

# Hospital Healthcare Chaplaincy

A briefing paper from the Hospital Chaplaincies Council

## **Preface**

In common with many members of Synod I have been a patient in the NHS, not only as a user of the services of my local Primary Care Trust but also as a patient in both acute and long term wards of hospitals.

In addition I have had the privilege of being some years ago a Bishop's Adviser for Hospital Chaplaincy and for the past five years have been chairman of HCC. The work of chaplaincy, as this paper makes clear, is astonishingly varied: it involves being on the sharp end of pastoral care and at the sharp end of the ethical dilemmas which face health service personnel on a daily basis. It involves 'presence' and 'engagement' in equal measure.

Yet this vital ministry, carried out by ordained and lay members of the Church of England is often overlooked by our Church and there is a danger that parish-based ministry and healthcare based ministry will drift apart to the mutual impoverishment of each.

As the division between community care and hospital care becomes increasingly blurred the need for the Church not only to understand but to value the specific and demanding role of hospital chaplaincy grows in importance.

This report highlights the work of healthcare chaplaincy. It does so in the belief that this particular form of ministry needs to be properly valued and understood by the Church. Yet it also recognises that all of us, whatever the setting of our ministry, are called by Christ to minister to the sick in his name and for his sake.

It is my hope that this report will encourage each one of us to re-examine our own calling and to re-affirm our commitment to work together for the common good.

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## **Introduction**

1. The National Health Service (NHS) is something with which we will all engage at some point in our lives, whether as users, visitors or as members of staff. The founding principles of the NHS were conceived prior to and during the Second World War and came to fruition in 1948. Much has changed since then and the ranges of treatment available have become ever more complex and costly. However, the fundamental aim of caring in a holistic way for all who use the NHS remains. Treating body, mind and spirit together recognises that a person is more than the clinical diagnosis with which they may present and is fundamental to the philosophy of the NHS.

2. In healthcare we see what it means for each individual to be recognised as a person in their own right, bringing with them a bundle of characteristics and memories that make that person unique. That means we can speak of sacredness in a way that allows each person to be treated as an end and not as a means. It is easy to deny this and speak of persons as ‘categories’ when there are targets to be set and realised but as Lady Oppenheimer (<sup>1</sup>) has reminded us, sanctity need not be a word confined in a narrowly religious way but rather it is a concept which should lead us to see our society as one in which every person has unconditional worth. For us, as Christians, this rests on the love of God who created us; for it is based on the notion of respect. There is no life that does not matter to God and no person whose uniqueness is not to be treasured right to the end of their existence.

## **Brief history**

3. The philosophy of holistic caring in the NHS has its roots in the Christian history of this country. Foundations such as St Bartholomew’s Hospital London created by Rahere in the twelfth century and other hospitals, founded by Christians in later centuries, came into being with the intention of serving Christ in those who suffer. In the early nineteenth century Voluntary hospitals were founded in cities often with unpaid medical staff and untrained nurses. The chaplain’s role was to comfort patients, to teach religion and to read the Bible to or for patients. He was also important in fundraising! The main committee would almost always have a cleric as a member but not necessarily any doctors. Prayers were an integral part of hospital routine.

4. The later nineteenth century saw the beginning of a modern system with trained nurses, and competent doctors. Medical School training was situated within the hospital. There was much fundraising, with a cleric usually prominent to guarantee respectability. The chaplain often assisted the matron in maintaining nurses’ standards of behaviour and nurses (but much less so doctors) were expected in chapel on a regular basis. Rich people were expected to contribute voluntarily to the hospital and one of the cleric’s functions was to encourage this.

5. From 1900 onwards government influence over hospitals increased. Medical and nursing skills improved. Clerics became less central to fundraising and administration. However, prayers were still said on the wards and Chapel attendance was widespread on Sundays and involved nurses and patients. The creation and design of hospital chapels, often in imposing and sometimes beautiful buildings, was a sign that God and his Church were at the very heart of healthcare.

6. The culmination of governmental influence came in 1948, with the establishment of the NHS, and the appointment of whole time chaplains in some teaching and psychiatric hospitals.

