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Joint SMF/NSS Response to the draft NHS chaplaincy guidelines 2014: 'Promoting Excellence in Spiritual Care'

This is a joint response on behalf of the National Secular Society and Secular Medical Forum.

The Secular Medical Forum (SMF) is a non-profit organisation run by volunteer healthcare professionals working to protect patients from the harm or disadvantage caused by the imposition on them of other people's personal religious views. The SMF campaigns for equality of service delivery and employment within the NHS in terms of belief or religious affiliation.

The National Secular Society (NSS) is a not-for-profit non-governmental organisation founded in 1866, funded by its members and by donations. The NSS advocates separation of religion and state and promotes secularism as the best means to create a society in which people of all religions or none can live together fairly and cohesively.

Opening comments

We recognise that some patients, while in hospital, wish for religious or spiritual ministrations, and the provision of this by a hospital chaplain offers comfort and support by being readily available and from someone familiar with the hospital. Others, perhaps a greater number, may wish to be able to call on someone to talk to who is not part of the medical staff.

The role of chaplaincy has evolved from solely providing religious support to secular institutions, and it now increasingly extends to providing a service to those without a religious

faith. The attentions of chaplains should benefit all who seek sanctuary from suffering or life's vicissitudes irrespective of belief. However, in practice there remains still a strong religious focus both in terms of employment and service delivery.

A chaplaincy service which remains deeply rooted in religious traditions and has not adequately addressed the more secular role it now also aims to fill, is inappropriately placed as an integral part of a secular institution such as the NHS. We have made recommendations to remedy this and to help ensure that the guidance better conforms with the requirements of the 2010 Equality Act.

In England currently, all paid NHS chaplaincy staff belong to a major faith group. There is not one NHS England chaplain appointed from outside one of the recognised faith groups. When non-religious applicants for NHS employment are disbarred from applying, there is clearly a pro-religious monopoly, which is unjustified: applicants also require "a satisfactory recommendation and authorisation" by their faith community to gain entry.[1] This unjustified monopoly is perpetuated, and reinforced by several of the stated requirements for chaplaincy appointment contained within this draft guidance document.

We think it essential that chaplaincy must move from a religious service to one fit for – and equally welcoming to – all members of the public. The appointment of NHS chaplains must become separate from the faith group or religious affiliation of the applicant. A chaplaincy service exclusively for religious workers is a religious service and is not a truly inclusive one. Whilst chaplaincy remains a paid job exclusively for religious applicants, then any mention of the inclusion of the needs of non-religious patients remains a lip-service, and the justification for public funding is seriously undermined. Consideration of the 2010 Equality Act should translate into a public service which does not discriminate in terms of religion or belief.

Most people, our members included, are generally content to receive care in a variety of forms irrespective of the care-giver's personal beliefs. However, to be offered care by someone appointed preferentially because of their faith, is insulting and may be actively distressing. A parallel would be the appointment of male-only GPs or MPs; whilst these men may adequately fulfil the job criteria it would be unreasonable and unlawful to exclude equally qualified women from applying for these posts.

We note that the draft guidelines do not address this inequality. We are concerned that the existing quota system offering a proportion of a chaplaincy service per local faith representation excludes non-faith patients and staff and implicitly associates the role of chaplain with that of a religious worker. Further, with the existing affiliation system, there is a significant risk of and evidence for conflict between a chaplain's NHS role and the requirements of his/her community of belief.

We recommend that an addition to the draft guidelines be made to include the explicit guidance that chaplains be appointed on merit and irrespective of their belief system, and that no requirement is permissible that states applicants must require a satisfactory recommendation and authorisation by a faith community to gain entry or anything similar.

[1] http://www.nhscareers.nhs.uk/explore-by-career/wider-healthcare-team/careers-in-the-wider-healthcare-team/corporate-services/chaplain/

We recognise that some patients, relatives and staff derive comfort and support from members of the chaplaincy teams. We support hospital visits from members of patients' faith communities, when requested and within reason, to offer pastoral support so long as this does not disrupt the delivery of essential healthcare to others. Indeed we believe that a far higher proportion of chaplaincy support should be provided by volunteers from the patients' faith groups as this is less of a cost burden on the hospital, and is also likely to be better matched to the patients' needs.

