CHAPLAINS' SUPPORT OF STAFF

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ABSTRACT

CHAPLAINS' SUPPORT OF STAFF

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This project explores how chaplains support staff members at the Women's and Children's Hospital. The hospital is part of the South Australian Government's health system. The project began because of a staff member's account of exclusion from support following an incident. The project involves interviews with staff to understand how they experience and perceive chaplains' support for them. The interviews were analysed to uncover themes and common threads.

Two major themes are evident. One theme being the support that chaplains provide as part of the institution or organisation such as being part of a team, their educational contribution, their symbolic role and providing support in formal responses to crisis and trauma. The other is the relational role of the chaplains as they utilise spontaneous moments to care, such as conversations in the corridor, being available when needed, making time for coffee and combining this with an inclusive and respectful attitude.

Staff members speak of the multi-cultural, multi-faith context and secular nature of the public hospital system, and the ways that chaplains both negotiate this environment and provide respectful and non-judgemental care to patients, their families and staff. They also value that the chaplains offer a different perspective from those of the medical and nursing staff by bringing pastoral and spiritual insights to the conversation.

The context of this project is the Australian society with its suspicion of institutions and the church in particular. The patient, family and staff population of the hospital largely comprise a cohort who has little or no church affiliation. Australians speak of spirituality but are suspicious of religion. Yet, in the relational themes that staff members describe is the identification of the hospital as a village or community and the chaplains as the village priest or 'holy man.' Chaplains are also valued for their ability to engage with the spiritual conversations and provide appropriate rituals, blessings and prayers.

Staff members overwhelmingly speak of how chaplains support them in their workplace, often in informal and relational ways. Chaplains are valued and appreciated. What began as a story of exclusion concludes with a narrative of inclusion.

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ACRONYMNS AND GLOSSARY

ADF Australian Defence Force

AFL Australian Football League
AFL is a particular form of football played in Australia

AHWCA Australian Health and Welfare Chaplains' Association
The AHWCA was a national association of chaplains that formed SCA

ANZAC Australian New Zealand Army Corps
The Corps was first active in the Gallipoli Campaign of WWI and has been a descriptor for soldiers from the two countries since 1915.

ATSI Aboriginal Torres Straight Islanders
The two general Indigenous groupings in Australia

CE Chief Executive

Certificate IV – Pastoral Care
A qualification in the Australian Qualifications framework that focuses on competency based training

CPE Clinical Pastoral Education
CPE began in the United States of America and has become accepted training for chaplains. Its focus in Australia is on self insight and reflection.

CSSA Chaplaincy Services South Australia
CSSA negotiates with the South Australian Government for the funding of chaplains in public institutions.

The Dreaming The sacred stories and myths of the Indigenous people that provide meaning, connection and community.

Debriefing The meeting where information is shared about an incident in the hospital and care for staff is provided

EAP Employee Assistance Program
Provided in the hospital by an external agency.

ED Emergency Department

HREC Human Research Ethics Committee

ICD-10-AM International Classification of Diseases, 10th Edition, Australian Modification

ICU Intensive Care Unit

IRB Institutional Review Board

JP Justice of the Peace
The role of a JP in Australia is to notarise documents.

Multi-disciplinary The meeting of different disciplines to discuss the health and welfare of a patient. These include medical, allied health and chaplains.

LAC Local Advisory Committee
The committee that provides advice to the conduct of the project.

LMH Lyell McEwin Hospital

Padre The term used to describe a chaplain in the Australian Army

SA South Australia

SA Health The South Australian Health Department
A department of the South Australian Government.

SCA Spiritual Care Australia
The professional association of chaplains in Australia.

UCA Uniting Church in Australia

WCH Women's and Children's Hospital

WHO World Health Organisation

INTRODUCTION

Sue is a ward clerk who manages the administration of a unit at the Women's and Children's Hospital (WCH). Our conversation in the tearoom was convivial until Sue began to share her distress over the recent death of a baby and the lack of support that she felt from colleagues. Her angst was double edged –care for the grieving parents and her own distress.

Sue felt that care for ward staff following this type of incident was delivered in an ad-hoc and seemingly arbitrary fashion. Sue was speaking out of her own hurt and pain and asked 'who can I call to get some help'. I responded 'me'. This surprised Sue and despite my having a good relationship with her she lacked an appreciation that she could avail herself of the chaplaincy service of the hospital.

As we shared, three layers to Sue's story unfolded. Her belief that chaplaincy is purely a religious ministry, her impression that chaplaincy support is only available to patients and their families, and her exclusion from the support systems of the hospital. This view was not isolated to Sue, but shared by other staff in the unit who also felt unsupported in their role. This limited understanding of our role caused me to explore how prevalent her views were and if other staff members were missing out on the care that they could be receiving.

Sue's story resonated with me because I see the WCH as my 'parish' and Sue as one of the community I am to care for. She is one of the 3,000 staff of my 'congregation'. The ministry of chaplaincy is exercised outside of the church context, beyond its walls and as a mission of care of the church. As such I need to learn the language, culture,

attitudes, values, history and operational functions of an institution and world outside of and foreign to the church. The WCH is a secular public hospital which values equality and inclusion; it is also a multi-cultural and multi-faith environment.

My previous research[1] saw chaplains self-identify their role and practice; this project sought an objective description of chaplaincy practice as seen and experienced by hospital staff. This project was developed to test how widespread Sue's experience was and to gain an appreciation of other staff members' understanding of and experience of chaplaincy support. As a response to Sue's story this project also aims to heighten the awareness of staff members about the availability of chaplains as a personal and spiritual resource support. A narrative research methodology was used for the project with a focus on listening to the stories of staff members about how they were supported by chaplains. Staff members at the WCH and the Lyell McEwin Hospital (LMH) were interviewed.

Throughout the interviews and the analysis of the transcripts I was keen to hear the voice of our staff, to appreciate the nuances, layers of understanding and meaning of their stories. These stories form the basis of this project and it is their insights and experiences that are reported in the case studies I have selected to report. The staff were generous in their sharing and affirmative of the support that they received from chaplains.

I bring a perspective to this project too. I am aware that in talking to staff about the project, in engaging with the narratives and in analysing the data I am not a fully independent voice. As the chaplain I am part of the hospital and it affects me and I affect it. My responses have been calibrated by independent perspectives in particular my Local Advisory Committee (LAC) who have provided advice and review throughout the

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[1] Carl Aiken, "*How we do Chaplaincy*" (Master of Ministry Thesis, Melbourne College of Divinity, 2010).

project. Another perspective is my ministry formation that is eclectic and has been informed by a mix of biblical, theological, personal and practice understandings.

The project has four chapters.

Chapter 1 provides the background or context in which the project was conducted. This includes the ministry context at the two hospitals. They are acute tertiary teaching hospitals funded and managed by the state government's South Australian Health Department (SA Health). As such they are secular institutions. This chapter also contains my theology of hospital chaplaincy and an explanation of the methodology employed in the project.

Chapter 2 reports the results from the interviews with staff members. It details how the role of the chaplains are experienced and seen by staff. Two clear themes arose from the interviews in respect to the chaplains' role. One theme was the roles that chaplains have in the organisation of the hospital, being part of the structure of the health service. The other theme is how staff experienced the chaplains in a relational way. These are the voices of the staff members who participated.

Chapter 3 details the insights that I gained from the project. What I learnt from the narratives, the nuances and meaning in the stories that deepened my understanding. This chapter also speaks to what is different both now because of the project and what is planned for the future.

Chapter 4 is the discussion and recommendations from the project. I discuss how the findings may apply in other health care settings, the importance of chaplaincy ministry as a key outreach from the church and the importance of professional practice. Included are recommendations about how the results from this project may be implemented in other hospitals, in particular those within SA Health.

The project has been supported by Rev Jeff May the coordinating chaplain at the LMH and my LAC. Jeff conducted the interviews at the WCH and the LAC members assisted with recruiting participants and provided advice and review to me throughout the project. The LAC comprised staff members and chaplains from the WCH. Staff members who were interviewed gave generously of their time and their insights into how chaplains support them.

CHAPTER 1

Ministry Context

I love a sunburnt country,
A land of sweeping plains,
Of ragged mountain ranges,
Of droughts and flooding rains.
I love her far horizons,
I love her jewel-sea,
Her beauty and her terror
The wide brown land for me!
Dorothea MacKellar[1]

The context of this project is the WCH and the LMH. Both hospitals are part of the SA Government's SA Health, the WCH being the major paediatric and maternity hospital and the LMH an adult acute care hospital in Adelaide's northern suburbs. The WCH is a teaching hospital associated with the medical, nursing and allied health schools at South Australian Universities.

To appreciate the context of chaplaincy at the WCH it is important to have an understanding of the Australian community; its foundations, national narrative, identity and religious landscape. Every community is shaped by its history and those experiences mould shared values, beliefs, and attitudes. While many of these are common to other countries, there are also nuances and differences that are significant. It is in the context of the SA secular public health system that this project is based.

White settlement in Australia began with the establishment in 1788 of a British penal colony in New South Wales (NSW). The national narrative that grows from this is

[1] Dorothea MacKellar, "My Country," *The Closed Door* (Melbourne: Australasian Author's Agency, 1911).

one of overcoming adversity. There is also the horrific treatment of the Aboriginal inhabitants, much of which is only recently being openly discussed. The settlement was not birthed in hope and expectation but in punishment and exploitation. The brief discussion here will not explore the wider issues and implications of this. Rather for the purpose of this project; it will focus on what has shaped attitudes toward religion and institutions.

Deeply seated in the national narrative is a distrust of authority and institutions, in particular the church. Historian Manning Clark traces the distrust of the church, and to some extent the state, to Samuel Marsden, the second chaplain to the NSW colony. [2]

Marsden was a controversial figure. He arrived in the fledgling colony in 1794 at first working with and later succeeding Rev. Richard Johnson the colony's first chaplain. Alongside his religious role, Marsden was a successful farmer using convict labour and a magistrate (judge) known for administering harsh penalties. The early colonists saw the church and clergy as being participants in a repressive penal system, acting as moral policemen and as sanctimonious spies who identified with and supported the ruling class.[3] This combination of political influence, collaboration, money, and abuse of power by those in clerical authority weaves deeply in the psyche of Australia.

Until 1901, the various colonies were fully self-governing. The process for federation began ten years earlier and between 1898 and 1900, referenda were held in all colonies to demine if the proposal for formal co-operation would proceed. On 1 January

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[2] C.M.H. Clark, *A History of Australia, Vol 1.* (Melbourne: Melbourne University Press, 1981), 141, 144, 156, 162, 368.

[3] John Thornhill, *Making Australia: Exploring our National Conversation* (Newtown: Millennium Books, 1992), 182.

1901, the Commonwealth of Australia was formed. This of course did not create a national identity and most of the population still saw themselves as British. This too was about to change.

It could be argued that the national identity of Australians as no longer being British is grounded in a military disaster and a song about a suicidal thief. The landing of the Australian and New Zealand Corps (ANZAC) at Gallipoli in Turkey in April 1915 began the legend and myth of ANZAC. In the documentary 'Why Anzac?' Sam Neil observes;

> Of all the campaigns and all the wars that we have fought and all the events in our shared history, this disaster is the one we choose to remember more than any other. Why is that? Somehow we elevated our single biggest military catastrophe into an Australian and New Zealand foundation myth and claim this place (Gallipoli) as sacred.[4]

The song is A.B. 'Banjo' Patterson's 'Waltzing Matilda'. Patterson's swagman or itinerant worker was displaced by the harsh justice and conditions of the depression of the 1890s. In 1891 there was a national strike of sheep shearers with tensions between the landowners and the itinerant shearers. In Queensland the military were used by the colonial government to crush the strike. Patterson wrote the song in 1895.

The same themes at work in the psyche of the first settlers in relation to the clergy were at work in Waltzing Matilda. The disaster of the military campaign at Gallipoli and the subsequent carnage of the Western Front in France during World War I reinforced the growing sense of Australians no longer seeing themselves simply as British. A growing national identity was being forged. This was reinforced by the incompetent leadership and cavalier attitude to the lives of ordinary soldiers by British generals. This combination of

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[4] Sam Neil, *Why Anzac?* (Sydney: Screen Australia, 2015).

factors reinforced the antiauthoritarian streak and suspicion of authority and religion in the Australian psyche. The Anglican Church in particular has continued to align itself with the rich and powerful. The contra voice has been the Catholic Church which for much of its Australian history has been the church of the poor.

While chaplains were sent to the first colony, there has never been an official Australian church. At its heart Australia has always been a secular society. While there has been strong association with Christianity in Australian history it has often been at arm's length. In the national census of 2011 68% of Australians nominated a religious affiliation, 22% recorded no religion and 10% declined to answer.[5] However, this is not reflected in active faith community participation with only 9% of the population being regular attenders.[6]

It is often suggested that sport is the secular religion of Australia due to its large following and media coverage. The football codes of Australian Rules Football (AFL) and Ruby League have almost tribal allegiances while Soccer has strong regional support. The outpouring of grief when a sporting figure dies is also informative. On the verge of a recall to the national cricket team Philip Hughes died during a game in November 2014.[7] His national teammates played a 5 Test Cricket series against India wearing black

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[5] Australian Bureau of Statistics, "Cultural Diversity in Australia," last modified June 21, 2012, accessed June 2, 2015, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/2071.0main+features902012-2013.

[6] Mark McCrindle, "Christianity in Australia," *The McCrindle Blog*, April 5, 2012, accessed June 2, 2015, http://mccrindle.com.au/Infographic/Christianity-in-Australia_Infographic.pdf.

[7] Philip Hughes a 23-year-old cricketer was killed in a freak sporting accident. While his funeral was held in the country town of his birth as a Catholic ceremony, it was also remembered nationally in a secular way.

armbands, and dedicated team wins and individual success to him. Michael Clarke the national captain and mentor to Hughes indicated that for his remaining career he will wear a black mourning band in Hughes' memory. There was an outpouring of community emotion and spiritual symbology around his death was palpable. Alongside this there are fascinating insights into a sense of deeper connection, a secular spirituality in the Australian community. The significant increase in attendance at the remembrance of Anzac Day and visits to the Australian War Memorial in Canberra speak to this.

With this background and in the context of secularity, the attitude of modern Australia to discussing religious subjects has been well named 'embarrassing', one that sits uncomfortably in Australian conversation.[8] Yet historian Manning Clark observed that matters of faith for Australians remains 'a whisper in the mind and a shy hope in the heart'.[9] Possibly Kelly's insight that Australians' embarrassment, shy hope, and reluctance to engage in a religious or spiritual conversation is because we feel we lack the language to name those things that are most meaningful.[10] Amidst this there is an ongoing discussion about spirituality, often without definition or common understanding. The one place of clarity is the spirituality of Australia's Aboriginal and Torrens Straight Islander (ATSI) population. Their spirituality contains ancient cultural stories of meaning and strong links, especially in rural and remote areas, with the Christian church.

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[8] Thornhill, *Making Australia,* 167.

[9] Thornhill, *Making Australia,* 172.

[10] Tony Kelly, *A New Imagining: Towards an Australian Spirituality* (Melbourne: Collins Dove, 1990), 11, 26.

Contemporary writers Tacey and Bouma[11] have echoed Manning Clark's sense of a shy hope of the heart, and point to a variety of ways that Australians connect to spirituality. Not though in a way that the church necessarily embraces or understands. Part of the dilemma for churches is community perceptions and attitudes. Australians distrust of institutions includes the church which is popularly seen as hypocritical, out of touch, rich and uncaring, and deeply tarnished by allegations of child abuse. While this could be discounted as a wide generalisation, it is evident in regular conversation. The churches that are attracting adherents tend to be those on the very conservative end of the theological spectrum who offer certainty and clear answers.

Yet there is an exploration of spirituality. However, it tends to be largely privatised or practiced in smaller groups. House churches are an example of the latter, often not connected with any mainstream denomination, and spirituality is only loosely informed by the traditions, rituals and practices of the church. Alongside this are alternative spiritualties that include an eclectic mix, often with a mindfulness or meditation flavour. Spiritual issues of exploring connectedness, community, compassion, forgiveness, mysticism and self-care are also evident.

Spirituality connected with nature or the land is important to Australians and the mythology of connection with 'the Bush' is a powerful part of the national psyche. Aboriginal spiritual expressions are deeply grounded in the land with a strong sense of clan location or 'country'. Aboriginal peoples believe that their locus of meaning, belonging and community is in their country and that they belong to it, it does not belong

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[11] Gary D. Bouma, *Australian Soul: Religion and Spirituality in the Twenty-First Century* (Port Melbourne: Cambridge University Press, 2007), and David Tacey, *Re-Enchantment* (Sydney: Harper Collins, 2000).

to them. Their stories of meaning, The Dreaming, are myths that identify the creation of their land, its boundaries and their spiritual belonging.

I am still connected to a local Baptist church; however my worship preference is a house church meeting during the week. On a recent Sunday morning I decided to visit three markets in the city that each had a different theme. Each of the markets were full of people browsing, conversing, tasting produce, relaxing and engaging. As we drove between the markets, the coffee shops we passed were full. The same could not be said of the churches. My dilemma is that I found myself more at home in the markets and coffee shops! This is in part because of the relaxed atmosphere, being anonymous with no expectations on me. I find in chaplaincy a similar freedom. Those who have expectations of me are largely from a committed church background and see me as an extension of their church. Those without this background are accepting of what I offer in chaplaincy and grateful for what I do. Another freedom in chaplaincy is not having the responsibility, as do church clergy, of providing the energy to make the organisation work in terms of motivation, strategy and program.

Australia was founded as a convict colony, has a national narrative of anti-authoritarian individualism and an identity of overcoming adversity. I find myself connecting with a part of this, frustrated by the inertia and narrowness of the church yet as a pastor am privileged to be able to do the work I do. I identify with a spirituality that connects with relationships, community and nature. While there is a belief in the Australian community about something bigger, the ‘man upstairs’, the lived experience is of a practical, secular society. It is in this secular, yet quietly inquisitive context that I and other chaplains work in the SA secular health system.

Methodology

Understanding comes to us in quiet moments of revelation,
and the power is in the story.
Dr Brendan Nelson[12]
Director: Australian War Memorial

My research project was conducted at two South Australian public hospitals, the WCH and the LMH using a narrative research method. This was chosen to hear the insights and perspectives of staff members, for them to tell the story of how they experienced chaplains providing support.

Ethics approval to conduct of the research was given by the Women's and Children's Health Network (WCHN) Human Research Ethics Committee (HREC) and the Institutional Review Board (IRB) of Drew University. Following ethics review, the project prospectus and research application was expanded to include the LMH to comply with the approval conditions of the WCHN HREC. The committee was concerned that there could be a conflict of interest in interviewing staff with whom I would continue a pastoral relationship, in particular that their anonymity and confidentially was protected. This concern was resolved with Rev. Jeff May, the Coordinating Chaplain at the LMH, conducting the interviews at the WCH and me at the LMH. This enriched the research by exploring how chaplains support staff in two acute settings, one paediatric and the other adult. Results from both hospitals were consistent providing internal validation for the research. As this project has a focus on the WCH it is these narratives that will be explored.

[12] Hon. Dr. Brendan Nelson, Director: Australian War Memorial, Remembrance Day Breakfast, Adelaide, 11 November 2014.

Members of the LAC and Unit heads at the WCH promoted the research and recruited participants, at the LMH the recruitment was done by members of the chaplaincy team. Posters were also placed on the notice board of staff break rooms. Participants were able to participate in an individual interview or focus group. The interviews and focus groups were semi-structured and sought the participant's perspectives on how chaplains provided support to them. The interviews and focus groups were digitally recorded with the participant's consent and professionally transcribed. All identifiable information was omitted.

An issue in qualitative research is the sample size required to achieve saturation and therefore reliability of the data. There appears to be no clear standard on this. It is suggested that 6 informants is enough, while another noted that in a comparison of a number of research projects, 12 interviews provided over 90% of the codes.[13] In this project there were 41 participants in 27 interviews conducted from the two hospitals. At the WCH there were 3 focus groups and 11 individual interviews. The LMH site provided 2 focus groups and 11 individual interviews. It can therefore be concluded that the interviews conducted for this project have provided a saturation that is appropriately complete and stable.

The interview transcripts were analysed using a thematic analysis following the approach of Braun and Clarke.[14] Their method provided a tool that allowed the research

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[13] Greg Guest, Arwen Bunce and Laura Johnson, "How many Interviews Are Enough? An Experiment with Data Saturation and Variability," *Field Methods* 18, no. 1 (February 2006): 78. And, Mark Mason, "Sample Size and Saturation in PhD Studies Using Qualitative Interviews," *Forum: Qualitative Social Research* 11, no. 3 (September 2010), 3.

[14] Virginia Braun and Victoria Clarke, "Using Thematic Analysis in Psychology," *Qualitative Research in Psychology* 3, no. 2 (Issue 2 2006): 80.

question to be central, provided flexibility, and a strong engagement with the research data; the staff members' stories. Braun and Clarke's method was also helpful in allowing the larger themes in the stories to be identified but also provided for the important individual insights to be recognized and valued. Their clear process allowed both the themes to be described and the meaning contained in them to be evident.

