CHAPTER 6

Are Health Care Chaplains Professionals?

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The world of the hospital chaplain is a complex and demanding one. As well as encountering some of the most disturbing and profound human experiences of vulnerability, illness and death, the chaplain, along with other health care workers, has to engage with the changing demands of the NHS. While some doctors and nurses still regard their career as a vocation (Whipp 1997), the chaplain remains a living symbol of the tension between vocation and career. This chapter explores one aspect of that tension – the notion of professionalism. It draws on the thought of sociologists who have attempted to define and interpret professions and discusses issues of social closure, professional dominance and managerialism in relation to health care chaplaincy.

Professions: definitions and frameworks

Sociologists have provided a range of descriptions of professions. These definitions have tended to emphasise the idea of professionals as people possessing unique skills that are put to the service of others. For many lay people the word 'professional' implies both special skills and propriety. It also implies accreditation, efficiency, competence, integrity and altruism (Pilgrim and Rogers 1993). It follows therefore that to be unprofessional is to behave incompetently, unethically, inefficiently or even fraudulently (Watson 1997).

Contemporary sociologists largely agree on the following basic propositions about characteristics of professionals:

1. Over the past two hundred years professionals have grown in influence, and expanded in both number and in types, particularly in this century.
2. Professionals provide services to people rather than produce material goods.
3. Professionals have a higher social status than manual workers through their salary or self employed status.
4. Professional status increases in relation to the length of training required to practice (doctors being an obvious example of this).
5. Professionals claim specialist knowledge about the work they do and would expect to define and control that body of knowledge.
6. Credentials give professionals a public and political credibility.

(Pilgrim and Rogers, 1993 chapter 5).

This is only a rough consensus and there is much disagreement about how professions should be understood from a sociological perspective. Durkheim, Weber, Marx and Foucault all generated frameworks for understanding professions. These, along with their relevance for chaplaincy, are outlined below.

Durkheim

For the Durkheimian tradition, professions are a source of community and stability within society. They achieve this by regulating their own practitioners and ensuring good practice through codes of conduct. Generally, professions regulate conduct in the interest of clients and to the benefit of the society they inhabit. Within this tradition the identification of a *checklist* of characteristics that distinguish professional from non-professional occupations forms the basis of a trait approach. Professionalisation is the process whereby occupations attempt to become professions by progressively acquiring these necessary characteristics. For example, the professionalisation of the clergy has seen a development in the previously haphazard approach to training programmes that integrate pastoral practice, psychology and sociology into training and ministry (Ballard and Pritchard 1998).

The relevance of the neo-Durkheimian framework to health care chaplaincy lies in the process by which chaplaincy has attempted to regulate

a 'skills and outcome' approach to its work through the development of a set of occupational standards – *Health Care Chaplaincy Standards* (College of Health Care Chaplains *et al.* 1993). This established the standard of performance expected in a given work role for chaplains, offering managers a definition of competent performance in the workplace.

Weber

The Weberian tradition contains two notions relevant to this question: social closure and professional dominance. It is argued that collective professional social advancement rests upon social closure, which functions as a means of excluding occupational groups seeking similar roles. Professionals thereby restrict access to the rewards and privileges of a particular job (MacDonald 1985). Through a sharp definition of the boundaries, others are denied access and thereby kept in a state of ignorance. The maintenance of social status for professionals depends, in part, on their capacity to persuade others on the outside of their defined boundaries that they offer a unique service.

The more formal attempts by chaplains in recent years to offer a distinctive service, based on national standards and agreed outcomes, may be seen as illustrative of social closure. The attempt to establish a unique body of knowledge to underpin a new therapeutic terrain in spiritual and religious care, to the possible exclusion of others, together with their specialised activities in the area of bereavement, death and dying, staff support and education, may be interpreted as attempts to control a knowledge base which is distinctive, thereby securing their professional role and relevance in the health care institution.

The concept of professional dominance is a key feature of the Weberian understanding. This is specifically concerned with power relations. Professionals exercise power over others in three ways: they have power over clients, power over new recruits and also subordinate others within a given group. The culture of the acute hospital in particular is shaped by medical dominance, causing the chaplain to experience a marginalisation of role and identity. The setting up and development of the College of Health Care Chaplains has been part of the process of professionalisation (defining credentials, creating a distinctive knowledge base, cornering the market). From another point of view, the alliance with the MSF Union may be seen as an alternative route to the securing of some kind of professional dominance.