A significant proportion of people regard organised religion as a negative influence both on their lives and on society as a whole. A chaplaincy service must both be and be seen to be separate from organised religion if it is to offer a service to all patients and staff. The universal desirability and acceptability of NHS chaplaincy services should not be assumed.

We have received a significant number of reports from the general public, doctors and nurses of unwelcome intrusion, insensitivity and breaches of confidentiality by members of chaplaincy teams. However, what is not clear is how many patients, relatives and staff have been distressed by the unbidden involvement of a hospital chaplain or volunteer.

We recommend that the guidance makes clear that patients can only be approached by chaplaincy staff or volunteers if they have indicated as part of the normal admission routine (not by being asked by a chaplain) that they wish to be visited, or subsequently make such a request of their own volition.

Further comments on the written draft follow:

Executive Summary

We welcome the new explicit recognition in the draft document of the need to provide guidance "*for the care of patients and service users who do not identify with a religious faith".* In this respect, the draft guidance notes the 2010 Equality Act yet consistently makes reference both to the qualifications of chaplains and to service delivery within a religious framework as noted in our response below. We have made suggestions for improvement where appropriate.

Introduction

In paragraph 2 it is suggested that *"chaplains are NHS staff qualified and employed to supply… religious… care…"*

Appointment to a chaplaincy role must not be predicated on ability to supply religious care. It is an integral part of a chaplain's role to support patients with a high degree of empathy, sensitivity, flexibility and compassion. Where religious care is requested, chaplains should facilitate involvement of the relevant faith community. Sometimes, the explicit request of a patient for religious ministration from a particular religious faith (and where the patient considers this important, denomination sect, and even someone of a particular gender) may accord with that of a chaplain. In such cases it may be appropriate for that chaplain to 'supply religious care'. In other cases, chaplains should follow the guidance for other healthcare workers such as doctors who are advised by the GMC not to discuss their own beliefs with patients unless explicitly asked to do so. The requirement that a chaplain is qualified to supply religious care is confusing and may carry little meaning for those religious patients who do not adhere to the chaplain's own religion; even if they have one. Such a

requirement may deter suitably qualified chaplains from applying for the role (see comments in opening remarks).

We recommend the removal of the word 'religious' from paragraph 2.

In paragraph 5 *"a growing body of evidence"* is cited to support the contention *"that appropriate spiritual care has an immediate and enduring benefit for those receiving chaplaincy in these situations".*

We recommend that paragraph 5 is reworded to remove these unreferenced claims and the evidence should be clearly referenced in the draft consultation guidance so that it may be assessed and evaluated. All good quality literature reporting the evaluation of chaplaincy services should be cited and briefly summarised. If, as with many services, high quality evidence is lacking, that should be acknowledged.

The omission of references in support of this general statement threatens the credibility of this consultation. Without an opportunity to scrutinise the evidence it is not possible to respond appropriately within the consultation period. We therefore request this information is shared with us and that we are given a reasonable time to respond to it, regardless of the formal deadlines.

In paragraph 6, it is suggested that the traditional model of part-voluntary chaplaincy delivery *"is a major asset for the NHS"*. This suggestion is potentially problematic and incompatible with the aspirations of NHS chaplaincy to be included as a professional role with professional responsibilities. People working on a voluntary basis will still need to be appropriately vetted, trained and supervised and will share responsibilities with the appointed NHS staff. We have had several anecdotal reports that some volunteers consider themselves exempt from the absolute bar on proselytising to vulnerable patients.

We recommend instead that the local faith or belief communities provide the individual religious or belief input. It would not be possible for a limited number of generic paid or voluntary chaplains to provide for the wide variety of patients of varying beliefs.

Patient and Service User Care: equality, safety, compassion

The first 3 bullet points are problematic:

i) The requirement for chaplains to "abide by the requirements of their sponsoring faith or belief community" is not compatible with an NHS service which treats all patients equally. It may also contravene the Equality Act 2010. The requirements of some faith communities, for example with regard to sex outside marriage, contraception, abortion, end of life care, proselytising, homosexuality or gender discrimination, are not acceptable attributes of a non-discriminatory NHS service.

