- the struggle to master the language and the encouragement from the Welsh speakers at the end of a Sunday service.
- the dear parishioner who, on the day my wife joined me in the parish, said: "Welcome home".
- the sense that two of my churches are on sites where Christians have worshipped for perhaps 1,500 years.
- the family who, mourning the death of their severely handicapped son, said: "We're all better people for having known Chris".
- the middle-aged man who came with his wife-to-be to an enquirers' group and said: "I don't think I believe, but I'm willing to travel and see where we end up".
- the excitement of getting a team of lay people together to lead a monthly service for children and their parents.

Most of all, he's in the many little signs of spiritual awakening as the old religion slowly dies, to be replaced by a new, vigorous, owned and explorative faith which is being embraced by the newcomers to the congregations.

There are setbacks. A couple of people have left for various reasons, feeling that they no longer belonged. Sometimes it feels as though we're pushing water uphill as we try to help the people understand that newcomers to church don't automatically know what to do in church. All three churches need extensive (and expensive!) repair work done.

We've no idea where this journey will end, but the journey is such fun that we have no doubt that Wales will be revived, probably not in the 1904 sense (the socio-economic factors which led to that revival no longer pertain), but in a new sense which we have yet to understand,for God is always doing a new thing.

DISEMPOWERMENT & HEALING

Paul Beasley-Murray and Derek Fraser

Paul Beasley-Murray

Two days ago I returned home after having spent my very first three nights in hospital. Grateful as I am for the care shown to me, I confess that I returned home questioning one aspect of that care,

namely: is disempowerment a necessary part of the healing process?

In one sense disempowerment is inevitable. Ill-health inevitably renders one physically weak and so one is physically disempowered. While we are unwell, we can no longer do everything we used to do. That sense of disempowerment is reinforced by limitations linked with treatment. For some, disempowerment takes the form of being confined to bed, with the result that they are no longer able to be 'self-caring' and instead have to allow others to wash and toilet them. Others, as in my own case, may be able to care for themselves and yet because of various pieces of equipment being attached to one's body, one is are never able to have a decent wash, let alone a shower. What a difference it made when I got home and was able to have a proper shower - I felt a real man again!

However, the hospital system appears to take disempowerment to unnecessary levels. My experience was that instead of being respected as a person with a mind of my own, I was simply a 'patient' there to be treated. The medical consultants, for instance, when they did their daily rounds, did not 'consult' with me, but with their entourage. Not one of the doctors I saw introduced themselves properly to me. True, they wore name tags, but I could not always read the name tag, nor did the name tag make it clear whether I was seeing a consultant, a registrar, or just a houseman. I had no idea who came where in the pecking order, nor did I know at the time why I was transferred from one consultant to another. Had it not been for a surgeon friend who followed the ambulance and then spent three hours with me in casualty, I would have had no idea as to what was concerning the medical staff. At no time in the course of my treatment did the doctors volunteer any explanation. Instead I had to tease it out from them.

This sense of disempowerment was reinforced by the way in which almost everybody presumed to call me by my Christian name. I felt already robbed of my dignity by having to go around in pyjamas which could never do up properly because of protruding wires. Why should I undergo further indignity by being treated like any Tom, Dick and Harry? Don't get me wrong: I am not the kind of person who insists on formality. In my church, for instance, I am glad to beknown by my Christian name. However, in a hospital setting the failure of people to address me formally was a clear

sign of disempowerment. Nobody dared to call the consultant by his Christian name. For him there was respect, but not for me, the patient!

And of course, for a first-time patient, there was the sense of disempowerment of having to adapt to a very alien world. The nurses were busy, but surely not too busy to explain the ropes to a 'new boy'? It took me two days to discover that there was a day room where there were books to borrow and a television to watch. At the very least I would have expected to have been given a booklet dealing with life in hospital, but if there was such a booklet, it certainly was not made available to me

I wish I could say that the chaplaincy team 'empowered' me at this time, but alas this was not the case. On my very first full day I was 'visited' by one of the chaplains together with a lay-visitor, but that was a patronizing experience. For just as the consultant and his team had stood over me, so too did they. No doubt their time was limited, but it would have been nice if one of them had sat down in the chair beside my bed and been 'alongside' me. Instead of enquiring how I was coping with this somewhat frightening experience, they asked how I came to be there and how long I thought I would be in for. Communion was promised if I was to be a long-term patient, but no prayer was offered in the short-term. With no Gideon's Bible in the hospital locker, I wondered whether I might have been given some uplifting card, but this proved not to be the case. So, although I was not further disempowered by the chaplains, I was in no way empowered by them to deal with my time in hospital!

Thank God, I am now back home, and I trust will soon be fully fit again. However, the question remains: is disempowerment necessary to the healing process?

