

The relevance of Michael Wilson's chaplaincy research for healthcare chaplaincy today

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In this article I intend to establish the relevance of Michael Wilson's chaplaincy research. I will describe the background to the study, outline the key features of the work and then summarise these key areas for further reflection and research.

Michael Wilson's *The Hospital - A Place of Truth*, Published in 1971 remains today a remarkably comprehensive exploration of the role of the health care chaplain, and has become a standard work on chaplaincy with a wide circulation and influence.'

The origins of this work are of interest. In 1966, The Queen Elizabeth Medical Centre contacted the University of Birmingham Institute for the Study of Worship and Religious Architecture for advice on specifications for a hospital chapel. The then Professor of Theology, Gordon Davies, suggested that it would be more fruitful to explore the role of the chaplain, and a working party was established. In October 1967, Wilson joined it as a Research Fellow with funding from the Joseph Rowntree Charitable Trust. He undertook the major study with the co-operation of the Department of Social Medicine in the University of Birmingham.

Health and the context of the hospital

Wilson makes recommendations about hospital chaplaincy with a number of surveys. This puts the exploration of the chaplain into the context of understanding the tasks of the hospital within the wider context of the work of the church as a community. Wilson argues that the focus of any hospital institution is always people in terms of their situation and destiny. He explores the task of the hospital and the meaning of health, and discusses the hospital as a resource of belief. The hospital is a school for society in which attitudes to illness and health, ageing and death are taught.

Wilson develops an understanding of the dynamic between learning and experience in relation to the kinds of attitudes that shape hospitals and the kind of learning that emerges from illness. 'The primary task of the hospital', he writes, 'is to enable patients, their families and staff to learn from the experience of illness and death and to build a healthy society.'²

He goes on to develop his argument by exploring the meaning of health through a discussion of different models of health at work in a hospital. Wholeness in this context means the whole of life. Death is part of what it means to be human. Illness is in part positive and tragedy is not something to be overcome but an experience to be understood. From this basis he argues that the Church should be involved in health planning, organisation and delivery. It should also encourage theological thinking about the meaning

of health as it is worked out through good and bad structures by disclosing the truth of our life, ourselves and God.

The hospital is a source of belief about human personhood -and society. While acknowledging the achievement of the hospital as an expression of human concern for well-being, Wilson assesses the institution as a place where problems are solved, one which thrives on the objectification of faults in human systems and their correction. He sees hope for the reshaping of hospitals as he outlines two important current forces in medicine. They are the development of social medicine and the development of community therapy and mental health.

In the discussion of the primary task of the Church in the hospital, Wilson asks questions about the interrelationship between involved detachment and critical responsibility, that is how far the Church should be identified with the values and structures of the institution of the hospital. He briefly explores the effects of being a Christian in the workplace of the hospital and asks whether or not a network of Christians affect the work and culture of the hospital. He defines the task of the Church thus: 'to express in its common life the truth that sets men free to be fully human.'³ This definition is a result of discussing the meaning of charity within a dynamic of giving. These general purposes then need to be applied to the circumstances of the hospital.

All this thinking bears upon the role of the chaplain. It suggests that the chaplain has to deal with some difficult conflicting expectations of the role. Wilson develops some distinctive ideas and concepts of the role of the health care chaplain: 'his work is a work of prayer and communication in thought, word and deed. His most powerful work is reflective and contemplative ... prayer and work are related.'⁴

Wilson believes that the chaplain is universal in belonging to all, and that the patients appreciate his friendship and the quality of communication with him. There are problems about identification and identity which seem to be resolved in personal terms rather than functional terms. In other words, the *success* of the health care chaplain depends more upon personal qualities than upon clarity of role if that is seen as a matter of clearly listable tasks and procedures which exhaust the content of the role.

The nature and role of chaplaincy

The role of the hospital chaplain is explored in depth and detail. Wilson accepts its difficulty, particularly in relation to the complex culture within which it is located, and also discusses the easily neglected relationship of the chaplain to the local congregation. He concludes that it is impossible to define the essence of a successful chaplain. In his analysis of surveys of the views of ward staff his conclusion is that 'It depends upon the man.'