The thematic analysis conducted described staff member's experiences, ideas, understandings and meanings. When immersed in the narratives it was possible to hear and tease out the nuances, layers of meaning, and depth of story, to compare similarities and differences; to uncover and explore the thickened narrative or truer story.[15] Swinton and Mowat have called this describing reality.[16] This process enabled the identification of common words, phrases and metaphors in participants' stories to determine the themes. These were analysed and interpreted to form the narrative outcomes of the project. It is from these that the response to the research question was addressed.

It is important that I also recognise and acknowledge my active role as a researcher and in identifying the themes or patterns, and that I bring my pastoral practice to the data.[17] The awareness and recognition of such a 'filter' is important in overcoming

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[15] Carl E. Savage and William B. Presnell, *Narrative Research in Ministry: A Postmodern Research Approach for Faith Communities* (Louisville: Wayne E Oates Institute, 2008), 88.

[16] John Swinton and Harriet Mowat, *Practical Theology and Qualitative Research* (London: SCM Press, 2006), 44.

[17] Braun and Clarke, "Using Thematic Analysis is Psychology," 80.

the problem of projection where my ideology could be read into the narratives.[18] This acknowledgement enhances the integrity of the method. To help mitigate against this tendency, LAC members reviewed the data and the conclusions drawn from it.

The use of a narrative or story has been utilised as a method in a variety of disciplines, including as a theological process, in therapy and counselling, and in research. The similarity is that each is looking for layers in the narrative to enhance insight and give depth of meaning. In narrative research it is to take the individual and their story seriously to gain an appreciation of their perspectives and perceptions.

The narrative research methodology was used in this project to enable me to better hear the voices of the staff members interviewed. Narrative research methods assist with this with their focus on listening to stories and seeking to tease out deeper meanings in their telling.[19] It is not seeking right or wrong answers but participants' personal experience, how they make sense of those experiences and how they give meaning to their life and hope for the future. Their experience of and reflection on their story are key.

This process of listening, teasing out, exploring meaning and personal reflection is what thickens the narrative, explores or deepens the layers of meaning. In doing so it provides a more comprehensive story. It is also important to note that in narrative research, the terms narrative and story are often interchangeable, with some researchers

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[18] Richard E. Boyatzis, *Transforming Qualitative Information – Thematic Analysis and Code Development* (Thousand Oaks: Sage Publications, 1998), 12.

[19] Savage and Presnell, *Narrative Research in Ministry,* 83. and Catarina Brown and Tod Augusta-Scott, *Narrative Therapy* (Thousand Oaks: Sage Publications, 2007), ix.

preferring one term or the other. In this project they are used interchangeably as is the custom with narratives being called life stories in some of the literature.[20]

Telling the story of an experience reconstructs what happened, the actions and context, and attaches meaning to the event. The context is often a community or group of people, in this project, staff members at the two hospitals. The meaning speaks to what is significant and relevant to the person in their story.[21] In listening to the stories, and in the analysis, it was important to explore their significance and enquire about what was missing in their narrative.[22] Often this is in the way participants used image, symbol and metaphor.[23]

In chaplaincy research a narrative method is helpful because a significant part of a chaplain's ministry is listening to peoples' stories. While chaplains listen deeply to the life stories that are shared with them they are not disengaged, rather working with people to explore the layers, nuances and meanings that the story holds. Anton Boisen, the founder of Clinical Pastoral Education (CPE), reminded practitioners that each person has a unique story and that we listen to the living human document.[24] Chaplaincy practice has a focus on the individual, a person-centred approach and meeting them at their point of

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[20] Sandra Jovchelovitch and Martin W. Bauer, "Narrative Interviewing," London: LSE Research Online (2000).

[21] Jovchelovitch and Bauer, "Narrative Interviewing."

[22] Bruce Rumbould, "The Relational Web" (paper presented at the annual conference of Spiritual Care Australia, Adelaide, South Australia, May 4-7, 2014).

[23] Heather Walton, "Speaking in Signs: Narrative and Trauma in Pastoral Theology," *Scottish Journal of Healthcare Chaplaincy*. 5, no. 2 (2002): 2.

[24] Glenn H. Asquith Jr., "Anton T. Boisen and the Study of 'Living Human Documents'," *Journal of Presbyterian History* 60, no. 3 (Fall 1982): 244.

need.[25] Adding to this Mowat observed that 'Story is core work and core data. The story gives chaplains their power to act as practitioner researchers...story is a method.'[26] Also reflecting on chaplaincy practice, Rumbould identifies the importance and power of story in that it connects '…in a coherent narrative a person's, and a community's, past, present and future.'[27]

How staff members recount their story provides insight into how they make sense of their experience(s) and how they shape their narrative gives understanding of the meaning for them. The research aim was to hear these stories to deepen the understanding of how chaplains' support is experienced.

A Theology of Hospital Chaplaincy Ministry

Chaplaincy ministry is multi-layered, informed by biblical understanding, theological perspective, personality and practise or function which interact with and inform each other. I articulate here my theology of hospital chaplaincy ministry. It is important to note that my faith and ministry formation is Christian from the General Baptist tradition. Key metaphors in my formation were the role of the pastor as shepherd and servant. The shepherd metaphor was employed to describe the care that was to be provided to the congregation and the servant metaphor to articulate the attitude that underpins the ministry. My formation has been further broadened by engagement in ecumenical and multi-faith contexts in both the wider community and at the WCH. These

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[25] Carl Aiken, foreword to *Spiritual Care Australia Standards of Practice, (Melbourne: Spiritual Care Australia*, 2014), 3.

[26] Harriet Mowat, "The Promise of Chaplaincy" (paper presented at the annual conference of Spiritual Care Australia, Adelaide, South Australia, May 4-7, 2014).

[27] Bruce Rumbould, "The Future of Spiritual Healthcare in Australia" (paper presented at the annual conference of Spiritual Care Australia, Adelaide, South Australia, May 4-7, 2014).

and more have informed my chaplaincy and my theology of chaplaincy which is an eclectic mix shaped by biblical, theological, personal and practice understandings.

Biblical

Biblical narratives that for me speak to chaplaincy include the creation story, the parable of the sower, the account of the woman at the well, the journey of the Emmaus Road, Jesus declaration of his ministry in Luke's Gospel, the social justice reminder in Matthew and the theme of lament woven in scripture in particular the Psalms

I find a number of images in the creation account well describe chaplaincy ministry. There is the initial chaos and although God brings order, the biblical writer reminds us that a level of brokenness remains. I find in the creation of humankind from the earth or the mud and the breath of life being given a dual image of the constant breathing in of new life to humanity alongside the picture of life still being muddy and needing reshaping. And in all of this God has declared a commitment to humankind and pleasure with the created world. In my chaplaincy ministry this is foundational in having an attitude of seeing each person as created in God's image, having the stamp of the divine on them. As such, offering dignity and respect to a fellow human is fundamental. In my chaplaincy ministry this involves an intentional practice of working with the person at their point of need and not imposing my agenda on them. The use of kenotic listening, valuing the meaning of their story and seeking to understand how I can best help them are keys to this. It is a relational ministry.

The parable of the sower and its explanation offers insight into layers of care and the realisation that ministry is not always 'successful' or 'bears fruit'. It is a reminder that there is hard work, and taking the big picture of the sower this includes ploughing the soil, sowing the grain, tending the crop and harvesting the grain. Underlying the parable

is the reality of agricultural life with seasonal variations that can mean abundance or famine. This parable describes the extremes of life in an acute care hospital with patients who fully recover to health to those who do not survive. The ploughing and sowing images speak to the role of introducing spiritual resources to those being cared for.

The woman at the well is at heart a narrative of transformation. Jesus meets her at her point of need not at the place of her assumptions. The conversation so changes her that she returns to the village and convinces her neighbours to accompany her to the well to hear Jesus. The woman was isolated from her community, from its human contact and support structures. Jesus reconnects and reconciles her with her community. Chaplaincy ministry often assists people find their community of support and helps them in reconnecting with their personal and spiritual resources.

In the Emmaus Road account there is the confusion, questions, and devastation of Cleopas and his travelling companion. The stranger brings inquisitiveness, engagement, a listening presence and calmness to the travellers. As they press the stranger to stay and eat with them, they become aware of the risen Jesus. Chaplaincy has the opportunity to journey as the stranger did with curiosity, inquisitiveness, engagement and listening. In valuing the patient or family journey a larger awareness is also possible.

In Luke's Gospel, Jesus proclaims his manifesto:[28]

> The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord's favor.

[28] The Holy Bible, New Revised Standard Version, Zondervan, Grand Rapids, Michigan, 1989. Luke 4:18-19

My chaplaincy reflects this mission of Jesus as I seek to bring good news to the patients, their families and staff. An acute hospital deals with a lot of brokenness, physical, emotional, social and spiritual. The good news is that God is present even in the midst of suffering. The release and recovery is not always from ailments, but can always be evident in a spiritual sense.

Grounding this manifesto in action Jesus offers a metric by which his followers will be measured. It is recorded in Matthew 25:35-36:

> **35** for I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, **36** I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me. [29]

This practical imprimatur balances the spiritual emphasis above. A key component of chaplaincy practice is to turn up! The practice of ministry for the other cannot occur without me being present, and in doing so offering dignity and respect.

I regularly encounter people struggling with fear, anxiety and despair. The lament themes of the scripture give voice to despair, protest, doubt and anger, a raw honesty is evident in the writing and also in the words of families, patients and staff at the hospital. This pain is often dismissed by some who are trying to be caring but this devaluing may have devastating long term effects. The abandonment experienced by Jesus was expressed in a heart wrenching cry. The lament of Psalm 6:1-7 is often heard in hospital:

> **1** O Lord, do not rebuke me in your anger, or discipline me in your wrath.**2** Be gracious to me, O LORD, for I am languishing; O LORD, heal me, for my bones are shaking with terror.**3** My soul also is struck with terror, while you, O Lord, how long? **4** Turn, O LORD, save my life; deliver me for the sake of your steadfast love.**5** For in death there is no remembrance of you; in Sheol who can give you praise?**6** I am weary with my moaning; every night I flood my bed with

[29] New Revised Standard Version

> tears; I drench my couch with my weeping.[7] My eyes waste away because of grief; they grow weak because of all my foes.[30]

For me, what admittedly is aspirational is the encouragement and challenge of the prophet Micah 6:8:

> He has told you, O mortal, what is good; and what does the Lord require of you but to do justice, and to love kindness, and to walk humbly with your God?[31]

As a life verse or mission statement these words speak about attitude and behaviour. In a sense it sums up my understanding of the theological undergirding of chaplaincy. As it is aspirational, the observation that I would add is that I need to live gently with myself and accept ongoing forgiveness.

Theological

Chaplaincy ministry is grounded in the pastoral ministry of the church and is part of the church's missional mandate. As a mission, chaplaincy is often exercised outside of the church context, beyond the church walls. In my case this is in the secular, multi-cultural, and multi-faith environment of a public hospital. In this environment, similar to a missionary in other cultural environments, I need to learn the language, culture, attitudes, values, history and operational functions of a world outside of and often foreign to the church. In this context I see the WCH as my 'parish'. The 'congregation' consists of 3,000 staff and around 1300 patients and their families each day.

The environment of the hospital is not only multi-cultural and multi-faith it is also pluralist, infused with a postmodern reality and inhabited by the breadth of generations, babies to great-grand parents. While there is an increase of interest in spirituality

[30] New Revised Standard Version

[31] New Revised Standard Version

accompanied by a decline in religion the result is a poverty of language to describe the new spiritual journey. The language of religion does not connect well with the new spiritual landscape.

In this environment, spirituality is a stronger focus than religion. The focus of the chaplaincy ministry is the agenda of the other, seeking to meet the patient, family, carer, staff member at their point of need. In doing so, Chaplains become translators and introduce a new language to enable people to find their pathway through new territory. Flinders University chaplain Geoff Boyce suggests that chaplaincy practiced in this way is a ministry of hospitality.[32] To this I would add that chaplaincy ministry also reflects the servant call of the gospel.

Missionaries return to the church and share insights of the world in which they work. In a similar way I have heard chaplains described as gargoyles. They are part of the church and their role is to be facing, observing, engaging with the world outside the walls. Yet at the same time part of the church and informing and interpreting for the church what they see.

Chaplaincy ministry is deeply embedded in pastoral care practice. At its foundation it is based on having respect for the dignity and uniqueness of others. It takes seriously the Genesis principle of each of us having the stamp of God on us. Clebsh and Jaekle identify four functions of pastoral practice; healing, sustaining, guiding and reconciling.[33] To these Clinebell adds nurturing as a pastoral function.[34]

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[32] Geoff Boyce, *An Improbable Feast: The Surprising Dynamic of Hospitality at the Heart of Multifaith Chaplaincy* (Glandore: G. Boyce, 2010).

[33] William A Clebsh and Charles A Jaekle, *Pastoral Care in Historical Perspective* (New York: Jason Aronson, 1964), 32-66.

Sustaining has a focus on offering support, comfort and understanding. Guiding involves helping people to discover their best way forward in a situation and seeks to clarify and sometimes confront. Guiding can also offer insight, truth or perspective. Healing is to help a person find wellness or wholeness. This may or may not be a cure from ailment as the focus is on spiritual health. Reconciling has an emphasis on restoring broken relationships with individuals, a community, God, or ourselves. The pastoral practices involved in providing this care include being present, listening, being other centred, prayer and announcing forgiveness.

A pastoral care approach is one that seeks wholeness for the person including physical, social, psychological, emotional and spiritual aspects. Valuing and respecting the person receiving care is fundamental. Alongside this is a recognition of the power differential between a patient and someone who works in the hospital and an appreciation of the vulnerability of the patient. As such chaplaincy is person centred and complements the work of other practioners who also seek the best for the person. Pastoral care seeks to develop a sense of purpose, resilience, belonging and connectedness. The resources of faith are significant in pastoral practice, rituals of meaning and connection, contemplation, exploring spiritual or religious issues and referral to a preferred faith representative.

In Australia less than 10% of the population attend church regularly and in the hospital daily census over 60% do not nominate a faith group to which they belong. Chaplains often hear 'I am not religious, but…' In this context there is an ongoing

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[34] Howard W Stone, *The Caring Church; A Guide for Lay Pastoral Care* (Minneapolis: Augsburg Fortress, 1991), 121. Stone quotes personal correspondence with Howard Clinebell who included nurturing growth and wholeness as a pastoral function.

conversation in chaplaincy circles in Australia about the difference between spiritual care and religious care.

Pastoral care has a long and rich tradition of theology and practice from which I draw and as a Christian chaplain my training, formation and heritage inform my practice. A sensitivity to persons of other faiths, or no faith, allows me to provide compassionate care to them and connecting them to the resources of their beliefs. Spiritual care has the hallmarks of good pastoral care; good pastoral care is always about the other person and treating them with dignity and respect.

A significant aspect of engaging in this missional space is being comfortable with eclectic spiritualties, in particular those exhibiting post-modern and secular influences. It is no longer a ‘one size fits all’ environment. Surprisingly in this space, some ancient spiritual understandings are helpful in building connections.

The Celtic traditions of the Christian faith speak of the ‘thin places’. The idea and experience is that the perceived distance between heaven and earth collapses and we are nearer and more intimately relating to the holy. Another way to express this is the liminal or in-between places are explored. Alongside this is the tradition in a number of faiths of mystics who more clearly hear the voice or prompting of the divine. This speaks of the sense of connection, presence, intimacy that has been named the mystery of the church. It is for the chaplain a being and sitting in a very real place that is at the same time almost indefinable except by metaphor. Words are inadequate to describe what is experiential and known. The Apostle Paul identifies a sense of this in Romans 8:26 ‘Likewise the

Spirit helps us in our weakness; for we do not know how to pray as we ought, but that very Spirit intercedes with sighs too deep for words'.[35]

A sense of this spirituality in the Australian context is about connection, meaning, purpose and community; I often ask about when and where they feel most at home both young soldiers and nurses speak of family, friends, the gym, the garden, and the bush. The first three are community connections and the last two often solitary pursuits.

In the context of this eclectic, personal, earthy and mystical spirituality there are also surprising traditional expressions. A belief in 'God' but without information or being informed. As has been identified earlier, there is an inability to give expression to what this internal reality means, a lost art of language.

Personal

The personal aspect of chaplaincy goes to the personality of the chaplain. It includes the personal facets of vocation, understanding of role, theology, personality, ministry practise, skills, the ministry setting, attitudes, connections, and vision for the role.

An important aspect is training and formation. Traditionally in Australia CPE has been accepted as an important component of the chaplaincy training and formation continuum. CPE course participants engage in both peer group and personal supervisory learning environments. The CPE process has two main themes; engagement in personal exploration and understanding, and reflection on ministry practice. In personal exploration issues including beliefs, attitudes, needs, fears and issues that underlie responses to others are explored, it is deepening a sense of who we are as persons and as

[35] New Revised Standard Version

practitioners. The reflective practice on ministry invites paying attention to personal agendas and needs and how they impact on or drive pastoral encounters.

Personal characteristics are likewise important. When advertising for, or selecting candidates for chaplaincy, attention is paid to the skills and abilities they possess and to the attitudes, personality and behaviour they exhibit. The job description details the skills required and the person description the relational abilities.

In the person description for the WCH, alongside being in good standing in the denomination there are also characteristics of integrity, spiritual sensitivity, vulnerability and trustworthiness. Relational characteristics are also identified including being able to relate well, calm in crisis, independence and ability to work in a team. High order listening and communication skills and strong coping skills and self-care plan. Having a reflective practice is mentioned and ability to work in a multi-faith and multi-cultural environment. Other requirements are to be comfortable with change, politically robust and have a good sense of humour.

Chaplains necessarily live in the tensions between the church and the institution they are serving, the liminal space.

Chaplaincy Practice

The practice of chaplaincy while very much related to the setting that the ministry is exercised in is also often described in images or metaphors.

The setting is important due to its significant difference from church based ministries. In a church the clergy either by hierarchy or influence are the key leaders of the organisation. This is so whether the clergy person is the senior leader or part of the leadership team. In this setting the context is of long term ministry and the voice of wisdom resides in the clergy who journey with their parishioners.

Contrasting this, chaplains in institutions are often part of hierarchical organisations where they are not at the executive level of leadership, but rather part of a larger organisation. They can however, have significant influence and be highly valued by the organisation. This position in an organisation can be a difficult transition for clergy who are often trained to be a key leader or part of a leadership team. In this setting, the voice of wisdom is no longer the clergy but the doctor.

Ministry too is different; the long term relationship church clergy have with their congregation compared with the short term nature of chaplaincy ministry with patients. The average stay of a patient at the WCH is currently 1.6 days. The ability of the chaplain to be able to make immediate connections is important, and being comfortable with possibly only seeing a family once. The shift in understanding, perception and practice from long to short-term can create conflict and uncertainty for the new chaplaincy practioner.

The organisational structures of the ministry setting may be difficult to adapt to, so too are the surrounding structures, expectations and understanding that others in the organisation have of the chaplain. Layered on this is the working rhythm of a hospital day which is subject to constant change. Another factor is the language used, that of the industry that the chaplain is part of, be it Defence, aged care, acute hospital, school or other setting. Alongside this are the protocols, procedures, cultural norms and expectations that are part of a hospital environment and culture.

Reflecting this there have been a number of ways that a chaplaincy role has been described, some terms relational such as the ‘Padre’ of the Australian Defence Force (ADF) and others that identify a function such as Christian Pastoral Care Worker in South Australian public schools. Alongside these, there are a variety of metaphors that include

traditional understandings; shepherd, servant/steward, spiritual guide, prophet, comforter, and Priest. There are also less traditional images; mediator, symbolic figure (representing God), hospitality, guest, (spiritual) midwife, stranger, companion, Shaman, and advocate.[36]

A key understanding of practice for me is that I meet the person at their point of need, having a spiritual assessment as the basis of what I do/share/provide to them. In respecting them it is important to value their personhood, their beliefs and their values. While offering the resources of faith to them, chaplaincy is not a place for evangelism or proselytising. This would be the agenda of the chaplain, not that of 'the other'. Any ministry would therefore be conditional and not reflect my biblical or theological understanding of chaplaincy ministry.

The hospital can be terrifying places for parents and children. A metaphor understood in the Australian community is the importance of 'country' to our Aboriginal community. For Aboriginal people their locality is identified in their Dreaming, creation stories speak of its formation and chart the boundaries of their land. The Dreaming also identifies the spiritual landscape of their community and their kinship connections. The country is home, it is known, it is safe, it is where they belong. I often use this as an image with families, the hospital is our country. Our task is to guide them through this place safely. There are a number of parts to this component of chaplaincy practice, from simply offering directions to find their way around to exploring the challenges they confront to helping understand what this place offers and provides. A particular part of

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[36] Aiken, *How we do Chaplaincy*, 28.

chaplaincy is to be an interpreter and help people develop a language for their existential and spiritual crises.