Disempowerment and the healing process - a response to the experience –

Derek Fraser, Chaplain at Addenbrooke's Hospital, Cambridge

Coming into hospital is often a challenge, especially if it is unexpected and in an emergency situation. Coming into hospital for the first time as a patient is to enter an unfamiliar world which can be frightening, disorientating and quite frequently disempowering. If the cause of trouble is unknown and if you are reasonably fit it is disturbing to suddenly find yourself stopped in

your tracks and faced with your mortality. The outside world of day to day life does not stop, but our involvement in it comes to an abrupt halt. The speed of life with its many and incessant demands suddenly stops and we catch in Paul's reflection a glimpse of what it was like and the feelings it stirred.

As a chaplain working within an acute hospital, I reflect on Paul's account of his experience penned in a number of ways.

First, it is always a challenge to individuals when passivity is thrust on to the agenda of one's life. We are rarely prepared for it and find it irksome and demanding. The whole tenor of existence for many is focussed around work and activity. Clergy are prone to excessive working with many finding it hard to rest, relax and recuperate or maintain any kind of healthy work-rest balance.

Entry into hospital as a patient forces upon a person the issue of being patient, passive and compliant. We are no longer doing, being busy and in control of our lives, rather we are on the receiving end, being served or done unto. The experience of being on the receiving end focuses our attention around questions of love and acceptance. Certain personality types find it easier to give than to receive, so it becomes doubly difficult to be required to receive.

Passivity is characteristic not only of only hospital life but is for many a permanent way of life (e.g. the disabled, the retired) and the accompanying feelings of disempowerment are quite poignant and frequent. It is a powerful emphasis within the gospel stories of Jesus and one we often overlook. Vanstone in *The Stature of Waiting* reminds us that the use of the passive form of the verb in the Greek in the latter half of Mark's gospel is a crucial emphasis in the account of Christ's life and ministry. [45] Passivity is a profoundly theological theme that emerges here and finds validation within the life of Jesus.

Second, the structure of hospital life is focussed around the primary task of providing medical care. It is true that good communication between staff and patients is vital, but it does not always happen. The medical staff are increasingly being asked to develop or enhance their communication skills so that patients are aware of what is happening. Good communication or customer care

[45] W.H. Vanstone, *The Stature of Waiting* (DLT, London 1982).

begins with a courteous introduction by the doctor of their name, followed by their role in the clinical team and then a request to talk with the patient. The choice of names used to refer to the patient can be a matter of hospital policy, but usually it is agreed by the nurse with the patient as the basic admission paper work is completed. People can be sensitive about their name and therefore it is important that the patient is referred to in a manner that they find acceptable and makes them feel valued.

It is surprising to discover that medical students sometimes feel they can walk up to a patient and not observe the basic courtesies of life. Modern patterns of training medical students in Cambridge now include actors being used in simulated scenarios so that students can develop these core communication skills in a practical setting. They learn to address the patient by name, introduce themselves and explain their role before proceeding to address the medical needs of the patient. They have to learn to change practice as customer care is seen to climb the healthcare agenda. I suspect there is still a long way to go before major change is embedded in how medical staff engage with patients in a universal manner.

Each hospital has its own culture around the identity and identification of staff. Addenbrookes has a strong ID badge culture where it is frowned upon not to wear your badge which details your role, title and a small picture. This enables patients to know who is addressing them and the whole emphasis in healthcare has been to personalise the delivery of care so that people feel valued and respected.

Third, within the caring professions, pastoral care seems, at times, a diminishing art. Many used to perceive chaplains as those who had dropped out of ministry because they could not hack its pace. Part of the legacy of that perception is that chaplaincy is left with a poor sense of identity and comprehension of function. Many in chaplaincy lack a focus for their activity and are unclear about what they are doing. Many visit patients haphazardly and never think to maintain adequate records so there could be any continuity of care and support.

If you were to ask a chaplain what it is they seek to do they would often describe it in vague and woolly terms. One colleague in a major teaching hospital in 1999 mused, “As to our role - it is difficult to say precisely what it is. It is something to do with alerting the organisation that we are here.” Another commented,

"My basic ministry is to listen - if I could do that for people I feel I would be doing my job". I ask the question in that context, "Is that all we are about?" I have argued before that clarity of thought and an ability to articulate our contribution adequately is vital.[46] Such self-definition and articulation not only provide others with an understanding of our role and function, but also serve to validate for ourselves what we are about. A crucial element in sustaining ongoing pastoral engagement is the awareness of our own motivation. I am not suggesting that there is a simple answer, but it is vital that chaplains work at this for themselves.

