Saturday 9th June
Plenary session 3

Group statements from Saturday morning groups

Adamantios's group
We were generally impressed by the facilities and the integration of the chaplains who were clearly well known by patients and staff alike. We would highlight the importance of good relationships and relevant presence in promoting interdisciplinary working and patient-centred care.

We need to be clear who we are, and in order to connect to others who care for the patients we need to recognise how we fit in with where healthcare is going, in our own settings at all levels, and have a role in shaping that.

Marie's group
The group values the field trips. we were reminded that in our work we are everything, but we are not doing everything wrong. We were inspired by the 'healing environment' concept in designing new healthcare facilities. Some difficulties were also observed with new facilities and we saw that having a good spirit in the ward or unit was also important.

1. We can learn from what other people do but we do not have to do the same
2. We discussed interdisciplinary working using a SWAT analysis. Strengths - the importance of holistic care, mutual learning, patient focus. Weaknesses - time consuming, patents don't always want this, many professionals visiting patients. Opportunities - broad understanding of spiritual care, deepen relationships, importance of patient experience, avoid being ignored in a secular society. Threats - loss of identity of the chaplain, accountability to the team is difficult for part time chaplains and those covering many wards.

Robert's group
One of the conclusions of the field trip is 'we have faith but in the attic'...
The visit to silent rooms gave a mix of views about our own position as a healthcare chaplain and the relation to our own tradition

It is a prerequisite to understand and respect one's self and ones culture and ones faith and tradition in order to respect and to understand the patient and our fellow-caregivers.

Simon's group
It is necessary for chaplains to work within the multi-disciplinary system. The chaplain is like an artist or catalyst of presence, meaning and wholeness.

Axel's group
Chaplains should work in an intra-disciplinary way within chaplaincy. This implies a clear identity of all chaplains, a lived relationship with their church or organisation and enough freedom to organise their work. it also implies a common identity of all chaplains as being responsible for spiritual care for patients.

Ruaad Ganzevoort was introduced by Anne

Axel presented the ‘final statement’ so far.

Ruaard

Basic tension - spiritual care, is it spiritual, or is it care? In VU they have programmes for spiritual care for all different types of people. Major change or development - medical care system started as expression of Christian caritas. Now we have to prove how spiritual care fits in to medical care. It is measured according to criteria of medical system. So where do we fit in? Some try to 'go native' to be a care giver like other care givers. Others try to stand out. To be utopia - a good place. Spiritual care could be defined not as just one discipline working with all others, but as the soul of the medical system. It transcends the care system. Every country and situation is different, and there are differences between different fields of healthcare.

Question - somehow we have to define a clear identity for all chaplains. Have to find language to negotiate that. If we don't have a shared vision of identity we are lost.

Can we find such a shared vision of identity? Issue is that it is not just a discussion on content, but on interests. Struggle between stakeholders. Stakeholders- reps of medical system, church authorities, spiritual caregivers (who have struggles within group e.g. faith people and humanist people, what about unaffiliated people)

Models we have for spiritual care are highly divergent, and there are 3

1. Spiritual caregiver as clergy person - represent the sacred
2. Spiritual caregiver is a caregiver like all the others in the hospital. Procedure, protocol
3. Spiritual caregiver is like a fellow human being, like a friend. Take on expert role, but don't consider self to be only expert, but fellow human being. Traditional measures and criteria don't work here

Everyone positions them self somewhere between these three models.

Also entering era of inter-faith spiritual care. People don't necessarily belong to just one tradition. They take bits and pieces from lots of places.

Have to work with people from different backgrounds. Not just working together with Muslims, Christians etc. but need to find a new way of describing what religion means to us.

What is the aim of spiritual care? What are the methods of spiritual care. To describe professional means we need aims, methods and theory of what we are doing. Need to be able to explain what we do to people who aren't doing the same thing. Need to transcend utopia and transform medical care. Look at care not as a technical profession, but as a relational field. See ourselves as the soul of care.

Spiritual vs care

Care for the story of humans in relation to the story of the sacred. Focus on story of humans is best understood by other medical professionals. But our unique selling point is a focus on the story of the sacred. People may understand this personally, but on't understand it within the context of an institution. Need to find the right language.

Meaning, coherence, belonging. We have to find a way to keep the repertoire of sacred stories available. Human stories will also be there but in secular society, sacred stories need to be kept available. What is role of sacred stories? From a spiritual care point of view, sacred stories are on offer for people. Not exclusive truths, but are offered to people as kenotic hospitality. We give up our claims and authority and offer sacred stories. They are places in which people find themselves at home again. They are wisdom tradition. They are a sacred space in which presence means transcendence. There is a move from

classical authority to an instrumental or therapeutic approach to place where there is more room for artistic, evocative, creative people. Not to be like all others, because then they don't need us. There is a non-reductionist solution to problems.

