Identity and Ministry in Healthcare Chaplaincy:
The liminality of the Church of England priest who continues to sing the
Lord’s song in the strange land of the National Health Service

Submitted by Anthony Paul Richard Kyriakides-Yeldham to the University of Exeter
as a thesis for the degree of Doctor of Philosophy in Theology
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Abstract

This thesis examines the dual identity of the Church of England priest employed as an NHS healthcare chaplain. In 1948, full-time NHS chaplains provided a Church of England ministry of liturgy and pastoral care. Their twenty-first century counterpart delivers existential spiritual or pastoral care. Though Church of England chaplains are licensed by the Church, their work is shaped by the NHS and the Trust which employs them. They are accountable to the Church and the NHS even though each promotes different values and serves different ends. Published literature alludes to the chaplain’s sense of marginalization from the Church and within the NHS.

Interviews with twelve full-time NHS chaplains, who are Church of England priests, focused on how they interpreted their dual identity as priest and chaplain, and the impact the two institutions had on these identities. This I framed using the theoretical model, ‘communities of practice’. Analysis of these interviews confirmed that chaplains thought they were disconnected from the priorities and values of the Church. This they described as ‘marginalization’, a term which appears elsewhere in published literature sometimes interchangeable with ‘liminality’.

I claim that liminality is not only conceptually different but makes a distinct contribution to understanding the work and identity of chaplain and priest. I argue the existence of liminal intelligence and its importance in the ministry of the chaplain. I maintain that ministerial priesthood needs to be faithful to its liminal credentials. These I trace back to the liminality of the cultic priesthood outlined in the Hebrew bible as well as the liminality of Jesus, his teaching and the communitas of the early Church. I propose that the role of the ministerial priest is not only about recalling the institutional Church to its liminal roots but that liminality is the essence of priesthood.
Acknowledgements

Predictably, with a research project that has spanned seven years I owe a debt of gratitude to many people. Some have shared their own research, journal papers or academic contacts while others have formed part of an invaluable support network. There are too many to acknowledge individually although I hope they will understand how deeply appreciative I am of their help.

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If I were to dedicate this thesis to anyone, it would be to the twelve healthcare chaplains who generously agreed to be interviewed, imparting their experience, knowledge and practical wisdom. In addition, there have been those healthcare chaplains of all faiths and beliefs with whom I have had the privilege to work these past thirty years, and from whom I have learned so much.

Finally, there is Denise my partner who has patiently, some might say stoically, stood by me through the highs and lows of an extended and extensive research project. No holiday would be complete without time set aside for ‘the thesis’. I remain grateful to Denise more than words can ever convey.
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List of Abbreviations

AfC  Agenda for Change
AODP  Association of Operating Department Practitioners
BBC  British Broadcasting Corporation
BHA  British Humanist Association
CAAB  Chaplaincy Academic and Accreditation Board
CCG  Clinical Commissioning Group
CHCC  College of Health Care Chaplains
CfS  Caring for the Spirit
CLF  Chaplaincy Leadership Forum
C of E  Church of England
DHSS  Department of Health and Social Security
EqIA  Equality Impact Analysis
GTM  Grounded Theory Method
HCC  Hospital Chaplaincies Council
HCFBG  Health Care Faith and Belief Group
HPC  Health Professions Council
HCPC  Health and Care Professions Council
JCHC  Joint Committee for Hospital Chaplaincy
KSF  Knowledge and Skills Framework
MFGHC  Multi-Faith Group for Healthcare Chaplaincy
NAHCT  National Association for Health Authorities and Trusts
NHS  National Health Service
NPM  New Public Management
NRPSN  Non-Religious Pastoral Support Network
NRRP  National Recruitment and Retention Premia
NSS  National Secular Society
ODP  Operating Department Practitioners
RRP  Recruitment and Retention Premia
UKBHC  United Kingdom Board for Healthcare Chaplains
Chapter One: The Introduction

1.1 Introduction

In this chapter I set out the research objective (§1.2.1) and research questions (§1.2.2) which address the issue of the nature of the dual identity of the NHS healthcare chaplain who is a Church of England priest i.e. the ‘NHS priest-as-chaplain’. I will introduce the methodology and methods which I develop in chapter five, revealing that my primary knowledge-base, which directs and governs my interpretative framework, is theology with its customary ‘texts’ derived from history, scripture, tradition, reason and doctrine (§1.3.1; see further in chapter three). My premise is that these ‘texts’ represent only part of the whole. They interact with another ‘text’ or con-text, that of the NHS priest-as-chaplain, a legitimate ‘text’ for theological study. I will advocate practical theology as my preferred framework in which praxis or theory-laden practice has primacy over theory-driven models of theology. The NHS priest-as-chaplain, a ‘living human document’ (Boisen, 1936: 185), I will consider in terms of socialization and social constructionism (see further in chapter two) as well as the sociology of profession (see further in chapter four). Given the nature of my research objective, I will argue that qualitative analysis offers both a descriptive and interpretative way forward (§1.3.2). I will explain my reasons for choosing a phenomenological research design on the basis of experiential narratives using semi-structured interviews, with twelve NHS priests-as-chaplain located in different NHS Trusts around England.

Turning to the context of the NHS priest-as-chaplain, I will note the unquestioned acceptance of the chaplain at the inception of the NHS in 1948 (§1.4.1) and, in contrast, will detail two particular challenges chaplaincy faces today from the National Secular Society (§1.4.2) and the British Humanist Association (§1.4.3). These disputes will lead me to explore how chaplaincy has changed since the introduction of the NHS. This will include its realignment as a spiritual rather than solely religious resource (§1.5.1), an encroaching professionalism (§1.5.2), the role of government (§1.5.3), the direction of chaplaincy’s national leadership (§1.5.4) and the implications of Agenda for Change (§1.5.5).
Finally, I will assess what previous research has contributed (§1.6.1), acknowledging the work of Swift (2008), Woodward (1998), Wilson (1971) and Mason (1998), and will anticipate what my own research might add to the current body of knowledge (§1.6.2): a rich, thickened description which makes no claims for reproducibility but in which emerging themes might inform a theology of priesthood.

1.2.1 The Research Objective of this Thesis
This research project considers, theologically, the inter-relationship of two identities co-existing in the person of the National Health Service (NHS) healthcare chaplain who is a Church of England priest; more specifically, it listens and analyzes the contextual voice of the Church of England priest ministering in the NHS alongside the customary ‘texts’ of history, scripture, tradition, reason and doctrine.

1.2.2 The Research Question
In formulating the research question, I aimed to address the nature of the dual identity of the NHS healthcare chaplain who is a Church of England priest: the NHS priest-as-chaplain. This is captured in the primary research question which seeks to determine whether in the current ethos of the NHS, the identity of the NHS chaplain in England remains congruent with the identity of the Church of England priest.

Without pre-supposing an answer to this primary research question, I planned for the possibility that an analysis of the evidence might suggest that the identity of the National Health Service Chaplain in England was not congruent or compatible with the identity of the Church of England priest. In which case, secondary research questions would then arise. First, why a dislocation of the two identities might have occurred? Second, what the nature of any perceived dislocation between the two identities might be? Third, how the thinking, experience and practice of the NHS priest-as-chaplain might draw upon, contribute to or challenge contemporary discussions of Anglican priesthood, especially in terms of ontology, function and relationship.
1.3.1 **Practical Theology as the Preferred Framework**

My initial ideas about how I would address the two identities of priest and chaplain were to place the thinking, experience and practice of the NHS priest-as-chaplain under the lens of the theological microscope. Rather than operating within a traditional theological model which moves from theory to practice, I see the NHS priest-as-chaplain as a ‘living human document’ and a legitimate ‘text’ for theological study equivalent to the more customary texts of scripture and doctrine (Boisen, 1926; 1936: 185; Gerkin, 1984: 42). While my primary knowledge-base remains the theological ‘texts’ of scripture and doctrine, history and tradition, my premise is that these ‘texts’ interact with that other ‘text’ or con-text, the NHS priest-as-chaplain. It is a text which I explore by way of the individual participants’ narratives or what has been described as ‘unnatural’ self reflection (Swinton and Mowat, 2016: 15). In this, it might be argued that there is nothing new. Down the centuries, Christian theology and doctrine have evolved out of pastoral practice: *fides quaerens intellectum*,¹ faith seeking understanding. Notwithstanding that, since the publication of Browning’s (1991) seminal work, *A Fundamental Practical Theology: Descriptive and Strategic Proposals*, it has been the evolving discipline of practical theology which has taken human experience seriously and has made it an obvious methodological partner for my research.

One drawback, however, lays in the fact that practical theology as a distinct discipline is complex and broad.² In the formative days of practical theology, four principal issues needed clarification: the province of practical theology; its status as an academic discipline; its methodology; and its normativity (Dingemans, 1996: 83). More recently, practical theology has been reckoned as an activity of believers, a method of understanding or analyzing theory in practice, a curricula area, and an academic discipline. These ‘four understandings are connected and interdependent, not mutually exclusive... and reflect the range and complexity of practical theology today (Miller-McLemore, 2011: 5).

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¹ The original title for Anselm’s *Proslogion*, in which is to be found the first known formulation of the ontological argument for the existence of God.
² In the same year that Browning wrote his seminal text on Practical theology, Maddox wrote an article he entitled *Practical Theology: a Discipline in Search of a Definition* (Maddox, 1991).
Challenging as it may be, any attempt to define practical theology needs to be descriptive and not prescriptive, provisional and not categorical, but it does not follow that a foundational definition should be unachievable or without value. Indeed, I would argue that it is essential to provide some yardstick of what practical theology is, for the purposes of this thesis.

Traditional models of theology have been characterized as descriptive, normative, critical and apologetic, and this holds for practical theology as well. The strategic objectives of practical theology may be identified as fourfold. First, practical theology is prepared to think ‘outside the box’, to critically interrogate and to contest what is embedded in the context, in particular traditionally-held views and practices, and to attend to those questions which, as a result, then emerge. So, for example, ‘what do we do with our theology?’ and ‘in this situation how do we understand our theology?’ It requires a re-appraisal of the inherited understandings that have guided past interpretations and actions in order for there to be the transmission of meaningful theology into people’s lives today. These are questions which may enable the context to be reframed theologically, facilitate action which is transformative, and so encourage the goal of faithful living. Second, practical theology is dependably and incontrovertibly theological in its hermeneutical framework. Third, the focus of practical theology is on the interplay between those practices which are faith-orchestrated and those practices which are world-orchestrated. Finally, practical theology has the role of advancing and upholding faithful living and authentic Christian practice (Swinton and Mowat, 2016: 9). In these ways, practical theology offers a strategic perspective that bridges hermeneutics with human experience in order to realize an integrative model that underpins the theological task as a whole (Ballard and Pritchard, 1996: 63f.).

At the same time, practical theology might be described as asystematic in that it is continuously re-engaging with the ‘changes and chances of this fleeting world’. It might be envisaged as casting ‘shafts of light into situations and issues rather than find[ing] answers or durable solutions. It is, in a way, ‘throw away’ theology that has always to reinvent its tasks and methods’ (Pattison and Woodward, 2000: 14). Even with this caveat, a foundational definition of

---

3 From the Church of England Order of Compline (traditional language).
practical theology might speak of that ‘place where religious belief, tradition and practice meets contemporary experiences, questions and actions and conducts a dialogue that is mutually enriching, intellectual critical, and practically transforming (Pattison with Woodward, 1994: 9).\(^4\)

1.3.2 The Integration of a Framework of Practical Theology with Qualitative Methodology

As the purpose of practical theology is to unravel the complex dynamics of practice, the methodologies of the social sciences clearly have a part to play and have become essential partners. Given the nature of my research objective, qualitative analysis offers both a descriptive and an interpretative way forward. Being aware that qualitative research is an over-arching methodology which reflects different theoretical paradigms, I needed to be specific about what I wanted from my research data. This was twofold: first, a thick description of each participant’s experience of living in the skin of two identities, that of the Church of England priest and the NHS healthcare chaplain; and, second, to discover how participants interpreted or made sense of the integration of the dual identities of priesthood and healthcare chaplaincy. To accommodate these objectives, I turned to hermeneutic phenomenology.

Hermeneutic phenomenology is both a methodology in that it provides an epistemological and ontological framework, and a method in that it provides the conceptual tools with which to engage with experiences and interpretations (Swinton and Mowat, 2016: 105). Phenomenology studies how meaning is generated in and through human experience. As McLeod (2001: 56) explains, it ‘seeks to set aside any assumptions about the object of inquiry, and build up a thorough and comprehensive description of the “thing itself”.’ Hermeneutics, as a science of interpretation, is distinct from phenomenology. It is not simply concerned with ‘what’ but ‘how’ interpretations become attached to phenomena. By nature, people are inquisitive and interpretative, as well as pre-disposed to

\(^4\) Pattison with Woodward offer this as a definition of ‘pastoral/practical theology’ which perhaps reflects the interchangeability the terms pastoral theology and practical theology had at the time that they wrote. However, Miller-McLemore observes that greater care needs to be taken in distinguishing between practical theology and pastoral theology. While the two terms focus on an area of common interest, i.e. lived experience, ‘practical theology is integrative, concerned with broader issues of ministry, discipleship and formation [and] pastoral theology is person- and pathos-centered and focused on the activity of care’ (Miller-McLemore, 2011: 6; cf. Graham, 2000:114).
pre-conceptions and prejudices. Accordingly, a person will construe a phenomenon from a biased angle or viewpoint. In this respect, hermeneutics is more than an epistemology. It presupposes an ontology.

Taken together, phenomenology and hermeneutics might seem unlikely bedfellows. The former strives to provide an objective explanation of the world and a person’s experience within that world, while the latter recognizes the bias and prejudice with which a person engages with the world. However, there are similarities as McLeod (2001: 57) illustrates in calling attention to three. First, both assume an ‘active, intentional, construction of a social world and its meaning for reflexive human beings’. Second, both ‘deal mainly with linguistic material or with language-based accounts of other forms of representation’. Third, both are ‘concerned with the development of understandings as a means by which people are able to anticipate events by sensitizing them to possibilities’ (italics in the original).

In his comprehensive assessment of hermeneutic phenomenology, van Manen (1990: 39) observes that ‘[a] good [phenomenological] description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way.’ Phenomenological research, he claims, is a dynamic interplay between six research activities: examining a phenomenon which is a focus of serious interest or offers an ‘abiding concern’; investigating a phenomenon as it is lived rather than conceptualized; reflecting on those crucial elements which set the phenomenon apart; describing the phenomenon through a process of writing and re-writing; and maintaining a strong relation to the topic of inquiry while, finally, balancing the research by considering the parts in relation to the whole and vice versa (van Manen, 1990: 30-31). Accordingly, the role of the researcher is to mediate the different meanings of the lived experiences (van Manen, 1990: 26).

This thesis adopts an approach which belongs to the overall group of qualitative research methodologies, and yet I am conscious of the fact that there is an ambivalent relationship between practical theology and qualitative methodology.
in general. An example of this tension lies in their respective understanding of the reality of truth. As Swinton and Mowat (2016: 68) summarize it, '[t]he inherent tendency of qualitative research to assume a fundamentally non-foundational epistemology which is highly sceptical about the possibility of accessing truth that has any degree of objectivity, stands in uneasy tension with the theological assumption that truth is available and accessible through revelation.' Despite this, Swinton and Mowat (2016: 86) argue that qualitative research methods can be used to ensure that ‘Christian practice is in correspondence to the event of God’s self-communication.' It is on this basis that I apply qualitative methods in order to gain access to the self-understandings and self-interpretations contained within each participant’s Lebenswelt or life world, and place these alongside the customary faith ‘texts’ of history, scripture, tradition, reason and doctrine.

1.4.1 Beginnings of NHS Chaplaincy

On 5th July 1948, at Park Hospital, Urmston (later renamed Trafford General Hospital), Sylvia Beckingham became the first patient to be formally treated on the National Health Service (BBC, 2008). It is unlikely that she would have seen a hospital chaplain as, at that time, there were only twenty-eight full-time chaplains working in the NHS and they were largely based in teaching hospitals (Swift, 2014: 41). By 2010, within the Church of England, there were approximately 325 full-time healthcare chaplains (75% of the total number of full-time healthcare chaplains in England) and 1,500 part-time healthcare chaplains (50% of the total number of part-time healthcare chaplains in England) (Hospital Chaplaincies Council, 2010: 5). If Sylvia Beckingham had received a visit from a hospital chaplain, how might this have been perceived by society-at-large? In 1948, NHS chaplains may have been few in number but there is no evidence that any person or group questioned the fact that chaplaincy posts were to be funded from the public purse unlike, in the twenty-first century, the sustained campaign by the National Secular Society (NSS) to end NHS-funded chaplaincy posts.

1.4.2 Challenges to NHS Chaplaincy: The National Secular Society

When, in 2006, Worcestershire Acute NHS Trust decided to remove six out of its seven chaplains, the NSS applauded this cut encouraging the Trust to ‘stick
by your decision and not be intimidated by this self-serving pressure’ (NSS, 2006). In the wake of the Worcestershire debacle, the following year Theos (a public theology think tank) surveyed Healthcare Trusts in England to establish the volume of cuts in chaplaincy. Among the 198 Trusts that responded to the survey, it was found that 256.9 sessions of healthcare chaplaincy had been cut, with a further 40.5 sessions frozen in the interim (Theos, 2007). The NSS publically welcomed this finding as ‘chaplains are parasites on the hard-pressed resources of the Health Care Trusts’ (NSS, 2007). In 2008, when an All Party Parliamentary Group on Hospital Chaplaincy proposed that NHS chaplaincy should be a ‘commissioned service’ in the same way as key NHS staff, the NSS condemned this claiming that faith groups had ‘a vested interest in having their clergymen (sic) paid for by the taxpayer’ (NSS, 2008). Malcolm Dodd, an NSS member, wrote to the chaplain of the United Lincolnshire Hospitals Trust in 2009, requesting details of her salary in order to ‘to assess how many more medical staff could be employed if you and your acolytes were funded by your real employer the C of E’ (NSS, 2009a). That same year, the NSS published its finding that the provision of chaplaincy was costing the NHS over £32 million, claiming that this could fund 1,500 nurses or 2,600 cleaners, and therefore should be ‘be phased out’ (NSS, 2009b). By 2011, the NSS noted that the cost of chaplaincy provision in England for the year 2009/2010 was £29 million with ‘no correlation between national benchmarking measures of quality and the proportion of Trust income spent on chaplaincy services’ (NSS, 2011). With structural changes in the commissioning and delivery of the NHS brought about by the Health and Social Care Act, 2012, and the creation of Clinical Commissioning Groups (CCGs) for this purpose, the NSS issued a briefing paper urging people to contact CCGs and MPs objecting to NHS funding of any chaplaincy service (NSS, 2012).

There is, however, one comment in the NSS 2009 report which contains a kernel of truth: ‘hospital chaplains have now reinvented themselves as ‘holistic carers’ and counsellors, offering services above and beyond the simply religious’. The report goes on to add: ‘[a]ny of these other duties could be undertaken by a non-religious – and properly trained - post-holder who could serve the whole hospital community without having to take into account the various religious sensitivities that constrain chaplains.’ (NSS 2009b). Yet
arguably, the NSS perspective is too narrowly defined, understanding the ‘care-giving’ work of a chaplain as religious because of ‘who’ and ‘what’ the healthcare chaplain represents. This is in the context of an NHS which has embraced a spiritual rather than religious agenda, and a Western culture which struggles with the meta-narrative of religious authority and privileges spirituality tailored to consumer choice. What is at stake here is not only the identity and integrity of the Church of England priest but the identity and the integrity of the chaplain, the congruence of the two being the raison d’être of this study.

1.4.3 Challenges to NHS Chaplaincy: The British Humanist Association

The identity and integrity of the NHS priest-as-chaplain has been furthered tested by the recent intervention of the British Humanist Association (BHA). Since December 2015 the BHA has challenged the basis by which a number of NHS Trusts have advertised for a Christian chaplain.\(^5\) In a template letter of intended legal action against these NHS Trusts, the BHA claims that ‘[i]n putting a requirement that the applicants must be Christian, the Trust does not... appear to have considered the diversity of the religion and belief of the local population. It is not clear that the Trust has discharged the Public Sector Equality Duty (for instance, has it done an equality impact assessment?), has respected articles 9 and 14 of the European Convention on Human Rights, or has had sufficient regard to the 2015 NHS Chaplaincy Guidelines’ (The BHA letter to Plymouth Hospitals NHS Trust dated 27 May 2016).\(^6\)

This last point is noteworthy given the welcome the BHA extended to the revised 2015 Chaplaincy Guidelines, Promoting Excellence in Pastoral, Spiritual and Religious Care. Andrew Copson, Chief Executive of the BHA, wrote: ‘we are committed to ensuring that all people with non-religious beliefs have access to pastoral support, just as religious people have access to such support, and look forward to expanding our own contribution as part of our growing community services work’ (BHA, 2015).

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\(^5\) These Trusts include Guy’s and St Thomas’ NHS Foundation Trust, Plymouth Hospitals NHS Trust, Wrighton, Wigan and Leigh NHS Foundation Trust and Hampshire Hospitals NHS Foundation Trust.

\(^6\) I am grateful to the Revd Paul Snell, Lead Chaplain, Plymouth Hospitals NHS Trust, for his permission to reproduce part of this letter (Snell, 2016: personal communication).
As a result of the letters the BHA sent at the end of 2015, and during 2016, a number of NHS Trusts amended their chaplaincy recruitment practice. One NHS Trust suspended the appointment of chaplains. Other NHS Trusts implemented an Equality Impact Analysis (EqIA) to ensure that their chaplaincy service reflected the local faith and belief demography. Some NHS Trusts decided to make appointments non-faith specific, in which case an advertisement for a Christian chaplain was amended so that the person specification required applicants ‘[t]o be authorised by your relevant faith or belief community, with at least 3 years recognition as a religious or belief leader [and to] be able to demonstrate integrity and good standing with reference to a specific community of religion or belief to which the applicant belongs and which recognises the applicant as a legitimate and qualified representative of that community for the exercise of religious, pastoral or spiritual care’ (Plymouth Hospitals NHS Trust, 2016).

The long-term impact of this BHA intervention on the integrity and identity of the NHS priest-as-chaplain is unclear. The BHA has a different agenda to the NSS. The BHA wants NHS Trusts to employ non-religious carers in chaplaincy departments and so provide pastoral and ‘spiritual’ care to non-religious patients and staff. At the beginning of 2016, the first Humanist chaplain to be employed within the NHS took up her post with the University Hospitals of Leicester NHS Trust. This part-time two year post is funded through charitable monies and is the first appointment restricted to non-religious applicants (Guyoncourt, 2016) and made on the basis of an EqIA. Speculatively, if the BHA is successful in its attempt to require NHS Trusts to fund non-religious carers in chaplaincy departments, this is likely to reduce the number of Christian chaplaincy sessions and affect the Christian ethos of chaplaincy departments.

In 2016, the BHA also established the Non Religious Pastoral Support Network (NRPSN). The name of this new organization may be significant. Both the BHA

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7 The NSS straightforwardly objects to the NHS financing any chaplaincy service (see §1.4.2).
8 The person specification for this post stated that an essential requirement was: ‘[to] demonstrate a mature reflective non-religious spiritual world view - which can be evidenced through discussion’ (Burleigh, 2016: personal communication).
9 The NRPSN sits separately from the BHA. Although Simon O'Donoghue works for the BHA (as Head of Pastoral Support) the NRPSN sits as a separate body with its own governing board and constitution. Essentially, the BHA has covered the cost of the set up of the NRPSN and
and the NRPSN point to the fact that between a quarter and a half of the population of England and Wales is non-religious,\textsuperscript{10} and that those who are non-religious need to have access to carers who share the same beliefs.\textsuperscript{11} This care is what the BHA and the NRPSN are prepared to offer presumably on the basis that they are ‘like minded’.\textsuperscript{12} Such a presumption lacks evidence. Whatever the intended purpose of the NRPSN, it now has a place on the Chaplaincy Leadership Forum\textsuperscript{13} and is a member of what was previously known as the Healthcare Chaplaincy Faith and Belief Group (HCFBG). Following submissions by the BHA, the HCFBG changed its name in 2016, having previously revised its name in 2014. At that time, the HCFBG claimed that this was in order to open its membership to non-religious groups.\textsuperscript{14} The latest revision to its name is once again attributed to a need to be more inclusive as well as to describe ‘what’ it does rather than ‘who’ it represents (Hodge, 2016: personal communication).\textsuperscript{15} This is perhaps a gloss. The NRPSN stipulated that its membership of the HCFBG was dependent on its change of name.\textsuperscript{16} The word ‘chaplaincy’ has been removed, predictably so given the NRPSN’s objection to pays the salary of Simon O’Donoghue, who acts as the NRPSN operations coordinator. However, the NRPSN will act independently of the BHA (O’Donoghue, 2016: personal communication).

\textsuperscript{10} ‘The 2011 census reported that 25% of the population of England and Wales identify as non-religious in response to the question ‘What is your religion?’, while the 2014 British Social Attitudes Survey (BSA), which asks ‘Do you have a religion, and if so, what is it?’ reports a much higher proportion of non-religious people in Britain, at around half the overall population (51%). This number rises even more dramatically for young people, with roughly two in three (64%) of 18-24 year-olds saying they have no religion’ (BHA a, no date).

\textsuperscript{11} ‘... there is a clear need for more non-religious pastoral carers in health care. This provision has been largely overlooked, with the vast majority of support workers and volunteers being religious. While they can still visit non-religious patients, we believe that it is imperative the non-religious have access to care by those who share their beliefs during challenging periods in their lives (NRPSN, no date).

\textsuperscript{12} This expression is found in the application pack for prospective Board members of the NRPSN (BHA b, 2016).

\textsuperscript{13} ‘In September 2013, the Chaplaincy Leaders Forum (CLF) was developed as an effective mechanism for dialogue between NHS England and the wider chaplaincy associations’ (NHS England, 2016).

\textsuperscript{14} ‘In light of NHS England’s emphasis on equality of access to healthcare and as a matter of principle, the Healthcare Chaplaincy Faith and Belief Group’s Council has been given serious consideration to its inclusiveness. Council has decided that it is important to open the group to non-religious belief groups, should they wish to be Full Members or take Observer status. To signal this greater openness, Council decided to change the Group’s name from the Multi Faith Group for Healthcare Chaplaincy to the Healthcare Chaplaincy Faith and Belief Group’ (HCFBG, no date).

\textsuperscript{15} Hodge is Chief Officer of the Network for Pastoral, Spiritual and Religious Care in Health.

\textsuperscript{16} ‘The NRPSN has requested and agreed a name change of the HCFBG. This is because we are unable to become part of any group that has ‘chaplain’ in the title. Chaplain is a wholly religious term and our research suggests that the term chaplain is a barrier to non-religious people accessing support. This is a view that has been accepted and understood by the other providers at the group’ (O’Donoghue, 2016: personal communication).
its use in describing its own work,\textsuperscript{17} and it is now known as ‘Network for Pastoral, Spiritual and Religious Care in Health’.

The strategies that the BHA has adopted, to force through a fundamental re-orientation of chaplaincy services in the NHS in England, have been remarkably successful. NHS England’s chaplaincy programme is only concerned with ensuring good patient care and compliance with policy and legislation (NHS England, no date). It is for each NHS Trust to determine the faith and belief profile of its chaplaincy department basing this on an EqIA using the 2011 Census General Report as well as patient and staff statistics. Of course, even then, the role and priorities of the NHS priest-as-chaplain will be laid down and managed by the employing NHS Trust.

1.5.1 \textbf{The NHS: from religious to spiritual}

If the meaning and expression of priesthood is determined by a coherent and consistent ecclesiology, to what extent is priesthood compromised once its role and priorities are regulated by a secular institution, an NHS Trust, employing the priest as healthcare chaplain? Within this setting, how can ordained ministry realise its theological brief to be a gift of God to his Church, to promote, release and clarify all other ministries in such a way that they can exemplify and sustain the four ‘marks’ of the church, i.e. its oneness, holiness, catholicity and apostolicity? (General Synod of the Church of England, 1997: 13).

In 1948, the Church of England reckoned that the majority of NHS staff and patients would have some allegiance to the established church and so justify the presence of Anglican chaplains within NHS hospitals. Indeed, there is evidence that, in the early days of the NHS, Christian prayer and liturgy did play a part in hospital life and that nurses were expected to share in such observances (Bradshaw, 1994). In 1955, Cox could write that ‘the place of the chaplain in the life of his hospital is that… he is set there to exercise the pastoral and liturgical office of a priest within what is meant to be, in God’s design, a priestly community (Cox, 1955: 41). Cox’s opening chapter is entitled

\textsuperscript{17} When referring to [its pastoral support in prisons, the armed forces and hospitals] the BHA does not use the word ‘chaplaincy’, which retains sufficient religious connotations to be inappropriate as a meaningful description – research we have undertaken demonstrates that the term acts as a barrier for the non-religious in accessing services (BHA b, no date).
‘The Theology of the Chaplain’s Ministry’, in which he argues that without clear theological convictions, the chaplain’s ministry ‘will be confused and vacillating, without power to enlighten and direct (Cox, 1955: 1).

In the twenty-first century this might seem a prophetic statement amid claims that healthcare chaplains have surrendered their religious identity and integrity to spiritual nebulosity: ‘bespoke metaphysical marshmallow that is non-specific, unlocated, thin, uncritical, dull and un-nutritious’ (Pattison, 2001: 34). Alternatively, to what extent is healthcare chaplaincy one example of fresh expressions of church advocated by the Church of England in its 2004 report, Mission-Shaped Church? (Mission and Public Affairs Council of the Church of England, 2004). These questions reflect the purpose and direction of this thesis, and will be the focus of later analysis (see further in §7.3.3 and §7.3.5).