Marx

The Marxian tradition conceptualised power relations on the focus of vertical structural relationships. The issue for neo-Marxians is where professionals fit into a social structure which is characterised by two main groups in society: those who work to produce wealth, and those who own the means of production, exploiting the workers for profit (Larson 1977). Unsurprisingly, sociologists following a Marxian tradition of analysis have had conceptual difficulties with the professions. Professions may be deemed to be either part of the ruling class (Navarro 1979) or part of the proletariat (Oppenheimer 1975). Alternatively, they may hold a contradictory position in society, being neither capitalists, nor full members of the proletariat. Health care chaplains might be seen as being in this contradictory position: they are both agents of social control, acting on behalf of the Welfare Capitalist National Health Service, and vulnerable to the same exploitation as any other group of workers by their lack of control.

Foucault

Foucault, working within a post-structuralist framework, was interested in the relationship between knowledge and power. His framework provides a different way of looking at applied knowledge and professional work. It has no notion of a clear or stable power discrepancy between professionals and clients or between dominant professions and subordinate ones. Rather, power is dispersed and cannot be simply or easily located in any particular groupage. It is bound up with dominant, discursive features of a particular time and place, though these may be changed and resisted. For Foucault and his followers the ways in which the person – the body and mind of an individual – is described (measured, analysed and codified), are central features of contemporary society. Medicine has a central role in the surveillance of sick and healthy bodies in society.

Managerialism, dominance and closure

The introduction of general management into the NHS has had a significant impact on all health care professionals. It is clear that this change has also seriously threatened the traditional autonomy of health care chaplains. Many have been forced to become more accountable and have been made to respond to a number of challenges about the outcomes of their work in the delivery of health care. Some have secured and developed their position in

the light of these challenges while others have clearly struggled to respond appropriately and creatively (Woodward 1999).

The medical profession, although similarly affected by the extension of managerial control over clinicians, has retained an unrivalled freedom to control the content of its work. The power of self-regulation and freedom from external judgement has contributed to a position of strength in relation to potential competitors, protecting medicine from boundary encroachment from other occupations. The power of medicine has in fact extended beyond self-regulation, given its monopoly over the control and organisation of health care in the wider division of labour. It has the power to direct and evaluate the work of other occupations engaged in the care of patients, without being subject to such gaze itself. The paramedical occupations, in consequence, have been excluded from the vital task of diagnosis. Their work is supervised by medicine and they lack control over their knowledge base (Larkin 1983), experiencing profound difficulties in developing their professional autonomy within health care organisations. Likewise, chaplaincy has had difficulty in defining itself as a form of paramedic group or persuading others that it is itself a therapeutic service. It has consequently remained on the margins of the debate about therapeutic intervention in the health care process.

Concluding the discussion about the sociology of professions with respect to chaplaincy, several comments can be made. It is evident that there is no agreed general definition of 'profession' when it is used by chaplains and it can be interpreted in a variety of ways. A number of debates are relevant to the development of chaplaincy. These include the process by which chaplaincy has attempted to regulate its work through the promotion of a distinctive skills, knowledge and training base. Further, it relates to the impact of the professional dominance of both managers and doctors on the culture of the NHS in general and the autonomy of chaplains in particular. The discussion about social closure is significant in respect of whether or not ordained chaplains should alone offer spiritual and religious care. This is an issue of identity and of how chaplains achieve a measure of organisational security within their hospitals. The post-structuralist framework relates to how chaplains handle the relationship between knowledge and power in their work. This discussion concerns the question of how chaplains use their theological knowledge within their work and their reflections on the context of the hospital: in other words the relationship between professional and religious identity. It is to this key theme that we now turn.

Clergy as professionals

Most sociological accounts of the clergy follow the general assumption that the clergy are a profession, to be ranked alongside lawyers, doctors, teachers and other professional groups (Parkin 1989). However, Russell (1981) argues that the apparently 'professional' developments of the clergy from the 1850s onwards have been overtaken by a new phase in which the Church begins to operate more like the voluntary societies, with fewer professionals and more part-time voluntary workers. This situation has generated an identity crisis focused on two major issues. First, whether to struggle to maintain public recognition, either by negotiation (so, health care chaplains) or by offering specialised secular skills such as counselling or therapy. The threat here is that the spiritual and religious tasks are left in the background. Second, how far to concentrate on the distinctively religious role and to work primarily with those in the churches, or else more alongside other 'caring' agencies as part of the team representing one, somewhat marginal, area of activity.

In this context the issue for health care chaplaincy is whether to accept a distinctive professional model or resist it, and if so how, in an increasingly differentiated society (Lyall 1995). It is a matter of how far the clerical role, professional as it may be in certain ways, needs even for professional purposes to retain a certain amateurism, generality and marginality. Russell lists the ways in which clergy have adopted a functionalist or trait approach to developing a professional model for themselves. There are significant difficulties in describing the clergy as a profession. These difficulties include issues of career structure, body of professional knowledge and employment practices.

Career structure

Once ordained, the clergy have no career structure. Career development (preferment) depends upon a system of organised patronage, exercised by bishops or other ecclesiastical officers but also by persons and institutions alongside the ordained ministry such as the Crown, colleges, party organisations and lay patrons.

