



# A Leap of Faith? Enabling Hospice Staff to Meet the Spiritual Needs of Patients

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## **T** Introduction

I'd like to invite you to follow the journey of a patient called Gordon as he arrives at Highland Hospice in Inverness for the first time.

Gordon arrives at the main entrance at 11am as arranged, having travelled from home with his wife, Marjory, and son, Kenneth. At the door to greet them is Rachel, one of the staff nurses.

“Good morning, Mr. MacTavish, I’m Rachel, one of the nurses here and I’ll be here to help you get sorted out.” Gordon extends his hand and says,

“Good morning. Please call me Gordon.” He then introduces Marjory and Kenneth, who are looking a little more anxious than Gordon.

“It’s lovely to meet you both,” says Rachel, “now if you’d like to come with me I’ll show you your room.” She leads them from reception through to the in-patient unit. She explains the various features on the way, helping to put them at their ease.

“Now,” says Rachel, “this is the ward area. There are four single rooms in this part, and over here is the nursing office and outside is where the ward clerk sits. These are volunteers who keep things running smoothly and keep us nurses in order!”

Rachel takes them to one of the three-bedded areas. “Now, Gordon, this is your bed, there’s a chair here, and your locker is just beside you. There’s another gentleman called John in the room with you, but



he's having a bath at the moment so I'll introduce you later. Now what would be more comfortable for you, the chair or lying on the bed?"

Gordon replies, "The chair's fine for the moment, thanks." Rachel then asks if he would like anything for pain but Gordon declines. Marjory busies herself with Gordon's case while Kenneth hands his father the newspaper he's been clutching.

Rachel has left for a moment and returns with a jug of iced water. "Are you needing a hand to sort things out, there, Marjory?" she enquires. "Thank you Rachel, but I think I've got everything sorted." she says. She asks about visiting and Rachel tells her that people can visit anytime.

"Now, I'll leave you to get settled for a wee while then I'll be back with Zoë who's one of the doctors and we'll get all your details. If there's anything you need or want to ask, I'll not be far away."

When Rachel returns with Zoë, introductions are made, and then Marjory and Kenneth take their leave promising to return later in the afternoon. "I wonder if I could ask you some questions Gordon," Zoë asks, "about why you're here and what's been happening to you. Is that all right?"

"Aye, fine." Once Zoë has taken Gordon's medical history and examined him, she leaves and Rachel checks other essential pieces of information.

"Right Gordon, I'll need to go and sort all this out now. I'll see you later." Rachel heads off to the nurse's office and prepares the documentation. The Initial Assessment Form is one part of this. When she gets to the box labelled 'Spirituality', Rachel pauses. "What *am* I going to put in there?" she murmurs.





## Apprehension and Discernment

Rachel's predicament is not uncommon. Spirituality may be something of a buzzword in health care circles, but it does not mean that it is any easier to understand. My Doctor of Ministry thesis arose out of my experiences as chaplain to Highland Hospice where I have been in post since 1994. The key role of the job is to "enable patients, their families and staff...to respond to spiritual and emotional need, and to the experiences of life and death in the context of a faith or belief system."<sup>1</sup>

I spend 15 hours of my working week at the Hospice and it is naturally impossible for me to provide spiritual care at the times it might be required. The saving grace is the word "enable" in the job description. I will never, nor should be, omnipresent so it is vital that other members of staff have a role in identifying, dealing with and where appropriate referring on people in spiritual need. It is, however, not quite as simple as all that.

I had noticed that the section on spirituality in the patient's notes about which Rachel was concerned was rarely filled in. Those sections about things like mobility, sleep patterns and communication were routinely completed. I began to wonder why this was the case and how often it was so. Over the course of a six week period I took note of how many Forms had any information written in them. During that time I discovered that fewer than one in eight had anything written in them at all and those that were completed mostly recorded a person's Church membership.

I then asked members of staff to think about possible reasons for this lack of information and the answers that I received suggested two possible hindrances:

- 1) Sometimes staff were unclear about what to describe, or not aware that there was anything to describe. This I called the problem of discernment.



- 2) Sometimes staff had some degree of uneasiness about the subject, and about how to respond to it, which meant that it wasn't discussed with the patient. This I called the problem of apprehension.

The evidence suggested that staff either didn't understand what spirituality was, or didn't know how to deal with it even when spiritual issues were identified.

## **Spiritual Care**

The present day interest in spirituality in healthcare has not been uninfluenced by the general changes that have been taking place in society. There are, however, some specific changes that have brought the care chaplains are charged to provide out of Cinderella's scullery.