1.5.2 Healthcare Chaplaincy: an encroaching professionalism

If there has been a loss of a clear sense of religious identity, an alleged culprit identified by some has been the incremental professionalization of healthcare chaplains (Woodward, 2001: 91). Arguably, the publication of a number of chaplaincy-related guides, handbooks and reports has contributed to this process of professionalization. Chief among these was the King’s Fund report which examined the role of the hospital chaplain (King’s Fund, 1966) and proposed that the chaplain should ‘see himself as an integral part of the hospital staff and... be recognised as such’ (King’s Fund, 1966: 11). According to the Hospital Chaplaincies Council (HCC), hospital authorities were favourably disposed towards the report and this, the HCC interpreted, as grounds for anticipating better communication and collaboration (Hospital Chaplaincies Council, 1967). Other publications followed (Sheffield Regional Hospital Board, 1963; Birmingham Regional Health Board, 1967; Tunbridge, 1973) leading to the definitive A Handbook on Hospital Chaplaincy, (Hospital Chaplaincies

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18 See chapter four for a detailed exploration of professionalism and NHS healthcare chaplaincy.
19 The Hospital Chaplaincies Council was established in 1951: ‘(1) to advise the Church Assembly, when requested, on questions of ‘spiritual ministration’ to patients and staff in hospitals; (2) to provide advice on questions of policy to diocesan bishops and Anglican Regional Advisory Committees; (3) to monitor and report ‘matters affecting spiritual ministration’ in hospitals; (4) to co-ordinate Anglican Regional Advisory Committees; and (5) to liaise, on behalf of the Church of England, with the Ministry of Health on matters relating to ‘spiritual ministrations’ in hospitals’ (Hospital Chaplaincies Commission, 1947: 14).
Council, 1978a). Notably, this included a commendation by an officer of the Department of Health.\textsuperscript{20} With each publication the view was reinforced that ‘[e]very Hospital Chaplain is now… a professional working amongst professionals’ (HCC, 1987: vii). Over the course of time, guidance on the appointment of hospital chaplains circulated by the Ministry of Health (and its successor departments) reflected a changing attitude towards NHS chaplaincy. While, in 1963, a Ministry of Health circular, HM(63)80, setting out the terms and conditions of service for hospital chaplains charged ‘Committees and Boards to provide for the spiritual needs of both patients and staff by appointing whole-time or part-time chaplains to every hospital they administer’ (Ministry of Health, 1963), by 1987 the Department of Health and Social Security (DHSS) had relaxed its requirement that a whole-time hospital chaplain could only be appointed to a hospital which had on average 750 patients or more (HCC, 1987: 7). In addition, the work of chaplains in supporting NHS staff was recognised by the inclusion of staff numbers when determining the appointment of a whole-time chaplain (DHSS, 1984).

This increasingly close working relationship between the Churches and the Ministry of Health (until 1968), and its successor the DHSS (1968-1988), continued into the early 1980s, drawing on personal relationships forged in the 1960s and early 1970s between ‘senior church figures’ and ‘influential administrators in the health service’ (Woodward, 1998: 93). Some moved to the Ministry of Health, or the DHSS, or, at the very least, would convey to civil servants a positive experience of chaplaincy. One of these, Law, became HCC Secretary in 1972 and a member of the working party, appointed by the Joint Committee for Hospital Chaplaincy (JCHC), ‘to review and report on the hospital chaplaincy service and especially the ministry, training and method of appointment of hospital chaplains.’ (HCC, 1973: 1). However, while the 1967 Birmingham Regional Health Board report (which was effectively a handbook for chaplaincy) and the King’s Fund report did little more than clarify the responsibilities of hospital chaplaincy, advocating terms and conditions of service, the JCHC report went further, laying claim to a role in any future NHS

\textsuperscript{20} In its Annual Report (HCC: 1978b), the HCC noted that ‘[t]he handbook was first submitted in final draft form to the Department of Health for revision and approval, and the Commendation, written for inclusion in this Handbook by one of the Department’s officers, was welcomed by Council.'
reorganisation. Perhaps this reflected the HCC agenda of ensuring a continuing place for hospital chaplaincy within the structures of the NHS.

To achieve such an end, the churches needed to speak authoritatively with a common voice. As a result, in 1981, the ad hoc JCHC became an independent committee representing the three main Christian denominations, with a constitution and mechanism for elected representation. This ensured DHSS recognition of the JCHC as the churches' official negotiating body for hospital chaplaincy. Five years later, this need to speak with a common voice led the Anglican Hospital Chaplains' Fellowship and the Free Church Hospital Chaplains' Fellowship to amalgamate into an ecumenical organisation, the Hospital Chaplains' Fellowship, with a new constitution, open to all hospital chaplains and paving the way for the process of professionalization to continue within healthcare chaplaincy.

1.5.3 **Healthcare Chaplaincy: Ideology and ‘spirituality’**

This was well-timed for, in 1989, far-reaching proposals for the reform of the NHS were published by the Government in its White Paper, *Working for Patients*. With spiralling costs, the Government needed to identify alternative ways of funding the NHS. Its proposals sought to increase efficiency, provide more choice, and make doctors accountable to managers. Central to this reform was the creation of an 'internal market' whereby Health Authorities and General Practitioners would become purchasers of services, so encouraging competition between providers of healthcare. These providers were, in the main, hospitals which were given the opportunity of becoming self-governing Trusts, independent of Health Authorities. Clearly, Government expectation was that market competition would reduce NHS costs. A further White Paper, *Caring for People*, proposed similar changes in primary healthcare, whereby, once again, Health Authorities were able to purchase care from different service providers. The National Health Service and Community Care Act, 1990, represented a mind-shift, and despite considerable opposition from some stake-holders, reflected a determined government willing to plough its own ideological furrow.²¹

²¹ Fry (Chief Executive, Christie Hospital NHS Trust, Manchester) observed of this period that ‘the NHS has been involved in the biggest ideological battle since the 1940’s... Certainly health managers have been politicised by virtue of their role’ (Fry, 1998: 15).
Whether it was doggedness or ideology, the Government chose this moment to make policy statements concerning patients’ religious needs, and did this without consulting the churches. The first concerned the Patients’ Charter, introduced in October 1991, which aimed to improve the quality of healthcare delivery, detailing patients’ rights and standards of service, e.g. with regard to waiting times. The first of nine national standards affirmed ‘… respect for privacy, dignity, and religious and cultural beliefs.’ As Woodward (1998: 99) points out, ‘[r]eligion was no longer confined to what chaplains provided. It was presumably incumbent on every NHS employee to show respect for [Christian and non-Christian] religious beliefs’. The second, and more significant failure to consult, came about with the publication of Health Service Guideline HSG(92)2, *Meeting the spiritual needs of patients and staff*. This replaced PM(86)15 which, in contrast, had been the subject of intense consultation with the churches in the 1980s.

The press release accompanying publication of HSG(92)2 emphasised that, for the first time, account was to be taken of a patient’s religious needs, irrespective of which religion. Moreover, Trusts were given freedom to vary all terms and conditions and no longer had a statutory duty to employ chaplains. In 1998, Clark, Chief Executive of HCC, commented: ‘The freedom that [this] gave NHS Trusts to provide (and in some areas not to provide) chaplaincy services on a local basis with differing arrangements for appointments, contracts, job descriptions and terms and conditions of service, has now resulted in considerable local and regional variations in the standard of service provided to NHS patients’ (Reid and Clark, 1998: 30). On this occasion, the chairman of HCC, the Bishop of Exeter, did write to the Department of Health about the lack of consultation (HCC, 1993). When HSG(92)2 was reviewed and replaced eleven years later, the process was very different. The Department of Health worked closely with stakeholders, establishing the Multi-Faith Joint National Working Party, consisting of faith representatives, Department of Health officials and the HCC chief executive. The new guidelines were described by the Chief Nursing Officer in a Forward as ‘a strategic and best practice guide to the provision of chaplaincy-spiritual services for patients and staff.’ She added: ‘I hope it will provide a firm foundation on which NHS Trusts can build and enhance existing services’ (Department of Health, 2003: 3). It was a
considerable improvement on HSG(92)2, comprehensively covering a range of issues.\textsuperscript{22}

Nonetheless, HSG(92)2 was noteworthy in one further respect: the Good-Practice Guidance that accompanied it tentatively acknowledged a difference between religion and spirituality.\textsuperscript{23} While the 1963 Ministry of Health circular, HM(63)80, ostensibly addressed ‘the spiritual needs of both patients and staff’ (my italics) it actually addressed religious needs. By the 1990s, there was growing recognition that spirituality did not correspond to religious faith and, in addition, religious faith was not synonymous with Christianity.\textsuperscript{24} The authority of the Church of England chaplain, as a representative of the nationally established religion, was decidedly diminished and, in its place, some healthcare chaplains sought to establish themselves, whether consciously or otherwise, as the professional in all matters spiritual and religious (Cobb and Robshaw, 1998: \textit{passim}). In many hospitals, chaplaincy departments were rebranded as Departments of Pastoral and Spiritual Care (Derriford Hospital Plymouth in 1999) or some such variant. Meanwhile, research among healthcare chaplains of different faiths, in the mid-1990s, led Beckford and Gilliat to conclude that ‘[t]he structural changes in chaplaincies have helped to re-shape chaplains’ sense of their professional identity by placing a premium on their ‘managerial’ functions and their ‘professional’ status among other health care professionals’ (Beckford and Gilliat, 1996: 27).\textsuperscript{25}

This was re-affirmed in NHS guidance, published in 2015, to replace those issued in 2003. \textit{NHS Guidelines: Promoting Excellence in Pastoral, Spiritual

\textsuperscript{22} There were eight sections: a framework for chaplaincy-spiritual care, appointments to chaplaincy posts, confidentiality and data protection, volunteers in chaplaincy-spiritual care, worship and sacred spaced, training and development, bereavement services, and emergency and major incident planning.

\textsuperscript{23} HSG(92)2 Annex refers to ‘religious or spiritual organisations’ as well as ‘religious leaders or spiritual advisers’.

\textsuperscript{24} The National Association of Health Authorities and Trusts published a report, \textit{Spiritual Care in the NHS: A guide for purchasers and providers}, which observed that ‘NHS staff should be sensitive to the fact the ‘spiritual’ needs may be experienced by anyone, not simply those with religious beliefs. Indeed, the acknowledgement of a person’s language, culture, dietary needs, customs, anxiety and fear – or even their sense of isolation in unfamiliar surroundings – is an important component of spiritual care’ (The National Association of Health Authorities and Trusts, 1996: 6).

\textsuperscript{25} It is reasonable to infer that Beckford and Gilliat were referring here to Church of England chaplains as chaplain-manager posts in the NHS were, at this time, predominantly held by Church of England chaplains.
and Religious Care set out to ‘respond to changes in the NHS, society and the widening understanding of spiritual, religious and pastoral care’ as well as ‘in the light of the 2010 Equality Act’ (NHS England, 2015: 2). Chaplaincy, with no affiliation to any one religion or belief system, was recognized as including not only religious care, but non-religious pastoral and spiritual care. This emphasis on responding to the needs of those ‘who do not hold a particular religious affiliation’ (NHS England, 2015: 6) and the assertion that ‘patients and service users have a right to expect that chaplaincy care will be experienced as neither insensitive or proselytising’ (NHS England, 2015: 9), drew a cautious welcome from Stephen Evans, NSS Campaigns Manager, despite the fact that the NSS remained critical of a multifaith approach and the absence of a ‘truly secular system of chaplaincy’ (NSS, 2015).

Of particular note are the many references in the Guidelines to the chaplain as a healthcare professional. So, for example, the second paragraph of the Introduction to the Guidelines states that, since 1948, ‘chaplaincy has evolved in response to changing needs with increasing professionalism. This has enabled chaplains to share good practice and begin to build a body of professional knowledge and emerging research. Chaplains are professional staff qualified and contracted to supply spiritual, religious or pastoral care to patients, service users, carers and staff. They are one of the smallest professional groups working in the NHS (NHS England, 2015: 7; my italics). This emphasis reflects a long established aspiration within chaplaincy leadership nationally to achieve professional status.

1.5.4 Healthcare Chaplaincy: national leadership and its professional agenda

In 1992, the Hospital Chaplains’ Fellowship and the National Association of Whole-Time Hospital Chaplains came together to form the College of Health Care Chaplains (CHCC). In 2003, arising out of discussions with the Department of Health, the HCC was instrumental in establishing the Multi-Faith Group for Healthcare Chaplaincy (MFGHC) which sought to develop multi-faith chaplaincy provision. Consequently, for the next seven years healthcare chaplains related, strategically, to three national organizations. (This remained the case until 2010 when the HCC underwent a review into its role. After a
period of apparent uncertainty, its responsibilities were passed to the Mission and Public Affairs Division of the Church of England). While the CHCC and HCC each had its own agenda, the common denominator was an appeal to the ‘professional’ chaplain (see further in §4.2.1). Following the demise of the HCC, the Mission and Public Affairs Division continued to promote the professionalism of healthcare chaplains.

To this list of professional bodies should be added the Chaplaincy Academic and Accreditation Board (CAAB) established in 2005 by the Association of Hospice and Palliative Care Chaplains, the Scottish Association of Chaplains in Healthcare and CHCC with the aim of encouraging higher standards and greater professionalism in the organisation of courses and meetings by accrediting both training courses and conferences, seminars and other professional meetings which are considered suitable for fulfilling Continuing Professional Development. In 2008, and with the additional participation of the Northern Ireland Healthcare Chaplains’ Association, the CAAB became the United Kingdom Board for Healthcare Chaplaincy (UKBHC). The UKBHC aims to define and develop professional standards of chaplaincy including education, training and continuing professional development; to operate procedures to consider, investigate and assess the professional conduct of registered chaplains; and to maintain and develop systems to promote and accredit continuing professional development and the professional registration of chaplains (UKBHC, no date).

1.5.5 Healthcare Chaplaincy: Agenda for Change and its impact on NHS chaplaincy

An important factor in this process of professionalization came about under a new government. If ideology had determined the remaining years of the Conservative administration, pragmatism was the hallmark of ‘New Labour’ after

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26 The Church of England Yearbook 2012 notes that the Mission and Public Affairs Division ‘shall include within its remit the following areas... the work of Hospital Chaplaincy and the Church's relation to the Department of Health and the National Health Service and Trusts and the provision of professional training and Continuing Professional Education for Chaplains’ (Healthcare/Hospital Chaplaincy, no date).

27 The policy adviser for Medical Ethics and Health and Social Care Policy in the Mission and Policy Division addressed the question of why the NHS needs chaplains and wrote: NHS chaplains are healthcare professionals who, recognised and supported by their respective faith communities, are uniquely qualified and trained to deliver spiritual and religious care to patients, clients and staff (McCarthy, 2010: 1; my italics).
its electoral victory in 1997. Labour’s commitment to maintain the previous Conservative government’s spending limits compromised any radical policy shift. Nonetheless, Labour was determined to overhaul working patterns and productivity within the NHS, as well as modernise the pay structures to ensure ‘equal pay for work of equal value’. This was ‘Agenda for Change’ (AfC), a programme which became ‘the most radical shake up of the NHS pay system since the NHS began’ (Connecting for Health, 2013); ‘[t]he goals were nothing if not ambitious’ (Dickson, 2007: vii). AfC was designed to develop new roles and new ways of working for one million NHS employees, including healthcare chaplains. A key AfC component, when it was implemented in 2004, was job evaluation: the process of matching jobs to national profiles.

I would argue that AfC was merely part of an evolutionary process. AfC job profiles for ‘Chaplain Entry Level’, ‘Chaplain’ and ‘Chaplain Team Manager’ did little more than formally acknowledge, contractually, fundamental changes to healthcare chaplaincy. The ideological reappraisal of spiritual and religious care had already been established with the publication of the Patients’ Charter (1991). The introduction of NHS Trusts, in 1991, provided the opportunity for this ideological reappraisal to become the basis of chaplaincy reform, both in its provision and practice. As the 1994 HCC Annual Report observed: ‘[t]he overwhelming number of Trusts now require that the whole-time chaplain, in addition to discharging the particular denominational duties for patients, relatives and staff, also assumes the responsibility for managing and co-ordinating all the Trust’s chaplaincy services. This includes holding, and bidding for the chaplaincy budget, making local arrangements on performance-related pay, being subject to the routine staff appraisal system, and providing in-depth information locally for the Trust on all areas of spiritual care for Christian and non-Christian alike’ (Hospital Chaplaincies Council, 1994).

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28 Initially, the Secretary of State for Health, Dobson, instructed health authorities to reconsider their contractual arrangements with private companies in line with Labour’s opposition to private healthcare, but this proved untenable given pre-election budgetary assurances. As a result, Dobson found he had no choice but to take over the PFI principle from its Conservative predecessor.

29 Until the introduction of Agenda for Change, the NHS used the Whitely industrial relations system as a framework for pay, terms and conditions. This was conceived by J. Whitely in 1916 and adopted by the civil service and local government. For many years it was criticised for its complexity, over centralisation and lack of flexibility.
However, a comparison of pre-AfC and post-AfC job descriptions illustrates that it was not until AfC that such changes were formalized. In his unpublished doctoral thesis, Woodward (1998) summarizes the main components of eleven ‘job descriptions’ which he obtained by requesting job application packs for general acute posts advertised between December 1997 and January 1998.\textsuperscript{30} He notes that ‘[i]n the analysis of the main duties and responsibilities it is clear that all job descriptions followed a standard template provided by the Hospital Chaplaincies Council… There is little variation in the framework laid down by the Hospital Chaplaincies Council and only two of the job descriptions depart significantly from this template’ (Woodward, 1998: 201). The template, to which Woodward refers, was originally published in 1978 in the first official handbook on hospital chaplaincy (Hospital Chaplaincies Council, 1978a: 9-10; see Appendix A), and later reproduced with only slight amendments until as late as 1998 (Hospital Chaplaincies Council, 1998: 6-7; see Appendix B). In other words, the job description itself remained substantially unaltered until the implementation of AfC.

The post-AfC job descriptions and person specifications were considerably more detailed than their pre-AfC counterparts (see Appendix C for a pre-AfC person specification). This was due to the very nature of AfC which was not merely a new pay system. AfC consisted of four components. First, it harmonized the multiplicity of occupational pay grades, pay points and salary scales. Second, the pay system was underpinned by a job evaluation scheme, which was based on sixteen factors.\textsuperscript{31} Each factor had different identified levels, and each job was scored accordingly. While jobs were evaluated locally, a number of national job profiles were drawn up and banded. Staff in jobs that matched these national profiles was assimilated on the basis of the agreed evaluation score for the appropriate profile. Third, a new career development

\textsuperscript{30} Nottingham City Hospital; Leeds Royal Infirmary; Chelsea and Westminster Health Care; Preston Acute Hospitals; Portsmouth Hospital Trust; Milton Keynes General; Leicestershire Royal Infirmary; Oldham; Southmead Health Services; and Central Sheffield University Hospitals Trust.

\textsuperscript{31} Communication and relationship skills; knowledge, training and experience; analytical and judgemental skills; planning and organisational skills; physical skills; responsibilities for patient/client care; responsibilities for service and service development implementation; responsibilities for financial and physical resources; responsibilities for human resources; responsibilities for information resources; responsibilities for research and development; freedom to act; physical effort; mental effort; emotional effort; and working conditions. (NHS Employers, 2013:19-72).
structure known as the ‘Knowledge and Skills Framework’ (KSF) defined the knowledge and skills required for NHS staff to work efficiently and effectively delivering quality services. As a framework, it is used to decide pay and career progression within AfC. Fourth, criteria were laid down as markers both for success, e.g. more patients being treated more quickly, and the avoidance of risk in implementation, e.g. implementation within available funding.

Whether AfC has achieved its intended aims and objectives is not at issue here. What AfC did produce was the realisation that the pay band onto which an NHS employee was placed was dependent on that person’s job description. CHCC advised its members to ‘[l]ist any new duties/tasks that are not expressed in your [job description] that you feel may add value to your role and hence improve the matching outcome.’\textsuperscript{32} The national job profiles for Chaplain Entry Level, Chaplain and Chaplain Team Manager are listed in Appendix D, E and F respectively. However, at Trust level, these were re-written to a Trust’s standard format and incorporated local variation (Appendix G). What is immediately apparent is the detail of both the job description and the person specification (Appendix H) which differ significantly when compared to equivalent pre-AfC documentation.

The difference between the pre-AfC and post-AfC job descriptions and person specifications directly relates to the secondary research questions i.e. how a dislocation of the two identities of priest and chaplain has come about and the nature of the dislocation itself. What, then, are the changes that occurred between the pre-AfC and post-AfC job descriptions? Cobb,\textsuperscript{33} writing from a post-AfC perspective, has provided a useful analysis of the role of the healthcare chaplain, identifying ten ‘generic key tasks’, i.e. to provide spiritual care and meet religious needs; to devise and conduct religious ceremonies and human rituals; to contribute to multidisciplinary teams; to provide bereavement care; to supervise chaplaincy volunteers and students on placement; to participate in education and training; to contribute to organisational development; to participate in clinical audit, service

\textsuperscript{32} An undated paper entitled ‘Amicus/CHCC advice to members on Agenda for Change – Job descriptions’ produced prior to October 2004.

\textsuperscript{33} At the time of writing, Cobb is a senior chaplain and clinical director at Sheffield Teaching Hospitals NHS Foundation Trust. He has been influential in the development of NHS healthcare chaplaincy.
review and research activity; to contribute to service development; and to liaise with local faith communities and voluntary groups (Cobb, 2005: 24-25). What stands out from this list are the final four key tasks which do not appear in the HCC template job description under its main duties and responsibilities.\(^{34}\) What these key tasks have in common is that they represent an enculturation into the ethos and values of a secular organisation and a distancing from the ethos and values of the church which has ordained the healthcare chaplain to preach the word of God and to administer the sacraments. ‘Ministry in healthcare is not exclusively defined by its relationship to a faith community because chaplaincy is located within three principal communities: the faith community, the healthcare community and the professional community’ (Cobb, 2005: 19-20). Should this statement by Cobb pass unchallenged or should it challenge the church? Arguably, the church needs to engage with the culture of the NHS, (its language, concepts and priorities) in order to speak authoritatively, knowledgeable, and with credibility to the concerns, needs and aspirations of those ‘without a city wall’. As Cobb understands it, ‘[i]n following the ministerial pattern of Christ, the Church is called beyond itself into the world to reach out to all people… The care of the sick in relationship to the ministry of the Church is therefore a vocation to live the gospel in the world, to reach out to those in need, and to be concerned for the individual within a wider relational and social context’ (Cobb, 2005: 19).

Swinton and Mowat, in an analysis of NHS chaplaincy in Scotland, summarize the situation thus: '[w]ith the general cultural movement away from religion, narrowly defined, to a more generic understanding of 'spirituality', understood as a diverse human universal, there has emerged a redefinition of the spiritual positioning of chaplaincy… Healthcare chaplains are now required to think about, interpret and act upon considerably wider definitions of spiritual care than previously assumed’ (Swinton and Mowat, 2016: 155).

\(^{34}\) However, among the eleven Trust job descriptions that Woodward examined, there is reference to liaison with local faith communities under main duties and responsibilities: ‘to provide information and facilitate appropriate contact with representatives of non-Christian faith communities’ (Woodward, 1998: 199); and ‘to develop effective relationships with leaders of other faiths and community representatives in order to establish a network of support for patients and staff’ (Woodward, 1998: 200). This perhaps reflects the demography of those areas from which Woodward obtained his sample job descriptions, as well as signalling the evolutionary progression of healthcare chaplaincy.
Cobb’s premise, however, that ‘ministry in healthcare is not exclusively defined by its relationship to a faith community’ (Cobb, 2005: 19-20), begs a question: what is the precise nature of the relationship between the health care chaplain and her faith community? Even if one accepts that a definition of health care ministry will be characterized by relationships other than that of the ‘sending’ or ‘commissioning’ faith community, the health care chaplain must still retain a definable relationship with her faith community if she is to be authentically representative of her faith community. Nowhere does Cobb seem to address this question. From a Church of England perspective, how is the meaning and purpose of priestly ordination to be understood by the Church and the ordained person when practised within a health care setting? As Swinton and Mowat suggest: ‘perhaps chaplains have to renegotiate the basis of their professional status in significant ways, and reflect carefully and honestly on how this may or may not compromise their integrity as ordained Christian ministers’ (Mowat and Swinton, 2005: 29). Mason strikes a similar chord when he writes that ‘there is a need for a theology which the individual minister can refer to as the key to understanding his own vocation and by whose guidance he can order his response to the social situation around him (Mason, 1998: 262). Perhaps the NHS has become a strange land in which the Lord’s song can no longer be sung by one who is ordained. Then again, it may be the role of the ordained minister to express that which challenges the Church to re-think its own concerns, needs and aspirations, and to reflect this in the office and practice of priesthood.

1.6.1 What is already known of the relation between priesthood and NHS chaplaincy

Despite much that has been written about priesthood, my initial research would suggest that many priests, in both parochial and sector ministry, find it difficult to articulate a theology which informs and underpins their vocation let alone orders their response to their ministerial context.

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35 Here, and elsewhere in this and other chapters, Mason’s work is referenced as J. Francis and L. Francis. (eds.) (1998). Tentmaking: Perspectives on Self-Supporting Ministry. Leominster: Gracewing. However, the original publication is to be found in Crucible, 1975, 14, 21-30 and reflects the gender language of priesthood which, at that time, was open only to me.

36 In 2011, I took informal soundings from two ad hoc groups of Church of England clergy in Exeter and London dioceses.

37 Or might this indicate an absence of any theology. Hanson comments that, in the past, Anglicans have drawn on the theory of Apostolic Succession to provide a theology of ministry ‘or been quite content to have no particular doctrine of the ministry at all’ (Hanson, 1975: 101).
To elicit or compile the views of Church of England priests on a range of topics (e.g. sociological, psychological, geographical and theological) researchers to date have used both quantitative and qualitative methodological approaches: questionnaire surveys (e.g. Ranson, Bryman, and Hining, 1977; Francis, Robbins and Astley, 2005; Village and Francis, 2005), individual interviews (e.g. Daniel, 1967; Davies, Watkins, Winter, Pack, Seymour and Short, 1991) and group interviews (e.g. Mason, 1998). In some instances, researchers have incorporated both qualitative and quantitative methodological approaches (e.g. Nason-Clark, 1987; Bunting, 1988; and Jones, 2004), sometimes as a means of identifying participants to interview (e.g. Homan, 1995) and sometimes to supplement information gathered at interview (e.g. Mason, 1998).

In the field of healthcare chaplaincy research, both quantitative and qualitative instruments have been deployed. When, in the mid-1960s, a new chapel was planned for the Queen Elizabeth Medical Centre in Birmingham, the University of Birmingham Institute for the Study of Worship and Religious Architecture was asked to advise on its specification. Gordon Davies, professor of theology, argued that the design of the chapel needed to be influenced by an understanding of what the chaplain did in the hospital. In October 1967, a working group was formed which Wilson joined as a Research Fellow. Subsequently, he detailed the role of the chaplain from the perspective of medical and nursing staff, ward clerks, patients and chaplains, using semi-structured interviews and questionnaires. Arguably, this enabled him to provide a theological and ecclesiological evaluation of the chaplain’s role although Swift contests this. Swift claims (2009: 47) that Wilson, by prefacing the data with introductory theoretical essays, selective biblical references and theological assumptions was pre-determining his theological and ecclesiological frames of reference. While directing serious questions at those involved in chaplaincy, a new experience for the chaplaincy world, it remained deductive and opinion-based. Nonetheless, the research, published as The Hospital – a place of truth, became a standard and influential text on chaplaincy (Woodward, 1998: 124).

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38 As a medical practitioner, Wilson worked in Africa. Later, as an Anglican priest he served in a London parish before becoming lecturer in pastoral studies at Birmingham University. Interestingly, Wilson did not practise as a healthcare chaplain.

39 The Primary Task of the Hospital; the Meaning of Health; the Hospital – a source of Beliefs about Man and Society; The Primary Task of the Church in a Hospital; and the Hospital: Fragmentation and Conflict.
For the purposes of my own research, Wilson’s view that ‘[t]he role of the hospital chaplain, like that of his master, is to be an enigma’ (Wilson, 1971: 57) might be usefully explored in terms of his later call for the chaplain’s role to ‘first be described in ontological terms’ (Wilson, 1971: 102). Although I will argue that ‘who the chaplain is’ informs ‘what the chaplain does’, I hold to Wilson’s emphasis on the word ‘integrity’ (Wilson, 1971: 55), by which he infers the holding together not only of health and sickness but more significantly the sacred and the secular.

Twenty-five years on, the context of healthcare chaplaincy has markedly changed, as two researchers clearly demonstrated. Beckford and Gilliat studied how the Church of England related to other faiths and regulated their participation in public life. It was a project that looked at chaplaincy in prisons and health care organisations, as well as the practice of religion in civic life, and where ‘all political challenges, conflicts and negotiations of a religiously and culturally diverse society can be observed in miniature’ (Beckford and Gilliat, 1996: 5). As a sociological investigation, part-funded by the General Synod of the Church of England, a variety of methodological approaches was used: quantitative, qualitative and ethnographic. The 109 healthcare chaplains who responded to the questionnaire (55% response rate), and those interviewed in twelve healthcare facilities, confirmed a changing context: chaplaincy reconfiguring itself around a more inclusive multi-faith philosophy of service. This, Beckford and Gilliat found, was a change welcomed by some and resisted by others. Particular relevant to my own line of research was their observation that chaplains had a greater sense of professional identity. Chaplains credited this to management responsibilities which had now become part of their work, and a growing recognition of their professional standing in the workplace.

