The Implications of *The Spiritual Revolution* for Those in Healthcare Chaplaincy

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First of all I would like to thank the authors for a most enjoyable book and a persuasive piece of research with which I don't intend to take issue within the compass of these remarks. Too much in it resonates with my own experience as a whole-time NHS chaplain.

The authors argue that a spiritual revolution is at least underway, in the shift from organised religion to holistic spirituality; and that this is occurring in response to a cultural shift, the 'subjective turn' as they call it, a turn away from life-as-obligation to an external authority, towards the authority of the subjective-life experience. Holistic spiritualities, the holistic milieu, emphasise the wellbeing of the subjective life, and are gaining ground at the expense of religion and the congregational domain, which emphasise life as obligation. They argue that while the spiritual revolution is underway but not yet complete in these areas, in certain other spheres, healthcare and education among them, there has already taken place something of a mini revolution in the direction of the 'subjective life'.

Two preliminary reflections

I have in the recent past been seeing a lady of 80 who has suffered several major bereavements in her adult life, but who has found it extraordinarily difficult to cry. It turns out that she had been a nurse, and had begun her training in the early 1940s. In the course of that training, she was taught that the nurse did not cry. With her patients and their families, the nurse was to maintain at all times a professional detachment, a competent coolness, and was never to give evidence of the weakness of tears. That training has affected her all her life. And yet, I am soon to take part in a study day for nursing staff on dealing

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with dying patients and their families, a day in which much attention is to be paid to the nurse as a human being, who must be aware of and pay attention to his or her inner life, and whose tears can often be very precious to a patient or relative. This is just one small way in which the concerns of the subjective life have changed things within healthcare.

The other reflection concerns the descriptions that the book gives of the characteristics of four different types of congregation. It strikes me that the NHS of 1948 and the four succeeding decades resembles nothing other than what the book calls a 'congregation of humanity'. I am thinking of its hierarchies and its deference to authority, but also more positively of its emphasis on duty, service and compassion. I might cite as relevant its discouragement of the personal, the subjective, and its stress instead upon the common good; also the rituals, the moral underpinning, the ethos which was assumed and accepted without requiring too much unseemly articulation. No mission statements in sight! At the risk of overplaying the analogy, I would say that the NHS which I am familiar with today has more of a resemblance to a 'congregation of experiential difference' – in the holistic language it uses, and the attention which it pays to individual selves, feelings, fears; in its offer of subjective enhancement and personal development of its staff; in the evangelical zeal with which its objectives are promoted; but also, for all its apparent conversion to the concerns of the subjective life, in its basic authoritarianism and its subtle pressure to conform. In the language of the book, subjective lives are not fully authorized within the new NHS, but only insofar as they conform to external expectations and guidelines. The subjective life is very far from having swept all before it, and I was much struck by the observation in the book that new versions of life-as-obligation can be seen to emerge, even as the subjective and its language become a major feature in the cultural landscape. It goes on to talk about a fundamental clash of values in our culture: on the one hand, those associated with the cultivation of unique subjectivities, and on the other, those associated with the 'iron cage of having to live the targeted life.' It is amid that clash of values that the hospital chaplain exists.

Spirituality and the NHS

So, in line with the subjective turn in the culture, we have a modern healthcare system which has adopted the language of the subjective, the language of the holistic. We are person-centred. We speak of choice, autonomy, rights. We offer complimentary therapies and counselling. Doctors are taught better communication skills. Staff are empowered, enabled, invited to unlock their potential. We speak of seamless care, an integrated approach, patient pathways, whole person care of mind, body and spirit. And with the latter in mind, spirituality and spiritual care have risen up the healthcare agenda.

In the NHS which the lady I mentioned knew as a young nurse, spirituality, if the word cropped up at all, would be equated with religion, and in turn, in that essentially monocultural era, with Christianity and with the domain of the hospital chaplain (although I would argue that then, as now, much good spiritual care would be given unconsciously by other staff). But great pains are now taken to distinguish religion from spirituality. HDL 76 'Spiritual care in NHS Scotland' describes spirituality in contrast to religion as being given in a one-to-one relationship; it is completely person-centred; it makes no assumptions about personal conviction or life orientation. As for spiritual care, it is a shared task, not the task of the chaplain alone. It can be taught. Perhaps it can be measured and audited. Definitions of spirituality abound in the recent nursing literature, usually including elements of meaning, purpose, identity and relationship, but not necessarily making room for a transcendent element. Yet, in a culture which stresses the uniqueness of the individual experience, spirituality is essentially what the person says it is.