ii) The guidance that "patients, service users and staff *must* be made aware of the nature, scope and means of accessing the chaplaincy within their setting" appears unrealistic and unworkable. **We recommend that the guidance states that on admission or the next convenient opportunity patients are asked if they wish to be informed about chaplaincy services, and that if not but they later change their mind they can make this known.** Failing

such interest being expressed the patient should not be approached. Additionally, it may be intrusive for patients or relatives who have no interest in a chaplaincy service. Further, the imperative to spend time explaining this service in this degree of detail will inevitably detract from other NHS healthcare provision.

iii) The desire to offer a round the clock service is laudable. However, the wording of this bullet point leaves more questions than answers. For example: whose responsibility will it be to provide this service once the nominated chaplain has exceeded the NHS working time directive? Will the NHS be duty-bound to supply a chaplain on demand? Perhaps it would be more realistic to suggest that NHS staff will make a reasonable effort to access volunteer or paid staff out of hours but this may not be possible.

Recommendation: the first three bullet points should be removed

We endorse bullet point 4 as one of the prime roles of a healthcare chaplain: "*Where requests for support relate to a particular religion or belief the chaplaincy should be able to access appropriate support for the patient and, when this cannot be matched, other chaplaincy support should be offered."*

This bullet point demonstrates how a non-denominational supportive, facilitative chaplaincy service might work.

The Executive Summary mentions that chaplaincy services are increasingly involved in paediatrics. No further mention is made of this area of work which is an important omission. It is very important not to assume that children and young people share the beliefs of their parents, and they may not be in a position to assert this when they are sick. During adolescence, young people are developing autonomous values and beliefs and assumptions made about these may be particularly distressing to them. This is particularly important when parents' religious beliefs are affecting the medical decisions being made for their children. In this situation, children and young people should, where appropriate to their developmental stage, be offered independent support which is not delivered by those from the religious faith involved. This is another reason that chaplaincy services should not be delivered by people who promote a particular faith.

Recommendation: We recommend that a paragraph is added as above to this part of the guidance.

Although mention is made of the importance of supporting those of no religious belief, as we have mentioned elsewhere, this is not sufficiently prominent in this document. If services do not adequately provide for this group, who represent up to 50.6% of the population (British Attitudes Survey 2013), they will be at risk of contravening the Equality Act 2010. It is therefore important that this guidance addresses the fact that there has historically been little attention paid to meeting the needs of this group and that this needs to be remedied. For example, parents of babies dying in hospital are not usually offered non-religious naming ceremonies, which some may value. In contrast, nurses will offer chaplaincy services to provide religious ceremonies.

Recommendation: We recommend that a paragraph is inserted which draws attention to the needs of the half of the population who are of no religious faith.

Staff and Organisational Support: informed, competent, critical

The first statement: *'Staff working in the NHS and their employing organisations are entitled to access support from the chaplaincy service'* is unreferenced and includes no further explanation. The word "entitled" implies an obligation on NHS organisations to provide more paid chaplaincy hours than would otherwise be the case. **We recommend that this is deleted.** Chaplaincy services should be directed to patients, who are generally unable to leave the hospital. Where appropriate, professional debriefing and/or counselling services should be made available to NHS staff. Where chaplains have the requisite skills for all or part of this work, and where staff are comfortable to turn to them, we have no objection to their involvement in this work. However it is vital that NHS organisations do not assume the adequate expertise of chaplaincy staff. Nor should staff be dependent on chaplains to support them where more appropriate support might be necessary. This is particularly important whilst the chaplaincy role remains so deeply rooted in religious practice (see comments in opening remarks).

The second sentence: *"Chaplains are trained in practice-guiding disciplines such as theology…"* is perplexing. Suitably qualified non-religious chaplains may have a good awareness of the religious practices of different faith groups without requiring any training in the study of theology. This sentence appears to betray a religious assumption behind the delivery of chaplaincy services.

We recommend the removal of the words 'such as theology', which should in any case not be a requirement.

Chaplaincy Staffing

The final paragraph notes that there is often inaccurate NHS data recording as to patients' faith. The final sentence states "*patients with a faith may be incorrectly recorded on NHS systems,..".* This assumption has then been used to inform further recommendations. In practice, it is the experience of many people without a faith that their belief has been assumed and recorded as 'CofE' even when they have explicitly said 'none'.

We recommend that the words 'with a faith' be removed from the final sentence and that the recommendations which rely on this assumption are themselves revised.