While Beckford and Gilliat were undertaking their research, a seminal study by Woodward was investigating ‘the world view and work of the acute health care chaplain’ (Woodward, 1998: 13). Similarities with Wilson’s research (1971) stand out, especially the recognition that in straddling the two worlds of Church and hospital there is unavoidable tension. Woodward described hospital

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40 This is perhaps unsurprising given that, in 1990, Woodward was appointed Senior Chaplain to the Queen Elizabeth Hospital in Birmingham and later wrote that ‘[Wilson’s study] has shaped practice, particularly at the Queen Elizabeth Hospital, Birmingham, by... the present author’ (Woodward, 2000a: 21)
chaplains as an enigma not only to themselves, but to the Church and the world of healthcare. Faced with what he perceived to be institutional insecurity, Woodward noted that chaplains felt they were continually battling with misunderstandings over ‘who they are’ and ‘what they do’. When interviewees reflected on their role and identity, Woodward (1998:265) was struck by the presence of mild anxiety and self-preoccupation which led him to question why such anxieties had not been resolved as part of ministerial formation. Allied to this was what Woodward (1998: 238) termed a ‘philosophic pragmatism’ and a discomfort with traditional models of theology. ‘Chaplains were invited to reflect on theological influences on their work but few responded in any detail’. As advocates of professionalism and focused on outcomes which were skills-based, chaplains appeared to have abandoned theology because, for them, it did not relate to or engage with the reality of their contextual experience. At best, theological influences were implicit rather than explicit (Woodward, 1998: 208). Even when traditional theology was brought to bear, Woodward considered this to be comparatively unsophisticated, citing Speck (1988: 19-26) as one example (Woodward, 1998: 143).

It is as if the fundamental knowledge base of theology, which would make health care chaplaincy distinctive, is a useless tool in the attempt to move the ministry of the health care chaplain to an acceptable professional base within the Health Service. Perhaps in a desire for security, the chaplain prefers to adopt and appropriate many of the cultural norms prevalent within the organisation of health care itself (Woodward, 1998: 276).

The influence Woodward has had on the development of my own research will become apparent, highlighting, as he does, many of the issues that are as current today as they were nearly two decades ago. Principally this can be expressed as ambivalence, in terms of ministerial or priestly identity, professionalism, religious faith, spirituality divorced from religious language and concepts, as well as a knowledge-base which might critically value and seek to apply explicit models of theology in ways that are authentic, relevant and creative.

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41 Woodward (1998) interviewed fifteen whole-time acute hospital chaplains: twelve Anglicans, one Baptist, one Methodist and one Roman Catholic.
One unavoidable weakness of Woodward’s research was the fast-changing nature of the NHS following the election of a Labour administration in 1997. Orchard’s investigation, in 2000, into the performance of healthcare chaplaincies in London was undertaken with an eye to changing government policy. It was no coincidence that the title of her research, *Hospital Chaplaincy: Modern, Dependable?* mirrored that of the Department of Health’s White Paper, *The New NHS: modern, dependable*, which set out the Government’s plans for the NHS. With a background in both NHS management and theology, Orchard provides a penetrating analysis using a two-stage methodology. An initial postal questionnaire targeting every Trust in the London area (n=57) was followed up by week-long case studies in five acute Trusts. The questionnaire response rate was 79% representing 83% of the Trusts approached. The research question, underlying and informing the methodology, asked: ‘[w]hat service models can be identified for chaplaincies in acute London Trusts and to what extent can their performance in meeting the needs of the local population be assessed?’ (Orchard, 2000: 14). When Orchard’s report was published, it read as a damning indictment of religious and spiritual care in the NHS: there was no definitive service model; no set of agreed operating standards and no cohesive vision for chaplaincy across the different Trusts. The nub of this research was its focus not on the *chaplain* but on *chaplaincy* and a more corporate or service oriented exploration. Orchard did not concern herself with the chaplain’s role and even less with ‘the ontology of the practitioner’ (Orchard, 2000: 13). Given this, it has only limited relevancy to my own research.

Since Orchard’s work, there have been several other contributions to research in healthcare chaplaincy using quantitative methodology e.g. Wright, 2001 who explored the way chaplains perceived spiritual care infrastructure and the spiritual care requirements of patients; Hancocks, Sherbourne and Swift, 2008 who looked at the significant factors influencing Church of England clergy to become healthcare chaplains; and Robbins, Francis, Hancocks and Swift, 2009 who applied psychological type theory in their consideration of the personality characteristics of Church of England healthcare chaplains. The most recent and significant contribution to NHS chaplaincy research remains Swift’s doctoral thesis, published as *Hospital Chaplaincy in the Twenty-*
first Century: the Crisis of Spiritual Care on the NHS. This delved into the current crisis surrounding the nature of spiritual care and the problems experienced by chaplains working within the evidence-based culture of the NHS. The juxtaposition of the Church and the NHS, through the lens of healthcare chaplaincy, gives an informed and politically astute investigation within a theoretical framework provided by Foucault, auto-ethnography and practical theology. Particular significant was Swift’s overt objective: ‘to examine who chaplains are, and ask whether their identity and concerns are in any way connected to an ambiguous status within both health care and their endorsing faith communities’ (Swift, 2014: 6; my italics). Although his extensive historical analysis is a useful reminder that, frequently, hospital chaplains have had to adapt to different successive narratives of the sick, Swift draws a parallel with modern healthcare.

He critiques the Department of Health document, NHS Chaplaincy: Meeting the Spiritual Needs of Staff and Patients as laying the basis for a remodelled chaplaincy in which identity was located not in credal or theological faithfulness but in the NHS. ‘Those who seek the service are consumers of faith-based products, and chaplaincy must therefore be branded and graded according to a centrally determined set of standards’ (Swift, 2014: 63f.). A second Department of Health document, NHS Chaplaincy: Caring for the Spirit, which set out a ten year development programme for chaplaincy was, for Swift, a means of redesignating the chaplain as an expert delivering spirituality in a management-style straitjacket of assessment, care planning, care delivery and review (Swift, 2014: 64). At the heart of both documents Swift observed an uncritical re-appraisal of who the chaplain was, inasmuch as what the chaplain does in the modern hospital cannot be separated from who the chaplain is. With his acknowledgement that in an age of uncertainty, chaplains can feel ambivalent and self-conscious, Swift conceded that insecurity itself ‘can breed renewed self-awareness and questioning which, if it is not paralysing, can lead to ministry which is fruitful, relational, adaptive and compassionate’ (Swift, 2014: 172). This is an empowering comment and one that has encouraged me to reflect, theologically, on the identity of the healthcare chaplain in partnership with chaplains at the coalface.
1.6.2 What this research adds

While the credentials of my own research can be traced back through Swift (2008) to Woodward (1998) and then Wilson (1971), its origins are to be found in the work of Mason and discussions he held with Church of England priests in the 1970s about self-supporting ministry. In a remarkable paper, Mason considered this group of priests ‘whose style of life differs markedly from that to which most of us are accustomed and which is still that of most parish clergy’ (Mason, 1998: 257). Those priests were not hospital chaplains but what today the Church of England calls ‘self-supporting ministers’, i.e. ordained priests who do not receive a wage, salary or stipend for their priestly ministry. However, a number of observations that Mason makes have clear ramifications for a theological enquiry into the meaning of priesthood and the ordained Church of England health care chaplain.

First, there is the issue of terminology and what job title is given to those priests who do not receive a wage, salary or stipend for their priestly ministry: non-stipendiary minister (but this could include those who belong to religious communities); worker priests (but the French model of worker priest is very different to the ministry model of the banker, police officer or teacher who is also a priest); or minister in secular employment (but there are those who are retired or who have been made redundant). Terminology is rarely neutral but reflects or conveys a particular mind-set or preconceptions or assumptions. ‘Choice of one term rather than another may perhaps constitute a declaration of interest, and this may be clear to the person making the choice or it may be concealed from him’ (Mason, 1998: 257). The hospital chaplain may describe themselves as hospitaller, healthcare chaplain, Trust chaplain, or spiritual care giver/provider/adviser. The crucial point, and one which has implications beyond mere job labels, is that priests who exercise ministry in a healthcare setting need to be able to interpret themselves to others, and indeed to themselves, with authenticity.

Second, and despite fresh expressions of Church (Mission and Public Affairs Council of the Church of England, 2004), the model of ministry most associated

\[42\] Mason’s article was written in 1975, at a time when the Church of England only ordained men to the priesthood. 40
with the Church of England priest is one rooted in the parish. This encapsulates a functional view of ministry, which is not only limited but mistakenly assumed, by many, to be definitive. It also reflects a view of ministry in which clergy have or, some might argue, had a recognized place in the social fabric of a community and society. ‘If we try to think in normative terms, as best we can we may say that the parish is to the clergy person what the manor is to the squire; the geographical and social context in which their social status is expressed. It gives meaning to the rank conferred on a person by ordination, by ensuring that there is a community which will respond to his or her actions, and respect their status’ (Woodward, 1998: 77f.). Given the social stability of pre-modern times, a model based on the parish priest’s role might have been all that was needed to uphold a person in his ministry. Within this role, theology might determine priorities, ascertain opportunities and manage suffering. It would not be called upon to assess and appraise any radical re-statement of the role. When the vehicle of priesthood is at variance with, or challenges, the traditional or accepted expressions of priesthood, a theological understanding of what it means to be a priest is critical: ‘a theology which the individual priest can refer to himself as the key to understanding his own vocation and by whose guidance he can order his response to the social situation around him’ (Mason, 1998: 262).

Finally, there is the need to provide an adequate, and again authentic, theology which will encompass the totality of a priest’s life as well as ministry in whatever setting. In this respect, Mason draws attention to Ramsey’s influential and classic interpretation of priesthood, *The Christian Priest Today*. One particular phrase stands out: the ‘inward meaning of all ordained priesthood’ (Ramsey, 1972: 4) which looks behind role and function to that of which role and function are merely an expression.

In my research I listened attentively to the voices of a group of Church of England priests as each shared a theology of both priesthood and healthcare chaplaincy. I was less concerned with whether those voices were articulate or struggling to find appropriate words, whether they expressed cogency or were still searching for meaning. My interest lay in learning from their experience and interpretation of priesthood, of which role and function are expressions.
Enquiries have been made of Church of England priests by a variety of disciplines e.g. sociology, psychology, and anthropology, but there has been a dearth of research in which Church of England priests in active ministry have been asked to share their personal theological understanding of priesthood. In the field of healthcare chaplaincy, a comparison of the questions asked by Wilson (1971), Woodward (1998) and Hancocks, Swinbourne and Swift (2008) show that none of these researchers directly asked their interviewees about priesthood, either its experience or its theology. Among parochial clergy, the research of Warren (2002) carried out between 1996 and 2000, looked at the way clergy lived and the problems with which they are confronted. Questions addressed how clergy perceived the role of the priest and what meaning it had for them, but the objective was to assess their emotional needs. A further study (Peyton, 2009) explored the enduring vocational commitment to ordination vows of contemporary Church of England clergy. While it examined personal and social experiences and their meanings, the focus was on the complex character of vocational work and how clergy embody priesthood in an enduring vocational commitment.

My own objective is not to promote the validity of one theology, nor attempt to construct a composite theology. Rather, in seeking to recognize the distinctiveness of each voice, my objective is to provide a rich, thickened description which, while making no claims for reproducibility, enables themes to be detected. While it is for others to determine whether the themes which do emerge resonate with their own experience, in which case there may be a degree of generalizability and transferability, my aim is to consider how those themes might contribute to a theology of priesthood.

1.7 A Summary
The research objective and questions have been introduced, establishing the nature and direction of this study in exploring the congruence of two identities, the Church of England priest and the NHS healthcare chaplain, co-existing in the one person. It has been argued that the research method, of which the

43 For her research Warren (2002) carried out an initial pilot study, in the form of a questionnaire sent to 347 parish clergy in two dioceses in England, after which sixty incumbents were interviewed.
focus is the contextual voice of the NHS priest-as-chaplain, is well served by a research methodology rooted in the descriptive and interpretative paradigm of practical theology. The background, development and complexities of practical theology, and its relationship to practical philosophy, have been documented, as too its value as a strategic tool by which the complex dynamics of practice might be unravelled. The decision to interrogate the data by use of qualitative analysis has recognized both its preferred status in partnering practical theology and an essential difference between the two: that for practical theologians, the nature of truth is accessible through revelation, a claim social scientists would dispute.

Having established the methodological credentials of the research, attention has been directed at the environment within which healthcare chaplaincy operates: the opposition of the NSS, the intervention of the BHA, an emerging awareness of spiritual needs, the implications of a professionalized healthcare chaplaincy service, the place of multi-faith religion and the recognition of non-religious or secular spirituality. In addition, the political backdrop to the NHS, and its influence on the development of healthcare chaplaincy, has been investigated. In assessing what is already known in this area of research, Mason’s paper is credited (1998) in which he calls for a dual-purpose theology: one which enables each priest to interpret his or her vocation and which also acts as a resource for the priest to determine an appropriate response to the demands of the context in which vocation is practised. Finally, in anticipating the original contribution this thesis will offer, it is noted that what research has been published, in which Church of England priests have reflected on the nature of priesthood, has been directed at the emotional and vocational struggles encountered by the priest (e.g. Warren, 2002).

1.8 Developing the Thesis
Having described both the methodology which will guide this research and the context within which the research questions have arisen, what follows is a review of the background, circumstances and literature surrounding the identity of the NHS chaplain. There are the many metaphors which have been used to describe the work of the healthcare chaplain. What might these reveal about the self-understanding chaplains bring to their work, role and identity? Arguably,
chaplaincy has developed in response to Government policy and to those changes which have taken place in society as a whole. In this respect, while retaining its Christian stance, NHS chaplaincy has embraced religious and belief pluralism as well as adopting secular models of spiritual need. What bearing has this had on the identity of the chaplain as someone shaped by a specific faith tradition?

Having documented how and why chaplaincy has changed, the insights offered by the social sciences need to be acknowledged: the related theories of socialization and social constructionism and their role and influence in the process of identity-formation. There is, of course, a further critical issue championed by postmodernists who question the existence of personhood as a single and continuous entity, in itself a central and non-negotiable premise of theological anthropology. Reconciling these differences may seem as daunting as attempting to square the circle. Despite this, I consider it a profitable line of enquiry as I explore theological categories which might frame the identity of the NHS priest as chaplain.
Chapter Two: Theoretical Issues and the Development of Personal Identity

2.1 Introduction

In this chapter, I will begin to survey published literature which relates to the nature of the identity of the NHS healthcare chaplain who is a Church of England priest: the NHS priest-as-chaplain.

Initially (§2.2.1) I will explore the uncertainty surrounding the identity of the chaplain (Mundle; Wright; de Vries, Berlinger and Cadge) and catalogue the self-descriptive images chaplains have used to sculpt an identity (Faber; Willis; Foskett; Macritchie; Moody; and Hanson). One question I will address (§2.2.2) is the extent to which that identity has changed in emphasis and direction over the lifetime of the NHS and possible factors that have contributed to that change (Cobb; Speck; Swift; and Engelhardt).

I will evaluate two theoretical perspectives, socialization (§2.3.1) and social construction (§2.3.3), and the part each has played in developing an understanding of identity. Advocates of organizational socialization (Jarvis; Van Maanen and Schein; Chao, O'Leary-Kelly, Wolf, Klein and Gardner; Jablin; Kramer and Miller; and Cohen) claim that it provides a conceptual framework with which to understand the acquisition of knowledge, skills and culture. A social constructionist approach (Berger and Luckmann; Stam; Alvesson and Sköldberg; Christiansen; and Lave and Wenger) holds that each person has a plurality of identities dispersed throughout his or her social environment, constructed and co-constructed as each person engages in different activities. I will take the insights of both these approaches and apply them to what is known about the personal and workplace narratives of chaplains: first (§2.3.2), the extent to which socialization might explain the cultural variance that appears to exist between the chaplain and the church (Swift; Engelhardt; and Stewart) and second (§2.3.4), the place of social constructionism in decoding the dialogical variance between ecclesial and secular ‘life priorities’ (Pickard; Avis; Castle and Drane).
In demonstrating ways in which the social sciences have significantly advanced our understanding of how identity might be formed and influenced, I will assess the challenge this presents for theological anthropology (§2.4.1). The human sciences, in an age of post-modernity, have deconstructed the notion of a unified inner self which for generations of philosophers and theologians stood as a seemingly inviolable principle: the ‘self’ construed as either the core of personhood given by God, timeless and authentic, or as a socially-constructed though stable ego. In the existentially challenging narratives of the postmodern world, I will evaluate the concept of ‘self’ as fluid and liminal, constantly reshaped by our roles and relationships. I will argue that the work of those Christian theologians who have been critical of modernity’s obsession with individualism (McFadyen; White; Thiselton; and Gunton), have still to engage constructively with the concept of the plural self in its various forms. To what extent is the unity of the self a theological premise that is non-negotiable, guarding against compromise or rapprochement with the proposition that the self is fragmented or multifaceted? Is it that in allowing the prospect of a plural self, the central tenets of Christian belief concerning the *imago Dei*, human nature and sin are emasculated? In acknowledging the disparity between secular and theological approaches to the concept of identity, and in the absence of any prospect of an inter-disciplinary consensus, I will weigh up what the dialogue itself might offer.

Finally (§2.4.2), I will gauge the insights of one theologian, White, who reviews the workplace as an expression of covenant faithfulness and political community based on trust and fidelity to a common purpose. Faced with the reality of a beleaguered NHS chaplaincy service, I will investigate moral and theological concerns confronting the identity of the NHS priest-as-chaplain posed by White’s analysis.

2.2.1 Healthcare Chaplaincy: the identity of the chaplain
Although Beckford and Gilliat (1996) claim that the healthcare chaplains they questioned in the mid-1990s had a confidence in their professional identity, evidence suggests that this was misplaced or transitory. Within a short period, uncertainty attended the chaplain’s call to be accepted as a healthcare
professional.\(^1\) The precipitating factor, according to Swift, was New Labour although he also cites the decision by the UK Information Commissioner to end the routine practice of NHS Trusts providing chaplains with patients’ religious details.\(^2\) For some chaplains, what was at stake was simple pragmatism: access to crucial information. For other chaplains, it was a matter of ‘theological identity and ecclesiological belonging’ (Swift, 2014: 58).

For NHS priests-as-chaplain ‘theological identity and ecclesiological belonging’ may be thought to reside in the fact that they are priests ordained by the Church of England. The model of ministerial priesthood that epitomizes the Anglican priest is one located in the parish system, ‘conceived as the most authentic manifestation of Church (Brown, 2011:3). That there are differences between parochial clergy and chaplains, and that these have given rise to tensions, have been generally acknowledged (Slater, 2015: chapter five passim; Brown, 2011: 3ff.; Threlfall-Holmes and Newitt, 2011: 39; Legood, 1999: xii). Among the differences, Thelfall-Holmes and Newitt (2011: 36f.) highlighted the transient nature of those populations and relationships to which chaplains are exposed; the irrelevance of congregational worship as a measure of ministerial success; the need to respond to pastoral situations with creative and imaginative liturgy not found in most prayer book; and the expectations that the secular institution might have about the work of the chaplain.

In contrast, Mowat and Swinton (2005: 28) claimed that any perceived difference between healthcare chaplaincy and parish ministry might be a ‘myth’ generated by healthcare chaplains to validate the distinctiveness of their role. This was despite the fact that their own interviews with forty-four chaplains clearly demonstrated that chaplains perceived there to be differences between hospital and parochial ministry.\(^3\) Compared with parish-based ministry,

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1 see §2.4.2.
2 This became the subject of an adjournment debate in the House of Commons in which Yvette Cooper, Parliamentary Under-Secretary at the Department of Health, defended the decision citing ‘much wider questions about the definition of health professionals and the way in which they are classified’ (Hansard, 2002: column 220WH).
3 This study by Mowat and Swinton (2005) was based on interviews with forty-four full time healthcare chaplains in Scotland of whom thirty-three were Church of Scotland ministers. The remaining research participants were Episcopalian (3), Roman Catholic (1), Baptist (3), Free Church (1), Anglican (1) and Methodist (1). It needs to be noted that the ecclesiology of the Church of England and the Church of Scotland differs. Instead of bishops, the Church of Scotland has a Presbyterian system of governance with a hierarchy of courts. The authority of
chaplaincy was characterized as tending to be side-lined in the workplace leaving chaplains more isolated; that its focus on ‘spiritual needs’ meant ‘agenda-free’ pastoral care; that there were fewer administrative tasks; and while its pastoral encounters might be more acute chaplains were able to ‘escape’ their place of work. For Mowat and Swinton, such perceptions were simplistic and the situation more complex than their participants assumed. I will return to this study in a later chapter (§7.3.3)

What else might inform the identity of the chaplain? A lack of acceptance is not confined to healthcare chaplains, but may be exacerbated with chaplains expected to move between various identities and roles, sometimes acting more as existential counsellors than as faith representatives (Mundle, 2011: 176). This generic approach to chaplaincy, with the implication it holds for spiritual, ontological and moral claims (Engelhardt, 1998: 231), will be discussed in greater detail later in this chapter (§2.2.2). At this point, what is at issue is the effect this diversification might have on role clarity.

these courts is similar to the authority the Church of England invests in its diocesan bishops. In addition, the organization of healthcare chaplaincy in Scotland is different. So, for example, in order to provide and develop more standardised and appropriate training opportunities for healthcare chaplains and spiritual care providers, the Healthcare Chaplaincy Training and Development/ Spiritual Care Advisory Unit was established by the Scottish Executive Health Department in 2001. This was made possible by the devolution of the NHS in Scotland to the Scottish Government in 1999.

4 In the UK Parliament (House of Commons), the following Early Day Motion, was tabled on 26/01/11 and addressed the regulation of Clinical Physiologists: ‘That this House welcomes the valuable contribution that clinical physiologists make to patient care in the NHS; notes their importance in developing and delivering a wide range of sensitive diagnostic and therapeutic procedures directly to patients in the disciplines of audiology, cardiology, gastro-intestinal physiology, neurophysiology and respiratory physiology; further notes with concern that, despite the Health Professions Council's recommendation in 2004 that clinical physiologists should be statutorily regulated and this advice being accepted by the Department of Health in 2005, statutory regulation has not yet been put in place; recognises the value of the current voluntary register which has been compiled and administered by the Registration Council for Clinical Physiologists; understands the Government's direction of travel that voluntary regulation is the preferred way forward for most new healthcare professions, but believes that, because of the potentially highly invasive nature of clinical physiologists’ activities, voluntary registration does not provide patients with enough protection against those who are unfit to practice; regrets that some of the delay appears to have been caused by the Department's otherwise worthwhile plans to better integrate the wider healthcare science workforce through Modernising Scientific Careers; and calls on the Government to publish a clear timetable for a draft Section 60 Order which will take forward statutory regulation as soon as possible to minimise the ongoing risks to patient safety’ (UK Parliament, 2013). This matter is still outstanding. On 24th April 2013 a group of organisations representing nearly 10,000 unregulated healthcare professionals, including the Registration Council for Clinical Physiologists, the Association for Cardiothoracic Surgical Assistants, and the Institute of Medical Illustrators, launched the Alliance for Patient Safety in order to achieve statutory registration (Registration Council for Clinical Physiologists, 2017).
Role uncertainty becomes intensified when practices which were previously familiar, well-rehearsed and dependable are swept away (Wright, 2001: 237). There is the paradox that role uncertainty can encourage a person to assume more and greater responsibility, beyond contracted boundaries, leading to role ambiguity. It is a dilemma for the chaplain who accepts a ‘vacuum identity’, plugging the gaps that emerge among the jobs of other healthcare workers (de Vries, Berlinger and Cadge, 2008).

Perhaps the uncertainty surrounding the identity of healthcare chaplains accounts for the many metaphors and images that chaplains have used to express and interpret the essence of their ministry, highlighting perspective, relations, directions, distances, causality, characteristics and values. Prominent among these is one introduced by Faber, comparing the role of the healthcare chaplain to that of the circus clown. Perhaps more than comic relief, the clown is a reminder of human frailty and weakness. The audience engages with the clown because they relate to the clown’s humanity. Just as the presence of the clown impacts on the atmosphere within the circus ring, so too the presence of the chaplain impacts on the atmosphere of the hospital: ‘being’ takes precedence over doing (Faber, 1971: 92).

Faber observes that the chaplain often finds ‘role’ a confusing and uncertain concept but claims this can motivate the chaplain to confront fundamental questions. What are the essential characteristics of pastoral care? What needs does it uniquely meet? What opportunities present themselves to those engaged in this crucial ministry? (Faber, 1971: 89) As Faber envisages it, a hospital-based pastoral ministry is the setting within which the chaplain, as a representative of Christ, identifies with the person who suffers. The chaplain offers a pastoral solidarity and supports the patient in her search to become one who risks believing in herself because, through the chaplain, she has experienced the realization that Christ believes in her (Faber, 1971: 90). This kindles hope as well as a willingness and ability to be in solidarity with others. For Faber, this representation of Christ speaks of an innate way of ‘being’: an ontological, all-pervading attitude.
Similarly, Wilson, in his influential study published the same year as Faber’s, concluded that the chaplain must be conceived ontologically, in terms of who the chaplain is rather than what the chaplain does (Wilson, 1971: 102). Autton, the ‘father of modern chaplaincy’ (Orchard, 2000: 10; Swift, 2014: 44), reckoned it was important for the chaplain to first address the question ‘Who am I?’ Unless the chaplain possesses a degree of self-insight, it will prove difficult to answer the question ‘Who is the patient?’ The chaplain needs to possess self-understanding or self-knowledge in order to negotiate the projections of patients who may perceive the chaplain to be an authority figure, a miracle worker or a problem solver. Without self-insight, the chaplain risks identifying with a delusory self-image or projecting themselves on to the sort of image she believes she ought to convey, and then spends her time trying to achieve it (Autton, 1968: 30).

Other images have proved as equally evocative as Faber’s clown. Willis depicts the hospital chaplain as scatologist and, less sensationally, as sitter, seedpicker, stargazer, sistership and storymeister (Willis, 1999: 391). However, one image he offers is particularly telling: the chaplain as God’s spy. This is inspired by some words from Shakespeare’s play, King Lear: ‘And take upon us the mystery of things, As if we were God's spies’ (Lear act v, scene iii). Willis considers the presence of the chaplain, in the middle of the night, called to attend a patient. What, Willis ponders, might others make of the chaplain walking the corridors of the hospital at such an hour, and voices, rhetorically, their bemusement: what has the chaplain to offer the patient that necessitates a visit at dead of night? The answer that Willis provides is at first sight evasive: that there is more to the chaplain than might initially seem the case. The apparent furtiveness of the chaplain is a distinguishing mark, for in the language of Shakespeare, the chaplain’s purpose is bound up in the mystery of things, as if God’s spies (Willis, 1999: 394).

Reviewing this notion of the chaplain as God’s ‘spy’, Mundle is critical. Not only does it raise questions about the specifically public role of the chaplain’s ministry, it implies that a chaplain does not need to be a transparent,

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5 Willis is a healthcare chaplain in the United States.
6 Mundle is a healthcare chaplain in Canada.
accountable and committed team player: instead, what is presented is an ambiguous, enigmatic person privileged and set apart from other healthcare colleagues (Mundle, 2011: 178). For that matter, the idea that a chaplain is somehow ‘set apart’ may convey a sense of distancing, even disinterest in healthcare collegiality. Foskett, a respected mental health chaplain in the UK, writing six years before Willis, considered the work of the chaplain to be concealed, a pastor and witness in but not of the healthcare system (Foskett, 1993: 20). In this respect, is there a more disturbing aspect to this hidden, clandestine identity that Willis and Foskett perceive? If chaplains believe that their advocacy work on behalf of patients could bring them into conflict with their healthcare organization, they may choose to fly under the radar: flying under the radar may be a means to avoid detection but, more importantly, it may also prevent a pilot being shot down by the enemy. If chaplains believe that advocacy on behalf of patients is too risky or exposed and not ethically appropriate, unsafe policies are unlikely to be challenged (de Vries, Berlinger and Cadge, 2008). A series of interviews with healthcare chaplains practising in England in the second half of the 1990s, led Woodward to conclude that many chaplains were indeed hesitant about adopting the role of saboteur, mole or whistle-blower. This, he attributed, not to any sense of wanting to avoid conflict with managers, but something possibly more worrying: chaplains seduced by a belief in the implicit goodness of the institution and its culture. For Woodward, this threatened a crisis of theological proportions (Woodward, 2000b: 26). More recently, however, Morgan has explored advocacy-type interventions among contemporary healthcare chaplains and, in this respect, has noted similarities between the work of the chaplain or spiritual care coordinator and independent advocates. This has led him to propose that both disciplines might benefit from sharing practices and training (Morgan, 2011: 214).

Among the many extraordinary observations that have emerged through the use of metaphor, the question of parallel realities is striking. To what extent is the healthcare chaplain confronted by two different, potentially conflicting

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7 Under the Health and Social Care Act, 2012 (s. 43 and s. 55), local authorities have a duty to arrange Independent Mental Health Advocacy and Independent Mental Capacity Advocacy services. Independent Mental Health Advocates assist people who are subject to a compulsory order under the Mental Health Act, 2007. Independent Mental Capacity Advocates practice a form of non-instructed advocacy safeguarding vulnerable adults.
realities, and needs spiritual wisdom or discernment to distinguish between alternative, sometimes opposing views, perceptions and interpretations? In other words, is the chaplain a mediator between disconnected or parallel realities? Reflecting on a series of conversations with elderly people from the Highlands of Scotland, conversations that took place in their native Gaelic language, enabled Macritchie to more fully appreciate that there was something quite profound at work in translating Gaelic, both the language and the culture (as arguably the two are inseparable) into the language and culture of the modern healthcare milieu (Macritchie, 2001: 206). The chaplain as ‘translator’ is located in that space between subject and object which Winnicott, an object relations theorist, termed ‘transitional space’, a space of experiencing, between the inner and outer worlds of the child to which both worlds contribute and in which primary creativity, or illusion, exists and can develop. It is the place of transitional objects: transitional in the sense that the omnipotent baby, where ‘me’ and ‘not me’ have yet to separate, can begin the process of relating to that which eventually will be perceived objectively. The ‘transitional object’ becomes the first ‘not-me’ possession, and although symbolic of a part-object, it is important in that it is neither the baby nor that object. In adulthood, there is continued relevance and value in this concept of transitional space. Winnicott maintains that God exists in this third space, an ‘in-between’ area of experiencing where inner reality and external existence co-exist; a ‘place apart’ for the never-ending human task of maintaining a separation of inner and outer reality while allowing for the inter-connectivity (Winnicott, 1971: 230). Ulanov marks out this transitional space as ‘clergy space’ where the challenge for the Christian, and especially for clergy, is to wrestle in the gap8 (I would add much like Jacob wrestled with Yahweh9) where all our knowing becomes unknowing (Ulanov, 1988: 54). For Macritchie, the chaplain as translator is the person who enables the discovery of meaning in this gap, the transitional space: meaning is uncovered and recovered by a process which is, in essence, a spiritual exercise (Macritchie, 2001: 209).

