

with. This was significant for management who perceived that the chaplains were being paid for but could not be effectively managed.

For the chaplains there would result greater control over resources, and the provision of a more flexible and locally responsive service to the hospital would be enabled. Such an arrangement would impose business like disciplines, remove the almost voluntary set of relationships team members had with each other and increase accountability. This last comment betrays an underlying weakness of a part time team who are moonlighting in the hospital.

Removed from denominational constrictions, based on an outdated formula of religious affiliation in an area, focus could be on the abilities of different members of the team to address specific needs within the hospital. In vision it appeared as a way of creating a closer ecumenical and spiritual community. We also saw ourselves as having a greater stake in the hospital and not having to relate to some distant denominational body.

The perceived disadvantage was more administrative work.

The paper was well received, encouragement was given, and in yet another re-organisation, those with whom we had built understanding moved on elsewhere. The only negative comment was regarding chaplaincy as being about spirituality not business plans. This was not a dichotomy we saw, as our desire was to provide an improved service for the hospital, but the warning was there.

Six years on, the seascape is different. The ACAD is closer. HDL (2002)76 has happened, but is not omnipresent. Privatisation has been reversed. The wards are fewer, the stays shorter and the budget redder. Some of us have seen the advantages of a denominational body in negotiating on behalf of small fish with a Trust that resembles a blue whale crossed with an octopus. Yet still, if anyone wants to play cards with us ... the table is open.

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## A Roman Catholic Perspective on Direct Employment

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Within a few months of its publication, I and my colleagues seemed to be eating, sleeping, breathing and even dreaming NHS HDL (2002) 76. As Argyll & Clyde developed its spiritual care policy so meeting followed meeting and tension built on tension. On more than a few occasions the gathered body of religious and spiritual care providers would have benefited from some of the peace and tranquillity they strive to bring others.

Why the tension? Several areas of difficulty contributed to it, concerning, for example, analysis given of today's society, the training and registration of chaplains, the implications of the data protection act, and the employment of chaplains, about which I will say more in a moment.

Significantly, it seemed to some of us that, in HDL (2002)76 and the draft policy which flowed from it, the death of religion was a given, and that "spirituality" had taken its place.

*"Chaplains in healthcare settings who once offered a purely religious ministry to members and adherents of their own denomination now devote most of their working time to patients, carers and staff who have no link with any faith community..."* (NHS HDL(2002)76)

Is that really the case? In my experience of the Royal Alexandra Hospital in Paisley most of the people with whom I came into contact were people of faith who did have a link with a faith community. Most of them declared themselves to be religious people, linked with a particular religion. Perhaps the

link was stretched a little further than it might be, perhaps there were events or situations that made it difficult for them to practise their religion as they might, and sometimes our meeting was the opportunity to do something about that through my ministry or through that of their faith leader. In fact this shouldn't surprise us since the statistics for our Diocese from the 2001 Census reveal that, of the 95% of people who responded to the question on Current Religious Belief at least 70 %, and as much as 80% in some areas, nominated a Christian religion; so for those 70 or 80 per cent of people we would contend that *religious* spiritual care would be most appropriate

Certainly there are in our area between 13% and 23% of people who profess no religion or faith but who still need spiritual care. Their needs are important and should be provided for. But the danger of the present climate is that we satisfy ourselves with a false common denominator of generic spiritual care that will never be able to provide for the religious care of religious people.

Now let me move to the issue of the employment of chaplains.

This is a major issue for the Roman Catholic Church. The present situation is that the Bishop appoints Chaplains, as and when he wishes, ratified by the Hospital Manager. The NHS reimburses the Church, at least in part, for the service provided. Although the Church of Scotland now seems keen to pursue direct employment of chaplains by the NHS, the Roman Catholic Church in Scotland will not do likewise. The Code of Canon Law determines that the ordinary pastoral care of the faithful is exercised by the priests in the parishes. That is why priests are normally appointed by the Bishop as chaplains to institutions within the boundaries of their parish. Of course, this is not always possible and the Bishop has the freedom to appoint chaplains resident elsewhere. Nevertheless, chaplains to institutions within the territorial boundaries of a diocese must be appointed by the local Bishop. This is because the Bishop has the duty to ensure that the needs of the people under his jurisdiction are cared for, whether they are at home, in parishes or, indeed, within institutions.

