THE SUPPORT OF CHAPLAINS EXERCISING PASTORAL CARE IN FIELD HOSPITALS IN OPERATIONAL SITUATIONS

AIM

The aim of this paper is to consider the factors involved in selecting, preparing, supporting and assisting the recovery of chaplains called to exercise pastoral ministry in field hospitals. The immediate concern of this paper is the Army, but there may well be implications for chaplains of other services, particularly in the context of hospital ships.

Basic influences are noted which pertain to this ministry at the present, together with a number of assumptions. First hand evidence indicating the extent of the problem will require further collation. Finally we will propose a way ahead in meeting the challenges indicated in this paper.

THE CONTEXT

A number of factors have over recent years led to the present situation:

1 At the start of OP GRANBY there were twelve British Military Hospitals throughout the world. Presently there is one main unit (90 beds) in Birmingham, and seven other minor units (20-30 beds) attached to civilian hospitals throughout the United Kingdom. There is one residential remedial centre at Headley Court.

2 At any one time there is only one chaplain engaged in full time hospital chaplaincy at the Queen Elizabeth II Hospital, Birmingham.

3 In the Department there is very little experience of full time hospital chaplaincy amongst CF1s and above.

4 The only long term (i.e. periods exceeding two years) part time hospital chaplaincy is presently conducted by MSF chaplains rather than by Regular chaplains.

5 In the Department as a whole there is again very little full time hospital chaplaincy experience, and, presently, very little chance of gaining such experience.

6 The total care process for casualties with chronic conditions is spread over a number of different locations from the operational theatre to the United Kingdom (and even at times in Germany). The result is that individual chaplains do not have a first hand knowledge of the Department of Health 'Pathways To Care' that particular patients are likely to follow.

7 In any operational theatre where a significant number of troops are deployed there is always an incidence of chronic illness e.g. diabetes, heart conditions etc. After diagnosis these can be as life-threatening (or life-changing) for the patients concerned as injuries sustained in conflict.

The impact of working in field hospitals should not be underestimated. It is evident from the first hand accounts of other health care professionals returning to Germany that their experiences have placed significant personal demands upon them, and that there is a real need to assist them in their recovery. There is no reason to expect chaplains to be exempt from this reality.

It should be noted that presently all field hospitals, apart from one or two key appointments, are staffed entirely by TA/Reservists who will be more familiar with NHS procedures and ethos than those in the military. This is another indicator that familiarity with the NHS will assist chaplains in their total pastoral care.

IMPLICATIONS OF THE CONTEXT

(Ref Para 1) Although it is undeniable that in the past twenty years medical procedures have improved

significantly the total care available to military patients has diminished. This is because the

attendant welfare and pastoral infrastructure which was considerable when centred on twelve military hospitals at the time of OP GRANBY is either non-existent or else is so diffuse that patients and staff (including chaplains) can be either confused or ignorant about the reality of what further care is available. To put it simply whilst the technical help available to soldiers has improved we do not have the support and infrastructure for their general well-being that we once had.

(Ref Paras 2-5) Hospital Chaplaincy is a specialist ministry (and within the Army a specialist ministry

within a specialist ministry). It requires the ability to work within a unique context with a highly trained team of practitioners from various disciplines who all have, in addition to their individual skills, been trained to work in that environment. It is an environment where events happen suddenly and circumstances change rapidly. It is an environment which demands great flexibility from all, and places significant emotional and physical demands on all who work within it. It is an environment where teamwork, experience and trust are at a premium, and it is an environment which can resonate for good or ill on the personal circumstances of both patients and staff.

In short, there is more to hospital chaplaincy than just visiting the sick (although when this is done properly it is in itself significantly demanding). The 'parish priest' model is neither adequate nor appropriate to respond to this particular vocation.

It goes without saying that not all are called to this ministry, either because of (or lack of) experience or because of personal inclination. This, coupled with the lack of preparation as reflected in paras 2, 3, 4 & 5 is the central issue of this paper.