### **Chaplaincy and the Church**

7. Healing, as the Archbishop of Canterbury has pointed out, involves trust. *“It takes time and commitment. Materially and psychologically, we have to ‘budget’ for such time and commitment; we have to be wary of short-terminism and corner cutting . . . healing is an imperative in a world that is irretrievably frail, often wounded, but no less imperative in facing the fact we shall all die.’* He goes on to say, *“Cardinal Newman once startlingly observed that if the church ceased to exist the world would soon come to an end. What he meant was that we often have little idea how much we owe as a culture to the sustaining vision of humanity as something to be revered, body and soul, to be approached with awe and reticence for its strangeness, its richness and its tragedy. The foremost theologian at the end of the second century, Irenaeus of Lyons, famously asserted that, ‘the glory of God is a human being fully alive’ meaning alive in, not beyond, this mortal body, which shares the image of God as truly as does our mental or spiritual life. Somehow here is the common ground for the cure of souls and the care of bodily persons that faith and medicine share.”*<sup>ii</sup>

8. It is on this common ground that chaplains and spiritual care givers find themselves. It is in to this common ground that they sink their roots.

9. Unfortunately, there has been a history of ambivalence between the Church and sector ministry, which has made some chaplains (not only in Healthcare) feel that their ministry carried out as employees of secular institutions has not always received the recognition and value from the Church that it should have done. This debate in Synod is an opportunity to re-engage the dialogue between healthcare chaplains and the Church, which has nurtured and ordained them (or trained them in a recognised form of ministry) and which, through the bishop, enables them to fulfil that ministry by holding his licence.

10. Healthcare chaplains make up a tiny proportion of total NHS staffing, yet they have access throughout the service and meet staff, in particular, in parts of the hospital which are rarely visited by others. Chaplains frequently have specialist ministries within units or hospitals, for example, in maternity, paediatrics, mental health, acute care, palliative care and elderly care. They also often work for different NHS Bodies including NHS Trusts, Primary Care Trusts and Hospices (many of which are charities). They frequently have teaching responsibilities within staff education and training, as well as a managerial function for chaplaincy and sometimes for other disciplines. Chaplains work closely with staff that deal with bereavement services and Patient Advice and Liaison Officers, to name but two areas not often thought about when considering chaplaincy

11. The make up of the Nation has changed since 1948 and this is reflected within the NHS. Trusts are now looking at the patient throughput and enabling those patients and staff members from the other World Faiths to access their own Spiritual care givers, who form part of the chaplaincy team. This embodies the principle of respect for all people as well as respect for difference. Nationally, the Church of

England, through the Hospital Chaplaincies Council, has been able to support and facilitate this approach specifically within the MultiFaith Group for Healthcare Chaplaincy.

12. The work of healthcare chaplaincy is often short term and intense. As well as churchgoers there are many people who have either lapsed from the practice of their Faith or who have deep and searching philosophical questions that they want to discuss. There is support for members of staff dealing with intense situations on a day-to-day, hour-by-hour basis. Relatives and friends of patients have their own agendas which chaplains address and chaplains have a responsibility to the entire institution they serve, for example by staff support, group facilitation and imaginative use of liturgy to express and reflect the thoughts and feelings of whole wards and units or the entire organisation at times of disaster, loss and crisis.

13. As demands on chaplaincy are increasing, the challenge is placed on the Church to support and engage with chaplaincy more effectively. Chaplains like the rest of those involved in ministry try their best, and often give of themselves sacrificially. They are always willing to walk the extra mile so that those in their care can receive the finest support. There are inevitably failures, as in all areas of ministry, however, as Christian chaplains we keep before us the example of him who, '*came not to be served but to serve, and to give his life a ransom for many*'.

### **The Context of Chaplaincy in the NHS**

14. Some *facts and figures*

- The NHS annual budget for 2006 is £70 billion
- The NHS employs 1.3 million people
- There are 1 million episodes of treatment each day
- The average length of stay in hospital is 3 days
- There are 7 million elective cases per year
- There are 320 Anglican whole time chaplains in England
- There are approx. 1600 Anglican part time chaplains in England
- There are 426 whole time and 3000 part time chaplains throughout the UK
- There are in addition approx 10,000 chaplaincy specific volunteers in England.