In Australia, chaplaincy in the health care system is recorded using four clinical codes identified in the Australian modification of the World Health Organisation's International Classification of Diseases (ICD-10-AM).[37] These four codes are Pastoral Assessment, Pastoral Ministry, Pastoral Counselling and Education, and Pastoral Ritual and Worship. Other codes in the ICD-10-AM volumes identify roles that chaplains share with other disciplines such as grief and bereavement care.

While these are the roles identified for clinical management in the hospital system, there are a variety of additional roles which add a richness and complexity to chaplaincy practice. My previous study identified the additional key roles as: Spiritual Care (that is not specifically Christian), Multi-faith Care, Staff Support, Witness/Represent the Church, Teamwork (Chaplaincy and multi-disciplinary), Administration, Research, Teaching/Education, Ethics, Professional Development, Community/Church Liaison, and Advice on Religious Diversity.[38]

In developing job and person descriptions and in promoting chaplaincy to public institutions in South Australia in the 1990s, Rev Richard Miller, Chaplaincy Coordinator for the South Australian Synod of the Uniting Church in Australia (UCA), wrote the following definitions:

> Holism:
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> Chaplaincy should be an integral part of the hospital. Its focus is in the unique pastoral and spiritual contribution to the overall care provided. It is

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[37] National Centre for Classification in Health, *Pastoral Intervention Codings, International Classification of Diseases Australian Modification* (Sydney: Sydney University, 2002/2005).

[38] Aiken, *Chaplaincy*, 30-31.

integrated and congruent with that offered by other disciplines and adds to the totality and 'completeness' of the care the hospital provides.

Spirituality:

Spirituality is that which gives meaning and purpose to being. Chaplaincy provides a spiritual resource for the hospital. It respects and can transcend differences of denomination and religion, recognising aspects of grace in all. The chaplain may minister to patients and their families, staff and the hospital itself, in ways that enable questions of life and death, reality and meaning, fear and hope to be articulated in a manner that encourages an exploration of such issues in an honest, caring environment.

Pastoral Care:

Pastoral care is a caring resource at the client's point of need. It allows the client to 'set the agenda' with the Chaplain being available to journey with the client as a vulnerable, caring, listening fellow human. The chaplain may provide a spiritual perspective and a liturgical resource as a tangible adjunct to pastoral ministry.

There is a complementary nature and overlap of the factors identified above. I am more comfortable in exploring a praxis of chaplaincy, a reflective and informed doing of the ministry rather than a theology. Theology, and ministry training, has often been separated from practice and does not always embrace reflective practice and personal supervision essential to healthy ministry. Praxis is not neat and tidy it is contextual, always developing and reliant on the setting in which it is practiced. So my chaplaincy is informed by an eclectic mix of biblical, theological, personal and practice understandings.

CHAPTER 2

Chaplains’ Support to Staff

I am a pastor and this is my parish.
Chaplain Ian Lutze
Repatriation General Hospital. Adelaide

Sue’s story told me that staff members at the WCH did not understand that chaplaincy support was available to them, instead believing that it was only for patients and families. A sub set was that chaplains were not being notified of significant traumas and therefore unable to provide their service to families. The narrative was one of exclusion, although not intentionally, rather in a functional way.

The chaplaincy team at the WCH comprises of three paid staff, me as the Coordinating Chaplain, an Anglican Deacon who works four days a week, a Catholic Priest who attends twice a week and four volunteer chaplains. Each of us has responsibility for specific wards or units of the hospital. We are appointed by our church to the hospital and in each of our job descriptions is the expectation that we will provide spiritual care to patients, their families and to staff members.

Sue’s story framed the questions for the interviews with staff members who were invited to share their experiences of chaplains’ support. The themes from these interviews formed the outline of this report and the narratives illustrate some of the ways that support for staff has been provided. The term “support” is broad and inclusive and can be nebulous. Staff members were specific in their descriptors and experience of support whose themes ranged from functional to personal and relational to ritual. The illustrations of support discussed in this chapter capture the dominant themes that staff reported that

they experienced. Also reported are the insights that they shared about the chaplains' role. The affirmation for chaplains in the interviews was affirming and humbling.

The role of the chaplain discussed here speaks to the practical aspects of providing spiritual care for patients, families and staff. Here are the voices of the staff members who receive that support. These are their descriptions of their experience. While shaped in a narrative from my perspective, it is our staff and patients and their families whose stories they are. I am the story broker for the staff, helping their stories to be heard, exploring meaning and valuing their experience and their voice. In them the chaplain is the midwife to meaning at the birthing of celebrations and devastations. Being the midwife to meaning sees me performing ritual acts to symbolise and identify what has happened. It may be an anointing or blessing, it may be a coffee shared or articulating what is obvious but what they have not seen. It may also be a clarifying conversation which identifies what they have not seen in their own story, or a quiet reflection, a question, a restatement.

As Ian Lutze has said, the WCH is my parish, my community; one staff member called it our "village" and that I am the holy man. This identifies the sense of the chaplain being present and bringing a sense of calm and comfort to staff members during difficult situations.

The Role of Chaplain

Staff members were invited to share their understanding of the role of the chaplain(s). The responses were diverse, offered rich experiences of care from chaplains and shared insights into how this was understood by them. They were nuanced in their understanding and insight and overall very appreciative of the service that chaplains provided. A number of roles identified by staff went beyond the traditional or expected

roles, in particular going beyond a religious practice to a spiritual one and included being a "glue" for the hospital.

Together the responses offer a thick description of the service that chaplains provide. The idea of "providing support to staff" was often mentioned, sometimes with a description or illustration of what that meant to them. Most staff members interviewed had extensive contact with key chaplains and this was reflected in their responses. They defined chaplains' support as being both relational and functional.

Staff members spoke about the breadth of the support chaplains provided and that it included encouragement, guidance and mentoring along with listening to them and valuing their work.

This understanding was supported by nurse educators who identified the educational role of chaplains supporting the development of student nurses and lecturing in the teaching program. The main role that chaplains have had in education is in the undergraduate, graduate nurse and midwifery programs, and in the annual Paediatric Palliative Care Course. Another and more subtle educational role is informing staff members about the chaplains' role.

The work of midwifery is usually around welcoming new life into the world, at times there is the sadness of a death. In the tragedy and emotion of a foetal death I provide care to both the family who have experienced the loss and to the midwives who care for them. That midwives feel these losses deeply was identified and the emotional attachment acknowledged as was the chaplains' support for them personally. They appreciated the blessing rituals and the chaplain being with families in a respectful, non-judgemental way is important to them.

One staff member articulated how over time their experience of chaplaincy support developed a more nuanced or deeper understanding of the role and in particular that chaplains were available for them. Identified too was the provision of spiritual support to both patients and staff is an insight that is nuanced with multiple layers of meaning. Staff members report that they see this in a different light to religious support.

Increasingly articles related to spirituality appear in nursing, medical and allied health journals. At their conferences and in their training, attention is being paid to the spiritual needs of patients. While spirituality is often written about in these fields, the responses to this research identified chaplains as the profession for whom spiritual care is core business. Chaplains working in the secular health care environment were valued for their ministry. Times when this is particularly evident is in trauma events and sudden death, in the intensive care units and also in the palliative care service.

It is here that the issue of spiritual, not religious is a significant theme. Also identified was the chaplain as someone who was neutral in their attitude, that they were part of multidisciplinary teams yet still had independence from the organisation. Chaplains are part of the hospital yet also able to speak to it. In the responses was the recognition of the importance of chaplains simply being around. It would seem that this presence and relationship gave chaplains entry to the critical issues and the debriefing conferences. Chaplains offer a non-medical voice and understanding of a wider perspective including the psychological, social, human and spiritual aspects.

A number of comments outlined a holistic understanding of the care provided by the hospital and chaplains in particular. While holistic care is an aspirational theme for most healthcare centres the dominant voice in hospitals can easily be medical ones. Holistic care has a focus on the person, not only their illness, and in doing so attends to

the psychological, emotional, social, intellectual and spiritual needs of the patient. Chaplains have sought to be proactive along with social workers and psychologists in advocating for holistic care.

Often the support provided to staff is seen by them as structured by the hospital, that was conditional to the workplace and only provided by the Employee Assistance Provider (EAP). Staff reported their experience of chaplains' support as personal and relational and able to transcend the institution. Time and space for meaningful conversations with staff members is at a premium. A number of staff valued the opportunity to talk with a chaplain, often in short moments such as at the bedside, in the corridor or the cafe. The support was identified as ranging from formal to informal, structured to serendipitous. Staff named the value they placed on chaplaincy care for themselves.

Chaplains are seen to be "in the loop" of the hospital and able to have conversations of a sensitive nature. Chaplains working in a secular hospital face the dynamics of multi-faith or no faith context with their particular challenges. There are also staff whose need is for a connection with the resources of their faith during times of crisis. For others this crisis is existential and needs addressing in ways that are more flexible. Staff members noticed the ability of chaplains to provide religious care and also be able to provide spiritual care that was not religious. Staff in Emergency Departments, Intensive Care Units, and the Delivery Suite report experiencing high levels of stress. It is here that sad and tragic events unfold and the whole spectrum of emotions and life questions are to the fore. After a traumatic event staff members have the opportunity to attend debriefing sessions which clarify what had happened and provide information about personal response they may experience. Debriefs are the formal gathering where we

discuss the events of a trauma which clarify what had happened and provide information about personal responses that staff may experience. Sometimes an EAP representative is present to support staff. At other times they are not and that role falls to me. A doctor will outline the medical situation as it is known at the time and answer any questions around that. This is partly for clarification for those who were in the trauma room and for the information of the support staff who were working behind the scene. Debriefs are intended to assure staff that their responses are normal. I invariably make a contribution about self-care. Staff members valued the role chaplains have in the debriefing sessions, and also in following them up in the days and weeks after an incident.

Sharing the load is another role identified by a number of respondents. The theme was that in doing their job the chaplains were supporting the clinical staff to do theirs. It may be the emotional and spiritual support for staff that has been identified. Emotional support is an affirmation of human feelings and fears and from a chaplaincy practice validating the cost that staff members pay for their care of patients, families and their colleagues. Spiritual support is making meaning of the event, building connections with sources of strength and resilience and acknowledging that we cannot always fix everything. It may be the practical aspect that the chaplain is caring for a patient in their room so staff can attend to one of the other myriad of demands.

The interviews have provided a rich, detailed and in-depth description of the chaplains' role from staff members' perspective. Not least in this was the appreciation in which chaplains are held.

The support that chaplains provide to staff will be discussed using the two themes. These are the organisational or functional support chaplains provide to the hospital and the relational aspect of their care for staff members. While these two themes overlap in

practice, describing them separately enriches the narrative and understanding of how staff members have identified the support chaplains provide them.

The Chaplain as Part of the Hospital

Chaplaincy in a public hospital is conducted within the framework of the organisation. There is a management structure that identifies a hierarchy of policy setting and decision-making. Alongside this is an architecture of procedures and standards, expectations and cultural understandings. It is in this mix that I work. The clear structure offers clarity and place within the space of the hospital. This structure includes the chaplains' role and person descriptions that detail the expectations and boundaries of their practice.

With this background, staff members spoke of the ways that they saw the chaplain "fitting in" and "belonging", chaplains are known as individuals, accepted by the staff and trusted. Alongside this is the sense that chaplains remain a step removed from the organisation and yet are part of it. There are metaphors of meaning and semiotic descriptions in this section, alongside of both/and. It is a section about where the chaplains fit.

When I was invited to consider the role of the Coordinating Chaplain at the WCH the Richard Miller identified three key areas of chaplaincy ministry. One was expected, care for patients and their families. Ministry to staff was the next and an area that some chaplains embrace and some have difficulty with. Thirdly Richard spoke about being chaplain to the institution, to the hospital organisation and culture.

One way of being chaplain to the institution is working with the hospital executive team. I intentionally engage them whenever I can. In the time I have been at the hospital the average stay of the Chief Executive (CE) is two and a half years. When an executive

leader is appointed I work to get an appointment with them early, to introduce myself and indicate that my support for staff includes them. My Army training has taught me that there will be a rare occasion when I need immediate access to the CE. Fortunately I have never needed to have such immediate access.

While hospitals have a clear structure and operational framework there remain subtleties around their functioning. There are clear management lines of authority and communication and yet informal and relational ways of working. While I have a reporting line to an Executive Director, that ministry with the executive team has seen me conduct the funeral of an executive leader's parent.

I have a friend who is in the funeral industry and he was arranging the funeral for Dave's mother. As the conversation unfolded he became aware that Dave worked at the WCH. When it came to discussing options for celebrants or ministers for the service, he mentioned that he knew me and that I could possibly be available if that was acceptable to Dave. To prepare for the service I visited Dave at his home with his family. Dave has had various roles at the hospital and we have had many conversations. In my role I also reported to him as my line manager for a time, we work well together and he values my opinions. As we meet around the hospital our conversation is sometimes about the life of the hospital or a particular issue and often about the social conversation of AFL.

In arranging his mother's funeral I moved to a more intimate space in Dave's life. He was close to his mother and the extended family loved her very much. Dave spoke about his mother at the funeral and I gained an insight into a competent and insightful executive director as a son. Our conversations in the passage and at the beginning of meetings now has a further layer or depth to "how are you?" We now have a deeper connection. I know about his family and their relationships, and he has experienced me

care for him and his family outside of the hospital at a time of significant need. We relate differently, because of our journey together.

When I began work at the hospital I intentionally invited myself to each ward and clinical unit to introduce myself and gain an understanding of their work and role. All of these units are proud of the work they do and have a high standard. I remember well my conversation with the midwives in our delivery suite. They are very protective of the women they care for and jealous of their territory. Their experience was also of a very good woman chaplain and wanted to know how I as a male would work in women's health. There is also a strong advocacy role by the midwives and they wanted assurance that I was comfortable working in an environment where stillbirth, neonatal birth and genetic terminations happen. My naïve response and one I have more firmly developed was that my role is pastoral and for the family at their point of need. I indicated that we could have the theological and political discussions at another time.

Over time the midwives and I have discovered that the male voice is important to the partners of the women in the delivery suite. While midwifery is a female dominant profession there are a number of men involved and a large number of our obstetricians are men. However, their conversation with women is usually around the medical aspects of the woman in their care. In the interviews they said that the pastoral voice to the male partners has a resonance as I speak of coping with grief and loss. While my conversation is the same as the midwives and social workers, I bring two perspectives. One is that I am being with the couple and do not have a role of attending to anything other than their spiritual and emotional care. The other is that I am able to use male inferences in the conversation and identify issues of male powerlessness in the situation. Interestingly, it was the midwives who first noticed the importance of this aspect of our work together.

As an attempt to raise the profile of chaplaincy in the hospital and to have a voice into the hospital I began a weekly email "Thought for the Week" on the hospital email. In part it was due to my sense of the hospital being my "parish" of three thousand people. It was going to be impossible to see all of them. In the thoughts I have intentionally made them inspirational and encouraging and rarely, when there is a community or significant issue, been pointed in my comments. There has been an overwhelming sense of appreciation and very little push back on them.

Over time I have had a number of responses to the emails. Some quirky and engaging, like a quote from Albert Camus that elicited the return email, "you mean I spent my teenage angst over what he wrote and he also said this stuff?" Another, more poignant, was, "this is the only email I get each week that doesn't ask me to do something." As I travel around the hospital I see the quotes printed off and on notice boards and in communication books for staff. Staff members tell me they forward them to their families and I have a secondary email list of retired staff who have asked me to send them to their home address. I have used a number of thoughts that have been given to me by staff members.

In the corridor when I meet a new staff member, or one I haven't met, I am often greeted with "you are the one who sends out the thought for the week". I have had people ask for permission to use them in presentations and one doctor doing a presentation on leadership asked me for as many quotes as I had on the topic. When I have been on holiday leave, I receive comments about the missed thought for the week.

Crisis, Trauma, and Debriefing

I often reflect that a hospital is an insurance policy that none of wants to access; but sometimes we do. Crisis or trauma is what we are trained for. We tend to see a

difference between the two ideas. A crisis is a diagnosis of an illness while a trauma is an accident.

My role in a trauma is multifaceted. The family may or may not want to engage with me. Often I am introduced by the staff and left, in part so that our people can feel that they have done something. While the care that our staff provide is compassionate and attentive, at its heart the role of nursing and medical staff is to fix the problem that the patient has. My role is to sit with the unfixable, to be in the dark place with them. It is uncomfortable to be with suffering of parents when an accident has happened and a child will not survive, or survive very broken. I am sustained by the belief that while God may seem far away that we are nonetheless accompanied by grace. At times I have had conversations around this and they speak of the faint whisper they hear and their heart's hopes. Care for the staff both during and after a trauma is a key role. During an incident I monitor and check on staff and encourage their work. Following its conclusion I am keen to affirm the work that they have done and remind them that this work comes at a personal cost.

The role in a trauma incident can also have a number of facets for me. A child had been brought in who had fallen from an amusement alley ride. It was a very public accident and drew significant media attention. My role was to support both the mother and the staff who were dealing with the situation. It was compounded because the family were from overseas visiting relatives in Australia and this was their last day before heading home. The child's father had died from cancer twelve months prior to the accident and she was an only child. It took some time for us to be able to contact family for support.

My first role was to assist our trauma nurse manager to move privacy screens while the child was transported from the ambulance to our resuscitation area. Media people were already filming and while there is tacit agreement between our hospital and the media outlets they often try for more access in more dramatic stories. So, we were moving screens to achieve a level of privacy and dignity. As the day unfolded I noticed a reporter had gained access to our emergency area waiting room. I invited him to speak to our media liaison manager at which he sheepishly left. Given the media coverage and being seen moving the screens, over the next few days I had a number of colleagues and friends inquire about how I was coping given how the situation was reported.

In conversation with the mother I discovered that she had a strong faith and that her extended family was connected with a church I knew well. This information and connection was a gift as I provided initial care for her. It also made it easier for me to contact the church and mobilise their support. With our faith connection I was also able to pray and support her in a way that was well understood by her. Due to the church and family connections that were established I was able to keep the emergency department staff appraised of the mother's return to her home and the funeral arrangements for the child.

During the incident I did not spend all my time in the room with the mother. It was also important to give her some space, especially with her child. Some of my time was spent caring for staff who found difficulty dealing with the immediate aftermath of the death. Some time was spent with the police from the coroner's office who came to investigate and take statements from nurses, doctors and the mother. In the debriefing session that followed this tragic time I was able to convey to the staff the mother's

appreciation for their support. Twelve months later, the trauma nurse reminded me of the anniversary. There are some incidents that sit with you.

Debriefings are always difficult because they engage raw emotion. Often, despite doing great work with patients and families our staff feel that they have not. Their expectations of themselves are high and they want what they see as positive outcomes. While they know they have provided good care intellectually, emotionally it is often difficult for them. I have used the images of “head and heart” with them to give voice to this. The head is the information and data and what they know. Their heart is their compassion, fears, hopes and dreams. I talk about how these sometimes sit well with each other, on occasion clash, and at other times one needs to be heard in preference to the other. Debriefs tend to be head moments where the heart takes over. In naming the ‘heart’ and their care I also identify some of the spiritual issues that are present.

Team and Multidisciplinary Roles

Being part of the team in the hospital is multi-faceted. It is easily seen in the engagement in crisis, trauma and debriefs that I have described. It is evident too in the multi-disciplinary meetings with the Oncology Unit when all of the disciplines gather to identify new cases or talk about existing ones.

As I work in a ward, clinic or bedside I am keen to chat with the staff member caring for the patient and family. They too have fascinating life stories. One nurse is an ironman athlete, another works on TV and film sets as a nurse between shifts at the hospital while one practices as a lawyer part time. Another staff member sails competitively at the international level and we have a former international cricketer. There are the delightful family stories such as the intensive care nurse who brought her twin daughters into emergency due to her concerns; and by the time they were seen by the

doctor were perfectly well. There is the courageous nurse who has taken on parenting her nephew because his family cannot cope with him. Some have aged parents, dysfunctional families and difficult personal relationships. I am privileged to hear their living stories.

One of the delightful reflections from the interviews is that staff say I notice them and take notice. And they describe me as one of the team, that I belong. Given how close a number of units are in their relationships this is a huge compliment. Sadly there is the other side to this. Staff speak about some chaplains and visiting clergy as "tasky", standoffish and not relational; focused only on the patient and not the larger picture.

Alesia is a ward clerk who lives in the neighbourhood in which I grew up. Her house is near the Rosewater football oval, a place where I spent my teenage years. Rosewater football club is known as the Bulldogs or "Bullies". Alesia doesn't have an interest in local football, so as part of our banter I ask her how the Bullies went on the weekend. Her invariable response is she doesn't know. Neither do I! Alesia is also a great cook and whenever there is a staff party on her ward, her delicacies are the most sought after. Sadly this year there had been an incident at a junior football game at Rosewater and police were called with a number of members of two families arrested. The conversation the next Monday was not about the football. I asked Alesia how she was after the incident and how it had affected her neighbourhood. She was still a little shaken, and pleased to be able to talk about it. The quiet neighbourhood had taken on a dark shadow and she was not sure how she would deal with it.