(Ref Para 6) When we had dedicated military hospitals, most treatment, even for chronic casualties (both

in-patient and out-patient) was given on site. Even if specialist remedial work or procedures were required elsewhere patients normally returned to the 'mother' hospital sooner or later; and although

they may be looked after by a number of different disciplines, the practitioners remained fairly constant. Chaplains of those hospitals had a good working relationship with all departments, knew the personnel involved and had an awareness of the general implications that various procedures would have. That sort of knowledge is not presently available to a chaplain in a field hospital in , say, Afghanistan when confronted by the questions of an amputee. Whilst there may be others who have a factual understanding of what may be ahead, the chaplain will not have in him/herself the awareness and confidence born of first hand experience, which more than anything else will help build trust in the patient.

It should always be remembered that patients 'hear' what is not said, as much as they hear (or think they hear) what is said.

(Ref Para 7) There is a tendency amongst Disease and Non-Battle Injury (DNBI) patients in field hospitals prior to repatriation to feel that they are somewhat second class. The truth is that once a patient enters hospital they are a patient, and all the above factors relate to people with conditions other than those created by conflict. Their situation could be just as life-threatening or changing, and possibly they are in greater danger of disappearing into the anonymous NHS system than battle casualties. If we are providing chaplaincy care to patients in field hospitals should chaplains not have at least a rudimentary awareness of what lies ahead when patients return to the United Kingdom?

PERSONAL IMPACT ON CHAPLAINS

In his famous book the 'Anatomy of Courage' Lord Moran laid out his theory of the 'Bank Account' concept of courage. In summary, he put forward the concept that an individual's personal reserves which enabled him/her to respond to highly demanding circumstances are rather like a bank account. If bank accounts do not have sufficient capital to start with, and are not topped up regularly, they can be eventually exhausted. Again, like a bank account, reserves can be depleted

either on an imperceptible daily basis or else in a major spending spree. Hospital chaplaincy provides either or both options for depleting a chaplain's personal reserve.

In the context of this model we have to be aware that both Birmingham and Camp Bastion provide very clear examples of high intensity demands on all staff including chaplains. Following Moran's model adverse impact of critical events can be either accumulative over a period of time (most of this process can be insidious) e.g. working in a totally new context where a high professional standard is expected of all and inability 'to perform' is fairly readily apparent and can have serious consequences) or drained in a very short time by the physical, mental and emotional 'overload' of working with a significant number of seriously injured patients.

Whilst a chaplain is trained and equipped (or should be) to maintain his/her personal reserves under normal circumstances, it is imperative that he/she should be given an adequate bank balance of psychological reserves to start with prior to deployment, complemented by a real opportunity to restore depleted resources post deployment.

In addition to all the above it must also be remembered that chaplains conducting hospital ministry do so in the context of all the other normal strains that would be placed on them because of separation and their presence in an operational theatre.

SUGGESTED WAY FORWARD

The following suggested way forward will seek to address the issues of

1 Suitability.

2 What skills need to be acquired ?

3 What support is reasonably readily available to prepare chaplains? How would training proceed ?

4 Recovery.

These suggestions are put forward in the understanding that we live in very constrained times in

terms of both financial and manpower resources. Where expenditure is necessary consideration should be given not only to the cost of that training but the potential cost of failing to give suitable training and preparation, both costs falling not only to the Army/MOD, but also to the Sending Churches. There is a moral issue here that the Army/MOD has not paid for the training and preparing of clergy before they entered military service, consequently there is a ***prima facie*** case for returning clergy to the churches in a reasonable condition in order that they may continue their ministry effectively in a civilian context.

SUITABILITY

There has to be recognition that not all clergy are called or equipped for this very specialist ministry. Whilst in the military there is always the potential for individuals to be required to function outside their normal area of competence; this should always be a call of last resort, and not a basis for considered long-term policy.

Unsuitability can be considered under two headings:

1 Temporary Unsuitability. Prevailing circumstances in a chaplain's life may well render him or her unsuitable on a temporary basis to undertake this ministry. Recent bereavement, divorce or a particularly demanding previous operational tour are the most obvious examples which would temporarily preclude somebody from this ministry.

2 Permanent unsuitability. Chaplains' records should be searched diligently for indications that individuals are emotionally or spiritually unsuitable for this ministry. Conversely where records indicate that an individual may have the experience to potentially be working in a field hospital this should be viewed as contributing towards the possibility, and not sufficient in itself. Special consideration should also be given as to whether TA or MSF chaplains, because of their experience, might be more suitable for this role than some Regular chaplains.

WHAT SKILLS ARE REQUIRED ?