The Bishop alone knows the burdens of a particular community (including its institutions), and the skills,

temperament and limitations of each member of his clergy. He is aware of matters that may not become apparent through application documents and interview but may nevertheless be relevant. He is best placed, after consultation with his advisers, to make appointments for the best pastoral care of the people within his diocese. This is not to deny NHS's duty to ensure that those who act as chaplains within their institutions are equal to the task. The NHS must be satisfied that the person appointed by the Bishop is the right person. In this regard I can only speak of the situation in RAH, Paisley where there is an excellent partnership between the Bishop and the Hospital Manager with regard to the appointment of chaplains. The Catholic Church is committed to such a partnership with the NHS and will do all that it can to improve upon the good practice that exists.

It will not surprise you if I say that the Catholic Church is hierarchical. It has a structure; it has a way of working that relies on the jurisdiction that a Bishop exercises over his Diocese, priests and people. To adopt a system whereby priests are expected/encouraged to freely apply for posts in the NHS would limit the ability of the Bishop to provide pastoral care for *all* of his people as he sees fit. It would limit his ability to appoint priests to particular places as and when he determines. Direct employment, including personal contract terms, would limit his ability to relocate priests as the need arises.

The question then arises that if the Church already has a well-established way of working would the Scottish Executive attempt to prevent the Church from working freely within its own structures?

The Guidelines describe the current situation, without clearly indicating the future pattern of provision. But they do say that

*"The 1990 NHS and Community Care Act also allows the NHS to directly employ chaplains. However, whichever employment arrangement is adopted, a close working partnership between the NHS organisation and faith communities is essential."*

The phrase "whichever appointment arrangement is adopted" shows that the Scottish Executive is open a variety of models, including the continuation of the present setup.

In any case No. 28 of HDL (2002) 76 says;

*“Any denomination or faith community can apply to the NHS to make a whole-time or part-time appointment. The Spiritual Care Committee will decide if a paid appointment is necessary. However, any officially recognised spiritual caregiver will have the necessary costs of his or her work reimbursed.”*

So, even when not directly employed by the NHS, the necessary costs of the work of Catholic Chaplains could be reimbursed.

There are, of course, some who wonder, innocently, why the NHS should pay the Churches for doing their own work. Without employing or reimbursing faith community chaplains, how is the NHS going to provide for the spiritual and religious care of their patients many of whom will not be satisfied with a generic spiritual care? The guidance from the Scottish Executive makes it the responsibility of the NHS to provide for the spiritual and religious care of their patients, not in the manner that the NHS determines but in the manner that the patient determines. This is the crux of the matter, for the NHS like the Executive and the Churches is at the service

of the community through serving the needs of individuals. It is the patient who has the right to spiritual care according to his or her own beliefs and membership of a faith community or not. The Churches provided this service before payment from the NHS was an issue and would continue to do so even if no payment were forthcoming. However, it is a sign of an open, multicultural and democratic society that people should be reimbursed for regular services for their own and the wider community.

I have dwelt here on the problems we faced in applying NHS HDL 2002 (76) to our situation but I applaud the Executive and the NHS for taking seriously the issue of spiritual care and for seeking to improve its provision for our fellow citizens who are in hospital. I applaud also NHS Argyll & Clyde for, despite some very difficult and tense meetings, they committed themselves to seeing through the process of dialogue until an agreement could be reached between all the stakeholders so that the needs of the community would best be served.

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## References

NHS HDL 2002 *Guidelines on Chaplaincy and Spiritual Care in the NHS in Scotland*. NHS Health Department Letter (2002) 76, Scottish Executive Health department, Edinburgh.