Implications for Chaplaincy

What are the implications for chaplaincy? HDL 76 has resulted in one obvious change…in line with most other departments of the kind, we at St Johns are now no longer the chaplaincy; we are the Department of Spiritual Care, a title which has caused a degree of general mystification among staff and patients alike, but they, like me, will get

used to it. It signifies a break with the old, it gives a clear signal that religious ministry such as traditional chaplains largely exercised and were expected to exercise, has given way to a person-centred ministry of spiritual care which makes no assumptions and expects no shared thought worlds or community allegiances. We change, as we must, in response to a changing culture of which the NHS is a part.

A little caveat at this point, though. Whether or not the spiritual revolution explored in the book has an irreversible momentum, it is not moving at the same pace everywhere. My experience is that the religious aspects of the chaplain's role are still very much part of the scene in West Lothian. Whether or not people practice their faith, there is still a hinterland of language and concepts upon which they try to draw, especially in times of illness, difficulty or loss. I am aware that in this regard we may be drawing on a religious capital which will inevitably decline as an older generation dies out. But even with those who claim no religious faith or allegiance, the matter is complicated. For many such, there is a positive appreciation of the chaplain as one who seems to symbolize something, to stand for something, and is expected to be a person of faith. In a strange kind of way, some nonreligious people still find comfort in the presence, even in the prayers of a religious representative, someone who can speak the language of forgiveness, love and hope. Again, perhaps this too will pass, as fewer people are exposed to even the most vestigial contact with religion, and even what might be termed a kind of nostalgia for transcendence fades. But we should not proclaim the terminal decline of life-as-religion too soon, nor assume that the language of spirituality is as current among the general population as it is among health policy makers, or even among chaplains.

All that having been said though, the healthcare chaplain now operates within a culture in which subjective life spirituality is without doubt gaining ground. And that brings its own particular challenges and uncertainties. And yet, if the old certainties and securities of the past have given way to a present state of uncertainty and flux…well, in this respect we share the condition of the society to which we belong, and

certainly, that of the healthcare staff who are increasingly the focus of our ministry.

What is the chaplain for?

We do face a measure of uncertainty as to what exactly the chaplain's role is now. What do we offer? Can we any longer use the term 'pastoral care', with its suggestion of shepherds and sheep, in this NHS of person-centred care and individual autonomy? And to whom do we offer what we have to give? To patients? To customers? To clients? To service users? The very language of healthcare has become a minefield.

And if, in place of religious care, we aim to offer spiritual care to all, as generic chaplains, in what way are we equipped to do that? Obviously we cannot use our biblical, theological resources in quite the same way as we might formerly have done. What is their significance, then? What is their significance, for example, if we are asked by a patient or family to conduct a funeral without mention of God? Do they constitute the body of knowledge upon which we base our claim to be regarded as healthcare professionals? Or must we now become counsellors, psychotherapists, or something else? (It is significant that the lady whom I mentioned at the outset was referred to me and regards me not so much as a chaplain but as a bereavement counsellor.)

And again, if, as HDL 76 says, spiritual care is a shared task, what is it that we bring to that task which others don't? If it can be taught to staff and offered by them as part of a care package, then is there not a danger that the whole spiritual care enterprise might rebound on us, and that we may be again confined to a religious ministry to religious patients, in other words to our particular area of perceived expertise?

So the new world of spirituality and spiritual care requires a lot of rethinking of role on the part of chaplains. We need to clarify for ourselves what our contribution is, in order to enlighten other people.

I would want to argue that our rootedness in a faith tradition nourishes our own spirituality, while enriching and resourcing our sensitivity towards the spiritual dimension in all of life. It helps us to retain a sense of identity, integrity and genuineness; and if we are happy in our own spiritual skin as it were, then we are helped by that to help others locate a spiritual path of their own, without either denying who we are, nor subtly steering others in the direction we ourselves have taken.

How do we operate, then, as chaplains, as spiritual carers within an NHS reshaped by the subjective turn in the culture?