Building upon his conclusions, Wilson argues for more ecumenical teamwork within chaplaincy. He particularly suggests chaplaincy departments look at the concept of establishing a *hospital chaplaincy teaching unit*, where the chaplain is a lecturer in health and human values, an administrator of the team and an initiator of research. Undergirding the framework are the following beliefs:

- 1 the role of the full-time chaplain should be more experimental, and
- 2 the role of the priest is always that of a generalist: 'the environment (the hospital) must not be conceived of in terms of a specialism so much as in terms of a foreign culture'.⁵

Wilson then asks what chaplains need so that they can be at ease in the hospital culture and warns:

The role of the counsellor clearly fits comfortably into the expectations of a therapeutic institution. But the chaplain may have changed his model of health based on the Gospel, for the medical model of sanitation, wellness through the eradication of defect.⁶

In a discussion of the nature of religious needs, Wilson highlights the effects of developing secularism in the late 1960s and early 1970s. He asks what areas of life are vested with religious significance. In an attempt to hold on to the distinctiveness of the role, he concludes:

The chaplain, therefore, is not primarily someone who steps in to complement care at the point of a ward sister's weakness, or because he can speak of God and she cannot. He enables staff to deepen the quality of their own patient care, he does not take it out of their own hands.⁷

He builds upon this model of the chaplain as theological educator within the institution:

The skill of the chaplain lies in his knowledge and communication of what it means to be fully human: that is to love God and his neighbour as himself in thought, word and deed ... His expertise is therefore common property. He too is human and what he learns about being human it is his professional skill to share with others. His self-knowledge is the key to his ability to help others. He is always, therefore, open to learn something from others.⁸

Again, the core finding of this research indicates a large degree of reliance on individual and personal categories - if people like the chaplain as a person, they respond to the possibilities of conversation. This leads Wilson to conclude:

The hospital creates particular divisions between sacred and secular, professional and private, formal and informal, giver and receiver; the chaplain will identify himself with both poles in each tension, and try to be himself, the same person in all his roles

... the role of the hospital chaplain is an enigma. Essentially an adventurer, he explores the dangerous territory of man's making and breaking; where every meeting is new and no situation is ever repeated.⁹

Drawing upon the industrial chaplaincy movement and the work of the William Temple College in Rugby, Wilson argues for the chaplain as an institutional theologian accessing the hospital structures at every, possible point of influence, power and planning. The chaplain is chaplain to the hospital as an institution. He will sometimes become aware that the hospital itself is a sick structure, promoting the very anxieties about death which society created it to relieve.¹⁰

The study concludes with a discussion of the practical aspects of the role of the chaplain in relation to death and serious illness. In the light of this it explores the relationship between beliefs and buildings as they relate to the kind of chapel necessary for a hospital.

For Wilson the chaplain should be the person who can embody the learning, non-sickness-centred and non-objectifying attitudes which all in the hospital ought to have. A chaplain will have many roles, formal and informal, prophet, priest, administrator, counsellor, teacher, healer, judge, servant. Beyond all these, his role is to be himself. He is to be a person, himself: to be the same person within the hospital as without, in his professional life and outside it.

The man who makes a consistent attempt to be himself in these different roles, to be truthful in his relationships, will make integrity and truth possible for others, that is, allow them to learn about themselves and others.¹¹

The key word here is 'integrity'. This comes from holding the sacred and secular, health and sickness together. It follows from this that the minister of word and sacrament will not attempt to gain a respectable image.¹² In the face of a highly professional institution, he will remain an amateur, a generalist, one whose work is that of prayer and communication in thought, word and deed.

Wilson's work gives the impression that the chaplain belongs to a different order from others in the hospital. He is to present a radical challenge by his life and works to the hospital. The chaplain has a Socratic role. A person who is trusted by all, he can ask questions from a frame of reference beyond the hospital. Wilson's chaplain does not compete with the professionals, to 'do' things, to find a role, but is rather a generalist. He is a universal man, relating to all equally as people and trying to be himself. He questions the assumptions of the hospital while identifying with its members.

This model affirms the ministry of the chaplain to all in the hospital and has connection with the whole church and the need to look for health rather than weakness and to question the hospital's assumptions.

