The Hospice Chaplain: Reconnecting with our sense of identity and mission

Laurence McGonnell. AHPCC Annual Conference, 23–25 May, 2022

When I was in the Seminary, some 35 plus years ago, it was customary for those about to be ordained to receive their appointments a few months before ordination. We were a Missionary community, which meant that appointments would frequently send us to far-flung parts of the globe. East, West or South Africa, South America, South Asia or South East Asia, the Middle East or perhaps, occasionally, a little nearer to home. Wherever we were appointed meant a good deal of old-fashioned research (this was long before Google!) New territory meant new customs, new cultures, new languages, different political systems, climate variations which could range from oppressive humidity and heat, to cold or cooler climes. There was a lot to prepare for. How developed would the place be? Would there be electricity? Water? Communications? Tarmac roads or dirt tracks? Was healthcare accessible should we become ill? Would we be welcomed by the local people, or was it an environment less welcoming to missionaries? What kind of illnesses were common to these faraway lands? What would we need to read up on? Do we have friends already working there? What were the social and economic conditions? What would our pastoral priorities be?

I still recall sitting in a group after Mass enjoying a beer one Saturday evening, with some of my colleagues who had just received their appointments. Appointment time was a mixture of excitement and anxiety about the unknown. Most appointment destinations were familiar to us, even if it was just a name and a dot on a World map. Asked where he would be going, I still recall one colleague saying, “I’ve been appointed to work with the *Helawi* people.” This was new to us, and after a moment of digesting the information, another colleague asked, “Oh. Where are they?” With a glint in his Liverpool eye, he responded, “*They’re four foot tall pygmies who live in six foot tall elephant grass, and they jump up and down all day shouting, “We’re the Helawi, we’re the Helawi !!!*”

Beyond the humour, there is probably something quite serious and familiar to us in this story. Covid has arguably been like an unexpected appointment to an unexpected destination. A place where none of us knew the lie of the land, or the climate, the customs or the language. There were no maps, and nobody there to guide us who had been there before and worked their way through this. There was no wisdom to impart, and no reservoir of tried and tested ways to reach out, to be-alongside, to support, comfort and reassure patients, staff, other colleagues and indeed our families and ourselves. We, indeed, were the four-foot-tall pygmies living in thick, mysterious Covid elephant grass, jumping up and down inside ourselves and asking, “*Where the hell are we, where the hell are we !!!”*

Today I want to reflect with you on being that **Hospice Chaplain**, two years down the line, taking the opportunity to pause and **reconnect with our sense of identity and Mission.**

While there are a number of sources that we could talk about that contribute to our sense of identity and mission as Hospice Chaplains, including (most obviously) the Church, the NHS, the arrival of the Agenda for Change and the absorption of Chaplaincy into a dominant Medical Narrative and Culture where Professionalism, Accountability Structures and Task-Orientation became strong identifiers. Our goal today is not to unpick this enormously complex journey, but rather to pause and think about how the Covid-19 experience, so fresh in our minds and memories, has interrupted the mood music of palliative care chaplaincy, inviting us to re-examine our maps, our Mission and the way in which we identify ourselves, and indeed the way we are identified by others.

So then, why do we say that the mood music of palliative care chaplaincy has been interrupted? What has changed? As I speak, I am ***very*** conscious here of the danger of launching out into over-generalisations, when perhaps one of the most identifiable realities of Hospice care in the UK is the sheer volume of variation. So many Hospices in the UK are Charities which are relatively small, local (*with a few well-known exceptions*) and take pride in making a local impact, building strong relationships and a sense of ownership with the local community. Some hospices have Day Centres and Outpatient Services, as well as In Patient Units. Some take pride in making these services a core-part of their offer. Some hospices will pay attention to cultivating non-medical elements of their offer, including art therapy, music therapy, writing, groups, reminiscence groups, carer groups, individual and group bereavement support, men’s groups, walk and talk groups, coffee groups, complementary therapy services and so on and so forth. Others take a more conservative position when it comes to these things, preferring to focus on the development of supplementary clinics, check-ups, or clinical education opportunities. So then, given such a wide variety, what gives us the confidence to say that there is indeed evidence that the mood music has changed?