8 Ann Ulanov’s work develops the image of a ‘gap’ that has increasingly come to replace ‘space’. While ‘space’ affords the distance and distinction necessary for identity and creative connection both to self and other, ‘gap’ occurs when the distance becomes too great for connection and thus too great for identity formation that depends on connection. (Thullbery, 2008: 84).
9 Gen. 32:22-32.
'Space' also appeals to Moody who considers a number of metaphors based on the 'wilderness' experience of chaplains, who surrender a church-based environment for one in which people are met on their own turf. In this outreach work, space for God-talk needs to be negotiated, a principle which those working within the pre-conceptions of parish relationships are likely to discount or overlook (Moody, 1999: 16). Ministry in the secular institution requires the chaplain to be both participant and observer: experiencing the same social, psychological, physical and spiritual demands as others yet attentive to situations which precipitate those selfsame demands. How is the chaplain to understand or read what is shared? Whether it is a healthcare colleague, patient, family member or friend, the importance the chaplain gives to each relationship can be measured by her spiritual awareness of what the other person is seeking. More often than not, the boundary between what is religious and what is secular can be difficult to discern (Moody, 1999: 23).

Drawing on biblical episodes, such as Elijah experiencing God in the wilderness\footnote{1 Kings 19:1-18.} and Jesus perceiving 'waterless regions' as the place of unclean spirits,\footnote{Matt. 12:43-45.} Moody reflects on the nature of wilderness as the terrain of spiritual engagement and confrontation: the province of demonic forces which, by the nature of their presence, ensures that God too will make himself known (Moody, 1999: 17). Echoing both Willis (1999) and Foskett (1993), Moody is persuaded that within secular institutions, such as prisons, military establishments or hospitals, where definitions are allocated and roles are allotted, the chaplain must remain an 'outsider', possessing a statusless status which is both precarious and privileged (Moody, 1999: 19). The chaplain mediates between the institutional, secular reality and the non-institutional, spiritual reality. In this respect, the chaplain has more in common with the shaman, a 'spirit person' frequently written off as a charlatan. Yet it is the shaman who can recognize the shallowness of society's apparent secularism: 'a riotous unreason at least as virulent as the crass scientism which dismisses all signals of transcendence as mere superstition on a par with the tooth fairy' (Martin, 1997: 7). In fact, the contradictory description, 'statusless status' was first used to describe the African shaman. It captures the essence of both social position and societal
function. The prophet beyond the city walls who owes nothing to group structures and relationships, accords and obligations. For this reason, the shaman-prophet-healer can assert an authority of indifference, not bound by social ties but liberated to judge, censure and mediate between individuals and within factions (Turner, 1969: 116-117).

The chaplain is also perceived, by Moody, to be the contemplative who embraces the stillness of passivity, surrendering the noise of incessant activity in order to allow calm discernment to disclose what is profound in the detail of the offhand comment or trivial episode (Moody, 1999: 21). Whether this is better captured in the representation of the chaplain as ‘watcher’ or as ‘prophet’, Moody detects a close relationship between the two and illustrates this in three ways. First, in life-threatening moments requiring life-changing decisions, the chaplain may act as intermediary, like a midwife. Second, where an institution is under-resourced, failing to prioritize a significant area of need, the chaplain may initiate a service e.g. bereavement care. Third, where institutional culture makes unreasonable, unwarranted and unjustifiable claims on staff in terms of their time, loyalty, behaviour and values, the chaplain is the one called to question and challenge. However, if the chaplain lacks the confidence to adopt a more nuanced approach, is too accepting of all that takes place in the name of the institution, the role of ‘critical friend’ is lost, to the detriment of the institution (Moody, 1999: 22).

Once again, remarkable insight breaks through such imagery. Particularly striking is Moody’s image of the chaplain as midwife,\(^\text{12}\) in part because it provides an alternative to those metaphors of ministry associated with male gender roles. However, Hanson, a midwife and chaplain, perceived a number of parallels in her two vocations. Acknowledging the work of Hammer (1994), who demonstrated the extent of midwifery imagery in the biblical account of God’s work, Hanson makes reference to the biblical story of Shiphrah and Puah,\(^\text{13}\) two midwives who imperil their lives by refusing Pharaoh’s instructions to kill the male babies of Hebrew women so evoking the image of God as midwife who delivers Israel from slavery (Hanson, 1996: 50-51). Another passage to which

\(^{12}\) cf. Rom. 8:19-25.

\(^{13}\) Ex. 1:15-22.
Hanson alludes is Acts 2:24 and the translation of this verse, by Hammer, which underlines the birthing imagery absent in many translations: ‘God raised [Jesus] up, having loosed the birth pangs [ὡδίνας] of death, because it was not possible for him to be held by it.’ In this fashion, Peter proclaims that, with the birth pangs of Jesus in his death and resurrection, a new age has dawned: imagery which is at the heart of the first Christian sermon, delivered on the Spirit-filled ‘birthday’ of the Church. With it Peter aptly communicates the creative purpose of Jesus’ terrible death: it was not a scandalous dead end, but rather labour pains bringing forth new life (Hammer, 1994: 64). In bringing to mind the vocation of the priest to represent the divine, to hold the presence of God before the people, the illustration of the midwife has innate rapport: the chaplain alongside people in their labour, in partnership with God as new life, new understandings, new possibilities open up which nourish and inform a person’s hope, meaning, purpose and direction and present a ‘new vision of what it is we are called to be and to do’ (Hanson, 2005: 208; my italics).  

In these and other images of the chaplain the question so often addressed is one of identity: who is the chaplain? Identity is a prime driver for those who seek to promote chaplaincy as a profession, and by way of professionalization resolve issues of role confusion and ambiguity. How realistic is this, though, when chaplains are prepared to be gap-fillers, making good service deficiencies within health provision, and laying themselves open to the charge that they are bolstering a role which no longer retains the parameters which defined their service in 1948? In order to lay claim to an area of responsibility, the chaplain first needs to declare, more precisely, what their responsibilities are (de Vries, Berlinger and Cadge, 2008) but, in this respect, there has been a radical shift of emphasis concerning the underlying role of the chaplain. This I turn to in the section that follows (§2.2.2).

2.2.2 Healthcare Chaplaincy: identity and the spiritual care adviser

In the earliest days of the NHS, the chaplain’s role in the hospital was to

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14 Gill Mack (1998: 325-328), a self-supporting deacon writing originally in 1990 before the ordination of women priests in the Church of England, refers to the imagery of the midwife. This pre-dates the work of Hammer and Hanson. For Mack, the meaning of representative ministry, in supporting the task of the ministry of the whole people of God, is informed by the language of labour, intimacy, bearing and bringing to birth.
proclaim the Christian gospel (Cox, 1955: 85) and to offer the Christian Faith and all its benefits (Thomas, 1955: 19). Today, chaplaincy delivers ‘spiritual care’, language the NHS uses to encompass religious, pastoral and spiritual aspects of healthcare (Cobb, 2005).

Spirituality has long been recognized as having a place within the NHS. In 1948, a Ministry of Health circular, RHB(48) 76, instructed hospital authorities to provide for the spiritual needs of both patients and staff although at that time it would probably have been synonymous with ‘religion needs’. Four decades later, in the 1990s, it is possible to detect a growing distinction between the terms ‘spiritual’ and ‘religious’. The Patient’s Charter, introduced by the Conservative government in 1991, stated that all health services should make provision for a patient’s religious and cultural beliefs (Department of Health, 1991). The wording reflected and spurred a growing debate about what spirituality entailed (Pattison, 2001: 37). The next year, further guidelines for the NHS, Meeting the spiritual needs of patients and staff referred to contracting with ‘religious or spiritual organisations’ (Department of Health, 1992). In 1996, the National Association for Health Authorities and Trusts (NAHAT) produced a document entitled Spiritual Care in the NHS: A guide for purchasers and providers which acknowledged that, potentially, every person had spiritual needs (NAHAT, 1996). By 2003, and the next guidance, NHS Chaplaincy: Meeting the Religious and Spiritual Needs of Patients and Staff, reference is made to ‘chaplaincy-spiritual care’. The reframing of chaplaincy into spiritual care was complete.

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15 NAHAT brought together NHS authorities, health boards and NHS Trusts into one representative body dealing with the separate and collective views of purchasers and providers. It lobbied government ministers and other decision makers. It merged with the NHS Trust Federation to form the NHS Confederation in March 1997.

16 This owed much to the work of Oluseye Olumide, an experienced hospital chaplain, and was commented on in draft form by Robert Clarke, Secretary of the HCC.

17 Perhaps ‘almost complete’ is to be preferred, given that in 2014, the Multi-Faith Group for Healthcare Chaplaincy, which was the principal adviser to the Department of Health on matters of healthcare chaplaincy, was renamed the Healthcare Chaplaincy Faith and Belief Group. This was to enable non-religious groups to be members and observers (Burleigh, 2014). Two years later, it became the Network for Pastoral, Spiritual and Religious Care in Health in order for it to be more inclusive, describing what it does rather than who it represents (Hodge, 2016). It remains the principal adviser to NHS England, an executive non-departmental body, to which the Department of Health transferred some of its work in 2014.
What often is not made explicit, I would hold, is the influence Speck had in this field.\textsuperscript{18} A prominent figure in the world of NHS chaplaincy, he introduced the notion that a deeper spiritual dis-ease might need to be addressed in the context of a caring relationship. An acknowledged influence on Speck was Frankl (1991 [1946]), the founder of logotherapy\textsuperscript{19} and a holocaust survivor, who claimed that the meaning of life was found in every moment of living; that life never ceases to have meaning, even in suffering and death. Speck (1988: 31f.) developed this idea within the context of pastoral care, maintaining that a patient may have a personal philosophy which has enabled her to make sense of life but which has nothing to do with religion. In this case, effective pastoral care would be about recognizing and responding to the spiritual as well as the religious need.

It must remain a matter for speculation whether, within NHS chaplaincy, the emergence of an agenda relating to spiritual need was associated with a growing awareness that the Church of England and other Churches numerically were in decline (Davie, 1994; Bruce, 1995; and Brierley, 1999).\textsuperscript{20} On admission, hospital patients might still identify themselves as ‘Church of England’, but this might be a matter of cultural rather than religious affiliation. As Speck (1988: 33) points out, although it is easier to elicit religious as distinct from spiritual needs, with a fall in church attendance, religious needs e.g. bedside communion recede making the religious role of the chaplain at best marginal or, at worst, immaterial. Given this situation, to what extent did chaplaincy need to re-assess its raison d’être?

\textsuperscript{18} Although see Woodward (1998: 115ff.).
\textsuperscript{19} The main principle behind logotherapy (a form of existential analysis) is the belief that what primarily motivates and drives each person is the search for meaning in that person’s life.
\textsuperscript{20} Recent findings suggest that between a quarter and a half of the population of England are disconnected from any faith community. The demographics of religious affiliation in Western society indicate that there has been a considerable shift in religious identity and attendance. In England, Scotland and Wales, the annual survey \textit{British Social Attitudes 28}, published in December 2011, revealed that half of those people surveyed (n=3000) did not regard themselves as religious (NatCen Social Research, 2011: 173). This is markedly different to the 2011 British census which notes that approximately 25 per cent of the population of England and Wales reported no religion (n=14.1 million) (Office for National Statistics, 2012). The difference between these two sets of statistics may be due to question wording, the response options offered and the context in which the questions were asked (NatCen Social Research, 2011: 174). What is not in dispute is the significant number of people in England who have no knowledge, understanding or experience of any religious faith.
The process which resulted in the 2003 Department of Health Guidance began in 1998. As Swift (2009: 62) recounts, it served the needs of a government promoting social inclusion and chaplaincy groups anxious to gain political backing in safeguarding and extending the role of chaplaincy. The future of chaplaincy lay in developing multi-faith provision and raising an awareness of spiritual need in the absence of religious need. Professional healthcare chaplains, it has since been argued (Swift, Handzo and Cohen, 2012: 185), are equipped to respond to all indications of spiritual need, whether this is expressed within a religious faith or existentially in terms of hope, anxieties about isolation, and the need for contemplative silence.

Such a broad understanding of spiritual care raises the question of what qualifies the NHS priest-as-chaplain to provide ‘secularized’ spiritual care devoid of faith content. Is it that the NHS priest-as-chaplain is conscious of the need to be recognized as the expert professional when it comes to that distinct brand of secular spirituality now promoted not only by the professional healthcare chaplain but more significantly by other healthcare disciplines (Crisp, 2008; Casey, 2009; McSherry and Ross, 2010; Royal College of Nursing, 2011; McSherry and Jamieson, 2011)? What, then, does one make of the proposition that the identity of the chaplain is shaped by a specific faith tradition of which the chaplain is an iconic representative? For one observer, denominationalism has come to be regarded as a form of aesthetic preference (Engelhardt, 2003:152) with institutional expectations not only re-defining the character of vocation in some generic sense (Engelhardt, 1998:232), but impacting on identity.

Healthcare chaplains may assume a responsibility and expertise for those people who profess no religion but who, arguably, have spiritual needs, but to what extent can they avoid, negotiate or surmount the religious (sub)text that is written into their quasi-professional role as priests or ministers and which, potentially, colours the perception of non-religious people who are in a state of spiritual dis-ease? My own experience, and that reported elsewhere, would suggest that it is because chaplains can be perceived as arriving at the bedside pre-packaged by religion that some patients decline a referral to chaplaincy (Greenstreet, 2006: 50). This uneasiness, uncertainty or typecasting of who the
chaplain is and what the chaplain does not only has an effect on the response of individuals, patients and staff, but can have a bearing on the perception of the NHS as an institution. Increasingly, NHS employers are advertising for Spiritual Care Advisers. In referring to this trend nearly ten years ago, Flanagan (2007: 6) drew attention to an advertisement for the post of ‘Interfaith and Spiritual Care Manager’ in a high security hospital. He suggested that the absence of any mention of a ‘chaplain’ in the advertisement was telling, and implied two things: that the Church of England’s claim to a national responsibility for the cure of souls was no longer recognized, and in addition, that its narrow understanding and interpretation of spirituality was failing to meet the needs and expectations of the times.

While healthcare chaplains, and their professional associations, promote chaplaincy as primarily responsible for the spiritually-inclusive well-being of NHS healthcare communities, it is noteworthy that it was left to McCarthy (2010), the Church of England’s National Adviser for Medical Ethics and Health and Social Care Policy, to call the NHS to account for its legal obligations under Article Nine of The European Convention on Human Rights as established under UK legislation and The Human Rights Act (1998). This stipulates that the member States and their agents (e.g. the NHS) take appropriate and practicable steps to facilitate religious beliefs and practices. Both McCarthy (2010) and Swift (2012) have used data provided by Clayton (2010), and gathered from seventy-three health providers in England between 2007 and 2009, to support the claim that a significant number of NHS in-patients are unable to practise their faith as they would choose.

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21 For example, in March 2013 Central London Community NHS Trust (the Pembridge Palliative Care Centre) advertised for a Chaplain/Spiritual Care Adviser.
22 Church Times (26 November 2004).
23 ‘Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance. Freedom to manifest one’s religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.’
24 Swift advised me that there was an error in his data (2013: personal communications) although the overall point he makes is still valid. McCarthy’s data seems more reliable. He writes: In 2009/10, there were 14,537,712 hospital admissions in England. An analysis... indicates that, on average [over the years 2007-2009], 22% of patients identified belief as ‘an issue’ while in hospital, 17.7% of patients wished to practise their religion, 2.1% reported that their beliefs were not fully respected and 2.9% were not able to practise their religion as they
What has been demonstrated thus far is the uncertain attempt by those who represent healthcare chaplaincy to establish the nature of that identity which gives meaning to the person who fulfils the role of the healthcare chaplain. I would argue that the uncertainty is in large part due to a failure to question, explore and develop an account of the nature of identity, as a phenomenon, which for my purposes provides the basis for an investigation into the identity of the healthcare chaplain. This I address in the sections which follow.

2.3.1 Identity and Socialization

The nature of identity is amorphous, elusive and contested as are the related concepts of selfhood and personhood. They are used, often interchangeably, depending on the adopted frame of reference and context be it anthropology, philosophy, psychology, psychoanalysis, sociology or theology. No one discourse alone can speak for all (White, 2002: 44), an important caveat for what follows.

No matter how broad these concepts may be, constantly evolving in ways which preclude rigid definitions (Ashmore and Jussim, 1997: 5), self and identity require clarification. A sociologist might claim that a person contains within themselves several identities associated with different roles and relationships they perform (Stets and Burke, 2005: 132). The social psychologist might seek to distinguish self from identity by explaining self as a process and pattern which comes about through self-reflection, and identity as a means or strategy by which persons or groups order and present themselves to others (Owens, 2006: 206). These two positions have common features but disparate lines of research. The theologian, recognizing the complexity of human identity, does well not to confuse matters further by using, in an indiscriminate way, two other terms directly related to it: selfhood and personhood (White, 2002: 44). It can be difficult to unravel the terminology which presents something of a minefield.

Nonetheless, there is one phenomenon, socialization, which finds a place in the

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had wished. Using the 2009/10 NHS statistics, this translates into absolute figures of 3,198,297 patients for whom belief was 'an issue', 2,573,175 patients who wished to practise their religion while in hospital, 305,291 patients who reported that their beliefs were not fully respected and 421,594 patients who were not able to practise their religion as they had wished (McCarthy, 2010).
vocabulary of most of the social sciences (Kesebir, Uttal and Gardner, 2010: 94) and provides one tool by which to view self and identity. Conceptually, it has received a mixed review being regarded, on the one hand, as one of the vaguest terms in social science (Brezinka, 1994: 2) and yet, on the other hand, clearly understood in its use by social scientists and the public alike (Morawski and St. Martin, 2011: 1). Generally, it is understood to be a process which accounts for the norms, customs and ideologies as well as the individual skills and learning within society.\(^{25}\) In childhood, primary socialization concerns the inculcation of attitudes, values and behaviours derived from significant, often parental, relationships. Secondary socialization, a subsequent stage of integration into wider society, occurs when a person becomes part of a new group e.g. changing school or employment.

In studying the identity of the NHS priest-as-chaplain in the workplace the notion of organizational socialization, a tertiary process (Jarvis, 1983), is particularly important. It owes much to the seminal work of Van Maanen and Schein (1979) who sought to establish a descriptive conceptual system of interconnected theoretical statements by which the structure and effect of organizational socialization processes might be understood (Van Maanen and Schein, 1979: 213). Organizational socialization enables an employee to learn the knowledge and skills necessary to fulfil an occupational role (Chao, O’Leary-Kelly, Wolf, Klein and Gardner, 1994: 730). By revealing the socialization process within an organization, it can become apparent how new recruits discover and assimilate an organization’s culture (Jablin, 2001; Kramer and Miller, 1999).\(^{26}\)

Professional socialization, for its part, addresses the process by which a person receives initiation into a role-based identity. Skills, knowledge, and attitudes, essential to the performance of the role, are learned. Associated norms and values are internalized which can determine future behaviour and a person’s

\(^{25}\) Given Brezinka’s negative assessment, it is important to acknowledge what Saks wrote nearly five years later. ‘Many of these criticisms have been addressed with methodologically sound and conceptually rich studies in the past 5 years’ (Saks, 1997: 235).

\(^{26}\) One influential model of this process (Feldman, 1976) proposed three stages: getting in (or anticipatory socialization) during which the potential employee acquires information about the organization e.g. using websites; breaking in (or accommodation)\(^{26}\); and settling in (or role management) at which point the employee is recognized as a fully fledged insider (Bullis and Bach, 1989).
self-concept (Cohen, 1981: 14). It is a process which, unlike organizational socialization, gives a person entry to a range of organizations, spans a career and is constantly evolving. Nonetheless, as two constructs, organizational and professional socialization are closely related.

In the next section (§2.3.2) I explore ways in which the concept of socialization might inform a more nuanced understanding of the chaplain’s identity.

2.3.2 Socialization and the identity of the NHS priest-as-chaplain

Essentially, socialization acts to mould the identity of the new employee as the culture of the workplace becomes assimilated: a culture composed of organizational mores, values, rituals, traditions, and mutually-held perceptions (Herrmann, 2008: 11). Of course, for the healthcare chaplain this may be at variance with the culture of the Church or the culture of the Christian gospel or both.27

Swift (2009: 159f.) refers to the counter cultural nature of the chaplain’s work, which in all likelihood NHS management would neither endorse nor condone.28 In fact, given the evidence-based world of modern medicine, it might seem that the chaplain has little to offer which would inform the core priorities of the institution itself. Gone are the days when the chaplain provided the moral compass and carried responsibility for fund-raising.29 Interestingly, the same sense of disconnectedness might hold for the chaplain amid the prevailing culture of the Church. Research (Hancocks, Sherbourne and Swift, 2008) suggests that, by and large, chaplains experience a sense of alienation from the

27 An example of assimilation may be discerned in the programme Agenda for Change (AfC) that the Labour government introduced in 2004 to overhaul working patterns and productivity within the NHS, as well as modernise the pay structures. AfC developed new roles and new ways of working for one million NHS employees, including healthcare chaplains. Two key AfC components were job evaluation (the process of matching jobs to national profiles) and a new career development structure known as the Knowledge and Skills Framework (KSF) defining the knowledge and skills required for NHS staff to work efficiently in their jobs delivering quality services. Arguably this represented an enculturation into the ethos and values of the secular NHS and a distancing from the ethos and values of the Church (NHS Employers, 2011).

28 See earlier (§2.5.1) when I discussed Willis’ metaphor of the healthcare chaplain as God’s spy and Foskett’s contention that the chaplain is in but not of the healthcare system.

29 Before the inception of the NHS, when healthcare was provided by private and voluntary hospitals, charitable sermons in aid of the local hospital were fashionable. This led, in 1873, to the founding of the Metropolitan Hospital Sunday Fund which co-ordinated and redirected annual giving to hospitals. ‘The pulpit was co-opted to preach the gospel of hospital funding, systematically publicising medical relief to motivate benevolence’ (Waddington, 2000: 51).
institutional and hierarchical Church. This has caused them to be described as refugees (Swift, 2014: 74) estranged, for example, because of liberal or radical views or issues related to human sexuality. Whether chaplains are in same-sex partnerships or married to another ordained person, these and similar issues make them a liability from which the Church has chosen to distance itself (Swift, 2014: 158).  

Indeed, some chaplains claim to have experienced the Church as abusive: an abuse emanating from the hierarchy, the dogmatic posturing and a rejection of emotions that for some are core to their identity and personhood (Swift, 2014: 162). Given Swift’s analysis, this would suggest a serious relational rift and absence of meaningful communication between the leadership of the Church of England and its ordained representatives in healthcare chaplaincy.

Added to which, healthcare chaplaincy has made a determined effort to assert its own professional credentials, primarily in terms of spirituality rather than as a faith representative, and so claim a role-based identity. This has meant clarifying those skills, knowledge, and attitudes, essential to the performance of the role, as well as identifying norms and values e.g. by way of a Code of Conduct, which guide behaviour and, by internalization, determine a person’s self-concept. However, framing chaplaincy as a professional group can carry negative connotations: a case of being professionalized or re-professionalized into roles which have no denominational point of reference (Engelhardt, 1998: 232); or professional in order to collude with an objectified view of humanity which serves the needs of the institution (Stewart, 2003: 6); or to secure legitimacy and so enable the chaplain to feel more secure in the institutional setting (Stewart, 2003: 7). Professional socialization might seem to prioritize function at the expense of ontology and therefore place it at odds with, for example, a catholic understanding of Anglican priesthood.

30 On 12 April 2014, a healthcare chaplain employed by the United Lincolnshire Hospitals NHS Trust, Jeremy Pemberton, was the first priest in the Church of England to be married to a same sex partner in defiance of the House of Bishops’ Guidelines, Pastoral Guidance on Same Sex Marriage (House of Bishops, 2014) (Davies, 2014: 2).

31 Although Engelhardt is here commenting on the role of the healthcare chaplain in the USA, it resonates with the role of the chaplain in some Healthcare Trusts in England.
The process of socialization, however, is much debated: is it a product of structural determinacy (behaviour primarily influenced by social context) or individual agency (conscious and subjective choices made as a participant rather than an observer of behaviour) or reflexivity (an act of self-reference: a person both shaping and being shaped by a given behaviour so neither can be deemed cause or effect)? To this binary equation of agency and structure there is an alternative approach, social constructionism, which I explore in the next section (§2.3.3).  

2.3.3 Identity and Social Constructionism

Social constructionism encompasses a number of different approaches which have emerged since the publication of Berger and Luckmann’s influential work in 1966, and which also draw on the insights of other schools of thought (Stam, 2001: 294 citing Berger and Luckmann, 1966b). Social constructionism is not a single synthesis (Elder-Vass, 2012). Rather, as a school of thought clustered around a central premise that all meaningful reality is socially constructed (Crotty, 1998: 42), principally through social discourse, it offers an increasingly important perspective within the social sciences (Alvesson and Sköldberg, 2010: 15) Human existence is a social activity if only because *homo sapiens* is, at one and the same time, *homo socius* (Berger and Luckmann, 1966: 69). The action of social discourse and the structure it creates interact dialogically: each person is a producer and the social world is what is produced. It is a dialectical relationship with each acting upon the other (Berger and Luckmann 1966: 78).

This has been described as a process of externalization, objectivation and internalization. Externalisation takes place when a person acts upon the world,  

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32 I would point out that both socialization and social constructionism have been subject to criticism. Significant in this has been a perceived dualism, and the philosophical problems that this raises: ‘epistemological riddles... about how external and internal reality are connected (Gergen, 2001: 123). Others (Cromby and Nightingale, 1999: 7; Gergen, 2001: 3) have censured its relativism, pre-occupation with critique and too narrowly defined contribution to social understanding.

33 Social construction or constructionism and constructivism are distinct. While both hold that knowledge is not absolute and cannot be divorced from the knower, constructivism emphasizes cognitive processes and the social milieu, in contrast to the constructionist’s focus on ‘discourse, dialogue, coordination, conjoint meaning making, discursive positioning and the like’ (Gergen, 2001: 124).

34 For example, the application of social constructionism has ranged from feminist to political theory and from literary to media theory but, as Elders-Vass (2012: 5) remarks, some have been more plausible than others.
perhaps producing an idea or initiating a practice. This is then externalized e.g. by placing it within a story or making it the subject of a book. Having entered the social realm it then assumes a life of its own being re-told or read. The original idea or practice becomes an ‘object’ of consciousness now endowed with factual existence or truth. Perceived to be part of the ‘natural order of things’, it has achieved an objectivity which veils its subjective origins located in the assumptions and interactions of human beings. Later generations accept it *de rigueur*, internalised as part of both their consciousness and understanding of the world as it is and always has been (Burr, 1995: 10).

The same processes that enable the construction or internalization of the socially objectivated world are also deployed with the internalization of socially allotted identities. By a process of socialization, a person becomes *that* specific person inhabiting *that* specific world. It is the same dialectic, between the individual and those significant others who determine the individual’s socialization, which creates subjective identity and subjective reality. Simply put, who a person becomes will be framed by key relationships (Berger, 1969: 16). Furthermore, the many expressions of self located in and delineated by a particular social setting, e.g. the family, the place of work or the neighbourhood community, demonstrate that our identities are dispersed throughout our social environments being constructed and co-constructed as we engage in different activities. These identities not only define who a person is, but are projected into a person’s social world. This allows the integration of a range of selves, which constitute the individual, in ways that have meaning both for the individual and others (Christiansen, 1999: 583). It provides a comforting story (Hall, 1992: 277): comforting, because in an age of uncertainty, characterized by a loss of predictability, fragmentation of experience, diversity of lifestyles, dissolution of structural categories (Giddens, 1991: 37), and at a time of rapid transition which may feel chaotic (Gergen, 1999: 195), the experience of identity can be profoundly affected.

Collaboration between an anthropologist, Lave, and a computer scientist, Wenger, went further, providing an empirical basis for considering an additional dimension in the construction of reality, more along the lines of social constructivism and social learning theory. It was a concept they called
communities of practice. In a study designed to establish how apprenticeships aid learning, Lave and Wenger (1991) observed that when people join an established group or community, they will attend to what other group members are doing, and possibly undertake work that is straightforward or easy, as they learn how the group operates (its relationships, activities, identities and artifacts) and what they themselves might contribute. Wenger, later, discarded some of his initial assumptions, instead focusing on the nature of communities of practice.

The notion of a community of practice is the simplest social unit possessing the general characteristics of a social learning system such as self-organization, dynamic boundaries and ongoing negotiation of identity and cultural meaning. It generates an organic process which produces tensions around meaning, time, space and power and these are captured in four dualities. The Participation-Reification duality addresses meaning which is created through participation and active involvement in a practice. Reification concretizes what can be a complex and ill-defined practice by using concepts, methods, stories and documents to make an abstract and discrete representation. This enables both sharing and participation within the community. The Designed-Emergent duality recognizes that a practice is not the result of a design but a response to it. Designers can plan an activity which is designed to achieve a particular purpose, but what is produced through community interaction and participation will be unplanned and may indeed conflict with what designers intended. It is the community members who negotiate and renegotiate meaning. The Identification-Negotiability duality describes the process by which individuals construct their identities both individually and communally and bring together power and belonging as they shape the community. Finally, the Local-Global duality deals with how one community of practice relates to another, sharing knowledge specific to one community that will be of relevance to another.

Concepts such as boundary objects, brokerage (Wenger, 1998: 106) and

[35] The concept of community of practice does not exist by itself. It is part of a broader conceptual framework for thinking about learning in its social dimensions. It is a perspective that locates learning, not in the head or outside it, but in the relationship between the person and the world, which for human beings is a social person in a social world. (Wenger, 2010: 179).
boundary encounters (Wenger, McDermott and Snyder, 2002: 84) are used to explain the interrelationship of different communities of practice.