There are some limitations to this vision of chaplaincy. There is little explicit theology to justify this ministry. There is a danger that this 'alternative' human being might stand above and beyond the hospital and lose contact with individuals because of his extraordinary *modus vivendi*. Finally there is little development of the exploration of what being himself' actually means.`

'The continuing relevance of *The Hospital - A Place of Truth*

This piece of work continues to have significance for chaplaincy in a number of respects. The first is how it has shaped practice, particularly at the Queen Elizabeth Hospital, Birmingham, by Peter Bellamy and his successors, the present author and Francis Buxton, the current chaplain. During the period 1990 to 1996 the opportunity for innovation in chaplaincy was limited by organisational change though the model of chaplaincy was extended across other acute hospitals in South Birmingham. The use of 'lay volunteers' in the team continued and the chaplaincy team was the first in the country to establish a formal ecumenical covenant. This model of ecumenical partnership, for which Wilson argued so strongly, has now been adopted by many other centres. The commitment to education and teaching also continues through a variety of partnerships and projects. Thus, Wilson's thematic research shaped and continues to shape aspects of practice.

Secondly, it provided the base from which many other writers and researchers have developed pieces of reflection.` While there are some indications of interest by chaplains in research Wilson provides a major thematic model for evaluating chaplaincy practice and a tool by which chaplains might continue to reflect on their roles and functions within acute care. Much of what he wrote about the hospital as an institution and aspects of the role of the chaplain remains relevant in today's health service. This is demonstrated in my own research and writing over the period 1992-1998, in which the chaplains interviewed continued to evaluate their role in personal terms and felt the tension between the hospital's values and their own beliefs and practices.¹⁵

In conclusion, there are three areas of Wilson's thought that need further work and development. Chaplaincy needs to continue to explore its knowledge base. Put in question form: what is the relationship between the chaplain as fundamentally a religious person and the desire to develop the chaplain as a religious professional? Is preparation for ministry an adequate qualification for employment as a chaplain? In a context where churches are recovering lay education and training is it justifiable to exclude lay people from appointments to full-time posts?

Secondly, Wilson offers the chaplain the opportunity to stand over and beyond the institution and encourages him to develop a model of ministry as offering interpretation of the cultures and languages of the hospital. He challenges the medical model of health and asks the chaplain to resist a problem-solving, reductionist approach to health. He also offers a more dynamic social model where the churches could play their part in the life of the hospital. Chaplains need support in exploring the inherent tension suggested between

their own 'languages and worlds' and the language and world of the hospital. This is set against a background of secularisation where the religious has become increasingly marginalised and misunderstood. Again put in question form: where do chaplains find their security? Are psychology and management better tools for the tasks of chaplaincy than theology? What skills are necessary for the chaplain in today's hospital?

Thirdly, set against the steady numerical decline of the churches and the diverse, multicultural nature of British society, Anglican chaplains need to explore the implications of their relative monopoly on chaplaincy. What does it mean to share power and work ecumenically and collaboratively? Can we continue to justify the predominance of the Christian representative figure when so few attach themselves to the churches as a source of truth and meaning? How are spiritual and religious needs to be met in a multi-faith society?"

Endnotes

1. M. Wilson, *The Hospital - A Place of Truth*, University of Birmingham Institute for the Study of Worship and Religious Architecture, 1971.
2. Wilson, *Hospital*, p. 31.
3. Wilson, *Hospital*, p. 44.
4. Wilson, *Hospital*, p. 52.
5. Wilson, *Hospital*, p. 82.
6. Wilson, *Hospital*, p. 85.
7. Wilson, *Hospital*, p. 91.
8. Wilson, *Hospital*, p. 102.
9. Wilson, *Hospital*, p. 107.
10. Wilson, *Hospital*, p. 112.
11. Wilson, *Hospital*, p. 55.
12. Wilson, *Hospital*, p. 52.
13. S. Pattison, 'Images of inadequacy: some theoretical models of hospital chaplaincy', *Contact* 69, 1980, pp. 6-15.
14. T. S. McGregor, 'Hospital chaplaincy', in A. Campbell (ed.), *A Dictionary of Pastoral Care*, SPCK, 1987.
15. J. Woodward, 'A study of the role of the acute health care chaplain in England', unpublished PhD dissertation, Open University, 1999.
16. J. Beckford and S. Gilliat, *Religion in Prison*, Cambridge University Press, 1998,

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