15. The NHS is rarely out of the news be it a financial crisis or problems with infection control or maybe a major ethical issue.

16. Many people who worship each week will be working at their local Hospital, Primary Care Trust, G.P. Surgery. Some will be involved in Trust Management Boards, in delivering clinical services or in the host of other functions that enable us to be treated when we become patients. Much of the work is unsung, yet vital to the smooth operation of the Service. These people deserve and need our prayers and support.

17. In the midst of this enormous 'industry' are hospital/healthcare chaplains. In 1948 there were a handful of whole time chaplains mainly within the London Teaching Hospitals and larger Psychiatric Hospitals.

18. The number of chaplains has increased to the figures quoted above. The hard work of chaplains and their ability to contribute to an ever-changing environment has enabled managers and other professionals in the NHS to appreciate the unique role that chaplaincy has within the system.

19. When NHS Trusts were formed in the early 1990s there was a fear that chaplaincy might become a casualty of financial pressures. The opposite happened and more chaplains were employed. However, using the latest Department of Health Guidelines for chaplaincy provision (November 2003), many Chaplaincy teams find that they are below strength. This does not mean that the chaplaincy team will be exempt if cutbacks are made when a Trust finds itself several million pounds in debt. Whilst we would argue that the saving in a chaplaincy post is very small in the total debt reduction - the reality is that the axe does sometimes fall on chaplaincy. As parishioners in other walks of life will have experienced, any enterprise governed by a financial "bottom line" is never secure.

### **Health-care Chaplains**

20. Why then are there healthcare chaplains? The command from our Lord is clear; we are to care for the sick.<sup>iii</sup> The parable of the Good Samaritan urges practical caring for whoever is in need. Christ himself is the ultimate healer. Health, healing, wholeness and holiness are inter-related. Perhaps the title given to the sick at the shrine of Our Lady of Lourdes, in Southern France, is the best clue. There they are called VIPs. That is how we are to regard and treat the unwell.

21. They are VIPs because, made in the image of God, their lives have been turned upside down by their illness (or that of a loved one). VIPs who may need to be reminded that God has not abandoned them, but is there in the suffering and distress. VIPs who need to hear the Easter Gospel that sin, suffering and death have been conquered. VIPs who need to hear the words, *'I absolve you from your sins, In the name of the Father and of the Son and of the Holy Spirit'*.<sup>iv</sup> VIPs Who need to see and feed on Jesus in the mystery of his Body and Blood. *'This is the Lamb of God, who takes away the sins of the world'*<sup>v</sup> who feel that Holy Oil on forehead and hands, *'through this holy anointing....'*<sup>vi</sup>

22. VIPs whose hands are held, who are given a cup of tea. VIPs who know that the chaplain will listen to them and care for them in Christ's name. Chaplains walk on holy ground alongside others and are privileged to share in their lives and those of their loved ones.

23. The focus, of course, must always be the patient. But patients are not in hospital in a social vacuum. There are relatives, friends, there are the 1.3 million staff (your NHS Trust may well be one of the largest local employers.) Then there is the institution itself, which needs understanding, loving and interpreting. Chaplains are there, as authorised representatives, to minister God's love and care. That will be expressed in different ways for the different denominations and Faiths who use the NHS. There is also a vital ministry to those who are themselves searching, whose spirituality might not be articulated through a Faith, but who are fellow travellers. Chaplains meet those who are angry, those who have lost faith in any god, in any church and sometimes in every other human being. They meet the despairing, the frightened, the lonely, the dying. Chaplains are at the heart of the Church's ministry.

24. One of the striking and disappointing things about the range of soap operas on television about hospitals is that they rarely show a hospital chaplain. Nothing could be further from the reality of day-to-day life in hospitals and other healthcare settings across the country. The chaplains are amongst a tiny number of staff who have access to all areas, who ‘walk the patch’ and who can take the pulse of the hospital, giving those findings without fear or favour to Chairman, Chief Executive and managers. From Neo Natal to Elderly Care to Accident and Emergency to the host of acronyms PICU, ITU, CCU, the fragile and challenging world of Mental Health, to ministry in Secure Hospitals and hospices there is nowhere which is beyond or outside the chaplains’ ministry.