Friedrich - no question, we all agree with you

Ruaard - If we agree, where does that leave us, what is challenge ahead?

Ewan - Thank you for so much stimulation and creative thinking. The Health Service is dominated by the medical model, but this is no longer sustainable. Innovation goes along with creativity and asking difficult questions. There is a risk, so do we dare to innovate

Ruaard - the system is exploding. Should we see care in broad sense as problem, something that costs a lot of money, i.e. A deficit approach. How do we keep costs down? Why should we? Care system is also a thriving economic industry and we want to spend a lot of money on it, like recreation, housing and care. We find it important. So what's the problem as long as we are willing to spend money on it? It challenges the idea that everything should be fixed. It is part of the spiritual; that life is limited. We get old and die, but sometimes it comes a little bit sooner. What should people die of? The tragic dimension of life should be discussed

Adamantios - Historically the healthcare system was a charity system then became more technological with focus on illness focused system. Now there are big changes again. How can we have self-knowledge about changes that are coming, but have prophetic task.

Ruaard - Prophetic dimension speaks to me. We have a history to claim that.

Simon - Challenge is to be prophetic within the system. Easier to fit in and speak their language, but prophetic language is not to be told anymore in classical terms. Tension here. Also a tension in basing care on religion and humanist belief. Caring for stories is a good way to look at it.

Ruaard - If prophetic, do we challenge the healthcare system based on own religious beliefs? What is prophecy based on? If on our own religious background it is difficult to express this to the system

Debbie - Work has been done with group of chaplains to put together a theory of chaplaincy. Is chaplaincy defined as offering spiritual or religious care? But we need to start with how we see the individual. From a faith perspective we see the individual differently than a doctor and nurse.

Ruaard - how do we see humanity?

Lothar - Prophetic role in hospital, but also prophetic role in church to tell the problems of society

Ruaard - Need to put the imperfect back into human existence. I wouldn't limit the prophetic role just to spiritual caregivers

Karlijn - Recreation is not useless. We get more balance in ourselves again. Task as spiritual caregivers is to get recreation back into system again. Need to integrate body and soul together.

Ruaard - that is a good point. We don't see the need to reduce money on recreation because tourism is an industry and has meaning and value in it. So why should we see money spent on care as wasted?

Marie - Prophecy is not just we and they. Staff also suffer and see problems so why don't we take care of them so they can do their work better as they would like to do. There is a line between technology and business of healthcare.

Ruaard - Word 'prophetic' has the risk of being seen as traditional. We don't go to the hospital director and say 'I will be a prophet now.' The prophet speaks not as an authoritarian, but speaks for the oppressed against the powerful. A prophet giving a voice to the powerless empowers them. A prophet takes a stand and in that respect seems powerful, but a prophet is not a king.

Ewan - Critical friends or lovers. There are many prophets outside the church. Are there community developers or politicians who want to move from deficit to asset based. Moving away from individual to communal.

Ruaard - This gives us an opportunity. We are outsiders as well so this role could be ours.

Simon - I still think that people expect a lot from medical and healthcare. Someone has to die and also our role to be prophetic says that not everything can be fixed. That we keep appealing to that fact. This dimension exists. We have to stand for that too. Sometimes spiritual caregivers want to fix things.

Ruaard - We help people to cope with life. It is very risky work because it suggests some form of instrumentalising. Sometime spiritual care makes work dangerous and risky. Asks difficult slow questions that are not easy to fix, but are much more profound. Wisdom comes through pain. In this there is friction with the medical care system. Chaplains need to fit in enough to be OK but be outside enough to have a unique selling point.

Challenge still in statements is to define what we mean by the spiritual dimension. Building connections but also allowing space for the tragic or unsolvable which is there. this is addressed in wisdom traditions including our religions. What is the wisdom of life, what should I do. Not how I solve this, but how I live through it. Spiritual caregiver is broker of wisdom. If people are looking for wisdom, we can help them find it. We don't have all the wisdom, but we know how to find it, where we look for it.

Ralf - Does this not instrumentalise it?

Ruaard - we have to explain what we are doing and why we think it would help, but wisdom itself is not instrumentalised. Wisdom in sacred stories and human stories will result in healing and wholeness for some.

Debbie - This is echoed in work when we started looking for definitions of health and decided it was healing. Health is not just about making the body better.