While clergy have a strong ethos of service, a distinctive form of dress, language and folklore, and a sense of group solidarity, these are secondary professional attributes. Other occupational groups may possess these secondary characteristics but not be regarded as a profession.

Body of professional knowledge

A central concept in relation to the question of whether or not we should see the clergy as a profession relates to the assumption that theology is their body of theoretical professional knowledge. There are problematic questions over the nature and use of theology. It is not clear how much theology, as currently conveyed in the course of clergy training, is of use to health care chaplains, and how confident they are in the practical use of religious discourse in their work. Some chaplains have turned to psychotherapeutic knowledge or managerial language as a source of security for their work (Woodward 1999).

Employment practice

Finally, at present, the churches embody employment policies which discriminate against women, gays and lesbians. There are no contracts of employment with equal opportunities policies that promote an equitable framework for clergy employment. In reality, there is a tension between those who believe that the Church is a 'traditionalist' organisation and those who believe that the future is 'adaptionist' (Gill 1989). This tension has focused on the integration of women into the priesthood of the Church of England and views about the acceptability of homosexual lifestyles amongst lay and ordained Christians.

In the light of the above, two statements can be made about Anglican clergy. First, in spite of a general belief to the contrary, in many respects they are not a profession in the normal definition of the word. They may have some features characteristic of a profession but these are secondary rather than primary. In the case of health care chaplains, aspects of their adaptation to the changing context within which they work mean that they have exhibited characteristics that demonstrate aspects of professionalisation, but they cannot be regarded as a health care profession alongside other professionals in the NHS. Second, the traditional paradigm for Anglican clergy is of the single-handed parochial person. The parish continues to encapsulate several key characteristics of the Anglican clergy and is the basic unit of Anglican life. This is a significant point in relation to how health care chaplains choose to define themselves in ecclesiastical terms. If we try to think in normative terms, at best we may say that the parish is to the clergy person what the manor is to the squire: the geographical and social context in which their social status is expressed. It gives meaning to the rank conferred on a person by ordination, by ensuring there is a community that

will respond to their actions, and respect their status. This is in contrast to most other professions in which the practitioner is required by clients on the functional basis of the specific service that can be provided. Specialist ministries, like health care chaplaincy, are usually undertaken by people to whom the Church gives no specialist training beforehand. They may, in addition, complain of feeling isolated and tend to define themselves in reaction or response to this parochial model, perceiving themselves to be displaced parish clergy (Legood 1998).

Towards professionalisation?

Notwithstanding the issues discussed above, there are factors which point towards the professionalisation of health care chaplains in recent years. These relate to the way pastoral carers, both within health care chaplaincy and beyond, have explored their identity and self-understanding as they work in institutional settings. In recent years, pastoral care has increasingly assumed the form of a modern profession, with the emergence of national professional societies, the promulgation of standards, the accreditation of training programmes and certification of pastoral care givers. This has generated criticism, not over the effort to ensure good quality pastoral care, but over the way these developments seems to contribute to its secularisation.

Some in chaplaincy have advocated greater professionalisation, stressing the importance of standards for the competence of pastoral carers. However, the nature of those standards has been controversial. The same role conflict we see confronting individual chaplains working between worlds exists in this collective arena where standards are being defined. Chaplains sit between the expectations of the more secular professional groups within the health care organisation on one side, and the expectations of more theologically orientated religious communities on the other. The professional groups exerting influence on the pastoral care community in this respect are primarily health care managers and central government, who have generated expectations around national frameworks and standards. The problem is that pastoral care is a religious activity and therefore its special body of knowledge, to a significant degree, is religious knowledge, itself perhaps better described as a kind of wisdom centred on spiritual practice and experience. In terms of standards, religion does not qualify as public truth but only as private belief.

Some chaplains are clearly eager to generate standards in what has previously been an ill-defined field. Chaplains are in search of an identity and degree of institutional security from whence the effects of modernisation on their role can be explored. They want their role to be understood and they want to exercise some influence on their hospitals. Inevitably, one of the challenges within the context of a professional existence is that chaplaincy is still in search of itself. This needs to be set against the feeling that retaining an element of amateurishness is part of the chaplain's usefulness. In contrast, the process of hospitalisation and the structures which control the delivery, tasks and functions of health care are very clearly defined. This is a regimented structure with clearly defined boundaries both between and within professions.

Unsurprisingly, the question of how the chaplain fits in to this clearly demarcated process is both challenging and problematical. The institutional position of the chaplain is not a neat one, and in order to perform the functions and tasks of pastoral care within the hospital a number of tools will be needed. These include anthropology, psychology and management skills as well as the normal ministerial training in theology and pastoral care. A whole range of factors will bear upon meanings of illness in a hospital and the chaplain is required to be flexible in both thinking and practice. The hospital acts as a kind of threshold that transforms a number of traditions and produces its own world of religious meanings, if largely divorced from the world of the Church. This hospital world is attractive and energising for some chaplains; for others it is complex, devaluing and confusing.