While there are many indicators of change that have begun to emerge, I will limit myself today to mentioning four of them. These may not even prove to be the four most significant areas of change (*or where change is needed*), and I’m looking forward to working with you later to uncover more in our workshops and group discussions. They are however areas that stand out to me from my own position in the trenches as a Hospice Chaplain, and as a reflective practitioner trying to make sense of how and why the feel of my work seems to have changed.

I want to look at **four** different movements:

1. From lack of clarity to effective Leadership
2. From traditional to creative means of connecting
3. From side-line to centre stage
4. From walking with patients & family to walking with staff

###### 1. The first movement I want to underline is related to effective Leadership.

You may recall the results of the international survey of “**What Chaplains did during Covid-19**”, led by Professor Austyn Snowden of Edinburgh Napier University which emerged last year. With over 1,600 respondents globally and around half of those from Europe and the UK, one of the core findings of the survey, repeated earlier this year by Professor Snowden at a WHO event on Palliative Care Chaplaincy, was that *local leadership consistently proved to be key to how well Hospices used their Chaplaincy Resources*. At the same event, Snowdon endorsed the ***Sinclair & Chochinov 2012*** model of Palliative Care, which validates the Chaplain as *an equal specialist member of the Professional Hospice Team*, along with medical, social and psychological specialists. Even as a non-religious person, Snowden recalled with respect and gratitude the support he received from a Chaplain when his own mother was dying ten years previously. For Snowden, “*There is no doubt about the place and value of chaplaincy at end of life*.”

But there again, the lived experience of many chaplains on the ground is one of confusion and uncertainty. What do their organisations expect of them? Conversations with a number of Hospice Chaplains over the last two years, reveals a degree of flux. Some Hospice Leadership Teams remain unsure as to how best to make sense of and how best to deploy their Chaplains.

Some Hospices used their chaplains extremely well, contributing significantly to the pastoral care & support of patients, especially significant when Covid regulations meant that visitor access was stopped. While this in itself felt like an affront to the very *raison d’etre* of Hospices (*a* *Moral Injury*), some Chaplains reported being able to liaise between family members and the patient, at times assisting in smoothing the tension that understandably arose between staff and family members. Why on earth wouldn’t it? Rules seemed draconian, with family prevented from seeing mum or dad, aunt or uncle for fear of inadvertently passing on a virus we knew too little about. And then there was the stage of allowing one visitor to be present. My heart went out to these visitors as well as the patients. The terrible responsibility of being the family member to pass on collective goodbyes, when we understood instinctively and relationally that the patient needed more than that. And if the patient were to take a *turn for the worse*, the prospect that they may be the only one present, with little support for themselves. And then the responsibility of making phone calls to other family members to inform them of the news. Moral injury seems an appropriate term on one level, but on another, it doesn’t quite suffice to sum up the whirl of emotions that accompanied this family member. And staff too. So many of them were deeply upset that they were unable to reach out in the way they were used to. Unable to show their faces from behind the safety of their N95 masks and face shields, unable to touch and hold hands with anxious patients as they were used to. And where Leadership saw and understood this, Chaplains became an important presence; being alongside the lone family member, and also being alongside staff as they tried to work through this. And then there were other Hospice Leadership teams who were less sure how to use their Chaplaincy resources. Citing NHS infection control concerns, some Hospices furloughed their Chaplains, or sent them home to work remotely. But how do you work remotely, when the core of what you do – *being alongside* – is fundamentally relational? How to you connect with patients and family members? How do you support colleagues? This brings me to the second of our five movements: *from traditional to creative means of connecting*.

###### 2. From traditional to creative means of connecting

My Hospice (at that time) opted to instruct me to *“work from home until further notice*.” I had little over twenty-four hours’ notice, to make sure that I had all I would need to continue my role remotely. With a team of around a dozen active spiritual care and chaplaincy volunteers to inform, this was a big ‘ask.’ Some of the team were quite calm and philosophical about it, imagining that this was a *knee-jerk* reaction fuelled by insufficient information about the virus, how it was passed on and how best to manage it. Others felt a sense of relief, as they had some underlying health conditions which meant that it was better for their own safety and the safety of their loved ones, not to come in to the Hospice. There was no Business Continuity Plan scenario for this one. There had been no Desk Top Exercise to anticipate the management of this kind of scenario.

