REFLECTIONS - "THE HOSPITAL FROM WITHIN THE PARISH"

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In the early part of 1996 I accepted, with sonic nervousness, the Bishop of Birmingham's invitation to leave the Queen Elizabeth Hospital for two small rural parishes on the north side of the Diocese, just within Warwickshire. This parochial responsibility was to be combined with work as Bishop's Adviser for Health and Social Care. Two months into this new responsibility, some of my apprehension has diminished as I attempt to engage with some interesting similarities and differences. My office, overlooking the main clinical building and on the edge of the University of Birmingham, and with the noise and business of ambulances, traffic, patients and their families, staff and all the machinery of health care, has been replaced with the sound of tractors, geese, and a study window which overlooks a fine mediaeval church. As I look, out three horses pass the window and the local gardener struggles with his lawn mower over the churchyard, trying to avoid loose stones and the maze of monuments. If any of you have reason to pass by this way, then please call in for some refreshment appropriate to the time of day. Of course, the particular pictures that I have painted may stand in sharp contrast one with another; but there are similarities. Both the hospital and the village are communities with their own joys and struggles and challenges. In both communities many hundreds of tasks and activities are being performed. Within both communities a number of individuals and groups will be facing or embracing life's experiences - anxiety, expectation, loneliness and alienation, hope, fulfilment and satisfaction, the joys and heartaches of relationships and the complex business of conversation, communication and meaning. Of course many of these life experiences find a very particular kind of expression in a hospital - though they abound in different sorts of ways in the life of any person or group.

At the heart of my reflection about this change from hospital ministry to parochial ministry lies the thought ... *Where is God in all this?* Other questions emerge from this thought like, What is the role of the Church (in hospital community or village community)? And what is my role as a priest within these communities? However, these are secondary questions, and behind them lie matters like the manner of our thinking and feeling about spirituality, and about God who is both present and absent, glimpsed and hidden in the lives and experiences of people.

I enjoy being the vicar with its visibility and status. The summer has brought a steady flow of offerings to the Rectory door - raspberries, redcurrants, plums, potatoes, green beans and more! In the same way, when the bleep went off and one was called into a situation of particular need, however difficult, it made one feel needed and important. There is a danger here. The challenge to pastoral ministry is *"whose needs are being met?"* While God can and does use the strength and giftedness of any individual's style and approach, we can easily get in the way if our pastoral presence isn't self-aware and gently and creatively questioned and challenged. There is a complex relationship between listening to others, listening to ourselves, and listening to God. The space and dynamic between those three is the very substance of ministry, shaped and moulded by whatever context we work

in. In that sense I am still wondering what difference the change of context makes, for in some respects those issues remain constant. In other words, what is the relationship between being, contemplation, attention to God and the roles and activities of professional caring? Where is God in all of this, or *what kind of God* do we envisage to be the heart and soul of our ministry?

These questions seem important to me at this stage in my ministry. My initial impression of living in a village, even amidst some high-powered professionals who commute from here into the city and beyond, is that life is taken at a much slower pace. There feels to be time and an attentiveness which has surprised me; I miss the energy and activity of the hospital but realise that the burning of energy is done at a cost. In this respect I guess I paced myself badly within the hospital work. Some of this was inevitable. My own particular unit went through very traumatic change and was one of the last hospitals to achieve Trust status because of its poor financial record. Some of the expectations were set by my own sense of where chaplaincy was and where I wanted it to go within the hospitals.

Approaching the middle of my sixth year I kept on wondering how my other colleagues elsewhere in the "acute sector" had managed to survive a decade or more within their own particular environments. How are motivation and commitment to be kept alive and fresh? What are the particular personal and ministerial costs to a lifelong "career" in hospital chaplaincy? These are of course as much challenges to be shared within any local Deanery Chapter as they may be within the local branch of the College of Health Care Chaplains. These issues feel important because so often the question of ministerial development is cloaked with a conspiracy of silence and dishonesty. All positive achievement in human life is done at a particular cost. There are, as we know, particular costs in ministry. Don't we need to find ways within which we can express our own sense of fragility, vulnerability and failure? Isn't that one of the things that those who embrace illness have to teach us?

Many of the families here in Middleton have their own private health insurance. Others prefer to use their savings to purchase private health care in the firmly held belief that it is of a better standard than that provided by the state. Health and well being are irredeemably social and political realities, whoever we are and wherever we live. Visiting a parishioner this morning in the local hospital, it surprises me to see the building and the activity of care with slightly different eyes. My parishioner has had a major operation and is being discharged after spending only three nights in the place. What hospital chaplaincy cannot afford to ignore is the radical changes in the structure and culture of health care today. What are the implications of the primary health care-led service for acute care? How will medical power and its knowledge face change in the next decade? Is it possible that acute care will continue to shrink with these hospitals cutting back on any service that does not have an identifiable and measurable difference on the health outcome of a patient? In all this, what appropriate models of chaplaincy should be employed? And nationally, what will the role of the Churches and theology be in these health care developments? I think chaplaincy needs to engage much more creatively with the dominance of medical power

and the medical model of health. There are other networks and partnerships we could work with in this critique and challenge. How can we empower ourselves and our patients to express what they want from others, especially doctors, in the process of health care? As long as some of these issues remain out of sight, I think that acute hospital chaplaincy is strangely insecure within the modern trends in health care. This, in part, reflects the role of the Churches within British society.

One final area of reflection. While 1 look back on my six years at the Queen Elizabeth Hospital with a great deal of affection and gratitude - the team achieved an enormous amount during difficult changes - I am challenged to think about the points of failure or silence. Is it not true that most affliction and suffering is lived through, often in silence and without any meaning whatsoever? From this perspective, much of the theological language is, at the very best, rather problematic in its relevance. I'm sure you can think of people you have met who have no language within which spiritual pain can be articulated and dealt with. This surely is the core of the matter? Hospital chaplains are at the forefront of embracing suffering and absorbing the destructive terrors of life that constantly threaten to destroy human health and wellbeing. One can't help but feel that much of modern living is impoverished because of the profound marginalisation of the spiritual in our world. Some may die in pain because they have no language in which to articulate their pain, purpose and experience. In this sense theology has failed to provide them with a framework in which living is understood and explored, and therefore dying celebrated and made something of. This is where chaplaincy has real expertise and could be a resource in so many different ways for our living and loving. This is our distinctiveness: working to uncover and recover the spiritual dimension of health and life.