I received an invitation to be the judge for the occasional multi-unit sports days which feature soccer or netball. My role is to chair the judging of the cheer squads, their outfits and performance. When it comes to winning the bragging rights for the best cheer squad, their favoured method of influencing judges appears to be bribery and corruption.

In good humour they try to influence decisions by cans of soft drink and chocolate, pointing out the failures of their opposition, and loudly proclaiming how they are clearly the better team. At the end of the day's events decisions are accepted in good humour.

The way that staff have spoken about the acceptance of chaplains as part of their team has been humbling. It has enabled me to reflect more on the role I play with staff and not be so focused on trying to do too much, rather accepting that I am seen to belong. This belonging has a number of layers to it including acceptance as part of the hospital team. It allows entry to the various areas of the hospital and permission to speak to families and staff. It also affords the opportunity to engage with staff members around issues that are not merely clinical, their families, their work life, their hopes and joys. This belonging is as the chaplain, the priest, the holy man.

My role is to be the chaplain and to bring my particular insights, to make pastoral and spiritual assessments of patients and families. In the meetings and conversations with nurses, doctors and other health workers I have the opportunity to include my insights. This is sometimes true also in the debrief space where I can articulate where and why a particular religious ritual or practice was significant to the family and their appreciation for the hospital of allowing it to happen. We have had thirty people in a crowded intensive care room while the Buddhist monk chanted. The African family had twenty while they ritually expressed grief. It has only been the nurse and me with an aboriginal child as the family leave because of their spirituality issues. It is a rich tapestry of inclusion in celebration of sadness.

A Non-medical Role

The interviews highlighted the importance of the chaplain's voice in offering a different understanding from the nursing and medical insights. The chaplains brought

important perspectives that complemented the medical care. Our role is to engage with the patient and family story, and that of the staff member when we are working with them.

My focus is on patient centred care and our tools are pastoral and spiritual methodologies. A senior Army chaplain speaking to a health battalion I was serving at the time said that I work in the areas that pills don't fix. It is an easy temptation for a hospital chaplain to be drawn into the impressive medical and scientific work that is done. It is important to remember the pastoral adage from the Catholic tradition that our work is the cure of souls. And that patients are more than hydraulics, pneumatics and chemistry.

I talk with kids, parents and staff about centring when they are in a stressful situation. A couple of deep breaths to settle and in their mind go to a safe place, one where they feel relaxed and at home. I offer a listening ear and often only the gift of listening, no solutions or fixes. A word of encouragement and comfort is important for some and a prayer for others. Pastoral counselling may be offered with an exploring of options and possibilities related to the hospital or work or family or simply coping. My role is to identify the humanity in all its richness in the hospital, the head and heart, the hopes, dreams, aspirations and fears, uncertainties and doubts of the heart. Also, bringing a bigger picture that my presence is a reminder that God is always present, always engaged and lives and grieves with us; that we are not alone and abandoned. This is the pastoral and spiritual voice in the midst of the secular institution.

We had a staff member who was manic and driven. At work as a manager she would be there for ten hours a day and then go to the gym for two hours. She had experienced significant family losses and was about to go on holiday at a beachside resort. My pastoral prescription was to take two minutes a day at the beach, try and put all

that was in her head aside and breathe in the sights and sounds of the beach. People, waves, sky. Any more than two minutes would have been impossible, in fact I wondered if even this would be a stretch. It was a delight to catch up with her when she returned to find that she had been able to achieve this, along with time to do some serious shopping!

One of the regular questions I am asked by key managers and executive leaders in the hospital is "how are you seeing things at the moment?" Their expectation is not of a spreadsheet with statistics, but of the morale of the hospital. A former executive I reported to called me the barometer of the hospital. A colleague at the LMH has been described as the glue that holds things together. The understanding behind their question is that as subjective as it is, we read the human space.

Reading the human space requires different skill sets than my medical and nursing colleagues. It is in part listening to the stories and the narratives that staff share with me as I move around the hospital. In hearing them my antenna is attuned to the "health" of their comments. They may well be stressed and overworked and the tempo of their work extreme. That doesn't mean that they are not in a good place. I am looking to hear for darkness in their story which may have to do with their mood or the edgy humour or a sense of being overwhelmed or desperation or of conflict with work colleagues or sometimes family. Statistically this will also be indicated in increased sick leave, workplace discipline and low productivity.

It has been called "taking the pulse of the organisation". My work sees me in most units of the hospital on both the women's and paediatric divisions. I have a wider, global perspective than most do. To use a medical image, my taking the pulse is to sense which part of the hospital "body" is having problems. With respect to confidential conversations I can be an advocate for areas that need extra support from the hospital leadership. There

is in a sense a prophetic role in this advocacy, to be a voice for staff who may feel powerless. Alongside this I also bring to the hospital leadership's attention the excellent work and the celebrations of significant achievement by competent, caring people.

Part of the Hospital but not Constrained

A delightful insight from our people has been that while I am seen as part of the hospital, belong there as much as they do, I also have an independence. They see me as not constrained by the institution. There have been occasions where it has almost been confessional as staff members, and even executive members have shared with me their struggles with the hospital and how to continually progress their work. This is especially so in the current climate of austerity which now seems to be the norm in SA Health.

I am seen to be independent and a fair trader. In part this comes from the sense that clergy bring a confidential listening. What is said to us goes no further, a reflection of the confessional in the Catholic and Anglican traditions. While in this context some would see our advice having some sacramental content, it is in my view a sharing of a common human journey where we all struggle with aspects of life at different times. One of the lines I use in my wedding services is that we need to live being forgiven and forgiving, not so much for what we have done but for who we are.

When the new sacredspace was built the old Chapel became a store room. It is on the hot floor of the hospital where the critical areas of ICU, Theatres and delivery suite are located. Given the space restrictions there is a need for a family room for end of life care. A number of nurses keen on this project have worked hard to bring it to fruition. They have networked, written a business case, elicited their manager's approval and got some funding. While there is agreement that this is an important need and that the old Chapel site is ideal the issue has been stuck in the decision making process. I have been

on the periphery of the discussions and heard that it had stalled. I was able to step around the politics and talk to an executive leader and simply inquire about the progress of the room.

Calmness and Comfort

I was new to the hospital and remember well being called to the emergency department. We had a number of casualties about to arrive. Not knowing quite what to do I went to the nurses station to gather more information. In the midst of my uncertainty this seemed a sensible thing to do. It was also a "safe" place where I was both out of the way and yet available for what they might need from me.

As I was standing there, wrestling with my uncertainty, one of our doctors rushed past, looked to me, smiled and headed into the treatment area. Events began to unfold and I was directed by experienced nurses to areas where I could provide support to families, a number of whom were related. Working with the social worker we tag teamed to provide care and connections for the families, and knowing our way around the hospital occasionally acted as guides to toilets, the cafeteria and the wards to which the children would go.

At the end of the crisis, during our debrief, the doctor who had rushed past and smiled looked across the table and said that he knew it would be OK because I was there. I still struggle to make sense of this and my Baptist heritage is wary of priestly roles. Yet I have been told this a number of times now. There is something about this being the "holy one" in the hospital, being the priest to the "village". I had been happy to see my role as pastor to the parish. There was this new level of understanding and insight that the staff shared with me, that of a priest, holy one, the person who embodies and does the spiritual work even if it is not always accompanied by ritual or prayer. In this secular

space the whisper and hope are evident and my chaplaincy ministry attunes to these spiritual themes. When I speak to my Catholic colleague about this, his response is often a wry smile! He is well versed with mystery.

I was also surprised when we had the on-line site visit with the LAC. Both nurses who were able to attend, one from emergency and the other from a critical care area of the hospital both identified a sense of calmness and comfort when I was around. I believe it is more than a talisman or magic. I think it is in part the mystery of chaplaincy presence and part of what the Celts call the thin places. There is something symbolic about it too, the God person and therefore God present.

Religious Roles, the Holy Man

Chaplaincy is a ministry that is exercised for but outside the church. I believe that chaplaincy at its best offers a bridge between the church and the world, one that has the potential to inform each other. Part of my thinking has always been that the hospital is my parish, the community in which I provide pastoral ministry. In this context a staff member described the hospital as a village and my role as the holy man.

There is a clear understanding by most of our staff that the chaplaincy team are Christina clergy. They seek this part of our role out for their patients and sometimes for themselves. It may be for a prayer, baptism, blessing or pastoral care for a patient or for themselves a marriage or funeral or maybe for advice about cultural or religious practices of a family or to organise a faith representative to conduct a rite or ritual following a death or a child's school religious project. Alongside these religious expectations is the "don't preach to me" message that is so deeply ingrained in the Australian psyche. Yet, at the same time the question will be "what does it mean?"

Kate had found love. She was a late starter in terms of romance, having had many relationships that did not progress. As a nurse she had travelled the world working. I was asked to conduct her wedding. We had worked together at somewhat of a distance as her unit was not one I visited regularly. I met with Kate and John her future husband and we planned the ceremony; but not too religious. The venue was to be a public garden.

One of the things I had to explain to Kate and John was that I am only registered as a religious celebrant by the government and I cannot do civil ceremonies. As we worked through what this would mean, we included readings, prayers, promises and blessings that looked very much like what we would do in a church. They were really comfortable with what was planned and invited friends to do readings and co-opted family into other roles. The garden ceremony went well and the only difference from inside a church was that after we signed the register, we toasted the bride and groom with champagne or beer.

The Kate and Johns I work with are not adverse the symbols, prayers and rituals of the church, but they want them to be in the context of a relationship. In this sense I am the holy man, the one who is symbolic of God, who brings a pastoral voice. The significant part of this is being both relational and pastoral. A lot of chaplaincy work is bridge building with the staff, gaining their confidence and trust so that they will introduce us to families in need. They are adverse to pretence, ego and self-importance. The bridge needs to be one that conveys hospitality and inclusion and leads to a place where they are valued and respected.

The hospital is my parish, my village, but not in a proprietal sense, rather as a community that we share. My role in this secular community is to be the Christian chaplain, I am included and belong and my contribution is valued.

A Different Perspective

The lenses I see the hospital through are different from the medical, administrative or allied health ones. Mine is a pastoral and spiritual care lens, and I am looking for different things. The other professionals in the hospital have a task to do, a problem to solve, a situation to fix. Against this important doing to and with patients and families, my job is to "be". This is sometimes claimed to be a chaplaincy presence, a symbol of something bigger in life. While I can appreciate the truth in this I would want to say that this is an active not a passive presence.

My role is in part to hear the stories that are unfolding. This may mean listening and taking them in, it may also mean that I provide an interpretive role or a clarification. I bring a theological perspective, a view from the faith community and a pastoral expertise. My pastoral perspective is one that seeks healing, reconciling, nurturing, guiding and sustaining for the family and for the staff. It does not mean that everything will be well or as it was before. My role is to offer these pastoral perspectives in the midst of brokenness, fortunately most times the brokenness can be fixed, sometimes repaired with ongoing issues, rarely and sadly at times it can't be.

Into this I am seeking to find out how people are making sense or meaning in a situation, their spiritual journey. Identifying their personal and community connections and resources, and drawing out their expectations and perceptions. I speak of courage, resilience love and care. My lens is also a filter through which I am able to appreciate how spiritual and cultural understandings are important if we are to provide holistic care.

One place this perspective is important is on the Human Research Ethics Committee (HREC). The role of pastoral care is identified as a requirement due to an appreciation that there is a specific insight that comes from this perspective. We also have

patient ethics consultations and at times I am invited to offer an opinion. In one very difficult case after robust discussion between different medical specialists a treatment contentious decision was made. I was asked if I thought they were making a good moral choice. I did, but I think the better question was whether they had made the choice agonising over the potential consequences and implications for the child. Again I thought they had. Despite this I had a very heavy heart over the weekend break; agonising decisions are like that for all of us.

Educational Contribution

I have been involved in a number of educational activities in the hospital including the annual Paediatric Palliative Care Course and the trainee and graduate nurse programs. In the formal educational programs I teach in the areas of grief and loss and of spirituality. We call one of these programs "Tricky Questions" and using a learner centred approach have the nurses nominate the questions we will engage with during the session. It requires some quick thinking and familiarity with a variety of issues that includes understanding of family dynamics, ethical issues, treatment regimens, religious beliefs, cultural issues, values, and belief systems. I find this stimulating and at the same time daunting. It is an on the spot question and answer. In this formal education space I work closely with the teams presenting the overall program, sometimes working with them in the learning and lecture space as well.

In one of our palliative care courses I was presenting the session on spirituality. In doing so I touched on the theme of magical thinking that attends some cancer cases where someone in the family is convinced that a miracle will occur despite all the evidence to the contrary. As I discussed this and advocated for a place where chaplains encouraging healthy religious and spiritual practices can provide support and connection for families

dealing with treatment one of the junior doctors asked for my opinion of a recent case. The situation had been traumatic with a highly religious family who were not prepared to have any conversation other than their child would get well, and God would do it. It was a case where I had tried to engage the doctor posing the question about how the religious issues were key to the family and needed to be addressed rather than engaging in conflict. When I responded to the question and identified some of the subtleties of the family dynamics, their faith tradition, who was supporting it, and that recognising their position and acknowledging the family's needs for certainty from their faith did not mean a conversation was impossible. It just needed to be framed differently, including exploring what informed their understanding and how they had in the past coped with difficult issues. The doctor's response was, "I should have talked to you".

Encouragement to take the everyday opportunities to promote and explain chaplaincy has been an outcome of the project. Someone once asked, "What is your elevator pitch?" The five to ten second soundbite to promote the service, the headline you want people to remember. Mine is, "I am here to help you make sense about what is happening, to help you with your connection with those who care for you and offer the support of faith."

Professional Practice

Operating as a professional member of staff is important for chaplains to be accepted and one with multiple facets. It ranges from dress and demeanour to continuing education, from registration with SCA to timely response to a page or call for service. Some in chaplaincy want to focus on the "art" of the role while others it is a "science". The Baptist Family of Churches in South Australia now have a chaplaincy accreditation course that has a focus on three competencies. The "head" or necessary academic

knowledge and training, the "heart" with a focus on a compassionate and caring personality and development in this area, and "hand" that identifies the practical skills necessary for the ministry.

As we developed the SCA Standards of Practice[1] the art or science divide in practice was often raised. It is of interest that this is also a conversation in the CPE both in Australia and internationally. I firmly believe both are necessary and to neglect either impoverishes our practice. Both the Baptist Church and SCA require me to maintain a professional development program of both learning and supervision. I believe these programs, when embraced positively, help people become better practitioners.

So, for me being professional includes not only quality chaplaincy with patients, families and staff but also reflection on that practice. It includes being attentive to boundary issues and the dangers of transference or countertransference. Another aspect is self-care, especially after a difficult case or number of them. My executive manager at the hospital has on a number of occasions taken my diary and identified self-care days that I am to take. Supervision and counselling, particularly addressing difficult cases is essential and I am privileged to have a number of sources for this. I maintain a connection with my faith community and attend the annual pastors' conference.

An important part of professional practice, along with being a reflective practitioner, is professional development. I have taken a lead role at the local chaplaincy level in this by contributing to the organisation of learning opportunities and by supervising two chaplains. The Drew University Doctor of Ministry program has been an

[1] *Spiritual Care Australia Standards of Practice* (Melbourne: Spiritual Care Australia, 2014).

intentional part of my professional development and the topic of this project is directly applicable to my work and that of the chaplaincy profession in Australia.

At the hospital I attend the weekly Grand Round that showcases research and innovation from within the hospital, interstate and nationally. I have presented at a Grand Round about my military deployments to Pakistan and the Middle East. In conversation with other professions at the hospital I speak of the importance of the professional aspects of practice and my involvement in them. The three key issues in professional practice in my view are reflective practice, supervision and professional development.

How the Chaplain Relates

The previous sections have identified the role and the place where chaplains are seen working in the hospital in functional ways, I now explore how we are seen to relate. Again the voices of staff members speak to how they experience chaplains personally, the relationships and engagements that we have. There are subtleties, nuances and layers in their stories and complementary themes within them, a thickened narrative. In these narratives is the story of who chaplains are, not merely their function.

Providing Support

The chaplain as confidant who is able to discuss work and personal issues is valued by staff. A staff member spoke about her husband’s cancer and how the chaplain had been supportive over months as he deteriorated and died, and of the follow-up support since. Offering care to staff that was experienced as genuine with their sense of being heard, care that they felt was personal and real.

A term often used by chaplains to describe their practice is “being present”. I have not found this concept to be overly helpful. While it is intended to describe giving oneself totally to the other in the pastoral encounter, I see it often used as a broad brush

description without content. My Army colleagues talk about presence as "loitering with intent". While it speaks of a relaxed presence, I believe that a chaplain enters a pastoral conversation with a clear agenda of conducting a pastoral assessment and meeting the person where they are. This is not presence or loitering, there is a clear intention to engage with people. It is enlightening that the presence of chaplains was noted by staff. They spoke of the chaplain always being there, a regular attender on the ward, available and approachable.

As well as being around the hospital wards, chaplains were seen to support staff members by being part of their unit teams. Continuity and consistency of care was appreciated by them. This sense was deepened by the reflection by a number of staff that when chaplains were providing pastoral or spiritual support to patients and families it in turn supported them to do their job. Nurses reported that they could attend to other parts of their role, that it made their job easier, that the role was complementary, and that there were parts of pastoral ministry that enabled people to tell their story in a way that was helpful.

Personal support in the form of mentoring, counselling, education and supervision were identified. Providing emotional and bereavement support was also mentioned. Offering staff members' permission to be human, to identify and value their feelings was spoken of. Staff appreciated being able to engage chaplains during their daily work around personal issues. They have missed the immediacy of the on-site staff counselling service that was removed and find the EAP disconnected with their work at the hospital. The presence of chaplains on-site offered a familiar face and ready availability was appreciated. Chaplains also provided support to groups of staff in debriefing sessions and often staff advocated for chaplains to be at the debriefs or to off-load to. Chaplains were

seen to support staff by bringing a wider view and pastoral perspective to a case or personal situation.

The wider view is layered with a number of nuances and meanings. Chaplains are seen as being part of the hospital, belonging to the institution and to the wards and unit teams. They are also subtly seen as not working within the scientific and problem solving models of medical care but attending to the human and spiritual aspects of life. Alongside this quiet acknowledgement of spiritual care is the appreciation of personal encouragement and recognition that chaplains give staff members. Chaplains are experienced by staff as having an understanding of the whole hospital and as being approachable. In relational terms this was variously described as wisdom, assistance or guidance.

The initiative and proactive nature of chaplains was seen at a number of levels, some personal and others to do with the quality of their service/ministry. Following up people after a critical situation was noted along with facilitating faith specific ministry. Simple but important rituals like candle lighting were able to be performed because chaplains were able to have smoke alarms monitored. Staff members spoke about chaplains going out of their way to ensure they were supported, or hunted down as one said! At the WCH the weekly hospital wide email "Thought for the Week" is seen as encouraging and affirmative. The support was described as being subtle and informal as was the place of conversations in the hospital corridors where staff were listened to. Spiritual guidance, enabling people to find a sense of meaning, purpose and connection was identified and the personal connection with chaplains that was different from a purely religious engagement. In all of this staff understand the chaplains role as a Christian minister.

The headings below were developed in the thematic analysis of the interviews for the project. They, like the discussion above, illustrate the voices of the staff as they describe chaplains supporting them. I will tease out the meanings of the headings with reflections and narratives of my chaplaincy practice. These will mainly be mine and from my perspective and experience.

Available and Present

I read in the chaplaincy literature and hear chaplains speak about the importance and power of presence. Being present with the families I care for is fundamental to good pastoral and spiritual care; it is being attentive to them, their needs, fears and celebrations and valuing the importance of sharing all of these emotions. Each time I engage with a patient, their family, or a staff member I have a clear agenda to listen to them, to hear what they are trying to communicate and respond to what they are sharing. By being present I am reading the room for clues that identify what is important to this family, I look at the affect of the people in attendance, I listen for clues in the conversations. Alongside this I am also exploring with them what is important for them at that moment. In this moment they lead the conversation. In the words of CPE I am reading the living human document. This is not a passive act.

My current professional supervisor was a police chaplain for over thirty years and we have sat on a number of interview panels for prospective chaplains together. It is often said that you have three seconds to make an impression. His question as he rates a candidate is, “if you were in a hospital bed and this person came into the room, would you make out you were asleep?” It is a good question for a chaplain needs to be aware of their environment, engaged with the people in the room and focusing on the individual. If they are not, they are only taking up space.