Hospices have been around for a long time but in their modern guise they can be traced back to the establishment of St. Christopher's Hospice in London in 1967 by Cicely Saunders. The purpose of the hospice was to provide people who were dying with adequate pain control and relief from associated suffering.

Saunders sought to establish a pattern of holistic care, or care of the whole person body, mind, emotions and spirit and raised awareness of the concept of 'total pain', which may exhibit itself in all four areas at once.

Saunders challenged the clinical status quo regarding the treatment of people with terminal illness. She brought about a re-examination of the nature of whole person care in general, and spiritual care in particular.

The care she advocated, based on God's love for his people, takes seriously the totality of the person's needs and does not view them in isolation. Spiritual care is viewed as a way of care dependent on the quality of the care and the depth of the relationship with the person offering the care. It is very much a collaborative effort <sup>2</sup>, which may include relatives and friends as well as different healthcare



professionals. It mostly happens as and when the patient wishes and he or she can choose with whom to share the messy moments of abandonment, grief and pain.

Spiritual care is rooted in the classical theological understanding of humanity as created by God. *Creatio ex nihilo* distinguishes Christian thought from other religious and philosophical concepts of creation. The creation narrative is quite bold in its assertion that God willed the earth into being which means that as part of creation it is separate from the creator and not merely a by-product of God's eternal being. The theological tradition of the Church is clear. The world, having been created by God, finds its reality in God's words of affirmation. (Genesis 1:31) The creation of human beings marks the culmination of God's creative activity. Humanity has been created in the image of God, has been animated by the Spirit of God, and it is this relationship which defines human nature:

"If we start from God's relationship to human beings, then what makes the human being into God's image is not his possession of any particular characteristic... it is his whole existence. The whole person, not merely his soul; the true human community, not only the individual...it is these that are the image of God and his glory."<sup>3</sup>

Moltmann's argument is important for our understanding of spiritual care. It is the whole person that counts before God, the body as well as the soul, the family as well as the person who is the patient. He points out that Western anthropology has shown a leaning towards making the soul paramount over the body and that Christian theology has never been far behind. This led the way for the systematic dualism found in Descartes, which, in turn, set the scene for the rise of scientific objectivism.

Jesus, as a product of his time and culture was concerned for the whole person and did not recognise the body/soul dichotomy of later Hellenistic thought. His words and actions however, show that he understood more than most, the inter-relation of the intellectual, the material and the spiritual. He taught that all human beings were equal



before God and that his disciples were to express love to all people without discrimination or distinction.

The secular world has inherited from Christendom the concept of care of the sick and the weak by society as a whole. However, secular philosophy, which forms the foundations of much health care knowledge and practice, challenges any fixed theological position. The fact is that the more spirituality has been viewed as having been loosed from its confessional moorings the more interest there has been shown. Over recent years it has being taken seriously by bodies such as the World Health Organisation<sup>4</sup> and lately by the Scottish Executive.<sup>5</sup> If global and national institutions are willing to discuss the nature of spirituality then perhaps it may be argued that secularisation is not be quite as pervasive as we sometimes imagine. Ward <sup>6</sup>, for example, suggests that “society may consist of individuals and organisations with more moral passion than is generally admitted.”

This particular phenomenon is succinctly described by Davie<sup>7</sup> as “believing without belonging”. Spiritual care in many health care establishments can be described as serving the needs of the large proportion of people who feel that Davie’s phrase describes them very well. It also describes the institutional approach, which can embrace the concept of spiritual care without having to adhere to any one creed or system of belief.

There remains, however, this sticking point for those who believe *and* belong. In a world in which truth has become relativised, replaced by opinion and feeling, how can any examination of human spirituality be at all objective since each individual experiences his or her own reality and interprets his or her own personal values?

Perhaps here we must stake our claim. There remains for the Christian essential values and truths. The basis of the Christian life is found in the response the believer makes to the gracious invitation of God. Those who profess faith in Jesus Christ and follow his example in discipleship, living in the power of the Holy Spirit, are in actual fact

living out Christian spirituality. The precise form will largely depend on the tradition to which the individual belongs.

Christian spirituality, of whatever brand, is rooted in a sense of belonging to a community of believers who collectively express their sense of the sacred in worship, in action, and through tradition. It is about being in relationship with God and living by the teachings of Jesus Christ for the benefit of the believing community and beyond itself to the wider community. Whatever development there may be in the spiritual life it is as a result of God's free gift. Properly understood, Christian spirituality is not merely an aspect of Christian life concerned with devotions, forms of prayer, fasting and other disciplines. Spirituality refers to the whole of Christian life in response to the Spirit.<sup>8</sup>

As Downey suggests, spirituality is about the application in the totality of life of a person's religious faith. The lived experience of the believer is the starting point of all spirituality. It is concerned with what someone does with their beliefs and therefore it is about more than simply holding a set of beliefs and adhering to a range of values. Whatever else may be said about it, spirituality necessarily involves the whole person, body, mind, emotions and spirit, and the individual's relationships, both to God and others, bound up in connection with all of life's experiences.