Of these four dualities, the principal one is participation-reification which, in providing a social history of learning, gives rise to a community of practice as participants define a ‘regime of competence’: those criteria and expectations which confirm a communal relationship. Competencies include the ability to understand the community’s purpose and its place in the world (joint enterprise); the ability to act constructively and consensually with other community participants (mutual engagement); and the ability to use the routines, language, ways of working and stories within the practice of the community generated through its history of learning (shared repertoire) (Wenger, 1998: 72-73; 2010: 180).

Wenger (2010: 186) claimed a causal link between identity and participation in communities of practice. Full membership of a community of practice assigns a person the right to negotiate meaning, including ways of being a person within that community. As a person engages in practice, experiences of participation are framed, a community observes and responds and so a person is reified as a participant. Identity thus emerges through a layering of participation and reification. In this respect, identity is both collective and individual. It is shaped both ‘inside-out and outside-in’: what a person actively negotiates for themselves and yet which is influenced by others. Both participation and non-participation in communities of practice affect individual identity since identity reflects not only who a person is but who a person is not.

However, the dilemma social constructionism presents is its twofold assertion that a person appropriates the world in dialogue with others and that both identity and the world have meaning for that person only while the conversation ensues (Berger, 1969: 16). Wenger’s ‘community of practice’ provides a possible resolution to this dilemma for within a community of practice there is the finding, sharing, transferring, and storing of knowledge, and the right to determine ‘expertise’, or tacit knowledge, i.e. important context-based experiences that cannot readily be captured, codified and stored. Additionally, Wenger (2010: 186) understands learning as a journey across a trajectory of
landscapes of practices. There is engagement, as well as the use of imagination and alignment, as an identity gradually forms becoming ‘personalized reflections of the landscape of practices’.

An additional question for social constructionism is the extent to which it furthers an understanding of the specific workplace identity of professionalism, an employment status that has pre-occupied healthcare chaplains since the 1950s (Swift, 2014: 42). Clouder (2001) was among the first to explore the role social practices might play in transforming undergraduates into professional people, drawing on Gergen’s social constructionist position that it is communal interchange, as against intrinsic processes within the individual, which is important for ‘individual functioning’ (Gergen, 1994: 68). Clouder (2001: 267) argues that on entering the social world of a profession, it is primarily direct dealings with others that clarify what a professional identity entails. Nonetheless, social constructionism provides for both structural determinacy and individual agency. A profession is structured by its membership which determines what takes place within the profession and facilitates the socialization of the novice professional. Put succinctly, individuals construct their profession which in turn constructs the individual professional.

This brief outline of social constructionism does raise pivotal issues. First, social constructionists believe that because identities are social they must also be multiple. Gergen (1991) writes about the ‘saturated’ or ‘populated’ self. This Wong (1999: 80) disputes. He asserts that ontological existence and the inner experience of the first person ‘self’ present social constructionists with an insoluble problem, denying a person the ‘right of self-expression and self-determination’. So, is the notion of a unified, monolithic self untenable in a postmodern world? What are the implications for Christian theology? These questions I will explore later (see further in §2.4.1). Second, the sociological analysis of professionalism, which took place in the twentieth century, largely ignored the emerging insights of socialization and social constructionism. To what extent have these insights influenced what has been called an era of new

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36 Walsh argues this volubly: ‘... the degree to which members of society are agents of their own existence and their relationships with one another is quite minimal, since not only are their actions determined by their position within structures and institutions, but so too are their thoughts, values and interests’ (Walsh, 1998: 11).
professionalism and eclipsed the twentieth century analysis? In chapter four I will review how sociology has analyzed professional work (§4.3.1) and the emergence of new professionalism (§4.4.1). Third, social constructionism holds that the production and construction of social realities are closely related to language, both conceptually and empirically. This suggests a discourse of professionalism. Again, I will examine this in more detail in chapter four (§4.3.2). However, in the next section (§2.3.4), I begin to discover what this might mean for the NHS priest-as-chaplain as she builds a hybrid world in conversation with others.

2.3.4 Social constructionism and the identity of the NHS priest-as-chaplain

From a social constructionist perspective there are significant implications for the dual identities of the NHS priest-as-chaplain if one accepts the premise that a person builds the world in conversation with significant others, and that an identity and the world can only have meaning while that conversation continues (Berger, 1969: 16).

This claim, that reality is created through social discourse in dialogical relationships, might well have a bearing on Cobb’s contextual model concerning the location and identity of healthcare chaplains (2004). According to Cobb, the identity of the chaplain is one which is socially negotiated. It is a continuous dialogue between the different perceptions of what constitutes the identity of the chaplain: on the one hand the perceptions of the chaplain and, on the other, those communities to which the chaplain relates i.e. the healthcare community, the disciplinary community and the faith community. Because each of these communities plays an important part in validating and determining the location and identity of chaplains, a complex interrelation of identities and associations is generated which can prove enigmatic for some healthcare professionals but which may also allow for the chaplain’s ‘unique and creative contribution to healthcare’ (Cobb, 2004: 14).

In contrast, clericalism would appear to operate within the acommunal bias37 of

37 ‘By ‘acommunal bias’ is meant the prevailing ethos of modern culture that favours individualism, competitiveness, and personal independence. What is presupposed is that the
modern Western thought and social life.\textsuperscript{38} There is a separation of clergy and laity. As Canon C. 12 claims for the ordained person of the Church of England: ‘No person who has been admitted to the order of bishop, priest, or deacon can ever be divested of the character of his order, but a minister may either by legal process voluntarily relinquish the exercise of his orders and use himself as a layman, or may by legal and canonical process be deprived of the exercise of his orders or deposed therefrom’ (Church of England, 2015). Authority and power is vested, primarily, in those who are ordained. By the laying on of hands an individual is set apart. This understanding of orders, as being the prerogative and preserve of the individual singled out from the community, is reflected both in the Catholic tradition of ontology and the Protestant paradigm of function. At ordination, from an ontological perspective, the spiritual essence of a person is changed or marked in some distinctive way, while from a functionalist perspective, tasks and responsibilities invariably become the province of the minister despite the fact that many of these could be fulfilled by any lay member of the ecclesial community (Pickard, 2009: 159).

However, this does not necessarily exclude a social constructionist approach to priesthood in which it can be argued that the reality of priestly identity is created through the social discourse of a dialogical relationship. Indeed, this constructionist construal of priestly identity might appear to have a close affinity with the notion of priesthood as a relational entity (Zizioulas, 1985).

More crucially, the identity of the Church of England priest and the identity of the Church are entwined and, in recent decades, both have been called into question. In terms of the Church, the concern is with its purpose in the context of a late modern or postmodern society: a lost ideal which, within present ecclesial structures, the Church struggles to regain (Pickard, 2009: 179). In Anglicanism, the absence of a focal ecclesiology has generated cynicism (Avis, 2000: 10). Even the Church of England’s National Officer for Evangelism\textsuperscript{39} questioned whether ‘ecclesiological software’ needed radical updating in a

\begin{itemize}
\item individual unit is self-contained and self-determining. In such a context, community is seen as necessary for the satisfaction of the individual, who is considered to be completely autonomous. Community is necessary but not intrinsic to being’ (Uniting Church in Australia, 1994: 14)
\item Swift (2004: 9) argues that the quandary for healthcare chaplains, with all the tension that surrounds their sense of identity and future direction, can be attributed to an Enlightenment model of professional identity presumably on the basis of its emphasis on individual freedom.
\end{itemize}
clerically dominated Church of England which was inward looking and unable to connect with ‘whole life issues’ consuming modern culture (Castle, 2004: 14). Yet, if the premise is accepted, that the Church of England in common with all institutions is a socially constructed reality which acts to both enable and constrain individual identity (Herrmann, 2008: 9), its confusion around meaning, purpose and direction, as well as its preoccupation with issues which do not engage with younger generations, will directly and negatively impact on the identity of its clergy. The Church, it is claimed, needs to reinvent itself if it is to engage with contemporary society (Drane, 2000: 3).

This, of course, is only part of the narrative of identity. In the foregoing sections, I have illustrated how the social sciences have significantly advanced an understanding of how identity might be formed and influenced. However, no one all-embracing understanding of identity has emerged despite the paradigmatic shift that identity has undergone in the past few decades (Sӧkefeld, 1999: 417). That shift, brought about by postmodernity’s incredulity toward metanarratives (Lyotard, 1993: xxiv), has seen the dismantling of the idea of individual personhood, that each person is a single and continuous entity. In its place has emerged the concept of the plural self which Christian theology regards as an aberration. It would appear that the unity of the self is a theological premise which is non-negotiable (Turner, 2008: 9). This I investigate in the next section (§2.4.1).

2.4.1 Identity and theological anthropology

In the West, it was a premise captured by Descartes in his first principle of philosophy, cogito ergo sum: that the self is the ‘substance’ constituting thought. If a person is defined in terms of mind and not body, in other words a person is considered to be their mind, a non-physical substance, the relationship between time and personal identity becomes established by the persistence of this non-physical substance. This is despite any ongoing change that may take place in the substance of the physical body with which it is associated. Descartes (2012 [1641]: 75f.) maintained that, in contrast to the

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40 Although it is claimed that Descartes’ use of the phrase je pense had a stronger metaphysical connotation in his earlier publication, Discourse (1637), than the phrase cogito in his later publication, Meditation (1641), it became paradigmatic for post-Cartesians that the self had a full and permanent existence (Marion, 1999: 34f.).
body, the mind does not have any parts and so cannot be subdivided. It is with the whole mind that one thinks, wills and doubts all of which represent different ways of thinking, rather than separate parts of the mind.

While this metanarrative of individual personhood pre-occupied generations of philosophers, it was with postmodernity that the enigmatic paradoxes and contradictions posed by ‘the problem of the self’ proved a fatal challenge to the assumptive basis of selfhood. Rejecting the premise that the self can be simultaneously ‘me’ and ‘I’, the object of the experience and the experiencing subject, the source and product of identity, the Cartesian self has been deconstructed, giving rise to the notion of a plurality of selves, fluid and liminal (Schmidt, 2012: 200), a chameleon or double-faced Janus but, in the final analysis, a differentiated and complex entity (Salgado and Hermans, 2005: 3).

Identities may relate to the past and what once was an accurate reflection of a person, to the present and who a person is in the here-and-now, or to the future and what a person would expect or aspire to become, feels compelled to attempt to become, or fears she may become. Identities can be social markers, provide meaning or direct attention (Oyserman, 2007, 2009a, 2009b). More radically, within a post-structuralist narrative, the self is no longer the source and the foundation of knowledge but rather the outcome of networks of power and discourse (Foucault, 1980: 98), or a terminal of multiple networks (Baudrillard, 2002: 128). No single metanarrative spans the range of theories advancing the notion of the plural or fragmented self – nor could there be – but each has played a part in furthering contemporary self-understanding. The notion itself, however, has polarised theologians. Movements like the Sea of Faith41 and Radical Orthodoxy,42 from their different theological perspectives, have welcomed the demise of modernity’s framework of metanarratives and discarded traditional concepts of enduring and unified selves and identities (Turner, 2008: 21). Other theologians (Pannenberg, 1985; Moltmann, 1990; and

41 Sea of Faith is a movement promoting a non-realist understanding of religion. In rebutting all supernatural beliefs, it holds that God has no objective or empirical existence, independent of human language and culture, although God is a potent symbol, metaphor or projection. An important influence has been the theology of Don Cupitt.
42 Radical Orthodoxy critiques and rejects the secular sciences arguing that the perspective they offer is atheistic and nihilistic. Instead, it seeks a return to traditional Christian doctrine. John Milbank’s book, Theology and Social Theory (1990) is regarded as a seminal text for Radical Orthodoxy.
McFadyen, 1990) in rebuffing modernity’s espousal of individualism, have still retained the idea of a unified, and in particular, social account of personhood.\(^{43}\)

For theologians, an understanding of human identity, recognizing what is significant and distinctive about each human being, remains problematic and yet unavoidable when faced with questions about body and soul (Murphy, 2006a; Cortez, 2010: 68ff.), gender (Gonzalez, 2004; Cortez, 2010: 41ff.), free will (Murphy, 2006b; Cortez, 2010: 98ff.) or the meaning of human life (Cooper, 2008). These are anthropological questions which most theologians would answer in terms of a person defined and determined by a relationship to God (Cortez, 2010: 5), a God of revelation and a God of redemption (Cameron, 2005: 54). It has been claimed that from the early Church Fathers onwards, anthropology was not a primary concern but a by-product of doctrinal development in areas such as soteriology, ecclesiology and eschatology (Turner, 2008: 1; Cortez, 2010: 3). Whatever the merits of such a claim, it does throw into sharp relief the emergence, in the twentieth century, of theological anthropology as a discipline in its own right. Powerful advocates for a theocentric theology, e.g. Barth, von Balthasar, and Pannenberg, asserted that by creating humanity to be the object of his covenantal relationality and eschatological purposes, God communicated the value he placed on each human life within the divine scheme of creation.

Yet what is human life or, more specifically, the nature of the human person?\(^{44}\) This has become a pivotal issue for theology and the principal task of theological anthropology in addressing questions such as ‘why is personhood important for an understanding of humanity?’; ‘what does it mean to be a self?’; and ‘how is personal identity formed and sustained?’. Such questions cannot be de-contextualized from the world or divorced from the range of experiences a person lives day-to-day. While the question, ‘what is a person?’, may seem straightforward, there are many different perspectives from which an answer might be sought. Indeed, Moltmann (1974: 4) contends that the nature of such a question requires comparisons to be made since abstract conceptualization is

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43 Earlier social accounts of personhood can be found in the writings of Buber (2004 [1937]), Bonhoeffer (1959 [1937]) and Barth (2010 [1948]).

44 As the psalmist writes, ‘What are human beings that you are mindful of them, mortals that you care for them?’ (Ps. 8:4, NRSV).
not viable. Should a distinction be drawn between the *what* question and the *who* question: who, rather than what, is a person? A *what* question might seem to address the distinctiveness of human personhood in a world of creatureliness while the *who* question seeks to differentiate one human being or group of human beings from another. In which case, it must be with the *who* question that the issue of ‘identity’ lies (Turner, 2012: 71f.). Ricoeur (1990) widens the debate still further in maintaining that the *who* question contains two distinct aspects of identity: *idem* identity and *ipse* identity. The former, a diachronic perspective, emphasizes sameness or the permanence and continuity of identity, and the latter, a synchronic perspective, focusing on the unique sense of self a person has about her own being (Leerssen, 2007: 335).

In navigating questions surrounding personhood and identity, theological anthropology seeks an ongoing if critical dialogue with partner disciplines from the domain of anthropology, especially sociology and psychology. There is no compromise on its fundamental premise, that authentic human living can only occur in relationship to God, but theological anthropology shares its propositions and assumptions in order both to inform and be better informed by the insights of those partner disciplines. A line is seemingly drawn, however, at the possibility that a person might have a plurality of identities or selves and simultaneously retain a sense of well being and individual integrity. Among others, Thiselton (1995), White (1997) and Grenz (2001) offer a theological critique of sociological and philosophical models of self-fragmentation which, to all appearances, assumes the principle that the divine intention is personhood as a unified being. Accordingly, the claim is made that plural selves, created not by God but by a process of societal instrumentalization, objectification and distortion, have led to dysfunctional isolation and fragmentation. Unfortunately, since theological anthropology, in general, takes the conceptual unity of the self as non-negotiable, the reasons for resisting notions of the plural self and pathologizing self-fragmentation, are rarely made explicit.

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45Secular anthropologists face a corresponding predicament. A narrow understanding of self-multiplicity (which excludes self-unity) cannot explain the nature of personal identity (Salgado and Hermans, 2005: 3). A broader understanding, conceptualizing the individual both as a vehicle of multiple, qualitatively distinct ‘selves’ and a one, ensures meaningful coherence, distance itself from modernism’s unified self and provides an element of subjectivity (Rowan and Cooper: 2).
Instead, recent theological debate has focused on the social configuration of the self and the conceptual relationship between individuals and their social world, wrestling with the claim that, ontologically or normatively, personhood is relational and particular. Drawing on the analogia entis, of divine identity and human identity, some have inferred that divine trinitarianism informs an understanding of human personhood: each human being made in the image of God, and God becoming incarnate in Jesus Christ. Gunton (1993) and Zizioulas (1991) frame their ontological understanding of human relationality in terms of a theological interpretation of perichoretic personhood i.e. human beings, in common with the persons of the Trinity, are each particular and yet revealed through their inter-relatedness. Ontologically, the particularity of personhood and relationality are understood to co-exist: being-in-relation rather than being per se. If a person is not distinguished by the particularity of unique traits e.g. bodily shape, genetic pattern and family history, that these represent nothing more than general characteristics, as individualism would maintain, because the self is an unchanging essence divorced from the social world, what makes a person distinctive becomes extraneous (Gunton, 1993: 46; see also MacIntyre, 1981: 33). Again, if a person is nothing more than a network of relations, there is nothing personally distinctive other than a location in a matrix of relations. There is no diachronicity over time, no unique history of experience and no place for self-development. A theological account of human life, which is both relational and particular, casts everyone as a participant in history rather than an observer, a product of the past and an architect of the future. Unity of life, or enduring continuity through time, is paramount.

White (2002: 48f.) has been an influential advocate for an enduring, unitary, relational continuum of personhood reflecting those aspects of the divine image from which an understanding of the nature of human identity is derived. In his view, modernity’s notion of the self-creating asocial individual brought about self-fragmentation, a pathological distortion of authentic human being (White, 1997: 6) leading to psychological and social instability (White, 1997: 57). In common with MacIntyre (1981), White (1997: 50f.) attributes self-fragmentation

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46 Harris (1998:233) objects to the suggestion that personhood can be defined solely in relational terms, citing those people who have experienced abusive or damaging relationships. The very fact that a person’s relationships can be damaged is, she argues, confirmation of personhood.
to the privatization of personal identity, the separation of social roles and relations and the deconstruction of the shared societal story of common ends, purposes and ideals: in other words, a sense of self-disconnectedness which requires healing. Turner is not convinced and believes that this begs an important question not addressed by White. If feelings of individual continuity and indissolubility are so difficult to ignore or reject, what is the precise nature of self-fragmentation that needs healing? Of course, Turner’s own thesis is that there are sound psychological and sociological grounds for supposing that self-multiplicity and self-unity are compatible, citing late-modern and post-modern interpretations of identity which accommodate both aspects (Turner, 2008: 32f.). Although acknowledging that some forms of self-fragmentation might prove to be pathological, he argues that self-multiplicity is both necessary and desirable as it enables people to respond effectively and resourcefully to new situations. Rather than an unhealthy pre-occupation with self-unity, Turner (2011: 137) advocates better individual management of self-multiplicity.

A more nuanced approach is adopted by Woodhead (1999: 66) who asserts that self-fragmentation is not a postmodern phenomenon but can be detected in modernity where, instead of self being a single and homogeneous entity, it is the multifarious phenomenon of an intermingling of different cultural strands: cultural possibilities which compete for the self. From these, Woodhead identifies four representations of selfhood: the authoritative or bestowed, the liberal-humanistic, the expressive and the utilitarian.47 These expressions of self come into conflict with one another and form the basis of Woodhead’s self-fragmentation thesis. Hers is an analysis which has relevance for Christianity and the developing field of Christian anthropology, especially for those theologians who are at the forefront of promoting a communitarian, trinitarian, relational understanding of selfhood. Many aspects of Christian doctrine and practice endorse the view that the human self, as creature, is insufficient and corrupt. Only through a relationship with God, and by his grace, can each person be liberated from their condition.

47 This schematization of modernity’s main cultural trajectories reflects the work of Tipton (1982), Bellah, Madsen, Sullivan, Swidler and Tipton (2007 [1985]) and Taylor (1989).
While willing to concede that, without sufficient evidence, it remains an assumption that selfhood and identity are in a state of chronic dysfunction, Woodhead aligns herself to Giddens. He (1990: 21) argues that the effect of macro-processes characteristic of modernity, e.g. the pace and scope of global change and the way in which social relationships have become disconnected from a local context and re-located across an indeterminacy of ‘space-time’, have affected what is personal and intimate. By emphasizing the plurality of competing strands of selfhood, rather than pursuing a postmodern agenda, Woodhead’s analysis is helpful but should not be misinterpreted as evidence of crises of identity. As Turner (2008: 14) points out, it is an analysis which supports the view that there are many different ways of construing the fragmented or plural self.

Unequivocally relational, two theologians, Pannenberg and McFadyen, have been at the forefront of engagement with secular anthropology in their development of an understanding of self, in particular psychological explanations of identity formation. Although both accept that the self is socially constructed, they distance themselves from pluralist implications of social construction and psychology. Despite agreement about the singular and structural unity of the self, Pannenberg and McFadyen approach the nature of the self and its formation from differing perspectives.

Pannenberg’s starting point is the Christian theology of creation and redemption from which he argues that human beings do not possess the _imago Dei_ but that it gives direction to the life of each individual: it is a trinitarian possibility rather than bestowed at creation. It is something to be attained and the destiny for which each person is created. Believing that the image of God is only completely realized in Christ, Pannenberg distinguishes between ‘being in the image of God’ and ‘being created _according to_ the image of God’. Christ alone is the proleptical realization of God’s eschatological self-demonstration (Pannenberg, 1973: 426; 1994: 249f.) but, for each human person, the image of God is eschatological, a disposition pointing humanity towards its destiny of fellowship with God at the end of history (Pannenberg, 1994: 202). Temporality is the essential character of humanness: openness for God expressed as openness beyond the momentary horizon of the world.
This Pannenberg conceptualizes by use of the term exocentricity: the self’s relational character both centred within the self and other-oriented in openness to the world and to the future. Self-transcendence and relationality of people to the future ultimately finds its true identity in Jesus Christ, the fulfilment of the image of God in its entirety (van Huyssteen, 2006: 140). It is this capacity for self-transcendence as well as the potential to achieve wholeness, at the eschaton, that sets human beings apart from other creatures. Wholeness attends the authentic self both as an expression of life in its entirety, from its beginning to the end of history, and also, at any particular moment, as personhood (Pannenberg, 1985: 235). The process of becoming infers the unity of a single continuous life while the episodic sense of self-unity inevitably incorporates an anticipation of final destiny or projected identity, transcending the immediate experience of reality through its relation to the wholeness of selfhood. This dual notion of wholeness, both present in the moment and directed towards the future, leads Pannenberg to conclude that a person is not wholly determined by their social environment or social constructedness for there exists a freedom. This arises out of a person’s anticipation of a future true self and the contingent nature of the relationship between present and future demonstrations of personhood (Turner, 2008: 136). Within this process of being and becoming, and the future influencing the present, a reading back from the future can provide a sense of vocation through which personal identity is discovered. Nonetheless, it is a vocation which is tentative given the essential nature of the future which remains provisional, contingent and creative (White, 2002: 81).

Moving backwards and forwards between arguments ‘from above’ (theological and systematic) and ‘from below’ (anthropological and fundamental), Pannenberg works from the presupposition that psychology can inform theology as well as vice versa. In contrast, McFadyen (1990: 17ff.) focuses on the insights of social constructionist psychology in order to support and develop his theological two-dimensional account of what it means to be a person created in the image of God. A vertical dimension locates this in the context of the divine-human relationship, God’s loving address to humankind structured dialogically.
and characterized by communion and freedom from coercion. A horizontal dimension locates this in the context of human relations by which individuals discover, from the God in whose image they are made, right ways in which to relate to one another.

In much the same way as trinitarian relations determine Personhood within the Trinity, McFadyen (1990: 93) argues that unique personal identities are shaped by human relations through a process of ‘sedimentation’ i.e. layers of significant conversations and relations over time. In that he understands each person to be an integrated, centred and autonomous subject his emphasis on significant social relationships nonetheless avoids essentialism. There is no ‘substantial personal core’ or ‘pre-social substance’, but a centre which owes its existence to a socially acquired belief created by a process of sedimentation determined by a process of interrelations. Although there is the risk that this reduces personhood to nothing more than relationships (Harris, 1998), McFadyen (1990: 318) appears to resist this in two ways: by sedimentation, which he defines as previous responses of the ‘I’ that have produced a unique and lasting cluster within the constitution of the developing personal identity, and a ‘deep self’, a core which is at one remove from relations and their effects in present time (McFadyen, 1990: 313f.; White, 1996: 104; 2002: 45f.). Furthermore, in drawing a distinction between what a human being is, a response to God’s initiating Word, and who a human person is, a unique self in the world, McFadyen does appear to cast personhood as more than simply a relational phenomenon (Duba, 2009). Alongside relationality, McFadyen is intent on preserving individual integrity.

In summary, neither theological anthropology nor those partner disciplines from the social sciences with which it has sought dialogue, has produced a definitive or all-embracing resolution to the issues surrounding personhood and identity.

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50 Cunningham (1998:198f.) argues that the metaphor of sedimentation can be taken in one of two ways: either as a slow, relentless, geological process over time or as residue that lies on a river-bed constantly shaped and re-shaped by the impact of undercurrents and tides, water life and debris. As descriptions, one is excessively static and the other more aptly dynamic. McFadyen, he points out, does not clarify which he has in mind.

51 A freedom to choose, however, has meant that wrong choices have been made resulting in relationships and social structures which are distorted and into which people are born. This is McFadyen’s (1990:41) interpretation of what original sin entails.

52 However, see an earlier reference to this distinction, section 2.4.1 paragraph 5.
That would be an unrealistic expectation. Perhaps more important is the dialogue itself, which has addressed not only contentious issues but has engaged with the paradoxes and contradictions inherent in the task of conceptualizing the self. For theologians, this has required a language and conceptual creativity which, borrowing a phrase from Percy (2006: 10f.) in his study of the shaping of ministerial and ecclesial identity, is aptly described as ‘a theological construction of reality’ and where sometimes it can be difficult to disentangle ascription and description. In which case, is there anything further that theological anthropology might contribute to a reading of the chaplain’s identity? This I address in the following section (§2.4.2)

2.4.2 Theological anthropology and the identity of the NHS priest-as-chaplain

In his theological construction of workplace reality, White offers insights which certainly have a bearing on the identity of the NHS priest-as-chaplain. His theological framework is covenant faithfulness and political community, founded on trust and fidelity to a shared cause. Although, others have explored these theological motifs more generally (Gardner, 1995), White explores this through the narrow lens of experience in the workplace of a Western-Northern culture. In White’s (2002: 131) view, the workplace has had a more direct bearing on personal identity than other influences, such as nationality and political affiliation. In an historical overview, White demonstrates the effect of work on personal identity down the centuries. However, with 19th century industrialization White (2002: 133) detects the first signs of an alternative form of human identity emerging with different roles and values. Although not without its critics (Habermas, 1984) this analysis has explanatory value.

The workplace environment, it has been argued, produces a culture of practice and cultural signs, communicational and symbolic elements in production and

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53 White (2002) briefly traces the varied effect of work on personal identity, covering biblical times and a creation narrative in which work expresses something of the creative energy of God; pre-industrial society and, for example, the effect the agricultural seasons had on the shape of the Christian liturgical calendar as well as Church teaching informing spiritual and moral identity; the Reformation and nascent age of Enlightenment, with a broadening understanding of vocation; and industrialization, a period in which work came to represent attitudes and values divorced from what had once been integral to Christian identity.

54 Habermas (1984) takes issue with some aspects of Weber’s description of modernity and the part work played.
work organization, (Casey, 1995: 2005) and these provide a constituent element of human identity (White, 2002: 134; Sedgwick, 2004: 4). However, the part played by the workplace in shaping identity has changed. Today, careers structured by incremental progression through the ranks of one company, ensuring both job security and a generous pension, are uncommon and, of course, were never available to unskilled workers. The fluidity of employment, e.g. with an emphasis on transferable skills, short-term or zero hours contracts and project-based work, and the deleterious effect this has had on the perceived value of occupations and careers and, more crucially, on a sense of vocation, has undermined what once gave meaning and direction to a person’s self-narrative. While it was not the only reference point providing meaning and direction, without a purposeful working life, other contexts providing self-meaning, such as family and the community, were threatened.

A critical ethnographic study of a Fortune 500 firm, with over 100,000 employees worldwide, revealed the extensive use of language encouraging employee identification with the corporation and its goals, and the levelling of work hierarchies which promoted a sense of team belonging and team mission, personal responsibility, initiative and autonomy. Overall, it found a narrative of belonging and participation which its author suggests reflects a more general recognition, by corporate business, that the socio-psychological vacuum, once occupied by trade unionism and occupational solidarity, is one corporate business itself must occupy (Casey, 1995: 134). White’s argument is that a self-conscious ethos of belonging and loyalty is being intentionally cultivated, a ‘structure for mattering’ as it has been described elsewhere, within which work provides the reassurance that a person has something to contribute and, when absent, that a person is missed (Handy, 1984: 55). White maintains this is hollow rhetoric, posturing a solidarity which was formerly associated with occupation, career and class affiliation. It relies on what is short-term and conditional, and is exposed to the uncertainties and changeability of economic factors. Rather than security of job tenure, fringe benefits and pension-rights,

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55 This is not to ignore other cultural, social and economic factors: for example, the effect of media communication which, in a consumer-driven society, has unseated the workplace as a primary source of significance.
56 Fortune magazine annually lists the top five hundred U.S. companies ranked by revenues.
the workplace is littered with short-term contracts, part-time working and the dislocation of distance working.

Within a bureaucratic and hierarchical workplace culture, particular values are endorsed e.g. compliance, respect and duty, which readily distinguish the workplace from the rest of life where other values prevail e.g. belonging, self-integration, integrity and love. In recent years, a new business ethic has since asserted itself intent on ‘designing’ a new employee with a new set of attitudes (Casey, 1995: 97) in which the language of belonging, participation and even intimacy is used and confuses the separation of the workplace and life beyond work. White (2002: 137f.) voices the concern that with a worker’s moral and social world appropriated, dissent is compromised and a company can assume a quasi-religious authority with the expectation that the employee will demonstrate an uncritical commitment and evangelical fervour to the company’s mission and goals. What does this profile of workplace experience, a culture of practice and cultural signs, contribute to what is known about the identity of the healthcare chaplain?