I began working at the WCH in 2000 in a department that was denominational in its structure with chaplains only visiting those who nominated a religion resulting in over half of the patients not being visited. My emphasis with my team from the beginning was that we are a team that complements and supports each other. Having promoted the team concept I was asked by one of my team soon after I arrived, “So if I see one of the families from my denomination is it OK for me to speak to the others in the room?” My somewhat blunt response was, “I would think it is rude not to!” I discovered that behind the question was in part a test of my stated philosophy. Also behind it I found from a number of my team was that they were chastised if they spoke to someone who was not on their denominational list.

I found the denominational structure to be both inefficient and limiting. While there is an important role for denominational or faith specific care related to shared rituals and understanding there remains a need to be more inclusive in our care. Denominational or religion specific care limits care to the “few” who belong. Such a restrictive practice at the WCH would mean that the sixty percent who indicate on admission that they do not belong to a faith group would receive no spiritual care. A purely denominational focus is also not understood by a secular staff who also see it as limited and exclusive; and believe that chaplains should be better than that. In my view such an exclusive attitude to the provision of spiritual care does not reflect my theology that includes the importance of the individual, hospitality, inclusion, and justice.

The change I negotiated with the team was for each of us to focus on specific wards. This was complemented with a referral system for patients or families with a specific denominational need so that the benefit of their faith community support was not lost and that the rituals sustaining their faith were still available. Ward based chaplaincy

provision has the benefit of a chaplain becoming well known to staff and having the ability to develop relationships with them; chaplains not only being present but being known and integrated into the unit.

Ward clerks are the front office and gate keepers of any medical unit and have their finger on the pulse. They are able to make our job difficult or easy simply by sharing or withholding information. Nurses at the bedside likewise can inform us of the progress of a patient or family or leave us in the dark. Building good working relationships with them is critical to us doing our role well and providing the best care to families. In developing good relationships we also care for our staff, we hear their stories, and they hear us hearing. The staff and the chaplain develop a sense of protective ownership of each other, complementing and building the sense of community on a ward. From a chaplaincy perspective this hospital community is my parish and I have the privilege of being the presence and gentle voice of God in this secular world.

One of our staff members, Bill, had a heart attack while playing competitive squash. His partner June is one of our clinical leaders. Bill was home recovering from surgery when I heard about the incident and June had just returned to work. I intentionally called to see her. She is often out on the unit floor supporting her staff or attending meetings but I caught up with her in her office at one of those moments when she had a small window of time. I asked about Bill. I think there is a difference between a chaplain asking and her colleagues. We both care, but I believe that the idea of presence is not just being in the room but the understanding of our role.

June spoke of her shock at Bill having had a time bomb in his chest; at her gratefulness he received immediate first aid and hospital care, her awareness that his fitness had assisted both the surgery and recovery. She had also become aware that Bill

had early warning signs that he had ignored or toughed out and was angry with him about that. The conversation reflected what staff identified in the interviews, that in the midst of the everyday we are listening to them and valuing what they are going through.

June and I also share care for a family who have a long-term association with the hospital. Due to medical mismanagement in the community and the death of her baby the mother trusts few health care professionals. June is the trusted medical person for the mother and has occasional contact with her. I tag-team with June to provide support for the family, the mother in particular, who carries enormous guilt that she didn't protect her baby and she lives with deep grief. Due to the nature of the baby's death legal issues remain. When I see June, it is one of our touch points, asking how the family is travelling. It is one of those situations where I am involved because of the respect for confidentiality that staff members understand chaplains have. They can be almost confessional or at least share a burden where they know they will be supported and that it goes no further. This understanding comes from their experience of how both my team and I work, the sense of the confessional from the media, film and popular culture, and our workplace policies around the privacy of personal information. The most important of these is their experience of chaplaincy care. Now there is the added dimension of June's partner Bill.

Another way I am present and available is being a Justice of the Peace. This enables me to meet many of the staff of the hospital who do not work on the wards I have responsibility for as they work in one of the many diverse areas of the hospital such as the labs, stores or administration. My practice is to witness documents as soon as I can, partly out of efficiency for me but also to subtly say that we are available to staff members when we are needed. The hospital has two other JPs, one who is regularly available but

constrained by work time frames, and the other who will only attest work related documents and discourages staff from bringing any personal documents.

Listening

In foundational pastoral care classes listening to people is emphasised and techniques are taught and role plays are assessed. It is a basic pastoral skill and a foundational ministry competency. Listening also requires practice. In chaplaincy ministry being inquisitive is an asset. The ministry practice of listening seeks to hear, make sense of, analyse and clarify what is being offered by the other person. What is being said is not only the words. In my pastoral encounters I am seeking to hear the layers of connection and meaning, the emotion and what forms the story I am being told. And seeking to understand why I am being trusted with this part of the person's life. I am looking for their deep story and being the midwife to meaning as it unfolds. I am also able to help them connect or reconnect with faith connections that may have been long forgotten.

Hospitals are always going through change, even more so when they are government facilities. I recall three conversations with three middle managers over two days that mirrored each other. The conversations were serendipitous and from unrelated parts of the hospital. All three of the managers shared how they had staff who were committed to the hospital and came each day and went the extra mile when asked. They also commented on the stress they and their teams were under due to budget constraints. Their concern was how this could quickly affect staff morale and work practices.

As I listened I recalled the words of wisdom from an experienced Army Warrant Officer whose question in this situation would be, “Are you just having a grizzle or do I need to take this further?” I sensed both were true. They wanted to be heard about their

struggles with the budget and affirmed their care of their people. They wanted it known that they found their teams inspirational. They wanted their teams to be valued, and I think to be valued themselves. Sometimes we need to do something with what we hear, and my reading of the pulse of the institution is valued so I was able to speak to hospital leadership about the challenges and the cost of change.

The social currency in the hospital is the tribal allegiance to AFL teams. Adelaide is a two team town and the rivalry is strong between the Adelaide Crows and Port Adelaide Power. At the end of the 2014 season, the Power assistant coach was appointed to lead the Crows and the usual rivalry was played out. Sadly, mid-season the Crows coach was murdered. There was an outpouring of grief by supporters of both teams. For a number of weeks it was the content of quiet conversations around the hospital. While secularism is strong in the Australian community, sporting and community leaders spoke about supporting the coach’s family and that they would be in their prayers. Like cricketer Phil Hughes’ death six months earlier, sudden and untimely death shocks us. In the context of the hospital I sensed it provided our staff with permission to grieve both the significant and little losses we all have.

While the question asked of me was “What do you think?” Or, “How do you make sense of it?” I found the question was really, “Please listen to me”. My response was “What do you feel? What’s going on for you?” While there were stories of personal shock and genuine sadness, there was also the opportunity for some to share their other griefs. It was an invitation to listen to them, opportunity to validate their humanity, their feelings, sadness, hopes and dreams.

I have suggested that my listening as the chaplain has a number of layers to it. It is listening along with hearing, a communication where the person feels valued and

understood. There is the general conversation and people wanting to tell their story, the need of each person to be heard and valued. There is another layer where chaplains are seen as safe, that the conversations are confidential. While we work in the hospital we are not part of their department and while part of the care teams not beholden to the usual hierarchical structures. We have an independence. While not in the context of a church structure there is the confessional or ritual layer to our listening. They have not just engaged with one of their friends but with the Christian chaplain, the village priest who represents and symbolises the presence of God.

Relational and Respectful

Staff members in their interviews identified three individual characteristics that were fundamental to their engagement with chaplains, each complementary and supportive of the other. Firstly the chaplain's personality, an ability to engage with staff and patients and do so without appearing anxious or uncomfortable. The second is to be relational in their approach being both respectful and non-judgemental and able to make connections with people quickly. The third was to be respectful in the conversation and in behaviour, part of which is being non-judgemental in approach.

While personality types influence how we relate they are not definitive. Our team has a number of extroverts, yet it is the introverts that often bring wisdom to the table. Their ability to reflect and process is important to us. The extroverts bring energy and enthusiasm. Wards and units have personalities too. The intensive care and emergency units have "can do" people who are calm in a crisis; the adrenaline junkies. Operating theatre staff tend to have obsessive tendencies and want everything in its place and are focused on one task at a time. Medical wards are populated with staff that are good at longer term relationships and nurturing for patients and families.

Chaplains need a personality that is not anxious and is comfortable in uncomfortable situations. They also need to be relational if they are to be accepted in the secular health care environment. Being relational is also a theological stance and takes seriously the engagement as chaplain in this world outside of the church.

Being able to quickly establish and build relationships was noted by staff as strength of the chaplains. They speak not so much of specific incidents but two aspects of encounters with me. The first is the corridor and workplace greeting and they note that this is not the usual hello. They have awareness that this is a genuine inquiry about their welfare and their life outside of the hospital. Secondly they spoke about how this would lead to a more specific conversation where important issues could be taken further either with a meeting or in subsequent chats.

Sadly this is not the case with some of our relieving chaplains who tend to be more functional and patient specific about their role. Possibly it is because they don't know the staff well or because the "country" of the hospital is unfamiliar and unsettling for them. Also, their focus is on the patient of their denomination. They seem to not get a bigger perspective of the others in the room.

I reflect that in my JP role, as I witness documents I have a mini United Nations at my office door. The Aussie who was applying for a medical fellowship, the Saudi who was extending a visa, the Filipino doing a legal document, the Indian whose son had a speeding fine, the Aboriginal with guardianship issues, and the Scot with visiting family. Alongside this cultural layer is possible faith or no faith commitments that include agnostic, Muslim, Christian, Hindu, Dreamtime spirituality and atheist. As a JP it is an easy case of witnessing the documents. At the same time I am interested in their story. The Aussie's struggle doing her higher studies due to family commitments with her

children including time out of the workforce and the contract nature of the work. The Saudi, a long way from home and struggling with Australian cultural issues, including being challenged by female nurses about his practice. The Filipino who wants to get her affairs in order so is setting up advanced directives about her medical care. I get a number of speeding fines where the children or partner was driving the car and I talk with the Indian dad about the frustrations of parenting yet love of our children. Traditional Aboriginal culture and kinship does not always follow neat western practices and with extended family often the carers. The feisty Scot who wants his family to visit, and is frustrated by the insurmountable paperwork from immigration bureaucrats.

The ability to engage without anxiety, develop relational connections and a respectful attitude is significant to our staff and essential in the multi-faith, multi-cultural and secular setting of the public hospital. Australian social researcher and commentator Hugh Mackay has identified kindness and respect as glues for a thriving community. Our hospital charter's opening statement is about providing "patient first" care. In my theology I spoke about each person being created in the image of God. The theme here is about taking the other person seriously, treating them with respect.

With our Indigenous communities there are a plethora of customs that are unknown to other tribes; it is a potential mine field. In a conversation with our manager of Aboriginal Services I raised this dilemma. My question about how to behave was framed with an acknowledgement that I would most likely get it wrong. I asked that if my attitude was respectful, what more I could do. The response was "that is all we ask".

We had a patient from a remote Aboriginal community who was accompanied by his "mother". Western concepts of kinship do not equate in our Indigenous communities and the "mother" may be an aunt, grandmother or cousin depending on the clan and the

situation. They will also not make decisions on their own; they need to consult with their community. This is rarely simple with remote communities. Staff found communicating with the mother difficult as she was very quiet and withdrawn. The little we knew was the community from which family they came.

I sat and was careful to not look at her, rather gazing at the floor in front of me. While in the Western culture this would be distant and rude, for her it was respectful. There are layers of detail about communication here but suffice to say that if I looked at her it would have been for her both intimidating and shameful and she would not have spoken to me. I began by saying quietly that I had been to where she lived, to her country. Country is important, our Aboriginal people belong to their country, the land and location from which they come owns them. There are many sacred sites in one's country so I was careful to only speak in general terms but enough for her to know I had been there. Also for this woman to be on someone else's country was dislocating and only allowed by invitation.

I spoke to her about the hospital being our country and our land being a place of technology, care and healing, yet foreign and scary for her. I also told her she was welcome and it was our job to guide her through our country and keep her safe. As the conversation unfolded with her poor and quiet English language it became apparent that she was fluent in five aboriginal languages and rarely used English. We quietly talked about how unsettling all the machines were and how staff were rushing around and had to do things quickly, the opposite to her traditional way of life with the community being considered and reflective before anything of importance was done. I shared that although it might appear rude they were trying to do their best and at the same time were uncertain of what they should do. This conversation was respectful. It was also spiritual as the

concepts of country and community are fundamental in Aboriginal identity and belonging.

My conversation enabled connections with staff, a number of whom have also worked in remote areas and understood the dynamics, and with a significant number who have not. The conversation with staff also needs to be respectful. If they do not know the social and cultural behaviours it is difficult for them to communicate with families. An attitude of respect is also at the core of making who the patient and family or staff member is the priority, working with their needs and agenda.

Chaplains enjoy a positive reputation amongst staff members. However, the image of clergy in the news media is very negative. The institutional church is seen as aloof and dogmatic. McCrindle Research identified the six key reasons why people did not attend church, they were: not relevant, outdated style, how the message was taught, clergy behaviour, no belief in the bible and personal busy-ness.[2] Staff members described chaplains as non-judgemental. This counterpoints the community narrative and is valued by hospital staff as they can trust chaplains with their patients.

The midwives in our delivery suite are one of the most protective groups in the hospital of their patients. This is even more so in the case of a genetic termination, foetal death or still birth. I am often invited to conduct a blessing in these incredibly sad situations and the invitation is at the instigation of the midwives.

In the interviews midwives spoke about chaplains' non-judgemental attitude. This is related to the genetic terminations in particular. There are a range of ethical opinions and positions on the conduct of such terminations. I have taken a position of providing

[2] Mark McCrindle, "Church Attendance in Australia," The McCrindle Blog, last modified March 28, 2013, accessed November 8, 2015, http://blog.mccrindle.com.au/the-mccrindle-blog/church_attendance_in_australia_infographic.

pastoral care, believing that theological and moral issues are secondary to a family's need. I also require this from my team. This is another of the complexities of being the Christian chaplain in the secular hospital and one that requires careful reflection.

My experience is that ethical issues are often more nuanced and complex than our churches understand. One of my trainee chaplains comes from a conservative Pentecostal tradition. Dianne had been well taught that all terminations were wrong and an affront to God. I had been called to attend to a woman who was having a genetic termination of her pregnancy. The tests showed that her baby was incompatible with life. I suggested to Dianne that I had a learning experience for her.

In the room the woman was accompanied by her partner and mother. The tiny baby was in a cot and the grief in the room was palpable. I spoke of the baby by name and explored the parent's hopes and dreams for their child. I performed a blessing that claimed children as loved by God and anointed the baby with violet oil. I also anointed the parents and grandmother's hands. In doing so I encouraged them to breathe in the fragrance and suggested to them that whenever they smell or see violets to remember their child as they are being spoken to by her.

In the debrief that followed, I initially asked Dianne what she had noticed. Her overwhelming sense was of the grief in the room. Her church had told her that such people were cavalier and uncaring. The reality of the experience clashed with her church's message. A conversation followed about pastoral practice, meeting people at their point of need, allowing God to do any judging necessary, and affirming the place of ritual and prayer in people's lives.

Spirituality and Religion

Australia is robustly secular and this is reflected in the SA public health system. There is an antipathy to institutions in general and this includes churches. The daily hospital census data indicates that over 60% of families do not nominate a religion at the time of their admission. While a number with faith connections are not captured it is an indication of a generation that has bypassed the church. Those who do nominate a religion tend to have little contact with their faith community. Taking the accepted statistic of less than 10 percent of Australians attend church regularly, of the 360 patients per day, 36 would have a faith that could be described as active.

I was visiting a boy in his early teens with a parent present. In my normal greeting I stated my name and indicated that I was one of the hospital chaplains. He asked what a chaplain was. Usually I answer that it is like a minister or priest but in the hospital. So, what's a minister or priest was the question. I was aware that the boy's parent was equally unsure of my role. While many young people have an experience of school chaplains due to federal government funding for their role some still do not. While not regular, this is not an isolated conversation in my experience. What it points to is a number of generations who no longer know the stories of the Christian faith. Whose religious idea is that there is a better place somewhere and that because we are good people we all get there.

As I introduce myself to families a regular response is "I am not religious, but…" While this is an apologetic and almost embarrassed opening for a conversation the sense that I have is that they are prepared to have an open discussion but are fearful of being "bible bashed" or having their views disrespected. There are still many families with a latent Christian understanding that they are willing to explore if they feel safe to do so.

All religions have within them complexities and a variety of beliefs and practices some from their understanding of their faith others influenced by their cultural setting. In the Christian tradition we have a range of denominations and within them a diversity of opinions. The larger Buddhist communities in South Australia have their origins in Thailand, China, Sri Lanka, Tibet, Cambodia and Vietnam each bringing cultural and ethnic influences to their practice. Our highly secular staff do not always understand the complexities and differences of the Christian church let alone those of other faith groups.

To be seen to be religious in Australia is usually described negatively as someone who is overt and pushy about their faith, with a strong tinge of moralism. Generally it would also be seen as someone who has a commitment to and attendance at worship and is engaged in the church community. When this is worn lightly and gently, it is readily accepted and respected. What is also respected is being true to one's beliefs as long as they aren't imposed on others.

Functionally "spirituality" in Australia is being able to discuss issues of importance and faith without the baggage of religious institutions, dogma and certitude. The title for a paper I wrote for the Oates Institute on spirituality was titled "That Slippery Sucker".[3] In a sense to define spirituality tightly is to lose its essence, yet to lack a description is to have no space for conversation and discovery. The meaning of spirituality in the Australian context is broad, encompassing the spiritual essence of many faiths and none. Not least is Aboriginal spirituality with its Dreaming stories.

There is a currency for spirituality at the moment. Unfortunately Australian Christian theologians have largely missed this engagement and chaplains who generally

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[3] Carl Aiken, "That Slippery Sucker…Exploring Spirituality," *Wayne E. Oates Institute Journal*, 2001.

focus on the individual they care for have rarely entered the debate either. The little response I have heard in conversation from Christian leadership is that spirituality is always part of a religious expression, they seem incapable of envisaging a spirituality that is not connected to a religious tradition and have subsequently taken themselves out of the conversation the community is having.

In 2013-14 I had been part of developing a spiritual wellbeing plan for the ADF, a program that has been put on hold due to chaplaincy politics and attitudes. The problem was the definition of spirituality. We had used the definition from an international consensus conference on spirituality. A few senior chaplains were unable to accept a definition that did not specifically use the word "God". References to transcendence or higher power were unacceptable. They remain unable to embrace a different world and engage in dialogue and conversation. Their rigidity has limited chaplaincy opportunity in the spiritual wellbeing space with the danger of making it yet another religious program that soldiers avoid. The definition that was rejected by senior defence chaplains because it wasn't theistic enough has been endorsed and adopted by SCA, CSSA and the chaplaincy team at the WCH is:

> Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.[4]

Spirituality is not without its rituals and practices and at its best religious practice is deeply spiritual. All faiths have rich traditions that engage with the breadth of human

[4] Christina M. Puchalski, et al,. "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus," *Journal of Palliative Medicine* 17, no. 6 (2014): 646.

experience and offer ways to express them. Spirituality and religion can be the best of friends or bitter enemies; it all depends on their relationship at the time. The problem is often when the complexity of their relationship is not acknowledged or understood.

The hospital "sacredspace" which replaced the old and transitory chapel was opened in 2013. In response to the eclectic spiritualties and diversity of faith traditions I developed the design brief for the architect specifying that the space was to be a place where spirituality and faith are valued and nourished and where everyone could be nurtured and refreshed, that it was to be inclusive of all or no faith. Its purpose was to provide for the expression of faith or spirituality in the midst of illness or pain and to provide for personal or group reflection, prayer or meditation. It was also to be a place for celebrations, rituals and for family gatherings for support. A welcoming space was envisaged. In terms of ambience we wanted the "sacredspace" to be invitational, calm and spirit nourishing. It also had to be respectful of Aboriginal heritage.

The sacredspace is a reflection of our chaplaincy practice, respectful and inclusive. It has not been without its detractors, especially those who do not think it is "Christian" enough. One particular conversation was around there not being a cross on the wall. I was sharing this conversation, and in part my frustration, with one of our palliative care nurses. With clarity and insight her response was, "well I don't need a couple of sticks on the wall to find Jesus". I am not sure that this insight would be overly helpful to the person who would like to see a cross. It did remind me that faith for me is relational, internal and who I am. It reflects the wider Australian community too, a small group of staff want the cross, or their version of religious symbol, held high. A larger section has moved past this and practices a spirituality that is eclectic and less formal. An

important theological theme for me is hospitality and the sacredspace is such a place and an example of being inclusive as a chaplain in a secular environment.

I recently had a conversation with a class mate from my theological college days. He commented that I was the one who engaged in creative forms of worship and the use of symbols and rituals. This resonated with my Army experience and also my practice with the hospital Memorial and Christmas Services. In our Memorial Service we light a memory candle, name the children on a PowerPoint presentation, give families flowers to take home and release doves. For Christmas the hospital school decorates the Cathedral which is also lined with balloons, we light candles, then release the balloons to the peal of the bells.