Without ‘micromanaging ‘this particular section, five broad areas of competence can be outlined which are not normally required of a chaplain.

1 Awareness of both military and civilian procedures for handling patients and their administrative structures.

2 A general awareness of actual treatment processes for various conditions and their potential personal, social, economic, spiritual and psychological impacts on patients.

3 The ability to function as a priest/minister and as a trusted and integrated member of a multidisciplinary team. This functionally is the biggest difference between a hospital chaplain and a parish priest who by comparison ploughs a somewhat more independent furrow. Ontologically there is also a profound difference as a hospital chaplain exercises the greater part of his/her ministry with and through other hospital staff, rather than the ‘one on one’ ministry of visiting the sick.

4 A hospital chaplain needs to learn to triage his/her response to patients in a realistic manner. A chaplain cannot do everything for everybody and they have to learn to deploy their personal resources to achieve the greatest benefit, and also have to learn to live with the consequences of some of their decisions. To achieve both of these takes time and experience.

5 The last consideration we call inoculation. People receiving medical care are very often in significant emotionally, spiritually and physiologically distressing circumstances. These factors inevitably impact personally on all staff, but this situation is aggravated by exposure to a high intensity of these circumstances surrounding each patient over a protracted period

of time. This is evident from the reaction of other healthcare professionals who have returned from recent tours of duty. There needs to be a period of controlled exposure of chaplains to such conditions to enable them to develop their own 'coping mechanisms' and also to understand their own reactions. Failure to supply adequate preparation and support will inevitably lead to disaster.

PREPARATION OF CHAPLAINS

In general terms at the moment the following path is suggested as a blueprint for Chaplain Preparation:

1 A period of at least three months working in an NHS hospital with a large A&E Department under the care of experienced hospital chaplains, and also participating in the Hospital Chaplains' Induction Course (without being involved in the administration aspects of that course). A little time should also be spent during this period familiarising chaplains with the care of 'mainstream' patients within the NHS system.

2 A month spent at DMRC Headley Court experiencing the rehabilitation process for patients returning from theatre, and also gathering a picture from the patients themselves of their personal experiences both medically and psychologically as they progressed through their treatment.

3 Chaplains should embed with the military hospital team prior to their deployment to theatre, and as a priority go through the Casualty simulator exercises with them, either at RTMC Chilwell, or 2 Med Gp's CASSIM at Strensall Training Camp near York.

It is envisaged that this whole process (including Theatre Training (OPTAG) and Leave) would take about six months. Whilst this is a significant investment in a chaplain's time and availability (particularly given the present financial climate) we believe that it is an essential investment in ensuring both quality ministry to patients and staff, and the long-term retention of chaplains within

both the Army and the Church.

RECOVERY

This subject, along with previous issues raised in this paper, requires much deeper analysis. However we would consider that in general the Army's response to this matter is far from adequate. We would recommend that a robust recovery programme not only involves elements of the RAChD but also the Hospital Chaplaincy Council. This programme should include decompression, retreats, 'time out' and individual counselling.

MANAGEMENT OF THE POORLY PERFORMING CHAPLAIN POST DEPLOYMENT.

Although the normal medical and psychiatric services are available to chaplains whose professional effectiveness has been compromised by injury or illness, it is the experience of at least one Army Occupational Physician signing a RAChD chaplain's P8 Medical Discharge Board in the recent past, that the patient concerned felt abandoned by his hierarchy. Although this may represent one chaplain's perception, the case nevertheless illustrates an area of concern which was earlier amplified in a returning TA chaplain's declaration to the congregation at his home parish – which included the same occupational physician – that he had never felt as unsupported and lonely as he had done during OP TELIC 1. The unit he had deployed with took a number of fatal and VSIL casualties. The burden of his complaint was that the senior chaplain of his denomination, whilst present in theatre near Baghdad, made minimal efforts to meet him socially let alone extend pastoral support.

It is therefore recommended that ACG(G) considers this paper in the round and decide which areas he should recommend for the CG's further consideration. CG is in turn recommended to staff such areas as he deems appropriate for further development in the support of chaplains exercising pastoral care in operational field hospitals, or indeed operational scenarios in general, to the appropriate areas of MOD in order that training doctrine be developed for said areas, and resources released for effecting said training.

For Consideration.

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