be a concerted attempt to have the legislation or its interpretation changed to enable a more “spiritual care friendly” approach to be practised.
- That faith communities of all sorts should make joint representation about the difficulties they are facing and about the need to modify the interpretation of the law for the sake of a significant number of people.
- That for the present Health Boards should be allowed to be pragmatic in their seeking to provide the best spiritual care, and that efforts should be made to increase the profile, the times and the ways in which people may give their consent to being looked after in a properly holistic way.

Rev Christopher L Levison

Healthcare Chaplaincy Training and Development Officer and Spiritual Care Advisor to NHS Scotland.

9 GROUP DISCUSSIONS (2)

The conference was dispersed for a second occasion into smaller discussion groups to consider the issues raised by the Rev Chris Levison.

10 PLENARY

Session Notes
Registration of Chaplains as Healthcare Professionals:
• formation of a Professional Association requires code of conduct, standards, competencies and educational qualification to be established.
• framework is being currently developed
• Universities are being approach to enter into discussion re willingness to develop certificate for the training of healthcare Chaplains
• hoped that by the summer of 2009 the first students would be sought, probably from within existing Chaplains.
• in time a Post Graduate Diploma and a Masters Degree would be developed
• qualification training would mean NHS staff and patients would have be able to have a clearer understanding of the role.

However, to achieve this it would require:
• requires a UK commitment agreement of about 75% of Chaplains throughout the UK
• still two different perspectives south of the border between those who support the development of training/qualifications and those who remain committed to Denominational appointments as opposed to ‘generic’ appointments
• definable competencies standards and a code of conduct still to be developed
• no formal application has yet been made to the Healthcare Professionals Council.

Tension may exist where Denominational appointments might not apply the same requirements as those Chaplains appointed to work generically to all faith communities by NHS

Implications for part-time/full-time working:
• both would be required to work to the same code of conduct and standards
• part time Chaplains might be viewed ultimately as assistants rather than Chaplains
• only those on the Register would be able to call themselves Chaplain.

There is still some way to go but the outcome would be good for the profession, the church, hospitals and patients.

It was pointed out that RC Bishops may be concerned about the church losing authority over a priest if the profession required them to be appointed as ‘generic chaplains’.

Matters of conscience:
NHS does not expect Chaplains to be compromised by a point of conscience but would expect such matters to be dealt with sensitively and pastorally and passed on
to another person. The Chaplains role is to facilitate appropriate pastoral care but people must always go with their conscience.

**Continuity of care:**
Views were sought on how it is envisaged that the ‘generic chaplain’ apply their role and provide continuity of care if they are of a different faith community

- patients spend considerably shorter periods of time in hospital today
- may be examples where a Chaplain may provide continuity of care by following a patient back into the community
- not everyone would want this or they may have a pastoral support network through their own faith community.

**Concerns about the term ‘generic’:**
If the term ‘generic’ is being applied to the appointment of chaplains might this lead employment criteria being generic rather than religious?

- there would be a continued expectation that Chaplains remain rooted in their own faith community
- term ‘generic’ may suggest blandness but in practice a generic Chaplain would be expected to understand the needs of other faith groups
- be able to pray in appropriate language rather than replace someone from that patient’s faith community.

**Moving forward:**
The NHS wants to see the process moving forward through:

- dialogue and consultation and does not want to dictate to faith communities
- rather to be bringing together all the strands of the different faith communities
- using the term generic is not about giving up the individuals own traditions though acknowledged there is the potential for misunderstandings at this point
- training would be at a post graduate level examining such issues, history and language of belief systems.

**Defining ‘in good standing’:**
Clarification was sought on how the term ‘in good standing’ with own faith community is defined – might this be interpreted differently by different faiths or denominations?

Might someone removed from ‘ministerial certification’ but remain a member of the faith community be able to continue as a Healthcare Chaplain?

- if a chaplain is disbarred by his/her own faith community Employment Law would become an issue
would also raise the matter of ability to give or not give Holy Communion
ordination does not provide evidence of 'being of good standing' in itself, it requires being accredited by their own faith community.

Guidance to NHS for future appointments:
A partnership approach is sought by the NHS and there will be continuing conversations around these issues.

- The key issue is that training, experience and skills are the key criteria in the appointment of a Healthcare Chaplain.
- It was pointed out that Quakers are neither ordained nor theologically trained and this needs to be taken into account in discussions about the future.
- In a similar way an RC Priest may have received their theological training in Rome.

In summing up Chris Levison thanked everyone for the valuable discussions of the day; to ACTS for facilitating the events; and to Mary Buchanan for chairing the day.

- The issue of HDL is not an easy one to resolve but he is excited in the concept of Spiritual Care. The fact that some may find it more difficult to see their current role fitting into this, means that everyone needs to keep working together.
- It is a complex issue but today's discussion has identified issues of commonality and it is important to remain open to each other; ACTS can provide the space for that to happen.
- Multi faith aspects of Healthcare Chaplaincy are important and consultation and dialogue will continue between Chaplains, Denominations and the NHS