I like to think of chaplains as pastoral practitioners who seek to build a relationship of trust through compassionate presence and thereby offer help and support to a diversity of people. Such support might focus on the emotional/spiritual adjustment to illness or a search for meaning and purpose during illness. The chaplain's speciality is to possess an understanding of the relation between faith, illness and the emotional and mental conflicts that arise. We seek to motivate and initiate meaningful use of each individual's beliefs and attitudes in the management of their problems.

Many clergy enter chaplaincy, but receive no training in how to do chaplaincy, nor do they engage in any kind of continuing training and development in reflective practice. We have developed in Cambridge a training programme including an MA in Health Care Chaplaincy to train and equip people who might come into the profession. It provides a taught element, but also has a part that contains pastoral reflective practice so that chaplains have the opportunity to develop their pastoral skills in the context of hospital life. It is important to recognise that while there are many skilled chaplains, equally there are others whose skills need developing and sharpening. Too often it has been assumed that clergy can pick up the skills on the job, but there are significant ways to enhance practice that as a profession chaplaincy is beginning to discover. [47]

It is against that backdrop that we see the patient visited, but feeling patronised and their needs not adequately addressed. The ability to come alongside a person and enable them to make sense

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[46] See Derek Fraser, 'Clarity and cost effectiveness', *SACH* journal 7 (2004).
[47] See F Ward, *Lifelong learning* (SCM, London 2005).

of their experience is vital. It is revealing that knowing the person being visited was a clergy person, they did not assume a shared agenda with access to common topics and a similar God framework. Not to come alongside and explore the impact of hospitalisation is a missed opportunity.

Many chaplains find the clergy a challenging and disconcerting group to engage with. I have always approached the clergy with some enthusiasm because we are able to talk using a common language and thought forms. In addition, because of my frequent encounter with clergy in hospital, I have learnt that they too value the opportunity to reflect upon their experience. For them it can be a learning opportunity where in the context of a safe space they can question for themselves the meaning of the experience. To be able to ask the question, "What is God doing in this situation?" can be helpful. It is fascinating to see some clergy quite challenged to think that God might be speaking to them so directly.

I always ask for the chance to pray for a person like that. I have a clear rule of thumb: if we have talked of God in any way, then I will offer to pray for a person. If we have talked of God at any depth, I will offer to pray for them and I will always check that they have the kind of items that might nourish them spiritually. That might be a Bible, a book of daily prayers or some inspirational materials. Sometimes patients are keen to talk at depth with a chaplain because they can be real about the dilemmas they face. To give permission to explore issues with no pre-conceived barriers can be enabling and empowering. It is sad that chaplaincy is often ad hoc, piecemeal and lacks a clarity and engagement with people that is winsome and empowering.

Disempowerment is part of the illness experience and an integral part of hospitalisation but it is not the last word.

A final thought focuses upon the fact that Paul wrote up his experience to invite a response. I was reminded of my pastoral reflective class where we would take a piece such as this, not as a verbatim record, but as a kind of pastoral scenario to explore and unpack at three levels: See, theorise and theologise. At a basic level it is essential to grasp what is being said, to understand the facts of the case and the superficial messages that are presented. At a secondary level it is important to explore what the feelings are that are presenting themselves both in what is said and what is reacted to. It allows the space to mull it over a bit and develop a

deeper, broader kind of seeing to the report. The third level is to see the significance of the story theologically. It is to engage with the story, as it is recorded for us, from God's perspective and see if that affords any kind of reorientation of perspective that we can bring to bear on the encounter and so enhance pastoral practice. I have already identified themes like passivity and passion as well as pastoral presence and incarnation. I am sure there are more to unpack, but that is for others to go further with the vignette.

IN FOR THE LONG HAUL

Hedgehog - A lovable, but sometimes prickly fellow

In days gone by, it was not unusual for the captain of a ship to lash himself to the wheel as the ship rode out a storm. That action had a symbolism which went beyond a mere fear of being washed overboard. It marked a determination not to abandon ship and an equal commitment to, if necessary, go down with the ship.

Hedgehog was chatting to a minister friend, who told me that, having served five years in his present church, he had done his bit and it was time to move on. He'd made all the changes he needed to (or could) make and there was nothing left there for him to do. Hedgehog's prickles stood on end in horror! It sounded as though he was afraid of outstaying his welcome! My friend's comments immediately connected with something said by Grace Davie, Professor of the Sociology of Religion at Exeter University (best known for coining the phrase 'Believing without belonging'). According to her research, the most productive period of a ministry begins around years five to seven and extend to about year fifteen (after that, there is a danger of running out of steam).

This confirms the research of the church growth movement in the 1980s that short ministries are usually ineffective ministries (unless the minister has been put into a problem church by his/her denomination with the specific intention to sort out the mess, then move on, leaving someone else to do the rebuilding), because the change and development created by a 'minister in a hurry' do not take root properly.

Now in my fourth year in my current parish, I realise why this is so. It takes several years to get a congregation to trust you as a