I went home with my laptop computer, a DECT phone to plug in to my home router, and little else. To be fair, this was hardly an exclusive experience of Hospice Chaplains. My wife worked at a Children’s Centre, and she too suddenly found herself working from home. Monday to Friday, from 9:00am to around 6:00pm, our box room and our spare bedroom became busy satellites of the Hospice and the Hemel Hempstead Children’s Centre. How our *Wifi* and telephone system coped with the level of traffic over the next several months, I’ll never know!

A month before being told to work from home, if you had asked me what *Zoom* was, I would probably have offered two possible answers: (1) an ice lolly I can remember from my childhood, and (2) something the technicians at NASA worked on. But needs must, and I felt a degree of triumph, having been able to coax our most hardened technophobe team member into getting online into our first ever Chaplaincy Zoom Meeting. The fact that I needed to call him every fifteen minutes or so to explain about switching his microphone on or off at the appropriate moment, is neither here nor there. It was pretty much a success. We were all there! The team agreed to continue to be available for patients as best they could, via telephone, Facetime, Zoom, WhatsApp etc. This was completely new to them, but it was also a new one on patients, family members and staff. Staff were not quite sure how to explain this new means of availability to patients, but somehow we managed.

Over the coming weeks and months, I was surprised at the level of progress we made. From little or no serious resources, over the coming weeks and months we managed to set up:

* A telephone and online pastoral support training programme for Volunteer Chaplains (delivered online)
* A telephone and online pastoral support system for patients both on the IPU and at home in the community
* Prayer Pods (1-to1 prayer support by telephone, where requested)
* A *resources section* on Spiritual and Pastoral Care for our Hospice website, including guides to mindfulness, anxiety management, self-care, religious guidance following a death, guides for a funeral service from home (when you can’t attend in person), prayer guides, home retreat resources, links to streamed services from local churches, mosques and synagogues
* A weekly Creative writing group
* Coffee and mingle Zoom sessions (checking in on isolated patients at home)
* Memorial Services online (Zoom)
* Bereavement support by telephone / online
* *Lunch and Learn groups* for Staff (a Zoom drop in session, where Staff could ask Chaplains anything they wanted, as they enjoyed their soup, salad or sandwich)
* Christmas Carols online
* Chanukkah online (which brought in people from as far afield as Israel, Germany and the US, as well as local people)
* Holy Week & Easter reflections Online
* Light Up a Life Online
* Check-in and support slots for staff and volunteers
* Clinical supervision online
* Pastoral reflection online

This was not of course all me... So much creativity emerged from within the Team, and I must give a shout-out here to one of my Team Members, Rabbi Eryn London, who kind of became my Social Media Guru! Chaplains found themselves in a completely new landscape, where new ways of enabling human contact had to be sought out and applied. Dinosaurs like myself were forced into a crash course on social media and the virtual world. For myself this was an entirely new experience. As a Psychotherapist as well as a Chaplain, I was instinctively wary of anything which would remove visual cues and data, handicapping me in my preferred way of engaging with other people, which was always, ALWAYS face to face!!! Even Zoom did not offer total comfort, as it still did not allow me to read the nuances of body language as I was used to. But pastoral needs would not evaporate under Covid, and Chaplains explored new ways of connecting, new ways of reaching out and new ways of being alongside. Some of these would doubtless be temporary, but there will be no complete ‘return’ to pre-Covid pastoral practices. I suspect that more of these new ways of working are here to stay.

I want to turn now to our third movement: From Side-Line to Centre Stage.

###### 3. From Side-Line to Centre Stage

Two things appeared to be happening at this point:

1. There was an Existential shift within healthcare. With unprecedented levels of demand and need, we were asked “to protect the NHS.” We all saw the pictures of Nightingale Hospitals being hastily erected in different parts of the country. The confidence of the Health System was knocked, and it was exposed to its own limits and vulnerabilities. On the front line of exposure to the virus, some staff became ill, with others even losing their lives. Even when staff did not become ill or worse, the internalised sense of vulnerability became very evident. Fear of exposure to the virus sparked a spike in psychological distress among front-line staff. Absences increased, and staffing emergencies intensified. The volume of staff taking time off because of ‘*stress*’ increased significantly, and was not softened by the weekly “Clap for the NHS.”
2. One strong message emerging from Chaplains was the significant increase in need for **Staff support**. In the last year alone, official stats tell us that over 27,000 doctors and nurses have left the NHS. Many citing the experience of stress and unrelenting patient need. Many have cited their desire to ‘retire’ from the increasing demand, taking time to look after themselves and their families. So many of the Chaplains I’ve spoken to, speak of the enormous increase in focus on staff.