## **T** Research and Conclusions

The idea of the project was to test the assumption I had made about the twin impediments of Apprehension and Discernment. This was done by obtaining the permission of patients to record a number of conversations I had with them and then sharing these with members of staff for them to comment on the spiritual issues they believed were raised in the course of the pastoral encounter.

The findings showed that on the question of discernment there was less of a problem than I had imagined there might be. For example, in

one interview with a student nurse, something raised in one particular conversation caused her to reflect on what she had said in response to another patient who sought understanding and forgiveness. That incident provided one good example of staff being able to discern spiritual needs. The nurse stayed with this individual out of a deep concern for him. She knew that there was a need and did what she could with the resources at her disposal. What prevented her interaction from bearing more fruit was a lack of knowledge about how to probe behind what was presented to her with pertinent questions.

Another nurse, who was trying to make sense of a patient's feelings of estrangement as death approached, came to the realisation that she had recently made a crucial spiritual intervention in a similar situation almost without realising it. Simply by sitting with a patient during a period of anguish had made such a difference to that individual, although to the nurse what she had done seemed quite insignificant. A third member of staff, on the other hand, thought she had uncovered a spiritual need (which was not in actual fact being presented) because she was unaware of the context in which certain comments were made by a lady whose faith was all important to her.

There was some evidence that discernment of spiritual needs was an issue. Things such as inexperience, lack of insight or simple misunderstanding can be factors in the ability of staff to recognise these needs. In examining their practice some staff are able to see that they are already providing spiritual care without being consciously aware of it.

Apprehension of spiritual needs was easier to uncover. One of the staff I spoke to mentioned the feeling that she, along with others, 'held back' in some situations for fear of 'saying something wrong'. She admitted to feeling out of her depth at times. More positively we can say that this person relates very well to those she cares for at a physical or emotional level, but does not find it easy to go beyond that into the spiritual. Interestingly, one of the patients expressed a similar concern; in his own case he did not feel able to bring up the topic of faith with staff for fear of not being taken seriously.





Another member of staff admitted to difficulties when dealing with a situation in which a patient talks of overwhelming anxiety and agitation, which could be described as spiritual pain. This conversation was seen as 'heavy', and dealing with it involved 'too much responsibility'. We should also note the difficulties a doctor experienced in identifying with a woman her own age, which created tensions and a raising of the level of uneasiness she felt in dealing with the woman's questions.

Knowing what to say to people presents a problem for more than one of the professionals I spoke to. Apprehension is undoubtedly caused by events, requests, or patterns of behaviour, which we do not understand.

There was sufficient evidence to support my original hunch, at least in part. In certain situations, staff found themselves unaware of the extent of the issue before them. At times they felt that they would rather not get too involved in the issue that was identified. Referral to the chaplain is one answer to this problem, but that may lose the spontaneity of the moment.

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## Engaging Staff in Spiritual Care

The conversations I had with staff members describe people who are dedicated to caring for their patients and who truly have their best interests uppermost in their minds at all times. I feel immensely privileged to work alongside them.

Based on the finding of the research, I looked for ways by which I could increase the sensitivity of staff to spiritual matters so that they would become more aware of them when they arise and more confident of tackling them at an appropriate level of sophistication.

1. There is a clear need for staff to understand what spirituality is about and to be familiar with some of the inherent complexities. The definition of spirituality<sup>9</sup> that has underpinned this project served as a baseline against which to measure what may, or may not, be something



spiritual. I am conscious that too tight a definition may be viewed as being restrictive, however I am also conscious that any exploration of ideas has to start somewhere.

Becoming more involved in the induction of new staff and in the general education of health care professionals by means of short courses covering what I have called “First Aid in Spiritual Care” has begun to tackle the problem of discernment.

2. There are situations in which staff feel that they do not have sufficient confidence to deal with the issues. It is possible to learn from the experience of others, and see how they dealt with a given situation. Much of this can be gained while on the job, but there are times when reflection on your own practice is hugely beneficial. As this is one of the principles of the Doctor of Ministry I feel duty bound to promote it! Nevertheless, there is immense value in members of staff taking stock of why they do what they do especially in the whole area of spirituality.