25. The opportunities for a chaplain are immense. From the minute they enter the hospital the variety of calls, of conversations, of demands is non stop. So often people will say, ‘thank you for all you have done’, but the truth is that in many cases the chaplain has received much more. When the pager goes, it can be anything from a member of staff asking, ‘Will you bless my new wedding ring?’ to an anxious nurse saying, ‘You’d better get to the Neo Natal Unit fast...’ Families remember the involvement of the chaplain for years afterwards. For example, a letter, written by a chaplain to a family who had lost a child, was framed and placed on their sideboard. At another Trust a patient came to the daily Eucharists during Holy Week. She had not been to church for a long time, yet started following the events of this great week. She died on Easter Day evening. What a preparation!

26. There are staff weddings, baptisms and inevitably funerals and memorial services. Wherever human life is experienced in a healthcare setting, in the sorrows and the joys, the Chaplain is there in the very midst of it all, because that is where God is. God aches with his people and would have them know his comfort, strength and love. The words written by Bishop Timothy Rees in the hymn ‘*God is love let heav’n adore him*’<sup>vii</sup> are extremely apposite,

‘And when human hearts are breaking  
Under sorrow’s iron rod,  
Then they find that selfsame aching  
Deep within the heart of God’

### **Chaplaincy and the NHS Trust**

27. Being employed (as well as paid) by the Trust makes whole and part time chaplains accountable to the Trust, in common with all other employees. However, there is also accountability to the Church. There is not a Faith called NHS Chaplaincy, which is separate from, for instance, Christianity. For Anglicans this accountability is expressed through the bishop, for it is his ministry representing the ministry of Christ in which Anglican ministers share. In an Anglican service to licence a parish priest or chaplain the bishop says, ‘*Receive the cure of souls which is both yours and mine.*’<sup>viii</sup>

28. Without the bishop’s authority (without his licence) chaplains cannot function. That is why in appointing chaplains whether for half a day a week or whole time there has to be an understanding between the Church and the NHS. There is a challenge in this. We will all have to consider how we are to reconcile the needs of the NHS with the fact that there are fewer priests and ministers but with an increasing demand for

ministry. Chaplaincy teams are already being enriched by the contribution of lay chaplains, permanent deacons and sisters/brothers in the consecrated life.

29. Many people in the recent past, when they went to hospital, expected to receive a visit from their local parish priest. That priest would have had access to patient lists and would have sought out people from his parish. But times have changed and issues of consent and confidentiality now preclude general access to patient lists, without patient consent. Hospitals have their own dedicated whole and part time chaplains who work with local clergy to offer the appropriate care to those using the health service. Local clergy are welcomed and encouraged to visit their parishioners, of course. However it is appropriate that they should speak to the person in charge of a ward and ensure that the time of the visit is convenient. If a sacramental ministry is to be offered they should consult the hospital chaplain.

30. The Information Commissioner's interpretation of the Data Protection Act<sup>ix</sup> has raised problems of access to patient denomination lists for chaplains. There are, believe it or not, stories of bishops being recorded on patient lists as 'religion unknown'. The first point to stress is that any patient who is an Anglican (or another Denomination/Faith) must on admission state their religion loud and clear and say they would like a visit from the chaplain. It is the Trust's responsibility to provide the chaplaincy services with information regarding religion as well as the person's consent to allow the information to be passed on to the chaplain. Ultimately, if these provisions are not in place, there could be a case to answer under the Human Rights Act 1998. A patient might claim that s/he was denied the right enshrined in Article 9 of the ECHR to manifest his or her religion in worship, teaching, practice and observance'.<sup>x</sup>

### **Mental Health Care**

31. Some parishes will be familiar with the Promoting Mental Health pack<sup>xi</sup> which is an imaginative and manageable way for parishes, deaneries and dioceses to become better informed, more confident and more supported. The opportunity to support other agencies already exists. The passing of the Community Care Bill in 1989 has moved hospitalised care for those with mental health problems to more localised settings. Thus the character of care has been radically altered. But the financial pressures are here as well. Support is more time limited and there is less continuity of involvement by a specific nurse or social worker. This is an area where effective training and experience for those engaged in pastoral work can have a rich reward and make a huge contribution. Even today there are ill-judged comments made about those who are mentally ill, and there is much education to be done within communities.