Even when it came to selling my home last July, it was interesting to hear the Estate Agent say that the ‘big’ selling points of a home *used to be* the kitchen and bathroom. Now, it is the garden. Having been forced to “stay at home,” many people, including NHS staff, began to re-imagine their lives and seek change.

Many Chaplains have reported over the years a sense of becoming peripheral to the dominant medical narrative, to the extent that within healthcare, to partially justify a continued presence, we have had to develop and modify hybrid means of demonstrating accountability. What I mean here is simply this: most roles within healthcare are task-oriented roles. We demonstrate accountability through the completion of a task, which is logged on the system, can be viewed by others and is added to the data. For Chaplains however, this model becomes a little more tricky. The core of what we do is *relational*, exploring ways of ‘being alongside’ patients and family members, gradually building trust as we wait to be invited into the landscape of their inner world. The extent to which this happens ultimately decides how useful and meaningful Chaplaincy support becomes for the individual patient or family member. Systems of accountability are more commonly designed to harvest quantitative rather than qualitative data, which can at times mean that Chaplaincy effectiveness is logged under ‘number of visits’, length of visits, communion received, patient anointed, funeral planned, funeral taken etc. Please don’t get me wrong; all of these things have value, but they don’t necessarily grasp the subjective and qualitative impact of Chaplaincy at the cutting edge. This is not always understood by management who themselves may be under pressure to demonstrate ‘quantity’ above the ‘quality’ of being alongside people.

But something else is changing here. How many of us have repeatedly heard medical and nursing colleagues ‘grieve’ the loss of relationship in what they do? How many times have we heard colleagues talk of “*not having time*” to connect with patients and family members? There is a dissatisfaction with the task-focussed model, and the rise of terms in recent years such as ‘person-centred care’. This is not new to Chaplains. Especially at end of life. Our role ‘has’ to be person centred, otherwise; we fail.

The existential crisis of Covid has also ushered in a deeper realisation of the inner world of human beings. It has become more difficult to ‘muffle’ our inner discontent, and people are beginning to look for change. We hear of unprecedented numbers on waiting lists for ‘counselling’ or CBT or other forms of psychological support. The last I checked, there were something like 1.6 million people waiting for CBT alone.

Chaplains report a growing awareness of their role, with several high-profile reports on Chaplaincy work both in the press and in the media. In one particular publication, Chaplains were described as “***the women and men who run towards the dying***.” We have seen evidence of a ‘*shift*’ in Chaplaincy moving from the background to the foreground, as pictures emerged in the media of Chaplains praying for dying patients with their hands against a door. This shift is evident, but still has a long way to go.

Thinking of Chaplaincy as a peripheral contributor to patient care and particularly to end of life care, requires a significant un-learning of biases. To really grasp a meaningful perception of the identity and Mission of Chaplains will require ‘letting-go’ of some stubborn and widely held assumptions or biases about Chaplaincy. This in itself could warrant an entire session for our conference, but suffice to say that one common candidate for ‘un-learning’ is the ‘binary’ language of ‘religious’ or ‘not religious’. When an MDT meeting reveals a patient is offering multiple indicators of total pain, the reason given for **NOT** talking to her about pastoral support is because “*she’s not religious*.”

Perhaps because of my psychological as well as theological training, I find myself more and more passionate about seeking out and using a language for spiritual and pastoral care that by-passes the binary bias. The words ‘*spiritua*l,’ ‘*faith*’ and ‘*religious*’ may become obstacles to some patients because of their theological root. But when we re-visit the etymology of these words, we discover that ‘*spirituality*’ finds its roots in the Latin word ‘*Spiritus*’ which means ‘***breath***’; ‘*faith*’ comes from the Latin ‘*Fidere*’ which means ‘***trust***’; and ‘*religion’* comes from the Latin ‘*religare*’ which means ‘***to bind unto or to be part of***.’ Suddenly, we have a language which moves from “what’s your spirituality / what’s your faith / what’s your religion,” to “***what breathes life and meaning into you? What gives you a sense of connectedness to the world, to others and to yourself? What or who do you trust most? What or who do you feel most connected to?”*** We then end up opening-up these questions to people of all faiths or none; placing no condition or expectation on the reason for us being ‘alongside’.