Clinical effectiveness workshops on the topic of spirituality have been held at the Hospice at which health care professionals can discuss, and reflect on their experiences in a supportive atmosphere. This has begun to tackle the problem of apprehension.

3. Staff working in the Hospice should be encouraged to examine and develop their own spiritual life. This is not only personally important but will have a marked effect on the level of spiritual care which they will be able to offer to patients. If staff have, for themselves, begun to ask and seek answers to the kind of questions patients will ask, then this will go a long way to meeting the needs of both.

Developing this side of things has not proved quite as easy. Dealing with the belief patterns of others is ultimately safer than delving into your own. However, addressing matters of faith and belief, both at a personal level, and within the context of caring for people who are dying is something worth striving for as it may help to tackle the problems of both discernment, and apprehension at a deeper level.



## Some thoughts for the future

The project was hugely beneficial in raising awareness among a particular group of healthcare professionals of their occasionally tentative and sometimes unconscious attempts at delivering spiritual care. It also served to stimulate discussion about, and reflection upon, the nature of the spiritual realm both from a personal and a professional perspective. As such it serves a limited constituency, albeit a very important one in the context of my ministry to the Hospice. However there are broader questions which spirituality in health care raises that were not part of the original thesis but might usefully be aired at this point.

1. Who, and in what circumstances, can offer spiritual care? The short answer is anyone who feels able to do so. Ever since the days of Florence Nightingale, nurses have seen this aspect of care as one that is part of their calling<sup>10</sup>. The medical profession too, are showing an increasing awareness that this area of care needs to be considered more seriously than it has been of late.<sup>11</sup>

The Church has a long tradition of providing pastoral care to the sick in hospital, through the visits of parish clergy and lay people, individuals who are invited into the institution to carry out their tasks. Over the last 10 years there has been a marked increase in chaplaincy provision which means that people who are already part of the institutional structure, chaplains and lay assistants alike who may well offer this ministry. In fact many hospitals could not provide the level of spiritual care that they offer without the contribution made by chaplaincy volunteers drawn from local Churches.

2. Several studies<sup>12</sup> have been carried out which suggest that the expression of spirituality can have a positive benefit on an individual's health and well-being. Since spirituality is something that permeates every area of life, in what way can it be viewed as a public health issue?

Whatever we mean by health we need to take account of all that is happening around us and within our own particular situation. In other words health is not simply about the eradication of disease but about the promotion of values, meaning and purpose. Is it possible to bring holistic, spiritual care into the realm of the health centre?

3. How may the Church have a positive input to these ideas? One of the main tasks of ministry is preserving the identity and the life of the community of faith but it also about sustaining the public life of which the Church is a part. It is in this realm of common grace that the Church can engage with secular health care establishments. Spirituality, as we have seen, promotes well-being and health. It is presumably cost effective too. In a target setting, cost-conscious era there may well be new avenues of ministry to explore always being aware that our chief motivation is to glorify God and to bring God's grace, mercy and peace to those who need it.

- <sup>1</sup> Highland Hospice, "Job description and standards of performance", 1994.
- <sup>2</sup> Ewan Kelly, "Three Approaches to Spiritual care in an acute hospital setting" in *Theology in Scotland* Vol IX, 2001, 1, p.57
- <sup>3</sup> Jürgen Moltmann, *God in Creation*, London: SCM Press, 1993, p.221.
- <sup>4</sup> World Health Organisation
- <sup>5</sup> NHS HDL (2002) 76
- <sup>6</sup> Michael Ward, "Off the Edge" in *Scottish Journal of Health Care Chaplaincy* Vol 6, 2003, 1, p.41
- <sup>7</sup> Grace Davie
- <sup>8</sup> Michael Downey, *Understanding Christian Spirituality*, New York: Paulist Press, 1997 p.46.
- <sup>9</sup> Spirituality is that part of a person's lived experience which seeks a relationship with God or other ultimate authority, and which endeavours to relate who they are to whose they are.

- <sup>10</sup> Ann Bradshaw, *The Spiritual Dimension of Nursing Care*, Harrow: Scutari, 1994.
- <sup>11</sup> Larry Culliford, "Spirituality and Clinical care" in *British Medical Journal*, No. 325 (2002), pp.1434-5.
- <sup>12</sup> E.g. Coyle, J, "Spirituality and Health: towards a Framework for exploring the Relationship" in *Journal of Advanced Nursing* 37(6), (2002) pp. 589-597; J McBride, G Arthur, R Brooks & L Pilkington, "The Relationship between Patients' Spirituality and Health Experience" in *Family Medicine* 30, (1997),122-6.