In my Army chaplain's role I have occasion to bless memorials and the odd helicopter. My practice has been to use a soldier's drinking cup and a sprig of rosemary and a twig of eucalyptus tree. In the blessing I sprinkle the memorial and speak briefly of life giving water and of remembrance and belonging to Australia. Most recently this was to dedicate a memorial commemorating battles in World War 2 in Papua. Following the service one of the Sergeants asked why I don't also have a branch of olive for peace. A developing ritual informed by the recipients.

In another conversation one of my Army chaplaincy colleagues quipped that I was a high church priest dressed in Baptist clothing. These two conversations have caused me to ponder some of my hospital practices. When I am invited to bless and anoint stillbirths in our Delivery Suite I use a simple liturgy and violet oil for the blessing. The reason is so that families have a connection with their baby through their senses. I suggest that when they see or smell violets to remember their child. As part of this I anoint the back of their hands so that they carry the fragrance throughout the day.

I have also used the practice of sprinkling water on the doors of units within the hospital that have been refurbished. The violet oil has been used too in this situation to bless the hands of the staff with the reminder that their hands touch with care and with healing. Recently we had three visiting surgeons who were in Australia as part of an exchange program. I was invited at the beginning of the proceedings to offer a blessing on those gathered. This I saw as a deeply religious act and again I used the hand anointing as part of the ritual. So again, being a priest to the village.

Staff and patients are seeking a connection that is real, one that is spiritual. They recognise a spiritual engagement when they experience it and have named it in their responses. Prayers, anointing and other rituals are embraced by them when they are offered as a relational response to a situation but vigorously avoided when they are simply a rote religious response. As chaplains we are tapping into the whisper in the mind and the shy hope in the heart. Staff recognise this connection and engage with it.

Not Religious, but…

As part of my reflective practice I write reflections on special cases. James is one of our special cases and illustrates some deeply spiritual dynamics with an absence of religion. It is also a case where the chaplain is an interpreter of meaning and bringer of sacrament.

It is a Tuesday in August. It's James birthday. There are cup cakes with the face of a fox on them. A big birthday cake. Chips, biscuits, slices, and fairy bread. I make the fairy bread. A number of the young nurses haven't made fairy bread; it's the thing mums and dads do. Simple really. Butter the bread, sprinkle the hundreds and thousands on a plate, press the buttered side of the bread on to the coloured sugar spheres and cut the bread in quarters. Aren't you going to cut the crust off? Hell no says one of the male

nurses, that's what you hold it by! I carry the fairy bread out to the table by the bed and am reminded of another offering of bread to remember a significant event a long time ago. I think we call it sacrament.

It's Tuesday in August, it's James' birthday, he is 9 months old.

James has a big brother. Jack has only ever seen his brother in hospital. With tubes, without them. With machines, without them. Jack does all the things a big 4 year old brother does. Hugs, kisses, questions, boredom. This birthday is a machine day.

James' Mum is devoted to him. She is quiet, attentive, gentle and stoic. She gets to cuddle James some days when he is well enough. His Dad is more outgoing, chatting, engaging, and always wearing an English rugby top. One of the things he talks about with me is rugby, a conversation somewhat foreign in South Australia. The conversation about James is limited, a good day, a bad day, a better day…

James was born broken, he won't be playing rugby. Multiple and complex issues the docs say knowingly. More simply his hydraulics and pneumatics are not very good. Heart surgery has helped the first. But he is growing too big for his breathing bits that can't be fixed and is needing more and more help from the doctors. They have had those "difficult conversations" with the parents.

It was a long party as they are in intensive care units, because of course all three shifts have to be part of it. The message went out to the night shift team, don't bring anything for nibbles tonight, there is plenty. And there was.

It's Tuesday, it's James' birthday, he is 9 months old and we had a party.

It will be Christmas on Thursday. It will be James' only Christmas. It is August.

The James story with its lack of religion has significant spiritual layers and those that are deeply religious in nature. I was visiting one of our intensive care units and one of

the unit heads asked to speak to me. The night before had been a horrendous case where a child was admitted who had no chance of survival. The on call Catholic priest was summoned with the child barely being kept alive until he arrived. He is a very conservative priest from overseas who is always dressed in his “blacks”. There was no time for briefing or any conversation in this critical moment and he was pushed behind the screen to the patient and prayers for the sick and anointing requested. As soon as he was finished he was swiftly ushered out. The child died minutes after he left the room.

The unit head asked me to follow him up. There were two concerns. The first concern was for his welfare because the situation had been so dire, and he had to confront it. Alongside this was a concern that because of the rush that the staff may appear rude and uncaring. In reality they greatly appreciated that he attended, provided what was requested and then left them to their role. So, the message to me was “check up on him”, and “say thanks for us”.

An emergency, a priest who was available, a religious ritual. A human concern from the staff for “this poor man who had to put up with all of that”. And, the quirky combination of not being religious and appreciating the importance of ritual and prayer for some of our families.

As I reflected on this event I was grateful to the priest for his timely attendance and willingness to “fit in” to what the family needed. I was also aware that our on-call team only come in for the traumatic and sad events and that I and the rest of our team have the celebrations to balance the sadness. The unit staff sensed a faithful priest, doing what was needed, and were aware of the emotional cost to him. They again showed their care for the wider team and for this short time the priest was included and appreciated as part of the unit’s care for this family. I am also part of that unit team, it is one of my

wards, and I became the team representative to convey their care, thank him for what he had done, and ensure he was OK

The complexity and conundrum of being spiritual. Clearly in the mind of our staff being a Christian minister, but some are not overly sure which kind – although not Catholic – one who is welcomed in their world. Engaging at the point of need of patients, families and staff yet not imposing a formula or mantra. Arranging for Buddhist monks to pray, having an on-call roster, responding to requests for prayer and blessings. Yet not being religious, and at the same time a Christian minister.

Corridor and Coffee

Like all villages and parishes there are open spaces. The key open spaces in the hospital are the corridors, Playdeck and cafeteria. There are smaller ones like the tea rooms too. The corridor has also been called the hospital street, an image about the traffic it carries. At any time there are people moving around. Logistics staff delivering supplies or mail, cleaners working through an area, staff members going to and from meetings and others moving between patient care jobs or going on a lunch or tea break. There are also families some moving with purpose, others lost and trying to find their way around. Chaplains are also in the corridor.

The corridor is more than a thoroughfare; it is a people place where lives are lived out. I greet most people and having been there sixteen years know many of them by name. "Corridor conversations" is a familiar term in hospital speak. People will ask, "Did you know about patient Smith?", or "are you in the loop about?" The information exchange is rich, often spontaneous, and always helpful.

There is something communal, safe, permission giving and intimate about having coffee with someone. It is an important part of my pastoral care and an intentional way to

connect with people when there is a significant issue. Regularly as I have coffee with someone, people passing will greet me with a wave, a nod, a smile. The Playdeck which has an outdoor café is overlooked by four stories of glass corridor. It is close enough to recognise people and often there will be a wave by a staff member as they walk along it.

As I go around this village or parish, the corridor offers many opportunities to engage. Most are simple relational greetings. Some go much further. One conversation was with a social worker. “Hi how are you?” is simply social lubrication most of the time. On this occasion there was a pause before the standard answer of “OK”. “So, what is it?” was my response. The chance passing in the hospital street became a serious pastoral engagement. Jane had been the on call person for the trauma pager for a number of weeks. She was a recent graduate and spoke about feeling overwhelmed and inadequate in her role. Alongside this Jane spoke about how she was not coping with the grief and loss experienced by parents and felt that this was possibly not a job for her. Jane had spoken to her supervisor and department manager about the issues and felt dismissed by them. Together we began to explore her issues, with people walking past us in the corridor and for both Jane and me acknowledging those we know while continuing the conversation.

I know the area well that Jane was talking about as I too work there in times of sadness and tragedy. One of the subtleties and differences in practice is that I am a regular visitor in the ED as part of my pastoral walk around to check on staff. I had heard of their appreciation of Jane as well as their concern about how she was coping.

As the conversation flowed, I spoke to Jane about the feelings of being overwhelmed and inadequate. In part my message was “welcome to the club”. I was also able to validate not only Jane’s feelings but also the feedback that I had from ED staff

about how she was seen as someone who cared and how this was valued by them. We spoke at length about the management issues in her department. It is not something I can fix for her. I did encourage her to address the issues more formally with an email to the two people to whom she had spoken and to address her concerns again.

Jane is in one sense typical of our new graduates and staff who transition from their education at University to the reality and formation of the workplace. While Jane had completed a practical placement at the hospital it had not included the extra work of the ED. In exploring the issues, providing some affirmation Jane went her way. We still touch base in the corridor, often only a greeting. Now and again, we pause and I ask how she is doing and it appears that she is more comfortable in being uncomfortable in the difficult spaces of our work.

It has also been a “two way street”. I was having one of those corridor moments with Sue, a nurse from our ED and touching base about a very traumatic case we had both been involved with. It was very public, a child killed on an amusement ride, and both of us had been seen on TV. Sarah, a nurse and good friend to both of us came along and asked how we were doing and suggested coffee. I thought I was fine and said so. I left to do a minor task and was coming back up the stairs when Sarah simply asked “are you sure?” As Sue was still there, I responded that I thought we needed the coffee!

The three of us had space in our schedule so spent a good hour reflecting, sharing, grieving and talking about how this one in particular had such an effect on us. I was personally confronted and reminded by Sarah’s care about the things I say to our staff all the time. The importance of staying human, of recognising and valuing the emotions and feelings that our work brings to us. That in our place it is right to feel raw emotions and to

express them. That we are not alone and can share with colleagues what is happening. I remain grateful for Sarah's insight and for Sue sharing the time.

"Coffee" is often code for care. Intentionally I have a coffee with any of my team who are in for the day. It helps me keep abreast of what they are doing and able to support them in their work. At a recent morning tea, there was one biscuit left and the Catholic priest offered to share it. As he prepared to break it in half, his hands assumed the position of breaking the wafer at the Mass. We have a very positive relationship so I teased him about how he was about to share the biscuit. Behind this is another reflection that when I was a new Army chaplain a senior colleague suggested it was always wise for the Padre to carry a mug with them. His reasoning was that the diggers would make coffee at every opportunity and that to share in that was important. He said it is a communion moment. I believe he is right and that the coffee and the deep conversations that take place there are a sacrament, as with the breaking of a biscuit.

The lead in to coffee with staff members is a more intentional level of care for them. The corridor gives the hint that this might be needed. There is also a clear agenda too because we have met for a purpose, it has been declared in the invitation to coffee or by their request. Coffee conversations are always significant moments. As a priest to the parish I think they take on a sacramental role. The humbling part is that it has also been a time when I have been cared for.

Corridor conversations vary from the superficial to the significant. Conversations can be just that, others become sacred moments, a time when mystery is evident and the thin places are experienced. They are aware they are talking to the chaplain. While I want to be careful to not over state, I do want to claim that at times it is more than me present. I

am still the Christian chaplain representing God in this secular place, hearing their stories and caring for my parish.

Counselling and Mentoring

Chelsea is one our bubbling and engaging people, she is a constant encouragement and the room lights up when she is there. She has a great ability to draw people together. Chelsea made an appointment and came to see me, she was not bubbly. She spoke about a number of issues including work and family and how she had seen a counsellor but felt it didn't go anywhere. The conversation unfolded and she indicated that her mother with whom she is very close was being treated for cancer. As I listened I heard a series of losses, a number of fears and a loneliness in her story. Chelsea also shared her good relationship with her husband and her love for her children.

At the beginning she had indicated dissatisfaction with the counselling she had received. I don't know what was different in what I said. However, the theme that kept resonating with me was grief and fear. I laid out for Chelsea how I saw this. The griefs were layered, her mum's illness and their changed relationship, her supportive husband but distant because of her concerns for her mum, an inability to engage with her children and her siblings. We spoke too of fears, about the future and possibly a future without her mother. These themes seemed to resonate and I asked her to reflect on them and if possible write them down. I also explored with her the picture of the elephant in the room around serious illness and wondered out loud what it might look like if she were to have a conversation with her mum about what was going on. This too she agreed to.

Our second meeting was more positive – the bubbly Chelsea was not quite back but she was not as far away as she had been. Bravely she had had the conversation with her mum about her fears and anxieties about a future that she imagined and dreaded.

Chelsea had gone further and talked to her husband and children. She was progressing well, and felt that grief and the fear of loss were where she had been hung up.

I met with Chelsea for a third and last time other than our chats in the corridor. It was a brief meeting. Chelsea was in a good place. There is still some way to go on the journey. Her mum's treatment is working. While there remains some uncertainty about the future Chelsea is now in a better place to deal with it. We celebrated her awareness of what was happening for her including her strong connections with her family and love for them.

One of our clinical areas located at the hospital has been undergoing a restructure for over twelve months. Their management is not at our hospital and has responsibility for a number of sites throughout the state. Staff are battle weary having advocated to management for their service which in benchmarking has been the most efficient state-wide.

On a number of occasions I have dropped by their area and chatted with them individually. Sometimes I arrive around the morning break and share a cup of tea. I have heard their pride in their work and the service they provide and their struggles and powerlessness in what seems to them to be a political decision. My role has been to hear them in their journey. What I can offer them is to validate their concerns, encourage their analysis of the situation, and affirm them. They were not experiencing any of this from their management.

Recently the decision to restructure was confirmed. Like the whole process it seems to have been poorly managed. Certainly other clinical staff in the hospital who use this service are dismayed. There was not much to do on this last day that they would all be together before the new structure was implemented. Some would go to other hospitals,

some stay and others rotate between our site and others. They were working so we couldn't go to the pub, but a wake seemed in order. We arranged for afternoon tea on the Playdeck. They had spent the morning and early afternoon with their off-site management team and were spent themselves.

We met for coffee and cake. They were past being angry and were resigned to the new structure. Their belief is that it is wrong and won't work. It is also their lot. They grieved. They lamented. This was their ritual vigil of saying goodbye to what had been. Their place of work will now seem empty with only a few staff. They are grieving relationships that will change along with the structure. My role in part was to facilitate the wake and to be the celebrant at this ending.

Most of my counselling engagements are much briefer than my work with Chelsea and this clinical unit. They tend to happen over a coffee or even more briefly in a corridor or work place. As does the mentoring and coaching that I do with staff from time to time.

In the Australian Qualifications Framework there is a certificate level competency based vocational training component. The certificates are studies prior to university training and designed for trade or hands on work. One certificate is designed for youth workers in churches and church organisations, the Certificate IV in Pastoral Care. I have had a number of students do their placement at the hospital with me as their mentor, coach and supervisor.

Jenny was with us for two years and has progressed to paid work as a primary school chaplain. There were the competencies in the course that Jenny needed to complete but the bigger picture for her was her engagement with patients and families. As a recent convert to a conservative church Jenny was structured and somewhat set in her beliefs. Working with a team from the wider church opened her understanding of faith. I

also gently and with support put her in a number of situations that were not black and white and challenged her thinking. She began to understand and appreciate how her life both in her church and her life experience prior to coming to faith had given her insights; she began to trust her street smarts. Jenny is a great school chaplain with insight and wisdom who has begun mentoring other chaplains.

Kevin is still one of our team and began with us to complete his Certificate IV placement. Kevin struggled at school, left early and spent a number of years in the workforce. He should be qualified in a trade but a number of employers did not complete the required documentation and Kevin also avoided the schooling components. Part of the problem for Kevin is some low level learning problems which make traditional education difficult for him. In a conversation with another colleague we were discussing a theological book and Kevin inquired about it. I observed that usually the introduction gave the broad outline of what the writer wanted to say, so slid it across the desk and invited him to read it. When he finished I asked him what he understood, and in a few clear and succinct comments summed up the book. For Kevin it is about an encouraging environment and time to process what he is offered. Kevin is now studying for a degree at a theological college to further his prospects for a ministry role.

Reputation

It is on the basis of our reputation with staff that they call chaplains to care for patients. Without this respect, there would be less call on chaplain’s services and less engagement with them by staff members. Some of the terms used by staff to describe chaplains identifies what their reputation is. They are described as available, non-judgemental, unhurried, inclusive, trusted, known, approachable, respectful of diversity and independent.

A comment by staff about chaplains being non-judgemental and respecting diversity is significant. The image of clergy in the news media is very negative. The institutional church is seen as aloof and dogmatic. McCrindle Research identified the six key reasons why people did not attend church, they were: not relevant, outdated style, how the message was taught, clergy behaviour, no belief in the bible and personal busy-ness.[5] Counter to this is the relationships that chaplains have developed with hospital staff and dismantling stereotypes. We have developed a reputation for doing our job well, being available and responsive to requests for spiritual care.

Being a public hospital, we have patients from all strata of society. Respecting the dignity of the other is one of my foundational beliefs. I have already discussed how the church in Australia is viewed as being judgemental and one of the negative perceptions. As important as being non-judgemental is, Australians also expect you to have an opinion and respect it if you do not try to force it on them. My practice is to be as flexible as I can in my attitude, respect for the other person, and inclusive. Alongside this is the clear understanding and expectation that staff have that I am a chaplain and hold beliefs that are important to me.

Summary

The aim of the project was to hear the voices of staff members about how they experienced support from chaplains. The expectation at the beginning of the research was that they would see this as minimal. This hypothesis was developed for a number of reasons which included often not being informed by management about a critical incident and often being involved serendipitously. Sue's story was that she did not realise and was not informed that part of the chaplains' role was to support her as a staff member. The

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[5] McCrindle, "Church Attendance in Australia."

interviews inquired about the staff member's understanding of the role of the chaplain. While the responses were diverse, there were a number that articulated a range of roles for chaplains including strongly affirming our support for staff. There was also a clear understanding, acceptance and appreciation of our role as Christian ministers who are able to navigate the complexities of faith communities and the secular environment of the hospital. This is only possible because of a theology of inclusion and relational practice. This relational theme runs through both the organisational and relational sections of this chapter. It is hearing the stories of staff, often told in snippets and in passing. It is hearing their whisper and hope for life and holding them as sacred; a priest to the village.

CHAPTER 3

Insights from the Narratives

Sue’s story that she did not expect support from chaplains is contrary to the narratives of other staff. Rather they have shared stories of a positive and supportive engagement with chaplains and shared insights into our practice that have a nuance and clarity in their understanding, expectation and experience of our ministry. Staff members described and illustrated my ministry for me. This was unexpected as my focus had been on what was not being done, on a negative, compared to the very positive response of our staff.

Hearing the voices of staff as they described the ministry of chaplains has been enlightening as they have a nuanced appreciation of our role. Their stories contained insights, nuanced understanding, and experience of chaplaincy support. These have given me a deeper understanding of how chaplains are seen and layers of meaning to our role with them and their appreciation of us. Reading the transcripts and hearing the interviews has been enlightening and truly humbling. They have strongly affirmed the ministry of chaplains in the secular hospital environment and identified the contribution chaplains make to the organisational or structural aspects of the hospital and the relational nature of chaplaincy ministry.

Reflecting on the stories in the staff interviews have together deepened my understanding of how staff see and relate to chaplains. They have been excellent and generous teachers. Their stories have drawn out and deepened my narrative of chaplaincy ministry. The themes from staff members’ stories about chaplaincy support have formed

the foundation for this report. The themes of relationship and inclusion that are part of my theology and practice have been described and illustrated for me. The staff members have shared their insights into chaplaincy ministry and seen a depth and nuance to it and have embraced its importance for the hospital and for themselves.

I am constantly seeking to promote and improve chaplaincy at the WCH this project provided an opportunity to intentionally focus on my role and practice. Immersion in a process of thinking about my ministry at the hospital over the last twelve months has been a significant part of this. There are three key factors that contributed to my enhanced understanding. Hearing the stories of staff members about our chaplaincy ministry is one. Personal reflection on what I have heard from hospital staff and from colleagues and in writing my narratives about my chaplaincy ministry. Finally, being able to engage in conversation with my colleagues and members of the LAC about what I have heard and discovered.

Generosity of Staff

I am humbled by the staff members' generosity of time and sharing their insights about chaplaincy ministry. The data for this research was provided by forty-one participants. That so many staff members were willing, in the midst of busy work schedules, to make time for an interview speaks to the value they place on chaplaincy. Their willingness and generosity in giving their time and their stories made the research possible.

Staff spoke about how they included chaplains in their teams and valued their pastoral and spiritual insights in the clinical context. Their stories identified the context of hospital chaplaincy and the professionalism that we bring to our role including how well connected we are to both the hospital institution and to staff members.

I also see their generosity displayed daily as they care for patients and each other. I experience it too as they include me in discussions around patients and families so that I am informed and prepared.

Availability of Chaplains

I learnt early on in chaplaincy that the first and most important rule is to turn up and to engage. While this is foundational to my chaplaincy ministry staff notice the willingness of chaplains to turn up when paged or called. They were also aware that we are in attendance when not called and provide care to them in the course of their daily work. Our availability was not only noticed, it was affirmed and appreciated. The importance of relationships that chaplains developed with staff was valued. While most chaplains would see that being relational is a key to pastoral ministry this was experienced and valued by the members of staff who were interviewed.