We turn now to the fourth and final movement: From walking with patients and family to walking with staff.

###### 4. From walking with patients & family to walking with staff

I suspect that even this title is a little wobbly, especially if it implies that walking with patients and families is somehow ‘lessened’ or that we ‘move on’ to walking with staff. This is not the intention. The focus on patient and family support remains as strong.

Many Hospice Chaplains I’ve spoken to over the last two years have commented on their own experience of being more ‘noticed’ by staff. While again I am conscious of the perils of over-generalising, these conversations have happened frequently enough for me to say with reasonable confidence, that more staff are engaging with Chaplaincy for pastoral and emotional support, bringing questions about their own meaning, purpose and identity. Covid has ushered in a wave of thirst for the inner world, with many people struggling to find a language that adequately puts words on their sense of ‘feeling unsettled’, of exploring and seeking something deeper. CBT will provide something to some of those who ask for it, but I suspect that the standard 6-8 sessions may not be sufficient to address what’s going on internally. I myself have had two more members of staff signing up for ‘supervision’ with me in the last week. These aren’t people who would describe themselves as mainstream religious, or even peripherally religious. The thirst to converse pushes them over the line of any concerns that the Chaplain just might have a proselytising agenda going on, even when they swear blind that they haven’t! There is a bit of a ‘dance’ that takes place in this regard... How many of us have had conversations with colleagues that begin something like this... “Of course, I’m not Religious myself, but...” It’s often the ‘of course’ part that causes me to stifle a smile. It’s another one of those ‘un-learning’ opportunities emerging. The assumption that for a person to be religious, somehow they can no longer adhere to logical thinking processes, and that it might be offensive to us as religious people to imagine that science supersedes and is incompatible with faith.

In my twenty plus years as a Missionary, one of the things that became a mantra for us was the importance of ***learning the language*** of the people you serve. I found this striking as I reflected with my own pastoral supervisor. It was uncomfortable to realise that it was not just the ‘others’ who had to do the un-learning. I do too... Perhaps part of the process of reclaiming my sense of identity and mission as a Chaplain was to let go of the internalised ‘victim’ within me. By that, I hastily add that I can suggest nothing about the internal processes of other Chaplains, but looking at my own self in the mirror, I recognise that part of myself which is resigned to a background role, supporting the more heroic and socially recognised roles of hospice doctor or nurse. Part of my mission and identity is to reclaim my role as: teacher and questioner, as well as companion and listener. We give ‘witness’ to the inner movements of patients, family members and staff. Interesting to recall that the Greek word for ‘witness’ is *Marturion*, from which we get the English word ‘Martyr’. Educating others is an integral part of our identity and mission (*because education empowers others*), but this process will always meet with some degree of resistance, and perhaps even suffering.

I don’t see evidence of a resurgence in organised religious affiliation among Hospice staff, but I do see evidence of the inner questioning that awakens people to exploring their own meaning, purpose and identity. In recent months, the UK has been recruiting nursing and medical staff abroad, bringing in some 23,000 new recruits (with the largest group being from India and the Philippines). This is just to cover the gap exposed by the even larger number leaving the NHS.

Perhaps a key part of our mission as Hospice Chaplains is not only to walk with staff by ‘listening’ to them, but **also becoming inner guides, and language teachers**. By language teachers, I mean building confidence in staff through access to spiritual care education. We cannot expect them to have ‘*spiritual care’* type conversations with patients and family members (or even with us) when they are not used to / or simply don’t have the language and means to have these conversations internally. We cannot of course impose this language or training on them, but I suspect that a well-prepared training opportunity would attract attention. One course title I advertised recently was: “Becoming familiar with the language and purpose of spiritual care.” It hasn’t happened yet, but let’s see!

The last thing I want to share with you on this matter, springs from sessions I’ve been invited to do with trainee GPs who have come in to the Hospice, but also with Registrars and other Junior Doctors.

