

# Keeping the faith

Although spiritual care is vital for the health of many patients, it can sometimes be overlooked. Iman Yunus Dudhwala, Multifaith Manager at Newham University Hospital NHS Trust, talks to *Amicus Health* about the vital role of chaplaincy in today's NHS



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**AH: What is a Multifaith Manager?**

**YD:** A Multifaith Manager is a contemporary title for head of Chaplaincy, Spiritual and Pastoral Care. I lead on the delivery of spiritual care to patients, carers and staff in the hospital and liaise between the patients, carers and staff regarding their spiritual, pastoral and religious needs.

**AH: I believe you are the only Multifaith Manager in the UK who is also an Iman. Does this present special challenges?**

**YD:** Yes, it's an honour to become the first from a newer British faith group to lead a chaplaincy department in the country. First of all it's a credit to the host faith community who have welcomed the non-Christian faiths in to their domain to the extent where as a Muslim I was given the opportunity to apply for a post which has historically been a completely Christian territory. Credit also needs to go to Newham hospital who became the first hospital in the country to open up this position to people of all faiths and with Newham being one of the most diverse boroughs, I think it's very fitting it's happened in Newham first.

The challenges are many, but to name a few, when I was

appointed as the head of chaplaincy, privately many staff were very apprehensive in seeing a Muslim taking up the senior post of Head Chaplain, but as time has passed and people have seen the work and the person, the whole Trust has become more and more supportive and realised it doesn't matter what religion the person may be, as long as they are able to work positively for the whole community whether they belong to a particular faith or not.

The other has been the demand on my time and resources from outside organisations due to the unique position I hold and balancing my time here along with my training and education nationally.

**AH: Do you think that chaplaincy tends to be an under-recognised profession in the NHS? If yes, why do you think that is?**

**YD:** Yes, I would say it is under-valued and quite a hidden profession. How many times have we seen a Chaplain on mainstream hospital dramas such as Casualty or E.R. (and yet chaplaincy has been part and parcel of the NHS since its inception in 1948). Actually, there was one episode of Casualty where there was a Chaplain, but he was the worst Chaplain I've ever seen, a gross misrepresentation of what we do and how we work.

The reason behind this is maybe because we live in a society which is very much based on science. The NHS models of practice are based on scientific evidence, concentrating on the physical aspect of a person. Chaplaincy is the only profession employed specifically to look after the spiritual component of the person which is to a great extent intangible and therefore overlooked by the majority. Although on the other hand, the NHS does claim to provide holistic care to patients, and at times of difficulty we are sometimes remembered.

I think this is changing as chaplaincy moves away from the traditional practice of just visiting the wards to interacting with all the different professions within the hospital. Chaplaincy is now included in clinical forums for health redesign. It may surprise a few, but Chaplains also have objectives, Knowledge and Skills Framework outlines, appraisals, and have to work towards targets and obviously more recently concentrate on financial savings...so we pray for financial recovery!

**AH: What does a 'typical' day (if there is such a thing) entail for you?**

**YD:** I don't think there is such a thing as a typical day for any chaplain anywhere. I could plan a day and it changes with any life changing event, which I am called to, be it an accident, a death, a birth or a staff crisis.

On a planned day, it could be training for staff, meetings with other team members ward visits, for example, the palliative care team, developing policy on bereavement and prayers in the afternoon or simply interacting with staff in the corridor.

**AH: How does your work as a Multifaith Manager fit in with that of other NHS professionals? For example, is it necessary to interact widely with other staff?**

**YD:** Very much so. As we discussed earlier chaplaincy is not well recognised. For Chaplaincy to be effective, Chaplaincy needs to be proactive in interacting with all the different professions working with the hospital and helping them to

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realise the value of chaplaincy. Obviously, palliative care teams have a close working relationship with chaplains, but also the health advocacy department, nurses, doctors, ethics and mortuary staff also work with us. Here at Newham, we have undertaken projects with the diabetes team, pharmacy and smoking cessation, areas which people may not associate any kind of link with chaplaincy.

**AH: What is your opinion of the current state of the NHS?**

**YD:** Technology is vastly improving what the NHS can do, and yes, government targets have helped many patients to be treated quicker. But I think we need to ensure that we meet fundamental requirements around respect and dignity for patients and staff, treating everyone as individual and not losing the essence of our presence within hospitals.

**AH: With the government's move towards greater patient care in the community, is there a danger that access to spiritual care will be reduced and how do you think this can be addressed?**

**YD:** This should be seen as an opportunity to increase chaplaincy for the wellbeing and pastoral support for a smooth transition from hospital to home. To provide a health service in the community is a government initiative. Chaplaincy is person-based, and patient-linked and therefore should go with patient.