The appreciation staff members have of the many relational aspects of the chaplains' work is also part of their story. As a counterpoint, staff members mentioned chaplains who visited for emergency ministry from either denominational lists or sometimes on-call rosters. While their availability was appreciated, that they didn't engage with staff generally and staff at the bedside in particular was reported in the negative. The relational thread weaves through much of what staff have experienced and reported and it also speaks to the way that key chaplains have engaged with staff. They have been intentional, inclusive, and attentive to staff members and what is happening in their lives whether it be work or personal.

What is evident is how a number of staff members have noticed and valued the corridor conversations and seeing me have coffee on the play deck. Intensive care nurses spoke about chatting with them at their workstation, and identifying this informal

conversation as a debriefing and clarifying moment. The surprise to me was not only that they noticed this but the value they have placed on it.

Affirmation: Part of the Team

There was strong affirmation of the role chaplains have in being part of a unit team. They see that chaplains have an integral place and unique contribution to offer as members of the care team and in the incident debriefs.

The chaplain brings a pastoral voice in the midst of medical and nursing imperatives, particularly a pastoral and spiritual insight combined with a wider perspective to the situations being addressed by staff members. Staff valued chaplains' participation in a crisis and in the subsequent debriefings. The nurse educators described the formal and informal contributions chaplains made to their students. Regular referrals to chaplains come from the delivery suite and palliative care team.

The executive leader that I report to has affirmed and encouraged this project. In our regular meetings and in the corridor chats an inquiry is made regarding the process of this project. In part this is to be supportive of me, and also a concern for the welfare of staff members, whose welfare is also on our regular meeting agenda. I am told that I have the 'pulse' of the hospital.

Relationships are Fundamental

The way that chaplains positively relate to staff and support them in both the workplace and their personal lives was appreciated. Staff spoke of chaplains having and making time and their ability to listen to staff members in an unhurried way. They were seen as respectful and non-judgemental, enjoying a positive reputation.

In their interviews staff placed high importance on the way chaplains related and that what was shared was confidential, or even confessional. Health care is a relational

endeavour, often nurses and doctors engage with patients and families around highly personal and deeply intimate matters. Chaplains likewise need to be able to relate to patients, families and staff with dignity and respect. That we do was affirmed in the interviews.

Again staff have unwittingly identified and articulated a theological theme. They have seen and experienced chaplains as having a relational basis to their ministry. It is the role of the village holy man to connect the community and give voice to its meaning. This is what they have experienced.

The Importance of Spirituality

The emphasis on spirituality rather than religion was expected in the results due to the secular nature of both the hospital and the community. However, the extent to which spirituality was identified by staff as important was unexpected. This may be due to a number of factors including the emphasis by chaplains on the spiritual care of patients and the increasing recognition of people's spiritual needs in government policy. There is also a focus on spirituality in the palliative care sector, nursing and medical journal articles and in the community's conversation. Staff members readily spoke of spirituality and identified addressing this as a chaplaincy role, and seeing religious rituals such as baptism and anointing as generically spiritual acts. Not only is the hospital and culture secular, but clearly postmodern, which makes these insights all the more telling.

It has been my practice to advocate for and to emphasise the spiritual needs of families and patients, and this has been taken up by our staff and affirmed by them. While it may be seen as the chaplain 'doing their thing', it is welcomed, if not fully understood. Staff members see the importance of rituals for families in crisis and are strong advocates for chaplains.

When asked to explore spirituality, most of the participants were somewhat vague. They were ‘good Australians’ in this sense, alluding to the ‘whisper in the mind and faint hope in the heart’. They describe their spirituality in practical or relational ways. They speak of walking on the beach or in the bush, or spending time with their community of connection whether workmates, friends for family. Few speak of a religious or ritual connection or attendance at a place of worship. Meditation, mindfulness or other spiritual experiences are rarely mentioned.

While there is the affirmation of the provision of holistic care that includes giving attention to patients and families religious and cultural needs, such practices remain largely privatised. For staff to repeatedly emphasise our role in spiritual care and to see us as the expert providers of that care was significant. We were described as interpreters in the spiritual space.

This can at times be confused by Christians whose understanding of faith is limited to their own denominational practices and expectations. Chaplains are expected to have a working understanding of what other faith traditions may need. There is little understanding by many staff of the complexity of the Christian faith, let alone the myriad dynamics of other world faiths. And then there are over three hundred Aboriginal clans with their own nuances and significant beliefs and practices.

Alongside this is an acceptance by staff of chaplains, and an understanding that we are religious practitioners who emphasise spiritual life and not adherence to a particular franchise or denomination. This acceptance is largely due to the way that staff experience chaplains as being non-judgemental. While deep in Australian history is a distrust of the clergy, being non-judgemental does not in the Australian context mean not having an opinion or a view point. It is about attempting to impose that on another person. Even

with this, chaplains are seen as having an essential role. In and part it is being the midwife to meaning, hearing the whisper and the hope and valuing their importance.

Parish, Community and Village

Since arriving at the hospital sixteen years ago, I have seen the three thousand staff members as my parish. The thought for the week remains a clear attempt to connect with them. My understanding of the hospital as my parish was articulated by staff members with descriptions such as community, village and holy man.

In terms of the village image, the sacred space is located in the Family Precinct of the hospital alongside the Aboriginal cultural centre, the community health service, Starlight Room, the Playdeck and café. It is the venue for hospital community events. It is very much the village square or marketplace and the place of community, meeting and celebration. The sacredspace is the village church. I have tended to call this precinct the heart and soul of the hospital. All of this speaks to a symbolism within the hospital, in a place where the usual symbols of priority are those of medical practice. Yet here is the human voice, the touch of people, of lives lived. I have addressed the issue of chaplaincy presence earlier yet here it is identified in what is particular, sacred and symbolic or ritualistic.

While the newest part of the hospital is now twenty years old, a number of units have been refurbished or rebuilt during my time here. Many have asked for a blessing when they reopen for patient care. My practice has been to use water, oil and eucalyptus leaves as symbols and create a short liturgy. I use the water and leaves to sprinkle on the doors of the unit and rooms to invite God's blessing. The violet oil is used to bless the hands of the staff, hands that touch families and patients with care. I have readily used the language of being priest to this parish – a somewhat ecclesiastical model for a Baptist!

Staff members have noticed this and spoken of the village model and the holy one, the village priest who is here. Subtly staff have taken my images further, a symbolic description of the work I do of the ministry of chaplaincy.

Personal Affirmation

Staff members' perception, understanding and insight into my role was unexpected. Chaplains often tell me they are not understood or valued in their workplace. This certainly is not the case for me. Staff members spoke of their awareness, understanding, and expectation, about my responsiveness to issues and availability to turn up to a situation. I have made responding to issues and being informed of what is happening in the hospital a priority. It is pleasing that this has been seen by them. To be recognised for the quality of my practice by staff members is truly affirming.

Staff members told of how their life stories were listened to and valued. This is surprising because it is 'unintentional' in the sense it is such an ingrained part of my ministry practice. It highlights how rare a commodity of listening and paying attention is in our community, even in the supportive teams where the respondents work. There is the privilege of hearing stories that are too raw to share with their team, and also to hear the story the team has but being the 'priest' adds another dimension of significance to its telling and hearing.

I have mentioned that our staff are great teachers, they have taught me that my perception from Sue's story about the acceptance of chaplaincy was flawed. I am working out of a model that is affirmed and appreciated by staff. It is a model based in my relational theology of ministry – a praxis.

Caveats

There are some caveats in the research. At the WCH three key areas with high acuity and regular chaplaincy presence had no interview participants. Staff members from these areas indicate variable support or a lack of support from their leadership. I expected a stronger engagement from them given the research topic. At the same time two groups who have a hospital wide role with whom I have irregular contact, nurse educators and palliative care, were generous in their time.

Sue and one of my champions for the project are both from one of the areas that did not engage with the project. The reasons for this are complex and layered. They include the stress of the staff in those areas who work with long term sick children or immediate critical incidents. The work environment may in part be a reason. Each area also has difficulties with leadership groups and cliques. Other reasons may include the nature of their work, possibly compartmentalisation of work and private life as a protective strategy, or disinterest in research.

Units that did engage well with the project have positive and clear leadership and positive work cultures. This is not to imply that there are no frictions or issues within them, rather that these are acknowledged and addressed. Each of these units also have strategies in place for addressing the stresses and difficulties of their work. These range from Friday chocolates to mixed netball teams, regular out of work engagement to intentionally address the stresses associated with peaks in service activity.

One of the ponderables of this research is that my role takes me to all of these areas. I spend about the same amount of time in each and feel generally welcomed and affirmed in them. Like all staff in these areas, I engage with patients and families who will enjoy a positive outcome and with those for whom life will be forever different.

Another question is, are those who were research participants the ones who strongly affirm chaplaincy, our cheerleaders.

Yet a number of them clearly stated in their interviews their lack of engagement with anything religious and their affirmation of chaplains support for them, being relational and non-judgemental. Another factor may be that these staff have understood the connections that they have with chaplains and appreciate how spiritual care complements the work that they do. As a consequence they have a sense of ownership and buy in to the chaplaincy service and therefore a willingness to contribute to the project.

Sue's story focused on a negative, the lack of support for staff from chaplaincy. While the interview participants negated this view, it would appear that there are some sections of the hospital where this may be the case. Their lack of engagement with the project may reflect this or simply be their disengagement from their workplace.

What the Narratives Taught Me

The focus of the project was on a functional ministry role with staff members at the hospital, how chaplains support them. The research journey has been one where they have informed me. There have been reminders of chaplaincy ministry practice, especially its relational and symbolic nature. It has been a personal journey where my insights have been informed, my understandings deepened and my vision expanded.

There is a strong aversion in Australian culture to self-promotion and being precious about oneself or overly important. Often described as a tall poppy syndrome this self-humbling thread is a strong cultural message. Those members of the community who don't understand this are quickly informed in laconic ways to 'get over it'. In a way this research has demonstrated for me the other side of this coin. That affirmation about who

you are and what you do comes from others. There is a sub-plot to all of this, another cultural aspect, and that is that almost behind your back, like in research interviews, people will affirm, praise and promote those who are seen to be doing good work. It is because of this that the research has been humbling. What I have learnt has been an uncovering of layers in the stories staff have shared, and the layers and subtleties of my ministry.

I discovered that staff members had a deeper perception and understanding of my role than I had assumed. This is a nuanced understanding as they hold my ministry practice in the context of the person, and personality. Their descriptions were based on their experience and observation of my work.

One of the subtle messages from the interviews was to value myself more in my chaplaincy role. That in the context of the hospital I am seen as one of the staff who lives up to their expectations, that I bring competence and capability in my work. Alongside this is the compassion that they expect from chaplaincy. In a secular and multi-faith context this is a significant affirmation and when twinned with the cultural message of avoiding self-importance I am seen as a team player who is respectful and non-judgemental. I can be confident in my competence.

Aligned to this is the sense of belonging. I have spoken of how the dominant voice in hospitals is medical, a hierarchy based on function and science. Chaplains work in the human and spiritual space. The voices of staff members are telling me to claim my place, that what I do is important. They speak about belonging in terms of how my voice and practice are different than the scientific one, about how my presence and insight make a difference.

I believe all of us work out of a lack of confidence at some level. While not pushing me to be over confident I was encouraged by the staff narratives to see more clearly the importance of my role and place in the hospital. Given how people have valued and sought out my opinion over the years, this is a slow awakening for me.

Staff members observe my practice of chaplaincy from a quick and light conversation at a bedside to engagement in significant grief and trauma and in doing so described my skills and abilities as they saw them. They spoke of my ability to hear depths in a conversation and address the issues either at the time or in a follow-up engagement. In this they identified my responsiveness and availability to them.

Staff members were also aware of the context of Christian chaplaincy ministry in a secular healthcare system; they observed the fine line of bringing a religious and spiritual practice into this environment. Again they identified a non-judgmental and respectful practice that works with a focus on the patient or family. They have named the relational nature of chaplaincy and how they have been valued and affirmed. It was because of this that they were both able and prepared to be an advocate for chaplaincy ministry to families.

The context is one where spirituality is more important than religion. While many spiritualties are eclectic or less specific, borrowing from many faith practices, others are grounded deeply in a belief and faith tradition. Our staff expect me to know about all of these nuances and have seen me navigate these pathways to provide care to families. To use a medical image, they expect me to be a specialist in religion and spirituality.

I have also come to understand the important role I play in education that ranges from the undergraduate and postgraduate programs to helping patients, families and staff understand the chaplaincy role. This ranges from formal lectures about spiritual

assessments and practices to quick conversations describing my role. Another role is educating clinical leaders about the value of chaplains in their area particularly in difficult times. Helping them understand how chaplains can value add to their team. Another aspect is the importance and subtlety of spirituality as it affects both patients and staff members.

There are a number of insights from the interviews that do not fit neatly into a category yet complement them. The sense that I belong as a holy man or wise voice, particularly one from outside of the medical or hospital structures is an understanding shaped by the staff. The relational nature of the corridor conversations I have described, the image of a village market place encounter. There was affirmation around the Thought for the Week that I post on the global email. Underpinning this is providing a professional level of care. I have become aware of how many advocates and champions for the chaplaincy ministry there are in the hospital.

On a practical level staff members speak about me as someone who gets things done. This has a tone of trust in my commitments that I follow through on what I have agreed to do. Staff identified me as being proactive and innovative. There are a number of experienced layers that enable them to make these comments from the development of our sacredspace to responding to pages and attending to patients. My role as a JP complements this.

Wider perspectives on chaplaincy did not only come from listening to the voices of our staff. They came too from the Doctor of Ministry Colloquiums, my colleagues and supervisors. Coming from a different cultural and religious perspective they identified the Australian context as being significantly different than the US. In doing so, they clarified what I knew and brought it to the forefront. I am working in a frontier context where there

are competing voices, claims, and agendas. While these are easily seen in the context of medicine, nursing, administration, allied health and others, it is more subtle in the area of ideas and world views. In my theology of chaplaincy I spoke about working outside of the walls of the church. I identified my secular ‘parish and congregation’. As the traditional church continues to slip in relevance to its community I am working with a community that has already left the church.

CHAPTER 4

Discussion

The voices of hospital staff members informed this report. Their understanding of and insight into how chaplains provide support for them identified and clarified the themes of the organizational and relational themes in the report.

The stories of staff members have given voice to mine. Theirs are of work, family, patients, relationships with colleagues all make up these stories. They are stories of celebration and frustration, stories of a life spent in care and caring and in the health system. Often the stories are not simple or linear but have depth and nuances, bringing insights to life. Staff members are usually aware of this complexity. Of interest is their ability to be critical and protective of the hospital at the same time; much like a sibling rivalry. It is their hospital; they have a right to gripe about it and become very protective if they sense an unfair criticism. Each narrative identifies, describes, illustrates, and imagines the event and brings structure and attaches meaning to it. The stories also tell of each person's belonging and place in the event.

The Setting and Context of the Ministry

The hospital can be seen in a number of ways. As a complex of buildings, bricks, steel and mortar. It can be seen as an infrastructure of administration and logistics. Some will see it as a place of technology, science and research. Another view may be a place of hope, safety and hopefully healing. One description is that it is a village or community. It is all of these and more. Its heart and soul is a place where people provide care for others. They do this in a relational way. So, the twin themes from the narratives again inform this

section, organisation and relationships. Along with this is the significance of the narratives which too are varied. Narratives from the hospital, of spirituality, and chaplaincy.

The purpose of a hospital is to care for people. People work there to provide that care. It is their community, one of their social networks. In this place they live, care, contend with frustrations, and do their work.

The hospital has a rich variety of stories some historical. There are stories of exceptional leaders and practioners and those about darker episodes in hospital life. Units and wards also have their narratives about staff members and patients that have touched their lives. Each of these contains a narrative of meaning, shaping the attitudes and the culture of the current environment.

Complementing the hospital stories are others. I have reflected on the Dreaming of Australia's Indigenous people and their rich stories of meaning which regulate social behaviour and responsibility, their connection with country and their family relationships. The Dreaming stories have been retold through the generations, an oral history of the people. In my Christian tradition there are also narratives, many that also have an original oral tradition. The stories of scripture also speak of belonging, and of appropriate relationships within a community. A belief in and sense of hope for an eternal relationship with God is also part of the story. Alongside these are stories of significance from other faith traditions. There are also the stories of people who declare that they have no faith but a spirituality that is rich in meaning. All of these come together in the life of the hospital. There are the big picture stories, and they combine with significant personal stories.

In this is also the story of the chaplains at both hospitals, and there is my story. These are stories of engagement, relationship, life shared, care offered and received, they are stories of inclusion and belonging. There are layers and nuances and depth of meaning and as I have reflected on the narratives a number of my key stories are at the fore that are told in this project.

With three thousand staff the hospital is a village. Like all villages there is the market square – the Playdeck, or the cafeteria. There are greetings and meetings in these places by staff who know each other. There are also hospital staff who work in isolated areas. They work in laboratories or scientific areas and have a small circle of contact. Some of these staff members enter the hospital entrance, spend the day in their work area, then leave the same way. Their contact with the wider village is limited.

As the holy man in this setting I bring a number of things to the table by being present. I represent God. I engender a sense of calm for some. I am valued for wisdom, ritual, inclusion, and for being able to make connections. In the theology I spoke about the place of mystery, the thin places. I am the one who speaks of this, who gives voice to the things we can't explain. The one who describes what is happening spiritually, who brings interpretation and elicits meaning.

Why Staff Support is an Issue

This project was conceived in a conversation with Sue, one of the hospital support staff who felt unsupported during a critical event in her ward. The gestation was one of reflecting on the conversation and my understanding that part of my role was to provide support for staff members. The birth was seeking to do something about staff who feel unsupported in their role and as a consequence hearing the voices of staff about their perception of support.

During my time at the hospital I have sought to fulfil the part of my role description that identifies support for staff as one of my three key pastoral roles alongside support for patients and their families or carers. Subjectively I have felt that my support for staff has not been as effective as I would like. Evidence of this is often finding out about an incident where I could provide care after the event. While this still remains to some extent inroads are being made and I have come to understand that I am not being excluded, it is a statement of the immediacy and busyness of a critical event.

Support for staff members is important because of the complexity of their work and this is recognized by the hospital with the provision of EAP services. The EAP services have not proved as helpful to staff as the discontinued in-house staff counselling service. The complexity of the work of our staff has many facets. There is the technical nature of the work in an often high pressure environment. This is coupled with governance requirements to ensure an effective health service. Added to this is the personality of staff members and the culture of the units that they work in that can add to stress. Our staff members and patient population also bring a wide range of social, cultural, psychological, spiritual and religious factors to the mix. Staff members also bring with them their own issues from life outside of the hospital ranging from personal relationship issues to family issues related to children or often aged parents.

Part of my frustration was with my understanding of what is effective care, essentially believing that I should be at every critical event. I have come to accept that this is an unrealistic expectation. Staff have indicated that it is often the quiet conversation with one or two participants affected by an event in corridors or at bedsides that have been helpful to them. They have indicated that much of the low level stress is addressed well by their colleagues and teams during their daily interactions.

Pastoral support for staff members is more than a functional imperative for me. As I have identified in this project, the hospital is my parish and I experience a pastoral responsibility for the 'parishioners'. To not fulfil this pastoral responsibility or calling is frustrating. Yet part of my growing understanding has been that the 'parish community' does a lot of care for itself. It is when they are unsure or unable to care that I receive the gentle message, 'can you have a chat with…?'

The Story Changes, Engagement Exists.

The narrative that I began with changed from staff not receiving support from chaplains to one where we are connected, engaged, involved, included and appreciated. My initial sense of disconnection and of staff members falling between the cracks is no longer the dominant story. This change has been because of the staff members' stories, how they have described the support that they have received from chaplains and their appreciation of it.

They have reported a number of ways that this has occurred. They identified the organizational and relational ways that chaplains provide support. There have been the formal components of staff debriefs following an incident, the independent voice into situations, engagement in and with their teams and a sense of sacred presence. Much of this has been because of my initiative of appointing chaplains to wards rather than a practice of denominational visiting. Ward staff have taken ownership of their chaplain.

Chaplains' regular visits to a ward and their engagement with staff members have developed relationships between chaplains and staff. Sharing about patient needs moves to sharing about life; celebrations, grief, struggle, or just life. Staff members indicated how significant this informal support was to them. Because chaplains are in the wards there is the opportunity for the occasional and timely conversation which can often create

a circuit breaker to a situation. What is evident is that the chaplains have taken time to listen to staff members, value their stories and where necessary clear their day so that a staff member or group can be supported. While this has been part of my practice and one that I model for my team I was unaware of its significance.