When I walk into the room, I suspect that the first thing on people’s minds is that I’m going to talk to them about the Religious dimension of Spiritual Care.

But my starting point is usually to ask: “***What are the two key questions of the modern scientific method?***” Usually at this point I’m met with varying degrees of silence!

The opportunity to educate us hugely important, and to my mind, this is part of my mission and role in a post-Christian world. In response to the silence, I usually go on to explain that the modern [*Western*] scientific method finds its roots in a branch of Philosophy known as Radical Materialism. There is often an illusion that the modern scientific method is in fact hundreds or thousands of years old. It is not. Even the term ‘evidence based medicine’ is as recent as the 1990s.

So then what is Radical Materialism? Broadly, Radical Materialism posits that we can know nothing, except that which comes from empirical observation & measurement. Nothing else can be of meaningful value. The two key questions to emerge from this, which become the backbone of modern science are: WHAT and HOW. What is going on for this patient? What is at the root of their symptoms or condition? How did this happen? How do we treat it? What is the most effective treatment? How does the disease respond to treatment? If a patient’s condition changes, what has changed? How are we to understand these changes? What needs to change in terms of treatment or medication? How do we respond? What do we look out for to know that the patient is responding to changes in treatment or medication etc. etc… What, How… What, How… What, How… These questions are crucial to the discipline of modern medicine, and yet it remains equally important not to reduce the entirety of the human condition or human thinking process to those two questions. Empirical observation and measurement does not led itself well to every aspect of human life or experience. What characterises human experience is the rich depth of our internal world and internal experience. I sometimes jokingly ask young doctors if they have partners or spouses. Many if not most say yes. I then ask them how they chose their partner, and whether they used double-blind trials to ascertain if their partner was the right one for them! Beyond the laughter is another serious statement. So much of our inner world does not lend itself to WHAT and HOW. Purpose. Meaning. Identity. Justice. Art. Even Music. Music is more than a collection of randomly selected sequential notes. The way in which they are put together can evoke deep feeling, memories, shared meanings, purpose or identity. In brief, we do well not to shrink, ignore or underestimate the value and importance of the inner world.

Palliative care necessarily exposes us to a broader range of questioning. When a patient is given bad news about their illness or prognosis, what is the most common question to emerge: WHY? Why me? Why now? Why does God allow this to happen to me? This simple but deeply profound question can reflect the intense inner processes that happen at end of life. Existential questioning, reflection on meaning, purpose, legacy and identity.

A few months ago I moved from Hertfordshire to Yorkshire. When I set out to choose a new GP, I am reassured by the GP who understands and is thorough in the application of the modern scientific method. To my mind, a good Doctor is well versed in the discipline of the modern scientific method, but to my mind a BETTER Doctor is one who understands the LIMITS of the modern scientific method, who recognises the necessary tension that exists in palliative care between What, How and WHY. As Hospice Chaplains, we work with the ***Whys*** of our patients and family members on a day to day basis, requiring us to seek out and find new ways of communicating the value and worth of these conversations to our medical and nursing colleagues.

In summary, reconnecting with our sense of identity and mission involves not just an external change in perception of who we are and what we do, but an internal re-discovery of our sense of identity and mission. We become less passive in ‘*being described’* through our role descriptions, and more ***active*** in educating others into a better, sharper and more accessible understanding of Chaplaincy. Colleagues and patients begin to recognise that our starting point is always the sacredness of their story; not a binary label of r*eligious or non-religious.* Our mission is to walk alongside people, staff or patients, accompanying them as they ask questions about identity, meaning, purpose and legacy. We are rooted in the depths of our own faith, and that faith sustains us as we learn to take care of ourselves, and as we care for others. We are always faced with limits; limits in how we can or cannot work, but this is also another human reality that we work with on a daily basis as we walk with others, who in turn try to negotiate their own limits. We seek not to settle into a static or ready-made role, but to find new and different ways of walking alongside others, even if it has to be a ‘virtual’ walking.

I’m going to give the last word to my coffee mug, which I designed last year with my Chaplaincy Team, and I suspect will speak to most if not all of us here...

READ TEXT ON COFFEE MUG: Chaplains are dynamic, responsive, passionate, creative, faithful, respectful and cooperative.

Thank you!