32. There continue to be grave and major concerns about the increasing numbers of people held in the Prison Service who suffer from major mental illnesses. Colleagues in the Prison Chaplaincy Service are only too aware of the inappropriateness of placing such people within the prison system. At the same time, following a debate in February 2003 about proposed mental health legislation, the Church together with many other mental health stakeholders continues to raise issues about the proposed new mental health legislation.

33. In summary, there is an insufficient balance between public safety and individual rights. The risk is that people in distress are sent away to other agencies,

rather than trying to understand them ourselves. Mental Health Chaplaincy is now facing increasing expectations as there is a demand from many quarters for the health service to address the spiritual needs of patients. That makes demands on chaplains but it also challenges them to develop more creative and accessible care, and requires that chaplains are to be involved more closely in the life of the communities served by the hospital. The Church is, therefore, challenged to support and engage with chaplaincies more effectively, not least at the parish level, for it is in the parish that many mentally ill people live and those parishes have a duty to offer pastoral care.

### **Chaplaincy in Palliative Care**

34. The goal of palliative care, defined by the National Institute of Clinical Excellence, is ‘the achievement of the best quality of life for patients and their families’. Working with the multidisciplinary team, chaplains are involved in offering this care. Whilst only 35% of funding for adult hospices in England comes from the NHS, hospices have realised the importance of offering spiritual support to patients, their friends and relatives and the staff who care for them.

35. The joint submission from Church of England and Roman Catholic Bishops to the Select Committee on the Assisted Dying for the Terminally Ill Bill stated, ‘Helping people to die well is not the preserve of any particular Faith. It is the profoundly compassionate and humane response to the reality of death which we all eventually face.’<sup>xii</sup>

36. The demands of ministering in this specialised context require support and encouragement and an appreciation of the ethos and ethics which underpin this work. Once again chaplains have the opportunity to act as bridges between the world of palliative care, the hospice and the wider community.

### **Chaplaincy in a multi-faith context**

37. In 1948 that handful of whole time chaplains were Anglican, with some part time support from Free Church and Roman Catholic colleagues. Today the situation is becoming quite different (although the majority of patients still declare themselves as Anglican/Roman Catholic/Free Church). The NHS now recognises the need to sustain people from the nine major world Faiths whilst also providing support to the spiritual needs of those who do not have a particular faith background.

38. The Hospital Chaplaincies Council has been at the forefront of supporting the work of the MultiFaith Group for Healthcare Chaplaincy founded in 2003 (as well as its predecessor group the Multi-Faith Joint National Working Party). This unique group brings together senior representatives from the nine main world Faiths who meet to discuss these important changes in the landscape of chaplaincy and to give advice to the Department of Health, to the Faith Communities and to Chaplaincy Teams. In some areas of the country this means employing chaplaincy representatives from across the range of World Faiths. In other parts of the country it will involve knowing who to contact and keeping them involved in the chaplaincy team as necessary.

39. Some Trusts are beginning to work together across a geographical area to provide a realistic amount of chaplaincy especially for the smaller Faiths. For some

this will be nothing new. Some Trusts had Muslim, Sikh and Hindu spiritual care representatives as paid members of staff back in the mid 1990s. There are now three whole time Imams as hospital chaplains, two in London (one of whom is the chaplaincy manager) and one in Bradford. Innovative work is being done in Birmingham with a highly respected female Muslim representative on the chaplaincy staff at the Birmingham Womens Hospital. Faith communities are trying to decide how 'to do' chaplaincy and these are exciting and challenging times for them.

40. As a nation we have learned over the years to be respectful of the needs of a patient from a Faith other than Christian and that respect experienced through cooperation within the chaplaincy team is proving very helpful. In many ways the teams can be an innovative example to the community of how it is possible to work together for the good of others, whilst respecting the differences.

41. There are an estimated 10,000 volunteers currently assisting in chaplaincy teams across England. Whilst volunteering should not be an excuse for not providing an adequate, paid, service the gifts and contribution of properly selected and trained volunteers is inestimable. There is a challenge for parishes to become engaged with their local Trusts and to see this as a real extension of ministry. Those offering themselves must be prepared for selection or training and inevitably for the possibility of being asked not to continue. However, opening oneself up to the possibility of working in this area could be an enormous gift and a chance to minister effectively to God's people.