Before the birth of the NHS, the chaplain had an assured place in teaching hospitals, asylums and work houses as an office-holder. From 1948, this status, and the mentality which accompanied it, was gradually eroded once the hospital chaplain joined the pay structures and professional expectations of the nationalized health service. Whereas the chaplain was the bishop’s man in those institutions destined to become general hospitals, the new institutional relationships of the NHS incurred a shift in accountability. Perhaps this encouraged another sense of belonging and participation as hospital chaplains sought to align themselves with the professionalism of the healthcare service. There was a confidence about the chaplain’s role, as is evident in Autton’s pamphlet, *The Hospital Ministry* (Autton, 1966). Full-time NHS chaplaincy posts

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57 The Poor Law Amendment Act (1834) provided hundreds of new employment opportunities for clergy (Tanner, 1998: 16); also The County Asylums Act (1828), section 39: ‘In every case where a county lunatic asylum shall be provided, a chaplain shall be appointed for the same, which chaplain shall be in full Orders, and shall be licensed by the Bishop of the Diocese; ...and such Chaplain shall perform on each Sunday, and on the great Festivals, the Divine Service of our Church, according to the Forms by Law established.’
increased from 28 in 1948 to 352 in 1998 (Hospital/Healthcare Chaplaincy, no date: a).

This was to change in the 1990s, a gradual process. Perhaps the *NHS and Community Care Act* (1990) played a part, with new NHS Trusts assuming responsibility for the ownership and management of hospitals previously managed or provided by Regional, District or Special Health Authorities, and so directly responsible for the employment of healthcare chaplains. The *Health and Social Care (Community Health and Standards) Act* (2003) took devolution a stage further, with the creation of NHS Foundation Trusts making decisions which were previously in the hands of central government. Financial stringency required the NHS to make hard decisions. Faith diversification, funded from existing chaplaincy budgets, meant a reduction in Christian chaplains (Swift, 2014: 76f.). The decision by the UK Information Commissioner to restrict access to patient personal information by chaplains because their work was not considered to be for ‘medical purposes’ had the effect of distancing chaplains from their healthcare colleagues (Swift, 2014: 58). Attempts, by chaplains, to achieve statutory recognition as a profession failed (see §4.2.1).

In 2006, the Worcester Acute Hospitals NHS Trust made the decision to close the chaplaincy department and reduce chaplaincy provision by two-thirds (Swift, 2014: 85ff.). Although the introduction of *Agenda for Change* provided chaplains with an on-call enhancement to their salary and a National Recruitment and Retention Premium, in recent years these benefits have been drastically reduced or removed altogether. In its *Annual Report 2015*, the CHCC registrar reported that following the passing of the Health and Social Care Act (2012), the

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58 In October 2001, a meeting took place with representatives from the Information Commissioner’s Office, the Department of Health solicitors and officials, HCC officers and C of E solicitors. All parties agreed that chaplains were not able to take advantage of the exemption in Schedule 3 of the *Data Protection Act* (1998), which allowed sensitive personal information about patients to be processed, without explicit consent, where that processing was necessary for medical purposes. Chaplaincy was not deemed to be included in the definition of ‘medical purposes’. The Information Commissioner took the view that as a definition, it was not wide enough to include spiritual care (Hospital/Healthcare Chaplaincy, no date: b).

59 An addition to the pay for an individual post or specific group of posts where market pressures would otherwise prevent an NHS Trust from being able to recruit to or retain staff, in sufficient numbers for the posts concerned, at the normal salary for a job of that weight.

60 The NHS Staff Council commissioned the Institute for Employment Studies to undertake an independent review of all the NRRP. The review recommended that all NRRP, including those paid to ... chaplains, should cease after 31 March 2011 or be converted to a local RRP where appropriate (NHS Employers: online). This was effectively a 15% reduction in salary (CHCC, 2012).
NHS re-organization in England had forced its employers to merge functions and outsource services to make financial savings. There had been the erosion of both pay and terms and conditions as well as down banding. The result had left the workforce demoralized (CHCC, 2015: 4). It might be argued that, with NHS Foundation Trusts assuming a quasi-religious authority amid the attrition to the working practices and rewards of chaplaincy, a chaplain’s moral and social world has been appropriated; that the perceived value of chaplaincy as an occupation and career and, more crucially, as an expression of vocation has declined along with what once gave meaning and direction to a C of E priest’s self-narrative in the NHS workplace (cf. White, 2002: 136).

Christian anthropology, as White (2002: 140) conceives it, asserts a continuity of personhood shaped by processes of change, growth and self-expression: a relational culture of belonging and self-giving encompassing self-fulfilment and self-expression. The evidence of a devaluing of NHS chaplaincy might imply that, any sense of belonging and collective purpose the NHS priest-as-chaplain once experienced in the workplace, no longer applies. The chaplain’s self-identity is threatened by a loss of coherence and credibility. A prudent worker, White claims, has little choice but to collude with short-termism, performing whatever role is required, and so selling ‘her soul in the shifting sands of an unreliable work culture’ instead of investing in a narrative which sustains and promotes personal meaning. The result is a sacrifice of both personal integrity and the continuity of personhood White envisages. A workplace culture which relegates faithfulness and loyalty is incompatible with a vision of Christian anthropology and raises moral and theological concerns for human identity (White, 2002: 142).  

2.5.1 Summary

This chapter has demonstrated the lack of clarity which today surrounds the identity of the twenty-first century NHS priest-as-chaplain, and which stands in contrast to the self-confident identity of the chaplain in 1948. The theoretical

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61 In this respect, I note a White Paper by the American College of Clinical Pharmacy which promotes the concept of professionalism as a fiducial or covenantal relationship between the patient and the pharmacist. In other words, it endorses a workplace culture which affirms the importance of faith and trust as values which underpin professionalism and which transcends occupational norms (Roth and Zlatic, 2009).
insights of socialization and social construction offer serviceable conceptual tools with which to review the personal and workplace narrative of chaplains. What emerges from the literature is the cultural variance that exists between the chaplain and the church highlighted by socialization, and the dialogical variance between ecclesial and secular ‘life priorities’ underscored by social constructionism.

While conceding that there is little common ground between secular and theological anthropology, given their different understandings of identity, it is a conversation which has merit by virtue of its engagement in the paradoxes and contradictions inherent in the exercise of conceptualizing identity, self and personhood.

Finally, White’s review of the working environment as a place of covenant faithfulness and political community based on trust and fidelity to a common purpose provides a useful perspective with which to explore and understand the employment challenges facing the NHS priest-as-chaplain and the consequential impact on personal and workplace narratives concerned with identity. What once gave vocational meaning and direction to a Church of England priest’s self-narrative in the NHS workplace has been irreparably compromised.

2.5.2 Developing the Thesis
This chapter has raised questions about the NHS workplace as an appropriate setting within which the ordained person is able, authentically, to live and convey the vocation of the Church of England priest. This, of course, raises the all-important question of what priesthood means in the context of the Church of England, its theological underpinnings and undercurrents which, generated over the centuries, continue to influence its development and acceptance despite postmodern cynicism and deconstruction.

What is the connection between contemporary expressions of priesthood and what may be learned about priesthood in the Hebrew Bible, the first century CE synagogue, the early Church and the Church of the patristic and medieval periods? What was the nature and extent of the revisions to priesthood that the
Reformers introduced from the sixteenth century onwards? Given the different stance the theological liberals and conservatives adopted towards priesthood in the nineteenth and twentieth centuries, what has been their legacy? How is priesthood discerned today in terms of its ontological, functional and relational credentials? These questions will be addressed in the next chapter.
Chapter Three: Theological Issues and the Development of Priestly Identity

3.1 Introduction
In this chapter I will be investigating the historical and theological antecedents of priestly identity which have contributed to the development of priesthood both in the Western Church and, more particularly, in the Church of England. I will offer accounts of how and why priesthood was introduced into the Church, how and why it adapted and evolved, and how and why it has fuelled theological disagreements and dispute. I will note those issues which not only continue to be debated within the Church of England but which, by their very existence, highlight the absence of a common understanding of priesthood. The repercussions of this for my research is that I will need to be sensitive to how participants perceive or interpret priesthood and the extent to which it is able to accommodate the ministerial role of the healthcare chaplain or has to adapt and evolve.

As this chapter unfolds, I will examine priesthood in the context of the Hebrew Bible (§3.2.1), the first century CE synagogue (§3.2.2), the early church (§3.2.3) and the church of the patristic and medieval periods (§3.2.4). I will consider (§3.3.1) the different interpretations of priesthood at the time of the Reformation in England: the theological conflict between English Protestants seeking a radical revision of holy orders and English Catholics wanting to retain the essence of pre-reformation priesthood. I will reflect on the via media of Elizabeth I, and the ways in which liberal rationalism of the eighteenth century and the conservatism of the Oxford Movement in the nineteenth century pursued narrow theological bias which heralded further polarization in the twentieth century. I will review the report of the Commission on Christian Doctrine (1938) and its attempt to establish a common understanding of ministry and its failure to defuse theological tensions which then resurfaced in the second half of the twentieth century. I will outline (§3.3.2) the extensive revisions, both in doctrine and practice, in the Church of England Ordinal since 1980 and the development of ministerial theology over the last thirty years. Finally I will survey (§3.3.3) the broad range of meanings associated with the
ontology, function and relational character of priesthood which are implicit in questions of identity raised in this research.

3.2.1 Priesthood in the Hebrew Bible

The Hebrew Bible provides clear evidence that Israelite social identity, religious beliefs and ritual practices were profoundly influenced by both priests and the institution of priesthood.¹ This is despite the fact that source materials provide different accounts of when priestly acts emerged² and who was qualified to be a priest.³ It would appear that priestly perspectives and practices, belonging to a later period, shaped the written record of early Israelite history (Bonfiglio, no date). Notwithstanding these caveats, there are three expressions of priesthood found in Israelite religion: the high priests, the ministerial priests and the universal priesthood.⁴ Of these, I focus on ministerial priesthood.

The principal role of the ministerial priest was as mediator between the people and God, offering sacrifices to God on behalf of the people. So, for example, this involved the ritual deliverance of a person, be it a leper or a new mother, from a preliminal state of impurity to a postliminal state of cleanliness (Nelson, 1993: 84). In these sacrificial ceremonies, the pivotal act which the priest performed was not killing the victim, essential as this was, but the burning of some, or the entire victim, on the altar and handling the blood.⁵ The objective of a sacrifice was not simply the death of the sacrificial victim but its transfer from the profane world to the divine realm and its ownership by God. Accessing

¹ The influence of priests and priesthood in the Hebrew Bible are found in the legal passages of Leviticus, genealogies (e.g. 1 Chron 6; Ezra 2; and Neh 7), narratives (e.g. Exod 32) and prophetic discourses (i.e., Hag 1; Mal 2) as well as the prayers and liturgies associated with Temple worship found in the Psalms. It is likely that priests, or those from a priestly lineage, played a part in writing and editing other biblical material e.g. Jeremiah (Jer 1:1-2), Ezekiel (Ezek 1:1-3), Zechariah (Zec 1:1; Neh 12:16), and Ezra (Ezra 7:1-6), while the book of Chronicles, its authorship unknown, reflects a priestly perspective.

² Yahwist (J) and Elohist (E) sources refer to those who were not priests making sacrifices in holy places during the ancestral period (Gen. 31:54), while in the priestly source (P) it is only after Exodus 19 that reference is made to ritual acts which presuppose the need for a sanctuary or a priest (Bonfiglio, no date).

³ While in Deuteronomy (e.g. 17:9) and the Deuteronomic history (i.e. Joshua to 2 Kings) all Levites are eligible to serve as priests, P restricts priesthood to Aaron’s descendants.

⁴ In Exodus, reference is made to Aaron as the high priest (Ex. 31:30), his four sons as ministerial priests (Ex. 28:21) and the people of Israel as a kingdom of priests (Ex. 19:6).

⁵ In early Israelite religion the lay person offering the sacrifice was responsible for killing the victim, either before the altar, under the supervision of the priest (1Sam 1:3-5; 24:25; 2:12-16), or without a priest present (Judges 6:25-26; 13:15-20). Nelson (1993: 59) holds that even in the Priestly Code, the lay person had some responsibility for killing the victim and, subsequently, skinning and washing it although this is ambiguous in some translations.
sacred space was viewed as mortally dangerous (Exodus 28:35, 43; 30:20-21; Lev. 16:13). In consuming the sin offering of the faith community, and as those who came close to Yahweh’s precarious presence, the priest carried the sin of the people (Lev. 10:17). In all this, ‘priests insulated worshippers from direct contact with the hazards of sacred space and holy things, yet priests also provided the connections that brought divinity near and made life with Yahweh possible’ (Nelson, 1993: 85).\(^6\)

The continuing influence of the priesthood, not only in terms of this sacral authority but encompassing political administration and foreign affairs, was further strengthened by the strategically important move of centralizing the priestly cult in Jerusalem, represented in 2 Samuel as David’s initiative\(^7\) although 2 Kings reports that it was a process consolidated under the reforms of Hezekiah and Josiah. It was an influence that continued down to the Hellenistic period (c. 1st century BCE). Arguably, the centralization of the priestly cult in Jerusalem was more significant than Solomon’s building of the Temple, important as that was.

From the 5th century BCE to the accession of Herod the Great (c. 37/36 BCE), when Israel was a theocracy overseen by the high priest, support of the Temple and its ministers, as prescribed by the Torah, became customary among the people. By the first century CE, there were approximately twenty thousand priests and Levites,\(^8\) although no more than twenty to twenty-five priests would have been required in the Temple on an average day. Normally, priests would serve for a week at a time, twice a year, as well as at the three pilgrimage festivals.\(^9\) Their duties involved inspecting and accepting sacrificial offerings, butchery and liturgical worship e.g. reciting Scripture\(^10\) and praying, as well as

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\(^6\) Aside from this cultic responsibility, the priest might cast the Urim and Thummim (cf. Deut. 17:9, 12), teach the Law (cf. Deut. 33:10), adjudicate on legal matters by discerning God’s will in the Torah (cf. Deut. 33:10), bless the people (cf. Numbers 6:22-27), carry out administrative tasks such as collecting tithes and, later, once the Temple was built, undertake its day-to-day maintenance.

\(^7\) cf. 2 Sam. 8:16-18; 20:23-25. Although both passages reflect editorial tampering and confusion over whether Ahimelech is the son of Abiathar (2 Sam. 17) or Abiathar is the son of Ahimelech (1 Sam 22:20) (Miller, 1986:173), 2 Samuel clearly represents David as responsible for centralizing the priestly cult in Jerusalem.

\(^8\) Josephus, Against Apion 2 (cited in Thackeray, 1926: 335).

\(^9\) Pesach (נֶסֶךְ; Passover), Shavuot (שָׁוָעָה; Weeks), and Sukkot (סֻכּוֹת; Tents or Booths).

\(^10\) This practice is first mentioned in Isaiah 56:7 which suggests this was a late innovation (Sanders, 1992).
the burning of incense\textsuperscript{11} and hearing confessions. Priests also had to undertake some menial work, such as sorting the wood for the sacrificial fire, for they alone were allowed to enter the sacrificial area. In this, and other tasks, they were assisted by the Levites who, for example, would bring the firewood into the Temple, act as gatekeepers and hold the music scrolls during worship (Sanders, 1992).

Apart from these set duties, priests were free to attend to their private affairs, many living in Jerusalem but others living in Judean and Galilean cities where it is likely they assumed leadership roles including teaching the law, serving as judges and interpreting the Bible. Some would have acted as scribes, a broad category which would have embraced copying texts, producing legal documents and providing expert legal opinion.\textsuperscript{12} However, the extent to which priests exercised a monopoly as experts in biblical interpretation or magistracy by the first century CE has been debated by scholars. Some have argued that these roles had been taken over by the Pharisees or lay-scribes\textsuperscript{13} (Jeremias, 1969: 237; Maccoby, 1980: 61; Rajak, 2002: 19) while Sanders asserts that although any monopoly may have disappeared, priests still retained these traditional responsibilities (Sanders, 1992: chapter 10).

In summary, therefore, the issues relating to the concept of priesthood emerging from this period rest on its institutional and sacral authority as well as a mediatory role between two worlds, the one temporal and the other sacred.

3.2.2 Priesthood in the Synagogue\textsuperscript{14}

Nonetheless, for a variety of reasons, the influence of the priest in the first century CE was on the wane. By this time there were three foci of religion: the Temple, the Synagogue and the home (Sanders, 1992: 48). Although the Temple was venerated by Jews both within and outside Palestine, a view corroborated by payment of the Temple tax and the frequency of pilgrimages to

\begin{itemize}
\item \textsuperscript{11} Prescribed in Exodus 30:1-8 and Lev 16:13.
\item \textsuperscript{12} Josephus perceived priests as the nation’s rulers and judges cf. Josephus, Against Apion 2 (cited in Thackeray, 1926: 366f.).
\item \textsuperscript{13} Whether these were two separate groups or the one was synonymous with the other is itself a matter of debate.
\item \textsuperscript{14} During the past twenty years there has been a renewed interest in ancient synagogues (Runesson, Binder and Olsson, 2008:5) described by one scholar as an explosion in synagogue-related research (Levine, 2005:14).
\end{itemize}
the Temple, following the Roman conquest (63 BCE) the priest had little power beyond Judaea. Diaspora Jews met in houses of prayer (synagogues or προσευχής) on the Sabbath to pray and listen to Scripture readings. The origin of the synagogue has been a matter of scholarly debate. Once assumed to have come about in Babylonia during the exile after 587 BCE and then imported into Palestine, following the return, it is now commonly held that the synagogue movement arose in Egypt and spread to other places in the Mediterranean (Griffiths, 1987) except Palestine, where the lack of evidence suggests that the synagogue did not arrive until the Herodian or late Second Temple period (Fine, 1996: 18) possibly as late as the first century CE (Grabbe, 1988: 410).

The extent to which the synagogue was assimilated into Palestinian society is difficult to ascertain, although the distribution of synagogues in Palestine offers speculative clues. In Jerusalem it was arguably unimportant except as a hub for foreign Jews (Flesher, 1989: 70). In other parts of Palestine, the synagogue was not necessarily an alternative to the Temple but might complement it. Where access to the Temple was limited e.g. in north Palestine, it could provide worship opportunities. Undoubtedly, what it did offer was a different religious experience. In the Temple, the separation of the priest and ordinary Israelite was conspicuous: the priest conducted the rites and rituals of the Temple while the Israelite man would purify himself and then simply observe. However, in the synagogue, the non-priest Israelite was a full participant (Flesher, 1989: 69). Although Philo claimed that a priest or an elder led the synagogue proceedings, synagogues belonged to the whole Jewish community and were not controlled by the Pharisees before the destruction of the Temple in 70 CE, nor subsequently by the Rabbis (Sanders, 1999: 10). They were more than religious centres in that they had administrative, juridical and social functions (Rocca, 2008: 306; Levine, 2000: 31-41).

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15 Levine suggests that the Temple rota for the priests and Levites was so arranged as to enable them to give readings of the Torah in local synagogues (Levine, 2000:36).
16 Women were allowed to enter the Temple only as far as the Middle Court, between the Court of the Gentiles and the Court of Men (Barrett, 1994: 179).
17 Two exceptions were the Passover sacrifice and the Nazarite oath (Flesher, 1989: 68).
18 Hypothetica, 7: 12f. (Early Christian Writings).
19 The ‘synagogue’, both in Hebrew (beth haknesset) and in Greek (συναγωγή) is interpreted ‘a house of assembly’.
Nonetheless, it is possible to discern a synagogal structure of elected officers amongst whom were elders;\textsuperscript{20} notables;\textsuperscript{21} the senior elder;\textsuperscript{22} the chief official;\textsuperscript{23} the assistant;\textsuperscript{24} and the scribe.\textsuperscript{25} What is noteworthy here is the absence of any mention of the priest. They were not considered officers of the community despite their hereditary rights i.e. receiving the five-shekel redemption money for each first-born son,\textsuperscript{26} reciting certain blessings at worship services,\textsuperscript{27} receiving tithes on produce,\textsuperscript{28} and performing certain purification rituals.\textsuperscript{29} The Temple in Jerusalem was the only place where the priest might preside (Burtchaell, 1992: 255).

In summary, therefore, the issues relating to the concept of priesthood emerging from this period centre on the diminishing power, influence and sacral authority of the Temple priest as synagogue worship developed. In the Temple, the ordinary Israelite male was an observer of worship whereas in the synagogue he was a full participant. Elected lay officers supervised all aspects of synagogue life which suggests that the priest may have become surplus to need.

\subsection*{3.2.3 Priesthood in the early Church}

An evaluation of the early church presents many challenges.\textsuperscript{30} An historical

\begin{itemize}
\item The Septuagint frequently translates the Hebrew plural of ‘elders’ as γερουσία or πρεσβύτερον i.e. a ‘council of elders’, cf. Ex. 3:16; 24:1, 9, 14; Dt. 5:23. As a council, elders were expected to be both statesmen and jurists, representing the people's interests to outsiders and ensuring lawful discipline. By the latter part of the Second Temple period, their power had diminished (Burtchaell, 1992: 228ff.).
\item A select group, within the council of elders, effectively determining the governance of the synagogue (Burtchaell, 1992: 233ff.).
\item President of the γερουσία, the council of elders, but not president of the synagogue who was the ἁρχισυνάγωγος.
\item The chief executive of the local community and one of the notables, who acted under the formal supervision of the elders but presided over the community, convening its activities and bearing responsibility for its staff (Burtchaell, 1992: 240ff.).
\item Whereas, in the Temple, Levites were assistants to the priests, in later rabbinical writing the assistant became known as the hazan with all but the smallest synagogues having an hazan to assist the chief official.
\item From extant literature, it has been conjectured that every synagogue had a scribe whose work involved drawing up the minutes and other documents of the assembly, elders and notables, dealing with correspondence, and acting as a clerk to the court as well as a notary advising members in the preparation of legal papers (Burtchaell, 1992: 251ff.).
\end{itemize}

\begin{itemize}
\item Ex. 13:14.
\item Lev. 9:22.
\item Num. 18:26.
\item Lev. 14: 1-32.
\item Unlike Jewish history of this period, there are few resources that document the earliest Christian communities. In fact, Gooder (2008: 16) suggests that tracing the history of the
\end{itemize}
account readily divides itself into three periods (Wedderburn, 2004: 2f.). A first phase draws on the early chapters of the Acts of the Apostles and some material from Paul's hidden years, to which he alludes in Galatians 1, but much of the detail is tenuous (Wedderburn, 2004: 2): as a general point, the New Testament provides many snapshots of life in early Christian communities with no clear indication of what, if anything, these snapshots have in common (Gooder, 2008: 16). A second phase focuses on Paul’s missionary activity, especially following the Jerusalem meeting outlined in Galatians 2:1-10. This, however, is a narrowly Pauline perspective. A third phase covers the turbulent years from the martyrdom of the two leading Christian figures, Paul and James (the brother of Jesus). Each had been a counterbalance to the other and maybe their deaths left a vacuum of authority. Other significant events at this time were the fall of Jerusalem and the eventual destruction of the Temple. Detail, concerning the development of the Church, can be harvested from the post-Pauline corpus of the New Testament together with documents such as Clement's first letter to the Corinthians and perhaps parts of the Didache (Burtchaell, 1992: 273). Yet as Conzelmann (1973:7) points out, these texts lack clear evidence about when, where and by whom they were written, as well as to which historical situation they refer. He concludes that there exists a gap of knowledge throughout the last forty years of the first century CE.

Undoubtedly, in its earliest years, with New Testament accounts of glossolalia, healings, prophecy and miracles, the essence of the church was charismatic.31 For Paul, the Holy Spirit was at the centre of Christian life, the key to everything (Fee, 1988: 607), and, according to one school of thought, a vision of the Church was not one which would accommodate official authority or responsible elders (Von Campenhausen, 1997:70f.), organizational structure or formality (Dunn, 1975: 291). How the church then developed has fuelled scholarly debate. From the Reformation to the nineteenth century, scholars such as Wyclif, Luther and Calvin, and later Baur, Ritschl, Lightfoot, Hatch, Harnack and Sohm, argued that early charismatic Christianity was forced to give way to a subsequent organized form of Christianity which, faced with heresy and schism, earliest Christian communities is akin to attempting a description, in a single narrative, the path of twenty rubber balls thrown into the air and left to bounce wherever they came down.

sought a unifying authority in the person of the bishop. In the twentieth century, others (Theissen, Gager and Meeks) have questioned the underlying premise that foundational charismata could not co-exist alongside institutional structures. Meanwhile, a more recent summary statement (Goeder, 2008: 23) suggests that self-definition by many Christian communities did not happen during the first century CE and that the notion of a single Christian community in Jerusalem generating further communities in Antioch which, with the persecution of Hellenistic Christians expanded to other Roman cities, is simply untenable. What is more credible is the existence of a mixed economy of Christian communities experiencing conflict, compromise and debate. Indeed, while some communities were expelled or withdrew from the local synagogue, it is conceivable that others continued to share a constructive relationship well into the second century CE.

So the conventional thesis, of an early church which was Spirit-led and spontaneous, may be incomplete. Traditional arguments about clerical authority appear to read history backwards identifying the apostles as the first bishops and so, among other things, justifying a hierarchical clergy. The alternative, reading history forwards, begins with the hypothesis that as the first disciples were Christian Jews, and used to the institution of the synagogue, they would structure church communities in ways that were familiar, following the patterns of the Hellenistic Jewish synagogue (Burtchaell, 1992: xii). The three-level ordering of offices in the synagogue i.e. the president, elders, and the assistant make plausible antecedent for the Christian offices which become significant in the second century CE (Burtchaell, 1992: 339). Although the New Testament makes little mention of anything resembling an official church order, this does not necessarily imply that such an order did not exist. Perhaps it was considered unimportant, a marginal reality. Perhaps, during the first century CE, the incumbents of these orders presided but did not lead. Could it be that they were subject to the charismatics of the first century CE as the charismatics of the second century CE would be subject to the bishop? Of course, this

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32 Although not an official church order, there is a differentiation of ministry: deacons (II Tim. 4:5), a college of presbyters who collectively give authority by the laying on of hands (I Tim. 4:14), teachers or catechists (I Tim. 5:17), and the episcopos or overseer (I Tim. 3:2). These, it has been argued (Stegeman and Stegeman, 1999: 299), are roles based on that of civic associations and synagogues.
revisionist historical account of Christian orders subverts accepted church practice. If it was of little consequence then, need it be normative for episcopal churches now and in the future?

If there is merit in the thesis that an official church order of president, elders and assistant did exist in the early church, there is no suggestion that the early church found a place for the priest. This is unsurprising given the selfsame situation in the synagogue. The word ‘priest’ (ἱερέυς rather than πρεσβύτερος) does not find a place in the early Christian community other than applied to Christ and to the church itself. As Burtchaell (1992: 323) acknowledges, it is not that there are no longer priests; rather, there are no longer any who are not priests.

In summary, therefore, the issues relating to the concept of priesthood emerging from these three periods, into which the history of the early Church may be documented, suggest that caution needs to be exercised in making any definitive claim about a clerical hierarchy at this time. The lay leadership of the synagogue may have influenced the later ordering of the Christian Church of the second century CE but there is no tangible evidence, merely speculation. If there was no official Church order in the first century CE, of course still a matter of speculation, on what basis might the Church determine its order in the twenty-first century?

3.2.4 **Priesthood in the Patristic and Medieval Church**

At the turn of the second century CE, three-fold ministry is evident in Syria and Asia Minor according to Ignatius (c. 110 CE). ‘A bishop is assisted by presbyters and deacons’ (Ignatius, no date). Priestly language is also found in the writings of others among the Early Fathers e.g. in the *Didache* (mid to late first century CE) and *1 Clement* (late first century to early second century CE). The first written description of Christian ministry as priesthood is supplied by Tertullian at

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33 Mention is made in the Acts of the Apostles (6.7) of a large number of priests who submitted to the new faith.

34 For example, in describing the offering of the first fruits, *Didache* 13.3 likens Christian prophets to high priests (Bradshaw, 2002: 202; Board for Mission and Unity, 1986: 32).

35 For example, in *1 Clement* (40-41) the cultic expression ‘offered the gifts’ is a role ascribed to the presbyter-bishop rather than the Christian community as a whole (Bradshaw, 2002: 202; Board for Mission and Unity, 1986: 32).
the beginning of the third century CE, when he applies *sacerdos* (priest) and, on one occasion, *summus sacerdos* (high priest) to the office of bishop in the North African Church (Bradshaw, 2002: 204). He gives no further explanation which implies that these were familiar episcopal titles despite the fact that, on occasions, Tertullian extends the use of *sacerdos* to presbyters. So, for example, in *De Virginibus Velandis* 11,1 (Hanson, 1979: 38). Again writing in the third century CE, Cyprian refers to the sacerdotal nature of both Christian ministry, which he models on an Old Testament understanding of priesthood, and the Eucharist, using Old Testament sacrificial terminology. His claim is that it is the priest who presides at the Eucharist in Christ’s place, *vice Christi* (Mazza, 1999: 125-126) but whether he means the bishop as priest is unclear as Cyprian also claims that presbyters participate in the episcopal priesthood (Bradshaw and Johnson, 2012: 58).

It is confusing, and this leads Hanson (1979: 40f.) to speculate that it was a period when there was no consistent doctrine of ministerial priesthood. As the decision emerged to have an official, permanent, ordained ministry express the priestly activity of Christ this became vested in the chief Christian minister, the monarchical bishop. Clearly, the relationship of the presbyter to the bishop needed clarification, and the fourth century *Canons of Hippolytus* and *Apostolic Constitutions* reflect this happening. The bishop is ordained as the one who presides at the Eucharist, has authority to forgive sins and allocates and co-ordinates the duties of the presbyterate and diaconate, among other ministries. The presbyter of the pre-Nicene Church is not permitted to preside at the Eucharist unless given episcopal dispensation in the bishop’s absence.