Despite the growth in numbers of chaplains and some measure of increase in professional competency, hospital chaplains remain in some ways an enigma to themselves, the churches and the health care world. What is clear is that the success of health care chaplaincy lies in the personal characteristics of the individual chaplain. Chaplains define their personal identity individually rather than through a tradition or corporate identity such as the College of Health Care Chaplains. They are often admired as men and women; sometimes as acceptable faces of religion and at other times as people who have listened and supported with a huge amount of sensitivity and skill. It follows then that while the role and functions of the chaplain may be enigmatic, their personal characteristics are not. Chaplains are appreciated for their personal warmth, approachability and readiness to support staff. These characteristics are both valued and affirmed.

Perhaps this hints at the dangers in the adoption of professionalisation strategies. It may not be desirable to define too closely the art of hospital

chaplaincy. It is a ministry of dialogue and of the exchange of ideas and feelings. It is always on the move; always changing, partial, informal and always passing by and through. Its constant feature, in addition to the strength of the personal characteristics of the chaplain, is the readiness and skill in listening to the voices of suffering. This is the unique function of the hospital chaplain, which some understand and value and others mistrust. In embracing a philosophy of the human ecology – that is the understanding and care of human beings as whole persons in the light of their relationships to God, to themselves, their families and a society in which they live – the chaplain continues to be a resource for the processes by which we live with our suffering. Chaplains therefore find themselves easily enmeshed in conflict. Their role is not to explain, cure or eliminate disease. It is to engage with the sufferer in the suffering, and to embrace it with sensitive pastoral care.

At the heart of ministry lies a conviction about the nature and person of God. A minister is a vocational professional in the sense that one of the undergirding questions motivating his or her work is: 'what does God want of me?' It is important, therefore, to ask how theology might become a useful tool in the attempt to move the ministry of the health care chaplain to an acceptable professional base within the health service. Perhaps in a desire for security, the chaplain prefers to adopt and appropriate many of the cultural norms prevalent within the organisation of health care itself?

It is within the context of the hospital as a secular institution that the Christian chaplain has to work out his or her obedience to the gospel. There is a theological basis for working with the culture as 'given' by the creator. There is a need to state a belief in God as not confined to the religious sphere or embattled against non-Christian structures, but as involved in all parts of creation. It is in this context that the need to be professional and the negotiation of freedom in controlling the content of chaplaincy work seem to be significant, but there are certain dangers in the ethos of professionalism. There may be some uncertainty or confusion about what 'professional' means in this discussion. For chaplains it is partly to do with being efficient and co-operative in relation to the hospital structures, and this understanding is to be encouraged; but it cannot stand alone. The issue is in part about a chaplain's sense of identity and role within the hospital. There will, of course, be some chaplains who hold the structures and value systems at arm's length while they continue their activity. This approach is, I believe, defective.

Health care chaplaincy has no option but to organise and develop a professional approach to its key tasks, but there are dangers. The organisation of health care is often ambiguous and complex. There is a need to get the chaplains' feet under the organisational table but often to remain on the edges and margins, and risk feeling impotent as a result. In the light of this, refuge may be taken in clear roles in order to cope with the feelings of insecurity: the chaplain as academic; the chaplain as manager; the chaplain as therapist. Perhaps a chaplain needs to be critically reflective about where self-validation comes from. It will not necessarily come from the attempt to be professional in a narrow sense. In the debate about clarity of roles and tasks, what part is there for the intangible, the immeasurable and the transcendent?

One of the areas within which there is a major theological crisis is in the chaplain's critique of the culture of which he or she is a part. Chaplains seem reluctant to take on the role of saboteur, mole or whistle blower. More reflection needs to be done on the assumption of the implicit goodness of the organisation and culture of health care today. In this sense chaplains have understandably become institutionalised. Their loyalty is with the hospital that pays them. There is discomfort in asking 'with whom or to whom do chaplains need to belong?' The role of the prophet is an almost impossible one to fulfil when the chaplain depends upon the hospital for validation and security.

In a postmodern world, clergy are not absent. They may be misunderstood but they still stand as valid representative figures. In the health service, chaplains live with paradox and tension; engaging with marginalisation and disempowerment. They are present in and potential transformers of the experience of illness in relation to staff, patients and their families and friends. It is perhaps inevitable that chaplains are odd, but maybe this is where their strength lies: not in their professionalisation but in their liminality. Their marginal position allows them to listen, to interpret and to share meanings and activities which in essence are liberating and transforming. Hospitals may well be poorer places without them.

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