42. For this particular work, selection, training and ongoing support are going to be vital. At the local level, various courses are offered by experienced practitioners, often sponsored by Churches or particular healthcare trusts. Nationally, it is encouraging that a foundation degree in healthcare chaplaincy is now offered at St. Mary's University College, Strawberry Hill.<sup>xiii</sup> This innovative degree sets the practical work of chaplaincy within the context of academic study and discussion, so equipping those who may not have had specific formation for ministry to understand more of what healthcare ministry demands and the context in which it is set. There are also Masters level degrees in Healthcare at the University of Leeds and Cardiff University.

43. Supported by the Roman Catholic and Free Churches, HCC leads the Joint Training Programme for healthcare chaplaincy. Clergy/Spiritual Care givers coming into the NHS are encouraged to attend a 5-day training course as an induction into the NHS and to how chaplaincy is worked within it. This comprehensive course tries to equip new chaplains for their demanding ministry. Many chaplains will be part time and not all chaplains will have the support of colleagues. At this early stage chaplains are encouraged to work in collaboration with others. Various courses are held throughout the year focussing on areas that are relevant for the modern chaplain.

44. From September 2006 the Introductory courses run by the Joint Training Office will be based at Cardiff University and attract 20 academic points, which may be used to progress a chaplain's continuing personal education and development. This new partnership is an exciting addition to the joint training portfolio offered to the NHS and the Church

## **The role of the Diocese**

45. The diocese has a crucial role to play in supporting the work of healthcare chaplaincy. Each bishop has an Adviser on Healthcare. This person, who, if not a member of the senior staff, should have access to the Bishop's Staff Meeting, brings the needs of chaplains and of the NHS to the table. S/he meets regularly with the chaplains and gets to know them and their Trusts, creating supportive and useful links at many levels. This recognition of the distinctive ministry in healthcare helps forge strong links between chaplains and the bishop/diocese. When was the last time a chaplain addressed a deanery or diocesan conference? How often do chaplains contribute to diocesan websites or newsletters? How much is made of St Luke's? What about a healthcare chaplaincy week around this time? When did a chaplain last invite the bishop to visit the Trust?

46. Parishes too, will be praying regularly for the work of their local hospitals and supporting Healthcare workers who form part of the congregation. This prayer is vital as it underpins all that is done. Parishioners will inevitably be caught up in the life of the local hospital or hospice and so much good work is already being done. There are always opportunities to extend this involvement. NHS Trusts are encouraging much more interaction between local communities and the Trust. As well as chaplaincy specific roles there are opportunities for Christian witness in other areas of Trust life. Praying for the sick is an integral part of the daily round.

47. There are also pilgrimages for the sick to places such as the Shrine of Our Lady of Walsingham, where the annual national pilgrimage for healing each August Bank Holiday is a focus for sharing the healing that Jesus longs to give his people.. This prayer and practical support is a sustaining force. As duties allow, chaplains are glad to share with parishes something of the joy and complexity of their ministry. When was the last time your parish asked someone from the local hospital chaplaincy to come?

## **The future of chaplaincy in the NHS**

48. In November 2003, the NHS published two major documents with an impact on chaplaincy. The first was an updated statement of policy guidance<sup>xiv</sup> and the second was a workforce strategy for chaplaincy<sup>xv</sup>. The latter document (*Caring for the Spirit*) was intended to help chaplaincies become more up to date in the way their service was offered and delivered in a "modernising" process which had involved all other staff groups before that time. *Caring for the Spirit* is concerned with the NHS aspects of spiritual healthcare and seeks to ensure that all those involved in NHS care can understand and contribute to the work of chaplaincies throughout the Country. It is a document without theological underpinning because it is written to help the NHS develop these services and not to reinforce any views about faith. Nevertheless, it represents a major commitment by the NHS to sustain spiritual care as part of holistic care and HCC fully supports its content which it helped to fashion and the steps being taken to implement some new ideas within a developmental framework.