**AH: With the government's move towards greater patient care in the community, is there a danger that access to spiritual care will be reduced and how do you think this can be addressed?**

**YD:** I think the simple answer here is that we still don't know what services cost. We are still running large parts of the NHS on historical budgets, which is no way to run a service, and quite frankly, it seems to be that this has to alter. Three months ago, the government declared that this was the road down which we're going to travel, and deficits will have to be faced up to by the individual Trusts who have them. It now seems, however, that this is not going to be the case. I am in the process of trying to get a debate in the Commons on this matter because I am not happy with the situation and it's not what we were told a few months ago.

**AH: The Bishop of Rochester recently urged fellow bishops to repel the advance of a multifaith society. What did you think of his comments?**

**YD:** The Bishop is certainly entitled to his opinion but I for one do not agree with it. I believe he is trying to look for a solution for the lack of public profession of Christianity and trying to blame this on a multifaith society and I don't think the two are linked. The very fact that Bishops hold competing viewpoints shows multifaith is not an issue. The Bishop of London only this week has emphasised upon the importance of religious understanding during an address at a meeting of political and religious leaders in Brussels.

The overwhelming view of Christian chaplains working in the field is that multifaith working strengthens all faiths - not just the UK's newer communities. The experience of seeing others practice their beliefs has encouraged many individuals to contest the idea that faith is a private and individual matter. There is a greater awareness in the NHS and elsewhere that



faith can play a positive and significant role in how people cope with the effects of poor health - and how communities are supportive.

**AH: The BNP has doubled its number of council seats in England, which could spark racial tension. What are your thoughts on this and does it impact on your work with your patients in any way?**



BNP needs to be challenged with coherent questions about its agenda, and where discrimination is either implicit or explicit it should be exposed for what it is.

I think a lot of BNP supporters are egged on by a few activists. Generally, in my experience, when people have the chance to meet and speak with me a lot of pre-conceptions fall away. Listening and speaking with a desire to understand is the biggest asset for those opposed to the BNP - and multifaith chaplaincy can be a vehicle for those encounters.

**AH: What do you value about your membership of Amicus?**

**YD:** It's a mechanism of support to preserve the rights of the employee. Agenda for Change terms and conditions is a great example of how Amicus was able to support Chaplains in gaining recognition for the work that they do.

Many Chaplains have also received great help from Amicus in securing their entitlement to housing allowance under Whitley Council and now RRP which has replaced the housing allowance was mainly due to the efforts of Amicus.

Anything could happen during the work of chaplaincy, and to have the security of help, support and advice, and back up of expertise on employment issues from Amicus is invaluable. I can't imagine doing my job without it.

**AH: Do you think unions play a role in promoting social inclusion?**

**YD:** It is a voice for those who sometimes feel or in fact genuinely do not have a voice. Unions are always listening and campaigning on challenges facing the disadvantaged and underprivileged. They try to broker financial settlements, improve pay and conditions, and working conditions, collective issues that concern everyone. You are never alone when you are part of a union.

**GC: Should the 'internal market' philosophy be dominant in the provision of health services?**

**YD:** No. Commitment to the highest standards of patient care, carried out by staff that are valued and supported, is the philosophy that should dominate health provision. Of course the means of delivering that care are vitally important, and will be affected by wider political and economic change. Let's not forget that good health provision is a prerequisite in a democratic society. We need the whole community to participate in our national life, and economic factors should not limit participation through illnesses which could be treated. If the internal market is to develop then it must do so on the basis of valuing the least powerful in society, not just those who have the capacity to work the system.

**AH: If you could be Secretary of State for Health for one day, what policy would you promote and why?**

**YD:** Hospices often have a staff-to-patient ratio that is mind-blowing when looked at from the acute sector. In order to increase the dignity of those nearing the end of life greater resources are needed, and that includes a larger provision of chaplaincy. Palliative care should be for all who are at the end of their life: not just oncology patients. It says a lot about our values when those who can't be 'fixed' are left alone with little support. We need a policy that says all those at the end of life require dedicated and skilful care. ♦

**YD:** The causes of rising BNP popularity, albeit from a small base, are complex. It is important that all sections of the community are treated fairly, as injustice can be one of the greatest causes of simplistic answers to major questions. All institutions, including the NHS, need to apply consistent policies to those in their care. Of course some communities and individuals may need extra help from time to time, especially as they become accustomed to British society. The

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