QUALITY IN HEALTH CARE

Editorial

Auditing the intangible

The tradition of caring for the stranger in one’s midst and treating him or her as a guest (hospes) crosses many cultures and religious traditions over the centuries. The early monasteries had their infirmaries primarily for sick people in their communities but often extended their care to sick pilgrims on their journeys to holy places. The rule of St Benedict included the statement that “the sick guests were to be received as if they were Christ himself.” In medieval times in England over 800 hospitals were situated along pilgrimage routes and around the great centres, catering for wayfarers, people who were chronically sick, and lepers.

The first St Bartholomew’s hospitals were situated in Dover and Rochester before the great foundation in London’s Spytelle Field. They were ecclesiastical rather than medical foundations, institutions for care rather than cure; although herb gardens were often found in monasteries, the prominent activity was for refreshment of the soul. Faith and love were more predominant features in hospital life than were skill and science. Such traditions die hard; although the balance may have shifted to skill and science, patients still want to have some ministration to their spirits as well as care and cure of their bodily illness while in hospital. These aspects have been investigated recently in a survey of hospital chaplains reported in this issue by a team at St Mary’s Hospital (p 174).

Although questions of what has happened to the patient to destroy his or her health can be answered by the advances in genetics, medicine, and pathology, the questions “Why me?” and “Why now?” need to be faced if the whole person is to be healed, whether or not the illness is reversed. Pain, fear, sorrow, anxiety, and guilt surround a serious illness, and this for some (though not for all, as the survey shows) is a time when a chaplain or visitor can be of help. In this way chaplains join with the nursing and medical staff in simply being there, alongside patients, listening, reading, and praying with them.

Whereas the act of making a visit is measurable the quality of the transactions and the results are more difficult to quantify. In a seminal study over 20 years ago, Wilson, a physician attached to the department of theology in Birmingham University who carried out many surveys, asked over 200 patients what they saw as the main function of a hospital chaplain. Most perceived him or her as a friend or representative of the church and two thirds as a comforter, adviser, or listener. But the quality of communication is all important, the focus cannot just be the communication of information: a fully informed patient may yet starve for the lack of communion with his or her fellow beings. For many patients illness is a crisis point in their lives, they learn not only about the faultiness of their bodies but also, for some, their impending mortality, for others, the strengths and weaknesses of their relationships: in these circumstances being in hospital is an entry into a living, learning arena, a place of truth.

Good illustrations of such experiences have been recorded by hospital chaplains working with dying patients and mentally ill patients.

Other aspects of a chaplain’s, rabbi’s, and imam’s task could form the basis of further audit and would include their work supporting the staff in counselling and education.

The hospital ethics committees, where their philosophical and religious skills are used as a counter to the purely utilitarian ethics of scientists or the priority given to anachronic autonomy by those who are politically correct.

The chaplaincy service in a hospital acts as a symbolic reminder for all of us that, important as it is to discover and alleviate disease as far as possible, it is not only what we suffer from but how we suffer that is important for wholeness, whatever the outcome. The St Mary’s survey clearly shows that most of those patients visited by a chaplain appreciated the time given to this dimension of care. Such chaplaincy teams would be the first to acknowledge that they have no monopoly in this support, sympathy, and help given in full measure by relatives, ward staff, specialists, and ancillaries. Such compassion is hard to measure and even more difficult to buy and contract for.

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