Chaplaincy in Acute Care

The 6th bullet point in this section recommends membership by chaplaincy staff of ethical… committees…

The subjects discussed on ethics committees will sometimes bring traditional religious values and current societal values into conflict. It is widely documented that doctrinal positions are much more conservative than those of the religions' followers – far less those in the population as a whole[2]. For example, end of life care where there may be a significant difference of opinion between those who champion traditional religious values of sanctity of life and those who are more guided by established principles of medical ethics such as patient autonomy. For this reason it is even more important that the composition of an ethics

[2] See for example: http://univision.data4.mx/resultados_catolicos/eng/ENG_catholic-survey.pdf

committee reflects and represents the population as a whole and is not and is not seen to be over-representative of a religious view. Nor should there be any assumption, explicit or implicit, that religious representatives have a monopoly on the practice of ethics. Whilst all NHS employed chaplains are appointed by the religious organisations they represent, it would be unethical to appoint them to an ethics committee solely on the basis of their chaplaincy role. Rather, each applicant to an ethics committee should demonstrate their competencies and capabilities in discussing complex medical ethical issues. This may result in the appointment of a local chaplain but should never be presumed.

We recommend that all members of ethics committees including chaplains should be interviewed as to how they consider complex ethical questions and where their priorities lie when their own faith is challenged by an ethical dilemma. This area is particularly problematic since it is our experience that some patients and staff have experienced direct harm due to the expression of the teachings of various religions.

Chaplaincy in Mental Health Care

We agree that *"Service users suffering from mental health conditions may have a complex relationship with issues of belief, doubt, faith and religion."* It is not uncommon for psychotic delusions to have religious themes. Therefore significant caution should be exercised regarding the involvement of chaplains, particularly those who choose to conduct their work with patients in clerical dress or offer religious perspectives. For example, it is still a mainstream religious view, expressed on the website of the Christian Medical Fellowship, that demons afflict people and that those demons need to be driven out or exorcised. People who hear voices or have other hallucinations are sometimes described by religious people as being possessed by demons. This is not a medical perspective and may be harmful to recovery.

There is a statement about adequate chaplaincy staffing in mental health with no further explanation. **We recommend that the guidance be amended to note that the use of a chaplain in mental health settings should be by specific invitation of the patient only and that chaplains working in such settings should be aware of the potential confusion and harm they may cause and should always dress in clothing that could not be mistaken for religious authority.**

Chaplaincy in General Practice

Paragraph 3 in this section states: *"A growing body of evidence links the use of chaplaincy to reduced stress, anxiety, depression, isolation and spiritual disease."*

Unreferenced and not apparently related to the primary care setting, this assertion is then used to justify their "obvious value in primary care". We do not dispute that some patients have found chaplaincy helpful and valuable but caution should be exercised about the precise role and limitations of chaplaincy and the suitable settings. The rationale for chaplaincy in hospitals is due to the fact that patients are removed from their community, and therefore from spiritual support that they would normally access in the community. When patients are in the community then there is no reason why they cannot access their usual spiritual support and we do not believe that the NHS should be duplicating this service, particularly in a time of extreme fiscal constraint. Again there is a statement of adequate

chaplaincy staffing which is unreferenced. **We recommend that the references are included or the claims removed.**

General practitioners are highly trained professionals who take a holistic view of their patients and are fully aware that an increasing number of people of all ages are isolated. It does not necessarily follow that chaplaincy attached to general practice will offer anything in addition to the existing statutory, voluntary and private community support structures, setting aside the financial implications on a service already close to financial breaking point.

The endorsement by GPs of any intervention in a particular setting for a particular problem is often perceived by patients as a strong indicator of the intervention's evidence-base and proven effectiveness. Whilst individual GPs are free to endorse what they perceive to be in the patients' best interests, most GPs are rightly very cautious about referring patients. **We recommend that the wording about GPs is amended accordingly.**

Chaplaincy in Community Care

The last sentence of the second paragraph states: *"Many service-users living with mental health illnesses are supported in the community and there is evidence that chaplaincy involvement can benefit both a reduced sense of isolation and increased resilience."*

There is apparent support for this assertion by reference to a paper by Dr Ewan Kelly, a senior lecturer in Theology at the School of Divinity in Edinburgh. However, on reading the paper by Kelly, there is no connection between service-users living with mental health illnesses (supported by whom?) benefitting from a reduced sense of isolation and increased resilience. Rather the referenced paper discusses a proposed new model of chaplaincy working to improve values based reflective practice which is still in pilot stage. How this relates to people with mental health issues is not explored in the paper. The first part of the sentence is vague and the linkage of the first with the second part of the sentence is extraordinarily misleading and sadly another example of the uncritical promotion of chaplaincy that characterises the guidance.