There was a consensus in the interviews about the support that staff members had felt from chaplains ranging from their engagement in difficult and critical situations to support for their ward and their personal lives. The thematic analysis applied to the interviews indicated a consistency with similar stories and themes occurring, that confirmed and complemented each other. The consistent message was that chaplains were available and engaged and that their work was inclusive, professional and appreciated.

Another aspect of the shift in my story is that engagement with staff exists. Narratives about the conversations in hospital corridors, at ward stations and in tea rooms, beside beds and in passing all articulate the valued presence of chaplains. Alongside this is the encouragement to continue to function in such a way because it is valued and appreciated. The words of staff members were a helpful reminder of the importance of relational ministry, a ministry of connection with fellow human beings. It is also a reminder of strategic imperatives in appointing chaplains, that they must be able to relate effectively.

Application and a Preferred Future.

While my description in this project is of a chaplaincy ministry model at the WCH and how it is received by staff members it is not a universal model in SA Health. The competing model is one that is based on a denominational structure where chaplains predominantly visit people from their faith group.

There are three factors that make the chaplaincy service at the WCH effective in the eyes of staff. The first is the principle of inclusion. The nature of a ward chaplaincy is that each patient is the recipient of care from a chaplain. In addition to this is the building of relationships with the ward staff, nurses, doctors, cleaners, clerks, allied health and other practioners who work on the ward. With this model the chaplain becomes part of the team. Secondly there is in the application of pastoral care which now has a patient centred focus not a religious adherence imperative. This model reflects the triage that is common to the practice of other ward staff with the most needy or complex patient or family receiving priority care. Chaplains are able to engage with other staff using similar language not only of triage but also of spiritual assessment which indicates a reason for pastoral interventions. Thirdly, this type of model is understood by staff members because it is similar to the one that they use. We begin speaking the same language and develop connections in our care that are complementary. Relationships also develop between the unit staff and the unit chaplain enhancing the quality of the referrals and conversation.

A denominational care model has none of this, rather chaplains work in a silo of care. In doing so, members of the denomination receive support during their hospital stay but those who are not members of a denomination receive minimal support. In the hospitals that use a denominational model there is a regular conversation about those patients who do not record a religion on the admission form. The chaplains in those hospitals care but do not have the time to follow up patients who are often more needy than those on the religious list. The denominational list is the priority not patient need.

The two models are structurally different. The denominational model reduces the ability to develop relationships with staff members. Part of the affirmation of the staff who were interviewed was that chaplains were available for those in need, were non-

judgmental about circumstances and had a focus on spiritual needs rather than on religion. A denominational care model is unable to work effectively in this way as religious allegiance drives the care provided.

This project offers an insight into the future of chaplaincy at least in SA Health. It quantifies for the first time the importance and effectiveness of a ward based chaplaincy model. It articulates the connections and possibilities for care beyond what is possible with the other model.

Future chaplaincy also needs to heed other insights from the staff narratives. That the chaplains need to learn and understand the language and culture of the hospital, and often of particular wards or units. Chaplains need to be able to fit in and have good relational skills and the ability to engage across the spectrum from cleaners to executive leadership. Behaving and being seen as a health care professional is important along with attending to personal professional development and being part of the education programs of the hospital. What this requires is the recruiting and selecting of individuals for chaplaincy ministry who have these abilities and combine them with a strategic view of chaplaincy by being an advocate for their ministry. All this requires a theological underpinning that sees the individual as having the stamp of God on them, a theology of relationship that attends to their story and assists them to find its meaning.

Church and Chaplaincy, Theology and Context

While this project is grounded in the practical theology of ministry practice it speaks to the wider view and ministry of the church. I have articulated my theology of chaplaincy being focused on people, being a pastoral response of the church to people in need. It is also a missionary endeavour in seeking to help people connect or reconnect with the resources of faith.

The theology I have articulated is also contextual. While I believe it is a ground up theology it is also experiential due to the constant changes that are happening in both its setting in a health care environment and the increasingly secular space of the Australian community. In the context of a hospital setting with people struggling with their health needs it is chaplains who are able to help them find their voice of meaning.

This theology values inclusion and prioritises the individuals need at the time. The practice is relational and has time to be in the situation without trite responses or answers and yet be a representative of the presence of God. Without ignoring the brokenness of the world this theology has an asset based approach which seeks to see and articulate what is good in a situation be it the humanity and care of the staff or the love and courage of families. In doing so there is a richer ability to acknowledge grief and loss.

There is in this an application of a number of gospel values. The mutuality and inclusion demonstrated in the story of the Samaritan caring for the injured traveller, or addressing the confusion and angst in the account of the disciples on the Emmaus Road. Another reflection is in the reconnection with her community that Jesus offers the Woman at the Well.

A major theme in this project has been around chaplaincy ministry and spirituality and how this sits on the periphery of the church. The place and setting, the structures and organisation in which chaplaincy ministry is practiced is very different from the church. Chaplaincy ministry is shaped by its context and by the theology and practice of the individual chaplain. It is also influenced by the demands of church leaders.

This is illustrated in SA Health hospitals with the variety of chaplaincy models that exist. The preferred model promoted by CSSA is one based on patient need. This has led to a preference for a ward-based chaplaincy model where a specific chaplain is

assigned to the more critical units. An example is that I have been wont to say that I won't see the Baptist kid with the broken leg, he will be out of here in a day and playing footy again, I will be with the kid who has the life limiting cancer. This significant shift to a triage care model is not always understood by clergy working in a local church or church leaders.

This preferred model is not embraced by all chaplains who see the denominational needs of their church's adherents having priority. In conversation with church leaders there is often a variable understanding of chaplaincy and for some no understanding of a public, secular environment. They have been so enculturated by their life in the church they seem unable to imagine a different environment. Their expectation of their chaplains is that they will specifically minister to their own.

This variable attitude to chaplaincy is due to a number of factors. For some, coming from a historical position of engagement with the state authorities a sense of entitlement and a belief that they belong. Another factor is a strong evangelical emphasis in some faith traditions and while appropriate as a church practice it becomes proselyting with vulnerable people in hospital. These nuances are not always understood and some church requiring their chaplains to practice their ministry in ways that may be inappropriate. In response to this chaplaincy organisations like SCA have developed Standards of Practice, standards endorsed by CSSA and the WCH.

My theology of chaplaincy specifically places the other person and their need as the focus of my attention and care. In my view this is foundational to a missionary practice where care is offered with no strings attached, it is a ministry of hospitality. Chaplaincy should not be about meeting our needs whether they are ecclesiastical or personal. That does not mean that we cannot offer the rich resources of faith and

community to sustain people, however they can only be offered in relationship, not imposed by a church authority.

A clear theological and practical difference between chaplaincy and church ministry is its focus. The dominant theological theme or motif in chaplaincy is spiritual. In the church it is evangelical. Both are appropriate for their setting. Difficulties arise when this significant difference is not understood by either party, by church leaders who see chaplaincy as an extension of their church outreach and chaplains who have not understood the difference of their setting. There can also be an arrogance where chaplains see themselves working with real people in a frontier ministry and diminish the work of their church based colleagues. Chaplains can feel marginalized from their church. Attending church clergy conferences or gatherings, I find it clear that many of my Baptist colleagues have little understanding of my work. Within their peer group of clergy chaplains are the minority and at times feel misunderstood. They have learnt different language and approaches to ministry that are not always easily explained.

Part of my theology is that I am a missionary, but not in an overseas setting. My context is in the secular hospital setting. Not as a strident or haranguing voice, rather one seeking connection with people. This connection is built through listening to their stories and hearing the beat of their heart, their passions for life and their frustrations, their joys and celebrations and their fears and pain. I do not want to suggest that church clergy do not do this as well, good pastors do. It is just not their dominant ministry practice.

This missionary chaplaincy role is determined in large part by the hospital, a state government secular organisation. The policies, procedures, functions, culture, organizational structure, leadership hierarchy are all at play in this. In most churches, the clergy are the dominant leadership group. They set strategy, influence the culture, and

plan the programs or operation of the church. In the hospital all of this is in place. The chaplain is part of the structure but not in a clear leadership role. Good chaplains however, have significant influence. Their opinions are valued, their wisdom sought, they are seen as having an understanding of the tone, the morale of the hospital and whether it is travelling well or not. They minister to and understand their parish, village, community.

Part of this influence for me has been the "Thought for the Week" that I post on the hospital global email. It is variously the weekly one-line sermon or the parish notice. It seeks to connect people and promote values about care and inclusion. I see it printed off and on staff room and office notice boards. Staff members forward it to their families. I receive regular feedback about how it is timely and helpful. One staff member told me it was the only email she received each week that did not ask her to do something. In the corridor people will mention the week's thought. There are also quirky and engaging responses that see humour or nudge me back about the thoughts.

Part of my chaplaincy philosophy is that the hospital is my parish. The delightful image from the research was to name it a village or community. I don't think church leaders generally get this aspect. My experience is that they tend to see it as a workplace and that somehow we as chaplains are somewhat separate from all of this. The staff have clearly told us we belong, and that we have a significant role in the hospital.

These all bring to the fore what the church looks like and how it ministers outside of its own walls in this century. What it means to be church on the frontier where its accepted understandings are in contention and often competition. I have described my role as that of a bridge builder or missionary for the church. The space, place and context of my ministry as a chaplain is so different than that of my church colleagues. The surprise in part for me is that our staff members 'get it' more easily than many of my

church colleagues who seem to expect me to be 'doing church' in the hospital. In my context this would spell the end of any ministry there.

My Changes: Stories of Place and Belonging

The interviews with staff members brought to light their experience of, insights about and understanding of chaplaincy ministry. Their story was overwhelming one of belonging. The first part of belonging was as part of the hospital or the organisation. This included the chaplains' role in ward teams, their ability to bring an independent non-medical voice to the discussions and the professional nature of chaplaincy. Chaplains were seen as the specialist providers of spiritual care and having a role in a trauma event and debriefing following an event. The role of chaplains in education, providing religious rituals when needed and a calming presence in the midst of crisis was also named.

Staff responses identified a number of relational roles that chaplains had. These included providing support for staff, being available, listening to patients and staff and being respectful. Staff indicated the importance of the spiritual care and its difference from religion, and the support chaplains provided through counselling and mentoring. The relational practice of chaplains was also seen in the serendipitous conversations in the corridor along with a non-judgmental or inclusive attitude.

These insights from staff have provided me with an outside and independent perspective with which to reflect on my ministry, to calibrate my views and to think about the future. A significant part of the staff member's perspective is how chaplains belong to the hospital, yet their separation or independence from the organisation. Staff members noted this but saw it as a strength of chaplaincy that allowed us to advocate on their behalf while at the same time seeing us as very much part of their team. The narratives of place and belonging have been strong. The picture of the hospital community as a village

and the role of the chaplain as a holy man were inclusive images. They offer a contra voice to the original narrative of this project which was one of disconnection.

Sacred and Secular

The setting in which a ministry is practiced is significant and defines the shape and scope of the ministry. The WCH is a SA Health hospital, a secular institution. As such chaplains are working outside of an ecclesiastical environment. Despite the secular location chaplains are welcomed in the hospitals as specialist providers of pastoral and spiritual care. They are also welcomed because of the relational way they go about their ministry.

Hospital chaplains need to comply with a number of governance requirements. These range from policies and procedures to compliance with workplace behaviours. While governance and compliance are increasingly required of churches, the hospitals have well developed practices around these. In a paediatric hospital the main requirements have to do with patient privacy, the reputation of the hospital, professional competence, continuing education, and mandatory reporting of any child abuse that is uncovered.

A key difference of working in a public hospital as a chaplain is that unlike church clergy we are not accountable for the strategic direction, planning, compliance, budget, volunteer management and health and welfare of the organisation. While there are some reporting and governance requirements we are free to commit most of our time to face to face ministry.

The restrictions placed on us are about being professional in the workplace. For chaplains this is being clear about our role as clergy. What would be seen by church clergy as evangelism is not appropriate with vulnerable people. Yet in this secular

environment staff members advocate to families and to each other for the chaplaincy service. They see that care for the spiritual needs of patients, families and each other is important. Value is placed on appropriate religious rituals for those who need them. Chaplains are embraced as part of the team and their non-medical voice sought out.

I have described the role of chaplains in hospitals as missionaries who need to learn new languages and cultures yet having a voice of connection for introducing people to the rich resources of faith. Providing care to staff in this setting is a key, they form the regular community or parish that a chaplain engages with. Hospital chaplaincy also needs to be a vocation where there is a strong sense of call to the ministry.

In part I have noted how there is the sacred in this secular world. I perform the role of a priest and my presence is also symbolic speaking of the presence of God and the interest of the church in this place. I have used the church image of parish to convey my understanding of the role I have. Chaplaincy is also a ministry in action, with a theology of practice.

A key part of the ministry in action is noted in the staff stories when they speak about the chaplain turning up when they are needed, and the sense that chaplains will be available when called. The expectation is that chaplains will be attentive, listen, and deliver a professional service. There is also the expectation spoken of in the narratives that chaplains are available to the staff to support them.

It is a mission of care. It is a vocation or calling. It is in a secular space. It is missional. It is also who chaplains are.

Professional Practice

A public teaching hospital such as the WCH has a strong emphasis on professional practice. This practice is based on recognised credentials to work in the area of practice

such as nursing, medicine, physiotherapy, nutrition and many others. The practice is supported by ongoing education from the hospital's internal programs and from the professional development offered by conferences and professional organisations.

While churches have begun to embrace professional development, it has been long term expectation for chaplains and one where chaplains have taken the initiative. Initially through the Australian Health and Welfare Chaplains Association (AHWCA) and now SCA chaplains have professional associations to belong to. SCA has instituted requirements for membership mirroring other professions that include regular professional development and personal supervision. Supporting this is the SCA Standards of Practice. This expectation is in line with hospital credentialing requirements. When I presented the SCA Standards of Practice to our Hospital Executive they were immediately endorsed and affirmed.

In ministry formation there are the three themes of head, heart and hand; knowledge, attitude and practice. There remains in chaplaincy a need for clarity around the skills and competencies for health care chaplaincy. There are few courses in Australia and those that are tend to leverage off general ministry training. It is also evident that clergy with good pastoral skills will make good chaplains. A key element however is having a professional attitude, behaviour and practice. It is generally accepted in most fields that if a candidate has good basic skills then the organisation can teach the specifics that are needed for the role. This is true of church clergy wanting to transition to chaplaincy. The key issues are good skills and a learning attitude.

What has been encouraging for me is how staff members have affirmed that I have the skills and competencies for my role. I have reflected a number of times on how this project has opened a Johari Window for me, the panel that is known to others while being

my blind spot. There has also been the encouragement to own my competency in practice. Staff members have encouraged me that I do good work, and to give myself permission to claim and celebrate what I do. While the Australian tall poppy syndrome helps keep us real it can also stunt our effectiveness.

Another aspect of professional practice for chaplains is to be able to clearly articulate what they do. This includes using spiritual assessment tools and an understanding of the ICD codes and how they work. Supporting this is the theology of pastoral care with its emphasis on guiding, sustaining, reconciling, nurturing and healing.

CONCLUSION

The context of this project is in an Australian community were authority and religion is viewed with suspicion and at times derision. Australia was not without its multi-cultural and multi-faith mix as there have always been immigrants to Australia who were not of British origin. Already inhabiting what became Australia were the Aboriginal peoples, some 360 clans or tribes. They continue to have cultural stories of creation and meaning and a spiritualty that is deeply embedded in the locality that is their ancestral place. They speak of belonging to the land. While the dominant conversation has been around the Christian church in its variety of guises in Australia there has always been an embryo of multi-cultural and multi-faith life present. While there may be some trappings of religion like prayers in Parliament, Australia has a strongly secular environment.

The context for the project was the WCH. Daily life in the hospital I work at, the WCH, offers a rich engagement of multi-cultural and multi-faith experiences. Alongside the marginal attitude to religion is a counter-intuitive engagement with spirituality some of which have traditional roots and others that are eclectic and personal. Yet in this setting and context chaplains are included, valued and sought out. There are a number of factors that underlie this, Manning Clark's observation of a 'whisper in the mind and a shy hope in the heart' where Australians sense if not believe in something bigger and beyond themselves.

This project has relied on the voices of staff members which are the primary source and basis for my project and provide evidence for my claims. The narratives have informed me by revealing perspectives of my chaplaincy ministry I was unaware of, others that were latent and those that I knew but have been unwilling or unable to

acknowledge and claim. Staff members have described them and helped uncover them for me. The staff's affirmation of my chaplaincy ministry has been humbling, encouraging and motivating and I now appreciate my role more fully. The importance of relationships with staff members and intentional engagement by chaplains with them is a priority for the education, nurturing and mentoring of both the chaplaincy team and visiting clergy.

Staff members indicated that Chaplains provide support that is effective and timely, encompassing the pastoral initiatives of being available and present, listening, and valuing the individual. Chaplains are experienced as being relational and an important part of the hospital team who bring a wise and pastoral voice and non-medical insights to the conversation. Chaplains are also interpreters of the spiritual in the secular space offering a presence and a voice that speaks to the human realities of fear, hope, grief and desperation Chaplains also symbolise and engage with the spiritual issues of meaning making and seeing God as present.

Without trying to fix problems chaplains are appreciated for being able to journey in the darkness with people to bring calmness and comfort to tragic events. At the same time they are midwives to meaning, at the birthing of celebration or devastation, and able to provide appropriate rituals or prayers to give voice to that meaning. In this context Chaplains are also the 'holy one', the village priest and their presence is symbolic of the presence of God. For those who need it we bring the significant resources of faith and through prayer, anointing and blessing connect people with their source of meaning. This is the place of sacrament and the thin places where God is palpably present. While eschewing organised religion Australians have in my experience an innate spirituality. In many ways it identifies with that of the Aboriginal people, a connection with the land, an engagement in family and communities that are life giving, a sense that there is

something bigger. In Aboriginal Dreaming the stories speak of the creating and sustaining spirits, secular Australians too speak quietly of similar spiritual connections that are not aligned to the doctrines or practices of faith communities but are equally real. The challenge for church and chaplains is to understand, appreciate and value these deep spiritual connections.

While this project has had a focus at the WCH they were informed and confirmed by interviews at the LMH. I believe there are lessons and insights for chaplaincy at the state and national level in Australia from this project. In SA two hospitals have chaplaincy departments that engage with staff members, and this engagement is appreciated and valued. A shift in perspective is needed by chaplains who only see patients, their families and carers as their priority. They are missing a connection with the staff who work in the same hospital.

Another lesson is to claim their ground as specialist spiritual care providers. Alongside this is for each chaplain to develop their theology of chaplaincy so that they are aware of what they do and why and accompany this with professional supervision to continue to explore their growth as chaplains and reflective practitioners.

While these suggestions relate to South Australia they are also applicable to chaplaincy in Australia. My experience in both hospitals and the military inform me that these insights are transferable. There is the opportunity for chaplains to replicate this study and discover if they are as well embedded as the chaplains at the WCH and LMH.

As the respondents in the interviews have affirmed, chaplains who are competent, relational and reliable who are able to bring a pastoral voice are welcome in their hospital. It is a privilege that I am welcomed at the WCH. I have said that it is my parish. It is also

a parish to which I belong. It is my parish where my chaplaincy role is to hear the faint whisper and shy hope and to give voice to the whisper and reality to the hope.

RECOMMENDATIONS

Chaplaincy Practice

1. Chaplains have a developed theology contextualised for the setting of their ministry placement.

2. Chaplains be selected not just on skill levels but also in terms of a person description. Having an ability to relate well across all levels of their ministry setting

3. Chaplains engage intentionally with their churches about the role and place of chaplaincy as a significant community and missionary ministry.

4. An expectation that chaplains have a professional attitude and practice, giving clear attention to continuing development, personal supervision, collegial practice with each other and other care providers in their setting.

At the WCH

1. To be more confident in my role, accepting that I am seen as an integral part of the WCH and have a valuable contribution to make.

Assessment will be through participation in supervision of my practice and be a regular agenda topic.

2. Engagement in educating staff members about the place and role of spirituality, religion, supported beliefs and practices, in both formal and informal settings.

A record will be maintained of the staff education sessions conducted and new educational opportunities sought and again on the agenda for my supervisor.

3. Continue to advocate for chaplaincy and for the development of a quality chaplaincy service at the new hospital as it is planned.

Continue to speak to the team planning the hospital, diary notes to remind me of regular contact with the team. An item for my team members and supervisor to check.

4. Produce an article in a peer reviewed journal on the results of this research and promote the results in forums and chaplaincy education.

Further Study

1. There is the opportunity for chaplains to replicate this study. Doing so will further inform the profession and add to the body of evidence of chaplaincy ministry. It will also provide insights from outside of chaplaincy, an objective voice from staff members that assesses what we do.

2. There is the opportunity to undertake a culture and values assessment of the hospitals in which chaplains work to better understand the environment in which they work.

3. Writing a personal theology of chaplaincy and possibly theologies for a variety of different settings such as aged care, corrections, schools and the military.

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