In practice this was to prove unworkable. With the Edict of Milan in 313 CE, which ensured state toleration of Christianity, and then the Edict of Thessalonica in 380 CE, which made Nicene Christianity the state religion, the

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36 *The man may preach, teach, baptize, celebrate the eucharist, but women may not do this, nor take on themselves any masculine function, far less the priestly office (nec ullam virilis munen, nedum sacerdotatis, officii, sortem sibi vindicare)*: *De Virginibus Velandis* 11,1 (Hanson, 1979: 38).
37 Probably of Egyptian provenance (Bradshaw, 2002: 83).
38 Probably of Syrian provenance (Bradshaw, 2002: 85-7).
39 These are typical of a genre of early church orders which claim to offer authoritative apostolic instruction concerning moral conduct, liturgical practice and ecclesiastical organization and discipline but which have nothing to indicate historical reliability (Bradshaw, 2002: 73).
Church became integrated into Roman society and expanded. As a result, the bishop became a more distant figure, at one remove from the local Eucharistic community for which he had once provided personal leadership. Now he carried a spiritual responsibility for everyone within his growing episcopal territory.

With the bishop separated from his people, the Church became governed less by an ecclesiology of communion and more by an ecclesiology of power. The claim by Jerome, in the fifth century CE, that without bishops the Church did not exist (Jerome, no date: 21, 2) would have been inconceivable to a Christian in the first century CE. A clerical class, as representative of the Church, was deemed necessary to ensure the safe transmission of orthodox teaching, although other less reputable reasons have been cited (Marriage, 1995: 93): not only ambition and privilege, but a male clerical élite able to curtail the threat of female leadership.  

Such ambition and *inanis gloriae cupiditatem* finds acknowledgment in the canons of the Council of Chalcedon (451 CE), the first Ecumenical Council to seek to regulate ministerial practice. Canon six was particularly important declaring that the practice of absolute ordination, whereby a person might be ordained without any connection to a specific congregation, was invalid. It further stipulated that a priest must be called by the community to receive valid *ordinatio*. As Leo the Great (c. 400-461CE) stated: ‘[h]e who is to govern all, must be chosen by all’ (Leo, no date: X, vi). For Schillebeeckx (1981: 41) an important corollary is inferred: that if a minister, for any personal reason, is no longer president of a community, *ipso facto* he reverts to the status of a layman ‘in the full sense of the word’. If Schillebeeckx is right, what does this imply for the NHS priest-as-chaplain working in a wholly secular context? In what sense can the NHS priest-as-chaplain claim to be president of a community? The case

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41 ‘Lust of empty glory’: Canon 10 of the Council of Chalcedon reads: ‘It shall not be lawful for a clergyman to be at the same time enrolled in the churches of two cities, that is, in the church in which he was at first ordained, and in another to which, because it is greater, he has removed from lust of empty honour’ (Percival, Schaff and Wace, 1900).
42 Canon VI of the Council of Chalcedon reads: ‘Neither presbyter, deacon, nor any of the ecclesiastical order shall be ordained at large, nor unless the person ordained is particularly appointed to a church in a city or village, or to a martyr, or to a monastery. And if any have been ordained without a charge, the holy Synod decrees, to the reproach of the ordainer, that such an ordination shall be inoperative, and that such shall nowhere be suffered to officiate’ (Percival, Schaff and Wace, 1900).
has been made (Welsh, 2014: 14) that being a priest is transitive like a verb which needs an object. To be a priest, it is necessary to be a priest for someone. A priest is more a verb than a noun. Should the concept of ‘presidency’ be interpreted more broadly? Schillebeeckx considers that the canons reflect not a ‘sacral’ priesthood but a sacramentalism of faith, not an ontological theology of priesthood but an ecclesial relationship (Schillebeeckx, 1980: 59).

Ward (2011) would disagree. His reading of fourth century patristic literature leads him to assert that the writings of the Church Fathers recognized the permanence of the character priesthood endowed and its cultic responsibilities expressed primarily in the celebration of the Eucharist. Although the priest undertook pastoral and didactic duties (which, later, in the liturgically-focussed priesthood of medieval times would be reined in), Ward (2011: 84) sees clear evidence for the indelibility of ordination because whatever the priest did sacramentally was considered valid in that it was perceived to emanate not from the priest but from God. He cites Augustine (354-430 CE) as the first person to clarify this in his description of the ministerial character as ordinis ecclesiae signaculum, an indelible designation by God.43

For Augustine, Levitical priesthood and sacrifice prefigured what was to come in Christ. With his coming, Christ offered himself as the sacrifice. As the head of his body, the Church, he enables the faithful to share in his self-offering. The Eucharistic offering is a sacrifice of praise and a representative memorial, but essentially a community action with the priest a representative rather than a substitute for Christ (Board for Mission and Unity, 1986: 35ff.). This was central to the Eucharistic doctrine taught by Augustine, bishop of Hippo Regius, and is important because both Catholic and Protestant were to appeal to the authority of his writings during and following the Reformation.

Over the next few centuries, feudal and legal factors were to lead to seismic change in such perceptions of priesthood. Some popes, bishops and priests

43 Elsewhere, Augustine writes ‘he who is a proud priest is in a class with the devil, but uncontaminated is the gift of Christ which flows through him undefiled, which passes perfectly clear through him and comes to fertile soil’ (Augustine, no date: 5, 15).
surrendered their independence as churches and clergy were privatized in the employ of landed gentry. The feudal system threw up prince bishops. Perhaps most significant of all, a renaissance of Roman law around the turn of the twelfth century detached the power of leadership from territoriality. For the Church, this led to a fatal divorce of ecclesial leadership from its gathered community. Whereas, before, it was baptism that had initiated the Christian into the company of the elect, God’s *ecclesia*, the Christendom of the Middle Ages made this less clear. The ‘initiation’ stakes were raised. It was as if entry into the Church required a further sign of commitment, that baptism was insufficient. God’s *ecclesia* became identified with the monastic community as the Christian ideal and the tangible expression of the gathered community. Later, Schillebeeckx (1980: 56) maintains, the Gregorian reforms shifted perceptions once again and priesthood was seen to be the true mark of Christian commitment, a personal life choice disconnected from a living community.

Of particular importance was this separation of the power of leadership from territoriality. This led to a radical change in the Church’s theological interpretation of priesthood and jurisdiction. Despite the injunction on absolute ordination by the Council of Chalcedon, the Third Lateran Council (1179 CE) circumvented this in practice if not in principle. The *titulus ecclesiae*, required before an ordination could take place, was radically reinterpreted. Instead of it being conditional on a named community nominating a person to be ordained as their minister, it became conditional on the ordinand being assured of a proper living, *stipendia convenientia*, once ordained, the responsibility of the ordaining bishop. In effect, *ordinatio* now conferred priestly power on an individual with no reference to a particular faith community. Ordaining the priest, in his own right rather than for a community, bestowed the ‘power of the Eucharist’. The priest could celebrate the Eucharist alone: unimaginable to an earlier generation of the Church. In time, other customs arose which formalized the distinction between clergy and laity: the priest alone consuming the consecrated elements; celibacy as a requirement for priesthood; and the silent canon of the Mass.44 Even when it came to legal proceedings, the clergy were exempt from civil jurisdiction while the laity was subject to ecclesiastical law.45

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44 The canon is that part of the Eucharist which follows the Sanctus and ends with the doxology. There are various explanations for the priest reciting the canon inaudibly e.g. it expresses the
A further innovation occurred at the time of the Third and Fourth Lateran Council when priesthood assumed an enigmatic sacramental character: *sacramentium ordinis*. Schillebeeckx (1980: 67) suggests that what emerged was a very vague theology of character but, later, developed into an ‘ontological and even magical sacredotalizing of the priesthood’. Ward (2011: 87) offers a different perspective: that Aquinas, and those succeeding him, believed that the essence of ministerial priesthood was the sacramental character of ordination as well as its indelibility as a *signaculum*; and that the centrality of the Eucharist was the primary *raison d’être* of priesthood. It was another Council, Trent (1545-1563 CE), that formally adopted this medieval conception of sacramental character, describing it as an indelible mark, a spiritual mark, impressed upon the soul (Tanner and Alberigo, 1990: 685). Legrand, a Roman Catholic theologian, disputes this (2008: 3.1) arguing that the Council of Trent did not teach that the character of the sacrament of ordination ontologically changes the priest. Such, he declares, is a Protestant misconception. Hypher (1995: 91), again a Roman Catholic, believes that the Council of Trent consciously sought to remodel priesthood so that its theology and identity would contrast with the theology of ministry promoted by Reformers.

What then was the intention of the Reformers? In part, the Reformation of the sixteenth century did seek to address distortions, not only in the relationship between the clergy and the laity but in the excessive claims that were being made for the office and function of the clergy (Board for Mission and Unity, 1986: 44). In this, Cranmer was at the forefront of the English Reformation as I go on to discuss in §3.3.1.

In summary, therefore the issues relating to the concept of priesthood emerging from this period suggest that there was no uniform doctrine of ministerial priesthood. At one stage, it appears that when a person ceased to be president of the Christian community they reverted to the status of a lay person but with growing clericalism this changed. If, as is likely the case, that the priestly activity of Christ was vested in the chief minister, the bishop, the relationship of the

\[\text{intimate relationship between the priest and God and also marks the special sacredness of this prayer (Una Voce, 2012).}\]

\[\text{For example, in matters of marriage.}\]

\[\text{1215 CE.}\]
presbyter and the bishop needed clarification. Moving into the medieval period, there is increasing innovation as the Church expanded territorially and accrued power. It was a situation that was to fuel excessive claims for priesthood and which the Reformers sought to address.

3.3.1 The emergence of the Church of England and the theology of priesthood

In England, Cranmer, with other ‘Anglican’ divines, sought to address such distortions, advancing a revised theology of priesthood evident in the shaping of the Edward VI Ordinal with its more Protestant understanding of holy orders. The Mass was proscribed but, with many opposed to Cranmer’s Calvinist inclination, in practice little changed. The Church of England was not purged of pre-Reformation theology or ecclesiology which suggests that it was a jurisdictional rather than a theological realignment that the Church in England experienced. Nonetheless, when Cranmer’s reforms were abrogated by Catholic Queen Mary, many approved. It was the via media of Elizabeth I which established the future ethos of Anglicanism. Finding merit in both the non-papal Catholicism of Henry VIII and the restrained Lutheranism of the Augsburg Confession, Elizabeth was essentially a pragmatist (Cox, 2007: 54-5).

The loss of both the Papacy and magisterium left a vacuum of authority that the Crown sought to fill. It was an authority based on three factors: the stability of the Church of England, the preservation of the episcopacy and the right of convocation to legislate in Church affairs. To pursue theological reform might have called into question the Crown’s authority to determine such matters. Consequently, the Church of England did not prescribe on matters of faith, and the doctrine of priesthood received scant attention.

Perhaps this accounts for the claim that while the 1550 Ordinal of Edward VI was liturgically more Protestant, later changes culminating in the Ordinal

47 Archbishop of Canterbury, 1533-1555: a committed scholar both very human and too often unappreciated as a reformer (Heinze, 1993: 279).
48 The revised Ordinal appeared as an appendix to the 1549 Book of Common Prayer (BCP) in 1550 and became an integral part of the 1552 BCP (cf. Bradshaw, 1971; Puglisi, 1998).
49 Among those who did reflect on the nature of priesthood were Latimer (c.1487-1555) who argued for Christian ministry to be divorced from sacerdotal priesthood, and Hooker (1554-1600) who held, in common with medieval and scholastic theology, that priestly ordination conferred an indelible imprint, Of the Lawes of Ecclesiastical Politie, V 77 (3).
incorporated into the 1662 Book of Common Prayer (BCP) are more consistent with a pre-Reformation understanding of priesthood (Chadwick, 1968: 141-9). Post-Reformation revisions of the Ordinal did not reject sacerdotal priesthood outright. Nonetheless, they did characterize the priest as something more, emphasizing a pastoral and teaching responsibility: role and functions as watchman, steward and shepherd. Instead of chalice and paten, the priest was given a Bible. Authority was given to celebrate the Eucharist, but the priest was more than the Eucharistic celebrant. It was an Anglican understanding of priesthood that may have lacked precision, even coherence, but certainly not intention.

The notion of a sacerdotal priesthood fuelled relentless debate between English Puritans, Tridentine theologians and Anglican Divines. By the eighteenth century, liberal Anglican theologians dismissed as primitive barbarism suggestions that divine anger needed to be placated or divine justice satisfied by the sacrifice of cross or eucharist (Board for Mission and Unity, 1986: 67). Later, to counter the perceived excesses of liberal rationalism, those behind the Oxford Movement sought to restore what they claimed to be an authentic Anglican theology: priesthood and eucharistic sacrifice embedded in Scripture as interpreted by the Early Fathers. The eucharistic sacrifice was solely Christ's; human priesthood merely symbolic, derivative and representative. Evangelicals, for their part, would challenge any hint of Levitical priesthood in Anglican guise.

However, by the end of the nineteenth century, many theological assumptions were being challenged. Inevitably, the high church party distrusted the new scholarship. Among them was Moberly (1845-1903) whose thinking bridged the nineteenth and twentieth centuries, not only because his work, Ministerial

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50 The Ordinal was a legal entity in its own right; see the Act of Uniformity (1662) and the title page of the BCP.
51 The porretio instrumentorum of the 1550 Ordinal were the Bible, chalice and bread. See Bradshaw, 1971: 21.
52 The Tractarians drew on the patristic language of seventeenth century Divines, e.g. Laud, Bramhall and Taylor.
53 For example Goode, 1853 and Dimock, 1910.
54 The Cambridge School of Lightfoot, Westcott and Hort, together with Hatch of Oxford are exemplars of a scholarship which took new methods of research enquiry in other disciplines and applied them to the areas of New Testament exegesis, textual criticism and church history.
55 e.g. Liddon, Gore and Moberly.
Priesthood, became a standard text for the next fifty years, but because he provided a motif (Cox, 2004: 29). This motif consisted of several strands. The priestly ‘indelible character’ was interpreted in terms of what a priest does rather than what a priest is, ministerial rather than sacrificial, drawing together the different aspects of the church’s life (social outreach, evangelism, pastoral care and worship) as the one sacrificial offering of the entire Body. Here was a ‘high’ view of laity. Priesthood belonged to the Christian community as a whole, for the priesthood of the ministry was indistinguishable in kind from the priesthood of the Church (Moberly, 1899: 258). The priesthood of all believers and individual expressions of that priesthood, duly authorized, were not contradictory or incompatible, but rather possess a symmetry and correspondence. Both the ministerial calling and the exercise of that ministry required the presence of the Christian community (Cox, 2004: 69).

Although it was those spiritually aligned to the Oxford Movement who dominated the debate about church and ministry in the twentieth century, the teacher and writer, Thomas (1861-1924) provided an Evangelical perspective. Critical of Moberly’s concept of ministerial priesthood, Thomas claimed that no clerical ‘class’ could assert exclusive right in exercising any spiritual function as priesthood belonged to all the baptized. Where a distinction did exist, this was between priesthood and ministry: the essence of ministry was located in prophetic preaching and teaching, not in sacerdotal mediation (Thomas, 1911: 293-4; 380; 382). In contrast, another Moberly critic, the Anglo-Catholic Baverstock (1871-1950), denied that the ordained person merely expressed priestly powers belonging to all the baptized. Rather, priesthood set the priest apart from the congregation just as the shepherd is set apart from the flock and the ruler from the subjects (Baverstock, 1917: 29). While Moberly’s priest participated in Church governance, Baverstock’s exercised sole governance. Such views might have polarized the debate had it not been for the ascendency of Liberal Catholicity and a wider consensus concerning the nature of the Church, ministry and orders.

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56 ‘Ministry’ here means those who are ordained.
It was a consensus that brought together leading Anglican Catholics,\footnote{K. Kirk (1886-1954), A. G. Herbert (1886-1963) and A. M. Ramsey (1904-88).} as well as Temple (1881-1944) and Quick (1885-1944) in a breadth of churchmanship reflected in the Report of the Commission on Christian Doctrine appointed in 1922. The Commission’s remit was to explore what doctrinal consensus existed within the Church of England with a view to the removal or reduction of those differences (Commission on Christian Doctrine, 1938: 24). At stake was the unity and effectiveness of the Church of England, endangered as it was by various theological factions (Commission on Christian Doctrine, 1938: 4). When it reported fourteen years later, Temple, the Commission’s chairman, could acknowledge that in the section dealing with ministry, the agreement reached was both significant and important (Commission on Christian Doctrine, 1938: 14).

What, then, was agreed? In terms of Christian ministry, that this is principally the ministry of Christ for there can be no Christian priesthood or ministry apart from his (Commission on Christian Doctrine, 1938: 114). It is an ‘every member’ ministry, given that the Church as the Body of Christ is charged by Christ to continue his priestly and ministerial brief of reconciling the world to God. Those ordained are commissioned by the Church, on Christ’s behalf, to exercise this ministry in ‘the performance of certain distinctive and characteristic acts’ (Commission on Christian Doctrine, 1938: 115): in other words, the essence of ministry is located in the Church as a whole rather than in any particular group or congregation (Commission on Christian Doctrine, 1938: 119).\footnote{Ramsey pursued this idea that orders should derive from the corporate life of the church, and so challenged the Augustinian principle, which had arisen out of the fourth century Donatist controversy, that as Christ is the essential minister of any sacrament, both baptism and ordination are ‘valid wherever carried out… [although] there full effect could only be realized by restoration into the one Church’ (Ramsey, 1936: 154). This principle, ex opera operato, displaced the earlier Cyprianic view that baptism and orders are inseparable from, and their validity dependent upon, the life of the Church. Instead ‘valid orders come first, perhaps even as an isolated channel of grace’ (Ramsey, 1936: 152) in which case the umbilical cord connecting orders to Mother Church becomes severed. For Quick, this was segregation (Quick, 1948: 143); for Temple illegitimacy since ‘[t]he question of Orders must be considered in relation to the whole life of the Body of which they are an organic part’ (Temple, 1915: 108).} Despite the Commission’s achievement in forging a theological common ground with regard to priesthood, tensions remained that would become more apparent in the second half of the twentieth century. On the one hand, representative priesthood implies that all God’s people are called to share in Christ’s high
priesthood; on the other hand, it sets aside some to exercise the duties and responsibilities of that calling on behalf of all. Temple (1920: 165) might insist that priesthood becomes ‘evil’ when it is thought to belong exclusively rather than representatively to those exercising ordained ministry, but his solution, essentially clerical professionalization, had implications for how priesthood would be understood and exercised by future generations. It was Hanson (1979: 88) who pointed out that an understanding or interpretation of holy orders was not in the hands of any one bishop or priest but for the Church, which confers those orders, to determine. In recent decades the Ordinal, the Church’s understanding of its ordained ministry, both in its doctrine and its practice, has undergone extensive revision in the Church of England. An early attempt to revise the BCP, including slight revisions to the Ordinal, was made between 1927 and 1928 but this was rejected by the UK Parliament.

The Ordinal in *The Alternative Service Book* (Church of England, 1980), which appeared in 1980, reflected the theological consensus achieved by the mid-twentieth century, acknowledging that God had ‘formed a holy people… a royal priesthood, a universal Church’, that Jesus Christ was ‘High Priest of our faith’, that God had ‘given gifts… to equip [priests] for the work of ministry and to build up his body’ and that those to be ordained are called ‘to share this ministry entrusted to your [whole] Church’ (Church of England, 1980: 362, 393-4). Although the emphasis here is on the ministry of the entire church, strangely there is no formal part of the liturgy in which the people have a clear role.\(^59\)

In the latest revision of the Ordinal,\(^60\) the ‘Introduction’ makes it clear that God’s primary call is to his Church, and out of this prior calling comes the Church’s call to its ordained ministers. The ecclesial horse leads, the ministerial cart follows. Before the ‘laying on of hands’, the people give their consent to the ordination and, as at baptism, a commitment to support, if not actually nurture those to be ordained. They have a clear role in the welcome at the end of the liturgy of ordination: ‘we welcome you as ambassadors for Christ: let the word of Christ

\(^{59}\) Bradshaw has made the point that where the preface to the earliest Anglican Ordinals refers to ordination ‘by publique prayer with imposicion of hands’, this meant just that: ‘prayer offered by the whole gathered community’ (Bradshaw, 1997: 8).

\(^{60}\) The Common Worship Ordination Services were approved for use by the General Synod of the Church of England in 2005.
dwell in you richly’ (The Archbishops’ Council, 2007: 44). Here is an attempt to give voice to an ecclesiology based on the whole people of God: ‘within the royal priesthood of your Church you [God] ordain ministers…’ (The Archbishops’ Council, 2007: 52). Such may be the liturgical intention, but, indisputably, it is the bishops who hold the final and absolute right of ordination. In which case, as the one who ordains, does the bishop act as a vehicle of God’s grace or as a delegate of the church? The Anglican answer would be both, and yet this latest revision of the Anglican Ordinal fails to give that answer unequivocal liturgical expression.

In summary, therefore, the issues relating to the concept of priesthood emerging from the Reformation, and subsequent centuries, revolved around an understanding of priesthood in which a sacerdotal pre-Reformation construal lingered. Despite the emphasis now given to pastoral and teaching responsibilities, the suggestion of a sacerdotal priesthood, set apart from the laity, remained a contentious issue between different factions of the Church.

The doctrinal Commission of the twentieth century may have ruled that ministry was not the prerogative of the priest, but in its acceptance that he was commissioned to a specific ministry by the Church, this may have legitimized clerical professionalism. Even today, the Ordinal is unclear about whether the bishop ordains as a delegate of the Church or as a vehicle of God’s grace.

3.3.2 The Development of Ministerial Theology over the last 25 years
In order to determine the essence of Anglican priesthood as the contemporary Church of England formally understands it, three official reports will be reviewed. Spanning more than two decades, these reports are: The Priesthood of the Ordained Ministry (1986); Eucharistic Presidency: a Theological Statement by the House of Bishops of the General Synod (1997); and The Mission and Ministry of the Whole Church: Biblical, Theological and Contemporary Perspectives (2007).

What these reports illustrate is a significant development in ministerial theology. Embedded in the earliest report, The Priesthood of the Ordained Ministry, is a ‘high’ view of priesthood, a special ministry ordained to speak and act not only
on behalf of the whole community, but in its relationship with the community it serves. The priest is not the delegated recipient of the Church’s authority and function. Both the office of priesthood exercised by the individual and the priestly character of the Church are drawn from the priesthood of Christ, but they are different. ‘Christ makes his priesthood present and effective to his people’ through the office of the priest (Board for Mission and Unity, 1986: 99). By implication, the priestly character of the Church is dormant, only to be realized through the effective ministry of the priest who proclaims the gospel, administers the sacraments of baptism and reconciliation and presides at the Eucharistic celebration (Board for Mission and Unity, 1986: 99f.).

A decade later, the second of the three reports, *Eucharistic Presidency*, acknowledged that the theological integrity of priesthood must be grounded in ecclesiology. The growing realization that the life and action of the Church is founded on the life and action of the triune God introduces three corollaries. First, given there is no subordination of being in the Godhead, no subordination can exist in the meaning and value of every human being. Second, the nature of the Church cannot be prescribed by its institutional structures but rather as a community of persons-in-relation reflecting the trinitarian nature of God. Third, trinitarian ecclesiology and the ultimate value it places on human relationships negate individualism. Accordingly, God has provided the Church with an ordained ministry to ‘promote, release and clarify all other ministries of the Church’ to the end that they reflect and nurture the four marks of the Church: its oneness, holiness, catholicity and apostolicity. Consequently, the priest has specific responsibility to foster unity in diversity for the sake of the world, to promote the holiness of the Church by directing and enabling it to share in the holiness of God, to represent the local Church before the universal Church and correspondingly the universal Church before the local Church, and finally to uphold the continuity of Christ’s teaching and mission of which the Church is an instrument.

Twenty years on from the publication of the first report, *The Mission and Ministry of the Whole Church: Biblical, Theological and Contemporary Perspectives* adopts a ‘broader’ approach to ministry as ‘belonging to the people of God, the *laos*’ (Faith and Order Advisory Group, 2007: 65) and not
simply the prerogative of clergy. Instead of a hierarchy of ministries, there is recognition that ‘the most profound truth about Christian ministry… is that it is the ministry of Jesus Christ in and through his Body (The Faith and Order Advisory Group, 2007: 64). Priesthood is one of a series of ‘full and equal’ ministries (Faith and Order Advisory Group, 2007: 67) lay and ordained, by which God’s missionary task is furthered, the Church being God’s instrument of mission. This is not to deny the threefold distinctiveness of ordained ministry identified in the report. First, within the context of a formal liturgical act, the Church assigns to a person ministry that ‘is permanent and lifelong, public and representative’ (Faith and Order Advisory Group, 2007: 67) shaping self-understanding and public identity. Second, ordination confers a nationally authorized and accountable ministry that, in principle, is universally acknowledged and interchangeable. Third, ordained ministry draws together the three dimensions of the Church’s task, i.e. ministering the word, the sacraments and pastoral care and oversight (Faith and Order Advisory Group, 2007: 67).

The remit of the report was not to provide a definitive and comprehensive theology of ministry and ordination. In fact, it calls for ‘more theological depth, clarity and coherence’ on the nature of the ministry, whether ordained or lay (Faith and Order Advisory Group, 2007: 80). Nonetheless, it provides a contemporary and authoritative understanding of what might be considered to be the essence of Anglican priesthood.

However, what is absent from these three reports is any clear statement about how priesthood has been or might be conceived in terms of ontology, function or ecclesial relations. To clarify this, those who locate the origin of priesthood in Jesus’ commissioning of the apostles and a continuity of succession (e.g. Ramsay, 1985: 7) are inclined to adopt an essentialist interpretation of ordination whereby the priest, presiding in persona Christi at the Eucharist, is ontologically transformed, embodying in his or her being and life the mark of God’s priest (Pickard, 2009: 156). Alternatively, for those who take a functional view of priesthood, the pattern of Christian leadership owes more to

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61 The Anglican-Roman Catholic International Commission (ARCIC, 1982: 41) maintained that the ‘common Christian priesthood’ and ‘priestly ministry’ are ‘two distinct realities’ which bear no intrinsic relationship but represent parallel tracks (Pickard, 2009: 19).
its historical context: Christian ministerial office arising out of roles familiar to Jewish and Gentile cultures, at the same time influenced by needs of time and place (Ministry Division, 1989: 33). With no ontological distinction between the ordained and the lay person, priesthood might be construed simply as functional and non-sacramental. In fact, it may undermine the need for ordination (Percy, 2014: 7). This does not necessarily follow, for as the Roman Catholic theologian Schillebeeckx maintains, the priest who serves an ‘ecclesial function’ is nonetheless a ‘gift of God’: theologically, a charismatic office of service, both leading the community and accepted by the community (Schillebeeckx, 1980: 70). Beyond individual ontology and ecclesial function, there is a further way of perceiving the priest: as someone who is not only set within a series of relationships within the community of faith but relates to others in a particular and specific respect. (Pichard, 2009: 160).

In summary, therefore, the issues relating to the concept of priesthood emerging over the last three decades illustrate the fluidity of an underlying theology of ministry. In the ‘eighties’, the priestly character of the Church was thought to be realized solely through its ministerial priesthood. In the ‘nineties’, the ordained ministry was one which was understood to facilitate all other ministries as institutional Church structures gave ground to a trinitarian model of the Church: a community of persons-in-relation. In the ‘noughties’, priesthood was recognized as just one of a series of ‘full and equal’ ministries. No clear statement exists on what the essence of priesthood might be, whether as ontology or function or ecclesial relationship. Perhaps this reflects the reality of the Church as a place of incomplete, divergent, even incompatible theological opinions.

It is in the next section that I consider one further report that deals with the issues of ontology and ecclesial relations in greater depth; a report that emerged from conversations which took place between representatives of the Anglican Communion and the Orthodox Church in 2005.

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62 This is the view of the working party which produced the report, Call To Order: Vocation and Ministry in the Church of England, and which addressed understandings of vocation current at that time within the Church of England.
The Anglican Priest: Ontology, Function and Ecclesial Relationship

The Church of the Triune God, a 'commended' report bearing no authority, was commissioned 'to consider the doctrine of the Church in the light of the doctrine of the Trinity, and to examine the doctrine of the ordained ministry of the Church' (Anglican Consultative Council, 2006: 11). Of particular interest is Section VI entitled 'Priesthood, Christ and the Church' which directly addresses the ontology of the priest observing that 'bishops and presbyters do not possess an indelible mark as if ordination were a magic seal granting them personal power to celebrate the Eucharist or any other liturgical action, apart from the ecclesial body' (Anglican Consultative Council, 2006: 73). Ward disagrees, arguing that mainstream Orthodox theology perceives ordination to be an 'ineluctable gift of grace to the soul of the recipient' (Ward, 2011: 90). Moreover, the Commission's denial of priestly ontology produces an apparent inconsistency in the report. On the one hand it holds to the view that 'canonical data leave no doubt that, once the Church decided to depose a bishop or presbyter, they returned to the rank of layman ... and were in no way considered to retain their priesthood' (Anglican Consultative Council, 2006: 74). On the other hand, '[t]he fact that ministerial rehabilitation and restoration of such persons did not ... involve reordination, does not imply any recognition that they were bishops or priests during the period of such punishment' (Anglican Consultative Council, 2006: 74). To square this apparent circle, the Commission claims that 'the Church recognised what had been sacramentally performed. The grace of ecclesiastical ministry was restored upon his assignment to an ecclesial community with no other sacramental sign or rite' (Anglican Consultative Council, 2006: 74; italics my own).

