For spirit’s sake …

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do be human, one has a spirit. That this spirit is named and nurtured in multiple ways around the globe does not detract from the fact that it exists at the core of each and every being. So how, in modern day medical practice is this essential aspect of health catered for, for the children and their families from non-Christian faiths?

Ever since the inception of the NHS, hospital authorities have attempted to “provide” for the spiritual needs of patients and staff. Almost every hospital in Britain boasts a chapel and during the past 50 years over 400 hospital chaplains have been appointed. In pluralist societies, it is however essential that the spiritual needs of all faith communities are identified and met. Regrettably, this has not been the case with respect to many of the estimated three million Britons, or the one in ten children subscribing to non-Christian minority faith and ethnic communities.

Acculturation—the process by which minority cultures gradually adopt the values and ethos of the majority culture—has for many families resulted in the erosion of traditional support networks. Such lay alliances have hitherto often been crucial buffers during times of illness, turmoil, and grief. And minority communities have, as has
repeatedly been shown by government reports on health inequalities, more than their fair share of morbidity and mortality, starting from the neonatal period and extending over the life course. It is therefore important that, as increasing demands are placed on chaplaincy services for support and advice, mechanisms are developed to ensure that such services are competent to cater for and sensitive to the needs of diverse populations.

Although some children from most religious backgrounds will have engaged in religious practices, in our experience this is particularly so with the South Asian and Jewish children who tend to absorb parental attitudes towards religion in the early years of their development without question or analysis. It is therefore important that children are given age and developmentally specific opportunities to share and explore their fears. Therefore in order to be effective, multi-faith chaplains must be aware of their own values, prejudices, and worldview as these will profoundly affect their response to cultures different from their own. Their service should, as a result, be flexible where individual needs are identified and accommodated, which is not possible with the present ad hoc system.

All children irrespective of background, deserve the right to receive care that helps them make sense of illness in the context of their life, and in so doing these children must be helped to live and die meaningfully in ways that are consistent with their own worldview. Experience suggests that despite the best of intentions, many of the current cohort of chaplains face difficulties in delivering spiritual care to those from non-Christian backgrounds. This is only to be expected since, in addition to the theological “gap”, there is also a lack of any in-depth appreciation of the workings of these “other” cultures. It is now increasingly being recognised that all British chaplains need to undergo a broader training programme than hitherto in order to enable them to better fulfil a more generic chaplaincy role. But this still remains the issue of Christian chaplains often being unable to join in worship with patients of faiths other than their own, thereby limiting the potential to utilise the spiritual “tools” that a particular faith community will often employ in an attempt to restore a sense of balance and wellbeing.

Symbolism is a universal religious phenomenon that has the potential to facilitate communion with an unseen reality. During times of uncertainty and spiritual pain, symbols such as incantations, sacred texts, and artefacts often assume heightened importance. Our experience suggests that this is certainly very true among the faiths practised by South Asian families in Britain. A bangle for a young Sikh boy (Kara), the family icon of a Hindu deity, and the Tawze (a black string tied round the neck or wrist of a Muslim child) can all, if appropriately employed help provide comfort, hope, and an inner sense of peace. In contrast, lack of understanding of the role of such symbols can create misunderstanding and further turbulence in what are already trying times.

A wider appreciation of multicultural symbolism is only one example of the many ways in which cultural awareness and empathy can enhance delivery of health care. It is important for spiritual carers not only to be familiar with particular religious rites but also to be aware of the underlying narrative that threads these practices together.

Cultural competence is an evolving process that depends on self-reflection, self-awareness, and acceptance of differences. It is based on improving understanding, as opposed to an increase in cultural knowledge. Evidence indicates that training is much more likely to be effective if a “whole staff” or “systems” approach is taken. Implementation of culturally sensitive care and not mere tokenism must be the goal, and this is in our experience best achieved if all health practitioners involved with caring for children have the opportunity for appropriate training.

With the Department of Health and the Department of Education and Skills (DES) now pushing forward the agenda for developing a health and social care workforce through the NHS University (NHSU), this could be made possible from 2003. The NHSU has been set up as part of the NHS modernisation plan to provide practical learning and skills for everyone working in the health service—that is, staff from all disciplines including carers and volunteers. Such an innovation can form part of a “continuous professional development” for “life long learning” for any section of the workforce.

We believe that this important development represents an excellent opportunity to incorporate generic issues on diversity and specific issues on faith into the training of chaplains so as to equip them with the requisite “insight” needed to facilitate and deliver multi-faith care to the diverse populations they serve. This will perhaps be most effectively achieved by working in collaboration with existing training providers. For example, the Markfield Institute based in Loughborough University, which currently offers MA and PhD programmes for Muslim Imams wanting to become chaplains.

Inclusion of a question on religious affiliations in the 2001 Census allows us for the first time to accurately indicate geographical areas where particular religious groups are concentrated, for example, Hindus in Leicester, Muslims in Bradford, and Sikhs in Southall. It is therefore now possible to identify areas in which it would be sensible and feasible to employ specific faith chaplains.

The broken are often the bereaved, the sick, and the lonely. This is particularly so for those from cultures different from those in the west. Happiness is often heightened and tragedy lightened when shared with the family. It is in the understanding and meeting the needs of such people that spiritual “doctors” come into their own—whatever their faith, whatever their background.

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Authors’ affiliations
A R Gatrad, Manor Hospital, Walsall, UK
E Brown, Acorns Children Hospice Trust, Birmingham, UK
A Sheikh, Division of Community Health Sciences, GP Section, University of Edinburgh, Edinburgh, UK

Correspondence to: Dr A R Gatrad, Manor Hospital, Moat Road, Walsall WS2 9PS, UK; steevemc@walsallhospitals.nhs.uk

A Sheikh is Chairman of the Research and Development Committee of the Muslim Council of Britain

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