49. These developments by the NHS have tended to reinforce the need for healthcare chaplains to align their work with other healthcare professionals with whom they have similar work patterns and behaviours. On the one hand, such an approach is entirely welcomed by other health professionals such as physiotherapy or psychology because

of the similarity in professional work. On the other hand, the regulatory framework which governs these other professions is inimicable with that for chaplains whose accountability is to their faith community and its regulations<sup>xvi</sup>. The tension between seeking alliance with other health professions and not being subject to the same regulatory framework has caused confusion in some chaplaincies. A closer relationship with the diocese would help allay the fears of those who see their work undervalued within the NHS and uncertainty about its value within the Church.

## Conclusion

50. One aspect of the future that is easy to predict is that there will be constant change and organisational uncertainty within the NHS. There are philosophical questions about what a National Health Service actually means. Does it have to employ all those who work in it? Are the huge Trusts the best form of delivery or are smaller units more 'user friendly'? There is much detail within the NHS that needs to be thoroughly worked through. Whilst all these things are being pondered the day to day work continues, people are born, people become ill, people are in need, people die.

51. The Archbishop of Canterbury, in his reflections on the desert fathers, underlines the importance of 'abiding', to which we as communities are called. *"All the temptations of Jesus seem to be about resorting to magic instead of working with the fabric of the real world. Jesus performs miracles, but never as a substitute for the bodily cost of love, which reaches its climax on the cross. He is determined to stay in the desert with its hunger and its boredom, to stay in the human world with its conflict and risk."* The Archbishop sees the church as a place where *'pledging is visible'*. The Christian church can be a sign of fidelity in a community *"from which so much has fled or drained away. In very unmagical settings indeed, cities and prisons, remote hamlets and struggling mission plants the church remains pledged speaking of a God who is not bored or disillusioned by what he has made - and so speak of the personal possibilities for everyone there . . . Christianity encourages me to be faithful to the body that I am - a body that can be hurt, lives in the middle of limitations, accepting unavoidable frustration without anger."*

52. Those thoughts can be applied not only to the Church but to the Church's work as expressed in Chaplaincy.

53. In some ways, the relationship between patient and chaplain can be like an anchor in the stormy confusion of the unfamiliar. Whatever the circumstance, being a healthcare chaplain - a vocation within a vocation - is a tremendous privilege. Chaplains rejoice in serving Christ in his people and assisting them on their pilgrimage in this world as we all move towards the Life of the world to come.

## References

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- <sup>i</sup> Lady Oppenheimer in a speech at Oxford University Summer 2002
- <sup>ii</sup> Archbishop Rowan Williams in 'Journal of the Royal College of Physicians London 2002:2;495'
- <sup>iii</sup> S Mark Ch 16 v 18
- <sup>iv</sup> *Pastoral Care of the Sick* Veritas 1972
- <sup>v</sup> *ibid*
- <sup>vi</sup> *ibid*
- <sup>vii</sup> *The New English Hymnal*. The Canterbury Press Norwich
- <sup>viii</sup> *Common Worship* Church House Publishing
- <sup>ix</sup> [www.hmso.gov.uk/acts/acts1998/](http://www.hmso.gov.uk/acts/acts1998/)
- <sup>x</sup> [www.pfc.org.uk/legal/echrtext.htm](http://www.pfc.org.uk/legal/echrtext.htm)
- <sup>xi</sup> Promoting Mental Health Pack, the Church of England website [www.cofe.anglican.org](http://www.cofe.anglican.org).
- <sup>xii</sup> Letter from the Archbishop of Canterbury and the Cardinal Archbishop of Westminster to Lord Mackay, 2 September 2004.
- <sup>xiii</sup> [www.smuc.ac.uk](http://www.smuc.ac.uk)
- <sup>xiv</sup> NHS Chaplaincy: Meeting the Religious and Spiritual needs of Patients and Staff; Department of Health; 2003
- <sup>xv</sup> *Caring for the Spirit: A strategy for the chaplaincy and spiritual healthcare workforce*; South Yorkshire Workforce Development Confederation; 2003
- <sup>xvi</sup> *Guidelines for the Professional Conduct of the Clergy*; Church House publishing for the Convocations of Canterbury and York; 2003; ISBN 0 7151 1005 5