Information Governance

Patients have a right to expect confidentiality within the health service. Breach of confidentiality is a serious matter and can lead to patient harm. Each patient is individual and will vary enormously in the amount of information they are willing to share, and with whom. In particular, some patients will actively dissent from any involvement of the chaplain in their care, as is their right. It is important to remember that patients expect medical care when they enter an NHS environment. Ancillary services such as hairdressers, hospital visitors, podiatrists and chaplains may offer some added value for some patients but are not an essential integrated part of every patient's care.

Yet, as noted above, we have received a significant number of reports from the general public, doctors and nurses of unwelcome intrusion, insensitivity and breaches of confidentiality by members of chaplaincy teams. As such, we fully endorse the highlighted section of paragraph 5 in this section which states: "*Chaplains must obtain explicit consent from the patient before obtaining any information about patients or processing such information for the purposes of providing Chaplaincy services.*"

We are disappointed to note that the College of Healthcare Chaplains disagrees and considers it vital that chaplains are empowered to attend multidisciplinary team meetings and to access patient notes without explicit consent. **We further recommend that the guidance specifically includes a prohibition on hospitals divulging patient information actively or passively to chaplains and that anyone observing such breaches be required to formally report them to the ethics committee and general management.**

General comments about the guidance

Despite the stated intent to include non-faith perspectives, the presumption of religion is maintained throughout the document with conflation of spiritual and religious needs. **We recommend the document is rewritten to remove the presumption of religion and the conflation of spiritual and religious needs.**

With such a wide variation in personal beliefs, intimate knowledge of different forms of religion or belief should be unnecessary. To be truly accessible service the personal belief system of a chaplain should be irrelevant. It should only be necessary for a chaplain to be able to demonstrate a high degree of empathy, sensitivity, flexibility and compassion with a willingness to ask members of the local faith community or belief system to contribute to the welfare of each individual patient, irrespective of the patient's or the chaplain's belief. This would mirror the existing guidelines for other NHS staff such as doctors and nurses who are advised not to share their own beliefs inappropriately with patients.

Public opinion is divided as to the benefits or harms of keeping chaplaincy as a funded NHS service. Whilst many declare benefit from the human or explicit religious service offered by a chaplain, there are others who have felt imposed upon, vulnerable or isolated – either by being offered something inappropriate when they were ill, or by being denied the special visiting rights seemingly granted de facto to religious patients so that they can see their religious advisers. Equally, the use of limited NHS funds to provide a universal chaplaincy service inevitably means that other parts of the NHS will not be funded. Around the country, air ambulance services and paediatric hospices are usually funded by voluntary donations from people who value the service they offer.

We consider that chaplaincy services would best be maintained, strengthened and developed through the setting up of a charitable chaplaincy trust. Religious organisations or belief communities and secular and non-religious organisations, may each contribute funds to maintain this service.

Comments on the consultation process

We would like to express concern at the way in which the consultation has been conducted. Despite being a public consultation we are aware of no public consultation document. The draft guidelines were published by NHS England – the body responsible for the consultation – yet no information about the consultation has been made available on the NHS England consultation and engagement website.

The draft guidelines were hosted exclusively by the chaplains' trade union body (the College of Health Care Chaplains) and we understand invitations to submit responses were sent only to individuals and organisations selected by the author and project lead on the guidelines.

Cabinet Office guidance on consultation principles states: "Information should be disseminated and presented in a way likely to be accessible and useful to the stakeholders with a substantial interest in the subject matter."

Despite expressing considerable interest in healthcare chaplaincy in the past, including correspondence and constructive face to face discussions with the author of this draft consultation neither the Secular Medical Forum nor National Secular Society were invited to respond, and only became aware of the existence of the consultation after being alerted by members.

A further potential obstacle to objectivity is the consultation process being conducted by the same person to as compiled the guidance being consulted over.

In summary, we are concerned that the process has been insufficiently transparent. Whilst the views of chaplains have been widely sought, we do not believe a genuine attempt has been made to engage with patients and the wider public on issues that affect the services which patients receive.

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