We can say that we will constantly be in listening mode: hearing the unique stories of the lives of individuals, translating the language, the metaphors; helping people to understand and to authorize their own experience. Being, in fact, what the other person wants and needs us to be at the time, and trying to locate along with them a coherent, hopeful, helpful spirituality, whether that includes the transcendent or not. And it is a great joy and privilege, a great liberating advance, to be able to focus on and celebrate in a truly incarnational way, what is deemed sacred in the ordinary lives and experiences of ordinary people, especially those who have had to struggle hard to attach any authority at all to what they have felt, thought, and lived through. It is good to celebrate, to practice, and to help cultivate with others what J. M. Keynes called the 'art of life'.

What is our role?

Part of the chaplain's role picks up what the authors identify as a possible continuing role of the congregational domain: that is, to enshrine core values of a particular community; to provide it, where necessary, with an ideal vision of itself; also to provide a focus and a focal point for occasions which reinforce a common identity or purpose, or express common joy and grief. From my own experience I would say that there are times when the hospital chapel is the natural focus and gathering point for the hospital community to express something important and unifying about itself; at memorial services

for staff members, for example, or services to mark a beginning, an ending or a significant anniversary within the life of the hospital.

Yet our role, at its heart, remains as it was: that is, to be, to be present, to be who we are. For in being there, by dint of our existence, we keep space for the sacred in this whole great scientific, technocratic, bureaucratic enterprise of healthcare. The preservation of sacred space, the guarding of sacred space is important, both physically in the hospital building, and spiritually in people's lives. And the sacred is strange and mysterious, and we are a reminder of that too. It cannot be domesticated by any institution or system, any more than it can ever be fully articulated by us. Our role is to bear witness to mystery, both to individuals and to the institution as a whole...to bear witness to the truth that even the most elegantly conceived spiritual care policy can become positively unspiritual if it makes no room for the unspoken, no room for mystery, no room for loose ends, for brokenness that cannot be mended, and for all the chaos and messiness and suffering of the human condition. This is uncomfortable territory for some worshippers of systems. In this world of loudly proclaimed person-centred care, our role, strange as it may seem, is to be truly mindful of persons.

And being truly mindful of persons means that we find ourselves in a situation of curious tension. On the one hand, we find that the person and spiritual care aware NHS gives us, as chaplains, every blessing and encouragement to tend the subjective life spirituality of persons. And yet, at the same time, we may reflect that to turn spiritual care into a mainstream policy, to define it, to make it the object of learning modules, tick box questionnaires, care plans, audit, accountability, and so on, is to domesticate and tame spirituality in such a way as to threaten to make it unspiritual. So we might find ourselves in some ways subverting this person-centred system, in the name of true spiritual care of persons.

The chaplains know, and are guardians of the knowledge, that there is a shadow side to all institutions and systems. We know, for example,

that staff live amid that clash of values which I alluded to earlier. Although they are apparently offered a kind of freedom and self actualisation, the reality of their experience is that they more and more have to operate within the 'iron cage of the targeted life', which is the enemy of freedom, fulfillment and the subjective life. And in order to go on knowing that, and guarding that knowledge, we ourselves need, even as spiritual care becomes mainstream, to preserve a little bit of the distance of being on the margins. If we lose sight of that distance, that difference, we could, in our eagerness for acceptance, in our eagerness to be understood and accepted and rendered comprehensible, risk becoming little more than a branch of customer care, delivering a product which the system has deemed useful, and exchanging relationships of trust for relationships of contract. And we need to be mindful too that the pressure is also on chaplains, that we too are in danger of losing our spiritual freedom, and entering that iron cage of the targeted life.

There is another challenge which looms large for chaplains. The authors allude several times to the fact that the rise in the holistic milieu, with its associated subjective life, spirituality by no means compensates for the decline in the congregational domain. The challenge for chaplains is not so much posed by those whose sense of the sacred has no element of the transcendent about it, but rather, by the increasing numbers who have no sense of, no perceived need of any form of sacredness, and who live and die without acquiring any concepts to sacralize the experience. I can only view this with profound pessimism.

Is the spiritual revolution in healthcare to be welcomed, grudgingly accepted as inevitable, or resisted? I think it best to reserve judgement, especially since my feelings about it contain shades of all three! The authors begin by quoting Matthew Arnold's words on the melancholy ebbing of the sea of faith, and again Yeats' more hopeful image of the keen delight of hearing the pebbles rattling as the tide goes out. I would simply add a third quote, from Tennyson: -

> *The old order changeth, yielding place to new. And God fulfils himself in many ways, lest one good custom should corrupt the world.*

For I still believe, perversely perhaps, that God is in there somewhere.