Once again, Ward disputes this on a number of grounds, claiming that the Commission was unduly influenced by the ecclesiology of Zizioulas, conceiving ministerial ordination not as a doctrine of character but an ontology of relation (Zizioulas, 1985: 226). Absent is any objectification of grace by which something is done to the individual. Instead, beings meet one another in their authentic existence without any qualification or objectification of the other person. Through ordination a person becomes a particular kind of relational entity: ‘if ordination is understood as constitutive of the community and if the community being the koinonia of the Spirit is by its nature a relational entity,
ministry *as a whole* can be described as a complexity of relationships within the Church and in its relation to the world’ (Zizioulas, 1985: 220; italics in the original). Descriptors such as ‘ontological’ and ‘functional’ are not only misleading but misnomers if the thrust of Zizioulas’ theology is accepted, that the ordained person is a relational being rather than the recipient of a personal endowment (Zizioulas, 1985: 227).

For Ward, this interpretation of Orthodox canonical practice and dogmatic tradition flies in the face of historical evidence. More significantly and from an Anglican perspective, Ward is particularly concerned that a denial of the indelibility of ordination confounds the theology of Richard Hooker, one of the founding fathers of Anglican moral theology (Joyce, 2012: vii): ‘suspensions may stop, and degradations may utterly cut off the use or exercise of power before given: but voluntarily it is not in the power of man to separate and pull asunder what God by his authority coupleth’ (Hooker, 1597).

Nonetheless, Zizioulas is not alone in conceptualizing priesthood in relational terms. Greenwood, a keen advocate of both lay and ordained ministry grounded within a trinitarian framework, argues that a relational understanding of ministry outmanoeuvres advocates of clerical function or ontology (Greenwood, 1994: 152). Clearly, one finds here the influence of McFadyen’s writing on humanity and personhood, and of McFadyen’s thesis that individuality, personhood and selfhood need to be interpreted in social terms, addressing ethical and political questions about the right character of individuality and relation (McFadyen, 1990: 18).

For Cocksworth and Brown, the analogy of the vine⁶³ confirms that Christian identity is primarily relational, in that a calling into Christ precedes what is done for Christ or even how a life, shaped by this calling, is lived for Christ. Moreover, in terms of their potential for power and by implication their manipulation of power, ontologically-derived claims for the priest imply indisputable rights while functionally-derived claims for the priest ensure organisational control (Cocksworth and Brown, 2006: 5).

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⁶³ Gospel of John 15.
This key debate between an ontologically-conceived priesthood as against a functionally-conceived priesthood has argued different understandings of ontology; e.g. as lifestyle: ‘a life of sacrifice, a life of voluntary and involuntary renunciation’ (Henshall and Henshall, 2001: 89); as overtly spiritual: ‘so that all aspects of ministry... flow from the deep spiritual foundations of prayer, the doctrines of Christ and the Church and is spirituality rooted in an authentic relationship with the Trinity’ (Christou, 2003: 31); as self-giving: ‘imperfect and in need of being made whole as it is’ (Avis, 2005: 4); as sacramental: ‘[t]he man who is as Christ in the sacrament is not just like anyone else ever: he bears the stamp... a sort of walking sacrament’(Farrer, 1970:110); and again ‘[t]he ordained person is a sacrament who performs sacramental acts’ (Countryman, 1999:139); and as what might be called ‘process ontology’, whereby a person enters into a new relationship with the Church at ordination which involves leadership, validated by the tasks the ordained person undertakes, but more particularly through a ‘ministry in and to the church by which the priest is formed into the image of Christ the servant of the Lord, thus modelling and representing to the church its own vocation’ (Heywood 2011: 185-6).

While Heywood claims that it is ordination that initiates a process of ontological transformation, Green perceives this as taking place within pre-ordination training: a process of theological self-reflection and transformation through participation in liturgical roles. Thus ordination is the formal ecclesial and liturgical act which acknowledges the individual’s transformation and the new relationship which exists between the ordinand, the Church and God in the public gift of office (Green, 2010:119).

For Avis, the moment of ordination leads him to ask whether it confers public recognition to what is already true, the acknowledgement and recognition that a certain person has certain gifts. Comparing this to marriage, Avis (2005: 48) asks what matrimony adds to a couple co-habiting or, more prosaically, why a married couple might kiss one another when they know that each loves the other. In other words, does a liturgical and sacramental act merely celebrate and confirm what is already the case, or does it add something to the relationship, advancing it in some new way.
Cocksworth and Brown (2006) parallel and contrast the relational identity of the baptized and the ordained. Inherently, the Church is priestly and each baptized person is bound to all in a shared identity: the priesthood of all believers. Nonetheless, the Church also sets aside those it discerns as gifted and called by God to represent, in actuality, the Church’s priestly vocation. Until the second half of the twentieth century, these different expressions of priesthood had existed side by side within the Church of England, though not on equal terms given the historically received primacy of three orders of ministry. It is this primacy that in recent decades has been seriously challenged. Gordon-Taylor (2001: 4) insists that just as the theology of baptism has become more prominent in recent years, so too there needs to be a more thorough theological discernment of holy orders. While there may have been a renaissance in the field of baptismal theology, in recent times and in society more generally ecclesiastical rites of passage have lost their significance. Pickard (2009: 23) suggests that the same holds for ordination as a life-changing rite for the individual and the church, a demise he considers to be ‘the fate of ‘Holy Orders’ in the modern Church’.

Even as the Church of England rebrands itself for the twenty-first century, an ecclesial body shaped by and for mission, questions are raised about priesthood. It was Inge who observed as long ago as 1994 that a functional understanding of priesthood can be too narrow, a list of priestly tasks that is short on content and which fails to define priesthood. Ontological definitions, by their vagueness, are no better. What is needed, not only in terms of its contribution to ecumenical conversations about holy orders, but more especially if it is to be a vehicle of mission, is for the Anglican Church to discern whether its theology of orders can accommodate mission apposite for Anglicanism (Inge, 1994: 149).

A way forward may be discerned in Green’s call for a hermeneutic of priesthood within which identity is a ‘fusion of horizons’ (Green, 2010: 118).64 This

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64 Here, I assume that Green has in mind Gadamer’s argument (2004: 305 passim) that understanding is a dialectic process which involves a ‘fusion of horizons’ (German: Horizontverschmelzung). In brief, all understanding involves a process of mediation and dialogue, an encounter, between what is familiar and what is alien in which neither remains
resonates with the assertion, made elsewhere, that clergy identity and integrity should be regarded as a ‘horizon of possibility’ than as an objective reality (Foster, 2008: 460). Green envisages such a hermeneutic as enabling the priestly office to be understood as a mobile category, capable of re-signification and transformation (Green, 2010: 119). Priesthood, so conceived, encourages a theological reappraisal that aspires to be imaginative and creative, released from pre-conceived notions of what priesthood might or might not encapsulate. Whether a ‘fusion of horizons’ or a ‘horizon of possibility’, such a hermeneutic directly addresses the tension or dilemma of the ‘dual identity’ of the chaplain, located between the different worlds of religion and healthcare and ‘between the two monolithic structures of the Church and the hospital. Each world or structure has its own domain and demands an assumption and a mission’ (Woodward, 1998: 234). Unfortunately, as Swift perceives it, in redirecting its attention from pastoral ministry to mission, the Church has failed to realize that mission is at the heart of hospital ministry: its dilemmas, uncertainties and myriad of pressing needs (Swift, 2014: 182).

When, in 2009, a review was undertaken into the work of the Hospital Chaplaincies Council of the Church of England, the Chair noted that the Church needs to be clear-thinking about its ministry and mission in the National Health Service (HCC, 2010: 1). Later in its report, the Review Group stated that a key principle guiding the preparation of the report was that healthcare chaplaincy is an integral part of the Churches’ ministry and mission (HCC, 2010: 4). Such sentiments seem at odds with what has been observed elsewhere (Swift, 2014: 182): ‘a complete absence of serious corporate engagement’ with healthcare chaplains many of whom are clergy driven out of the Church in an exile largely the making of the Church. As Swift implies, healthcare chaplains need to do more to engage the Church and to communicate a theology which draws on their convictions or experiences (Swift, 2014: 182). I would add that this needs to be a theology which negotiates the different concepts of priesthood in the context of healthcare ministry.

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In summary, therefore, the issues relating to the concept of priesthood which stem from the conversations between the Orthodox Church and the wider Anglican Communion provide an opportunity to reflect more broadly on a range of ontological interpretations of priesthood which have emerged in recent years. This imaginative engagement with what might be the essence of priesthood encourages me to consider what the text of the NHS priest-as-chaplain as a ‘living human document’ might contribute to this debate.

3.4.1 Summary

In the course of this chapter I considered various theological perspectives which have influenced the evolution of priestly identity from the early Church through to the present day. The intention has been to address how the Church of England priest might theologically conceive his or her priesthood especially given the disparity of views.

Having explored the construal of priesthood in the Hebrew Bible, the first century CE synagogue, the early church and the church of the patristic and medieval periods, I then reflected on some of the theological re-interpretations of priesthood which gained ascendancy during the period of the Reformation in England. Given the ministerial militancy of English Protestants and the conservative intransigence of English Catholics, I have suggested that it was the via media of Elizabeth I which prevented a theological impasse within the Church of England. However, in tracing the liberal rationalism of the eighteenth century and the conservatism of the Oxford Movement in the nineteenth century, each with its own specific theological agenda, I find the trigger for the polarization which characterized the twentieth century. In summarizing the work of the Doctrinal Commission of the 1920s and 1930s I identified the potential for further theological unrest which did occur in the second half of the twentieth century. Having outlined the extensive re-interpretation of doctrine and practice with each revision of the Church of England Ordinal since 1980, I scrutinized the development of ministerial theology over the last twenty-five years by means of three official reports of the Church of England and one further report arising out of ecumenical discussions and which was commended. This final report brought to the fore issues of priestly ontology, function and relational character, and enabled me to introduce a new conceptual model of priesthood.
a ‘fusion of horizons’ or ‘horizon of possibility’, which claims to be both imaginative and creative, released from historical pre-conceptions. I concluded this chapter with a call for healthcare chaplains to take part in this theological debate about the conceptualization of priesthood: in particular, to address this in the context of healthcare ministry.

3.4.2 Developing the Thesis

The theological underpinnings and undercurrents, influencing the conception and reception of priesthood, will have been encountered by the Church of England priest during formation and ministerial practice. Consciously or inadvertently, these will be carried into the context of healthcare chaplaincy by the NHS priest-as-chaplain. There is, however, a further key variable which needs to be taken into account because of its potential impact on the character of the NHS priest-as-chaplain, i.e. the gradual professionalization of healthcare chaplaincy.

In the academic world, the defining properties and effects of professionalism and professionalization have undergone extensive reappraisal and revision since the turn of the millennium. The impact a professional agenda has had on both the NHS chaplain and the Church of England priest will be the subject of the next chapter: theoretical issues and the development of professional identity.
Chapter Four: Theoretical Issues and the Development of Professional Identity

4.1 Introduction

In this chapter, I will explore those ways in which the professional identity of the NHS priest-as-chaplain has changed over the lifetime of the NHS and why this has occurred (see further in §4.2.1). As I trace a growing perception that the chaplain is a healthcare professional, I will question whether chaplaincy, as a discipline, has fully engaged with what it means to be a profession and what professionalization implies and incurs (see further in §4.2.2). Taking into account the political narrative in which national chaplaincy bodies in England have been engaged, I will ask whether chaplaincy has fully recognized the ‘new professionalism’ of the twenty-first century or whether it is still unduly influenced by the sociological analysis of the professions which dates to the second half of the last century and of which I will provide a brief synopsis highlighting the work of Durkheim and Foucault (see further in §4.3.1). I will assess Woodward’s (1998) sociological analysis of NHS chaplaincy and establish whether, and in what ways, he was able to anticipate any of the issues which have become more apparent in the first decade of the new millennium (see further in §4.3.1).

The contemporary cynicism towards professionals, brought about by crises in public life (see further in §4.3.2), leads me to review postmodern professionalism in terms of professional scripts and renegotiated identities. I note the part played by New Public Management (NPM), and consider themes of culture and conformity, and professionalism as a disciplinary mechanism (see further in §4.3.3). I examine two recent experiences of occupational professionalization: first, healthcare chaplaincy in the Netherlands and, second, operating department practitioners in the UK. This will examine both disquiet and disappointment among those affected, as well as probing the role of the State in managing and determining professional boundaries and responsibilities in healthcare. In this, I will investigate the impact of the ‘new professionalism’ on NHS chaplaincy (see further in §4.4.1) and any part it has played, or sought to play in reshaping the identity of the NHS priest-as-chaplain (see further in §4.4.2).
As I conclude this chapter, I will establish in what respects theology might engage with professionalism and, to this end, I will draw on the work of Campbell (1985), focusing on issues of power, knowledge and altruism, Bridger and the place of vocation, and some final thoughts on virtue ethics concerning character, theological convictions and spiritual practices (see further in §4.5.1).

4.2.1 Healthcare Chaplaincy: the professional identity of the chaplain

Among the images and metaphors that healthcare chaplains have used to flesh out the question of their identity, there is the occasional early hint that the professionalization of chaplaincy was a debate waiting to be had. Even in the late 1960s, Autton (1968: 2) was emphatic that chaplains needed to be clear about what their ministry involved in order for them to develop a skills-based professionalism. The chaplain was like the clown, the perceived amateur among celebrated experts. Whereas hospital doctors, and other allied healthcare professionals, are the acknowledged trapeze-artistes, the hapless clergyperson is relegated to the role of the clown (Faber, 1971: 86), although this fails to grasp the rigorous training and rehearsal that clowning involves. Grock, a celebrated clown, knew from his own experience that he had to be the inveterate professional (Faber, 1971: 87).¹ For both Autton and Faber, professionalism was a means of acquiring and demonstrating competency in the field of chaplaincy. Woodward (1998: 111) claims that Autton led the field in this respect, promoting skills-based chaplaincy with its own programme of training.

The professionalization of healthcare chaplaincy was a gradual affair. Professional accreditation was considered in 1978 (Hart, 1978: 3) but the NHS and Community Care Act, 1990, which introduced the ‘internal market’ for health care and the language of business, made the issue more pressing. NHS ‘administrators’ became ‘managers’ as NPM² took hold with a government intent on modernization and making the public sector more effective. The mantra of NPM was the three Ms of ‘markets’, ‘managers’ and ‘measurement’

¹ Rooted in Renaissance theatre, particularly commedia dell’arte, the modern clown of Western art-form owes much to the commedia troupes who were professional performers (Beardsley, 2006: 5).
² New Public Management, derived from the philosophy of the private sector, is an umbrella term for various reforms in public sector management, the aim being to produce greater efficiency and cost-effectiveness (Parding, Abrahamsson and Berg-Jansson, 2012: 296).
(Ferlie, Ashburner, Fitzgerald and Pettigrew, 1996). For those working in the NHS, these changes had a profound impact. Paradoxically, because professional bodies were weakened as all NHS employees, including chaplains, were brought within the new structures of institutional management, professional groups sought to re-assert themselves. In 1992, at their annual conference, chaplains addressed issues of professionalism in terms of processes underpinning the delivery of chaplaincy and the necessary skills (Woodward, 2000: 27). As professionalization evolved, there were signs of discomfort and uncertainty alongside a sense of inevitability.  

In a paper addressing ‘hard and perhaps awkward questions’ Swinton (2003:2) observed that many healthcare chaplains considered that their future lay in developing the identity of a healthcare professional. Recognizing that the question of professionalization was becoming a burning issue, Swift (2004: 8f.) claimed that the quandary for healthcare chaplains, anxious about questions of identity and future direction, arose from an Enlightenment mindset hard pressed to accommodate a professional identity servicing religious and spiritual reality. What, Swift asked, were the theological implications of expecting chaplains to practise their craft according to the same evidence-based criteria by which other healthcare practitioners operate? Would this eventually lead to a form of spiritual assessment that would confidently differentiate the effectiveness of religious traditions and rituals by means of applying the principles of clinical truth?  

3 Evidence of this comes from chaplains and academics e.g. ‘[t]here are certain dangers in the ethos of professionalism... [but h]ealth care chaplaincy has no option but to organise and develop a professional approach to its key tasks and roles’ (Woodward, 2000: 28); ‘the chaplain remains a living symbol of the tension between vocation and career... one aspect of that tension [being] the notion of professionalism’ (Woodward, 2001: 84); ‘[i]n chaplaincy we need to develop the confidence to contain the tensions that can arise from aspects relating to the art and the skills of our professional practice. Pulling in opposite directions can often lead to a disastrous outcome’ (Speck, 2003: 6); ‘[c]haplains are first and foremost called to care for the spirituality of human beings, i.e. that dimension of humanness that refuses to be captured by standard scientific methods. If chaplains in their quest for ‘professional credibility’ forget this, they risk losing something that is fundamental to authentic chaplaincy’ (Swinton, 2002: 225); and finally the observation that chaplains ‘have been seductively encultured into embodying a whole set of professional standards which are now light years away from the kind of expectation and norms which would be imposed on people working in parishes or in other spheres’ (Percy, 2003: 18).

4 In a survey of chaplains conducted by the CHCC in 1999, only 52% of respondents favoured professional registration, whereas by 2005, this figure was 95%. This was regarded as a mandate to eventually establish the UKBHC (English, 2009: 10f.)

5 Foucault is critical of the post-Enlightenment claim that all life can be textualized and argues that ‘what we encounter are not hidden ‘truths’ revealed by skilful pioneers, but claims to truth
would be required, it was argued, would be an acknowledgment that a person’s spiritual distinctiveness or character is of a different order from that which acquiesces to scientific method (Swinton, 2002: 225).  

Of course, in some respects nineteenth century workhouse or infirmary chaplains, forerunners of twenty-first century healthcare chaplains, were already part of a long-established profession privileged by an accountability to the bishop and their representative establishment role within the workhouse. Consequently, they had little to gain by setting-up an occupational association (Tanner, 1998: 23). It could be argued that this remained the case up to and following the formation of the NHS in 1948. In 1946 the General Assembly of the Church of England established the Hospital Chaplaincies Commission to maintain a watching brief on the place of chaplains within the proposed NHS. This was succeeded, in 1951, by the Hospital Chaplaincies Council (HCC) to represent the interests of the Church of England in all matters related to hospital chaplaincy in England. Yet, with the birth of the NHS, chaplains became aware of a new sense of common identity (Swift, 2006: 59) and with it the advent of various Chaplaincy associations: the Church of England Hospital Chaplains’ Fellowship, the Free Church Hospital Chaplains’ Fellowship and the first hospital chaplains’ ‘trade union’, the National Association of Whole-Time Hospital Chaplains.

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6 An interesting parallel, in this regard, is Occupational Therapy (OT) which originated in the USA and was introduced into the UK in the 1930s. Influenced by the Arts and Crafts movement, OT was and, for some, remains antithetical to medicine viewed exclusively within a science framework (Hugman, 1991; Clouder, 2001:28).

7 The remit of the Hospital Chaplaincies Commission was ‘to enquire into: (1) The church’s ministration to her members in the mental institutions of the country, to consult with the Minister of Health with a view to future provision for this work within the National Health Service, to make recommendations with regard to the training of men for this specialised service, and to report. (2) The status of chaplains in other medical institutions appointed under the National Health Service Bill’ (Hospital Chaplaincies Commission, 1948: 1).

8 The remit of the HCC was ‘(1) to advise the Church Assembly, when requested, on questions of ‘spiritual ministration’ to patients and staff in hospitals; (2) to provide advice on questions of policy to diocesan bishops and Anglican Regional Advisory Committees; (3) to monitor and report ‘matters affecting spiritual ministration’ in hospitals; (4) to co-ordinate Anglican Regional Advisory Committees; and (5) to liaise, on behalf of the Church of England, with the Ministry of Health on matters relating to ‘spiritual ministrations’ in hospitals’ (Hospital Chaplaincies Commission, 1951:14).

9 The aims of the National Association of Whole-Time chaplains were: ‘(1) To secure an efficient and adequate Hospital Chaplaincy Service. (2) To defend, maintain and further the interests and status of all full-time chaplains within the Hospital Service. (3) To procure equitable salaries and conditions of service for all full-time chaplains employed in the Health Service. (4) To co-
Forty years later, at the beginning of the 1990s, the introduction of NHS Trusts\textsuperscript{10} was arguably the most significant re-organization of the NHS to affect chaplains. So perhaps it was predictable that, in 1992, the Hospital Chaplains’ Fellowship and the National Association of Whole-Time Hospital Chaplains would come together to form the College of Health Care Chaplains (CHCC). As a new body, it was open to all health care chaplains of any church, denomination or faith community. This perhaps reflected a sense that church structures no longer provided a means of support, and that different skills were needed to enable chaplains to negotiate their place within the NHS (Swift, 2006: 59).

At first, the HCC and the CHCC worked collaboratively,\textsuperscript{11} but this did not last. In part, this may have been due to a belief that the HCC wanted to protect the interests and influence of the Church of England in the NHS (Swift, 2014: 76). The NHS management-led initiative, \textit{Caring for the Spirit}, which ran from 2003 to 2007 and sought to develop healthcare chaplaincy in England, was staffed from Church House, the headquarters of the Church of England, and consulted with specifically invited chaplains (Swift, 2006: 60). Again, in 2003, the HCC was pivotal in establishing the Multi-Faith Group for Healthcare Chaplaincy (MFGHC) in discussions with the Department of Health. The purpose of the MFGHC was to develop multi-faith chaplaincy provision yet its administrative support was provided by the HCC, and its Chief Officer was the Chief Executive of the HCC.\textsuperscript{12}

This diversion into the politics of healthcare chaplaincy highlights competing claims by chaplaincy organizations, and the recognition that no group’s interest in chaplaincy is going to be value free (Swift, 2006: 61). Between 2003 and 2010, three organisations, the HCC, the CHCC, and the MFGHC claimed to represent healthcare chaplaincy. While each had its own agenda, for the HCC

\begin{quote}
operate in every way possible with all other groups and professional bodies, in the welfare of both patients and staff in hospital.’ (King Edward’s Hospital Fund, 1966: 48).
\end{quote}

\begin{quote}
\textsuperscript{10} Under the NHS and Community Care Act 1990, health care providers in the hospital and the community were able to apply for self-governing Trust status. This allowed them to develop their own management structures, to decide the use of their assets, and to set terms and conditions for their staff. Initially, 57 units were granted Trust status in April 1991, and by 1996 over 95 per cent of providers were Trusts (Open Learn, 2012: (§1.2)).
\end{quote}

\begin{quote}
\textsuperscript{11} An example of collaborative working was the jointly funded appointment of a National Training and Development Officer in 1996.
\end{quote}

\begin{quote}
\textsuperscript{12} Until 2010 when the HCC effectively ceased to exist.
\end{quote}
and the CHCC the common denominator was an appeal to the ‘professional’
chaplain.\textsuperscript{13}

Although overtures (see Imison, 2002: 22-30) to the Health Professions Council
(HPC)\textsuperscript{14} for healthcare chaplaincy to gain statutory recognition as a profession
failed,\textsuperscript{15} a political awareness emerged among chaplains (Swift, 2006: 60) which
resulted in co-operation between three chaplaincy bodies: the CHCC, the
Association of Hospice and Palliative Care Chaplains and the Scottish
Association of Chaplains in Healthcare. In 2005, these professional bodies
endorsed a common \textit{Code of Conduct} and established the Chaplaincy
Academic and Accreditation Board which in 2008 and, with the additional
participation of the Northern Ireland Healthcare Chaplains’ Association, became
the United Kingdom Board of Healthcare Chaplaincy (UKBHC), ‘advancing the
professional standards of healthcare chaplaincy’ (UKBHC). As part of its remit,
the UKBHC set up and continues to maintain a voluntary register of healthcare
chaplains. Higher Education Institutes\textsuperscript{16} offer post-graduate degree
programmes in Chaplaincy Studies and an appropriate model of reflective
supervision is now considered essential for professional identity, strengthening
good practice (Sutherland, 2010: 2). Yet ambivalence remains amid fears
voiced that a new profession might not only be dangerous but positively
damaging (Haig, 2010: 4f.). This epitomizes the case which I set out in the next
section (§4.2.2), that profession is a concept which has been readily
appropriated by constituencies within chaplaincy but remains little understood.

\textsuperscript{13} Before the HCC was disbanded, its website stated that its remit was ‘[T]o enable [chaplains]
who work in the particular and complex setting of the National Health Service to meet NHS
standards of quality and professionalism by providing high quality training’; the work of the HCC
is now incorporated into the work of the Mission and Public Affairs Division of the Church of
England which maintains ‘professional training and Continuing Professional Education for
Chaplains’ (Hospital/Healthcare Chaplaincy, no date, c); the CHCC ‘promotes the professional
standing of chaplaincy’ (CHCC, no date).

\textsuperscript{14} The HPC became the Health and Care Professions Council (HCPC) from 1 Aug 2012.

\textsuperscript{15} Following the UK Government’s Command Paper, \textit{Enabling Excellence – Autonomy and
Accountability for Healthcare Workers, Social Workers and Social Care Workers} (2011),
statutory regulation ended other than in ‘exceptional circumstances’ where there is a
‘compelling case’ and where voluntary registers, such as those maintained by professional
bodies and other organisations, are not considered sufficient to manage the risk involved.’ In
2016, the UKBHC applied for its voluntary register to be accredited by the Professional
Standards Authority (Professional Standards Authority, 2016).

\textsuperscript{16} For example: York St John University, St Mary’s University Twickenham and St Padarn’s
Institute (formerly St Michael’s College Cardiff).
4.2.2 Healthcare Chaplaincy: professionalism or professionalization

Many reasons have been put forward to account for the gradual move towards the professionalization of chaplaincy. Among these, the need for healthcare chaplains to be accepted as fully integrated members of the clinical team and acknowledged as competent, qualified and vocationally focused (Swift, Handzo and Cohen, 2012: 185); to ensure a service that is accountable for quality, sound practice and value for money (Kelly, 2012: 473); and to prioritize both continuing professional development (in line with the NHS programme Knowledge and Skills Framework) and research (Swift, 2014: 80). However, with one notable exception (Woodward, 1998), chaplains have failed to engage in any depth with the nature of profession, professionalization and professionalism (Orchard, 2000; Cobb, 2005; Swift, 2014). Swift (2001) and Kerry (2001) discuss the need for the chaplain to be a professional person but fall short of asking questions about professionalism itself. Cobb (2001) explores the moral dimension of responsibility, which he considers inherent to professionalism, but fails to recognize its presence in non-professional occupations.¹⁷ A short paper on professionalization, by Swinton (2003), was prompted by his concern that chaplains might be called upon to account for who they were and what they did. Seeking to open up a dialogue about the nature and identity of healthcare chaplaincy, Swinton posed the question, ‘What does it mean to be a professional?’ Nearly fifteen years on, this remains a pertinent and central question, a question which I will address later in this chapter (§4.4.2).

At the same time, I would not want to disregard or dismiss the detailed sociological analysis which Woodward (1998) provides. Unfortunately, though understandably, it is rooted in a twentieth century mindset which many twenty-first century sociologists have since discounted. His comment (1998: 55f) that sociologists are unable to agree a definition of profession remains valid, as does his acknowledgment that the significance and value professionalism represents for healthcare chaplaincy has generated a wide range of views

¹⁷ Swift (2001) argues from the premise that the chaplain is a professional and presents an alternative view of professional practice based on a re-definition of spirituality in healthcare. Kerry (2001) locates professionalism within a competency framework. Cobb (2001) suggests that there is a moral perspective to the role of the chaplain which is inherent to professional practice i.e. a responsibility to do no harm and the integrity to act for the good of the person for whom care is provided.
among chaplains. Woodward’s analysis, however, does provide a useful stepping stone into the sociological accounts of profession, professionalism and professionalization which I address in the following section (§4.3.1).

4.3.1 The sociological analysis of professional work
Among sociologists, the 1950s and 1960s witnessed a burgeoning interest into the nature of professional work: what were its key characteristics and how might it be defined? Initially, this turned on the notion of an ‘ideal type’ whereby professions could be differentiated from non-professions. Ad hoc lists of attributes were generated centring on professional knowledge and expertise but also noting the place of altruism, public service and an ethical code of practice (Greenwood, 1957; Goode, 1960, 1969; Wilensky, 1964; Etzioni, 1969). However, little thought was given to the nature of language (Mauws and Phillips, 1995) as well as issues of equivalence and difference when taking account of historical developments (Morrell, 2007:9).

A subsequent variant of this, which some have considered theoretically more sound (e.g. Saks, 2012: 2), drew on the work of Durkheim, the pioneer of the science of sociology in the late nineteenth and early twentieth centuries. Durkheim (1893), exploring the development of societies, argued that social solidarity, i.e. a set of norms, values and morals that typify a social group, differed according to the type of society. Mechanical solidarity, found among traditional and small scale societies and based, for example, on a common lifestyle might evolve into an organic solidarity typical of complex modern societies and based on an interdependence and complementarity among its membership (Durkheim, 1982, 1992). Characteristic of complex modern societies, professions were perceived to play an important buttressing role. The function of professionalism was conceived to be the provision of a dominant belief or value system that underpinned the stability and civility of advanced social systems. It was an hypothesis that attracted the attention of later sociologists (Goode, 1960; Barber, 1963) with some (Pilgrim and Rogers, 1999; Saks, 1995) arguing that professions are recipients of a privileged status within society, underwritten by the State, and based on an assumption that a profession, as the guardian of specific knowledge and expertise which is both
complex and indispensable for society, will act as a self-regulator thereby safeguarding the public in general and clients in particular.

Doubts, however, were voiced (Saks, 2012) about the merits of a taxonomic approach given what, arguably, are naive and ahistorical assumptions. For example, while professionals might claim access to specialist knowledge and expertise, as the basis for professional advice or action, the nature of such knowledge and expertise, be it substantive or theoretical, has not always been obvious (Hughes, 1963: 655). Influenced by interactionism and labelling theory, some sociologists have claimed that an over-emphasis on difference has meant that similarities, between privileged professions and lower-status occupations, have been over-looked (Becker, 1962). Brante (2010) noted features common to auto-mechanics and professionals e.g. the employment of specialists and generalists within both occupational groups. For too long, it is claimed (Parry and Parry, 1974: 160), ideological pretentions have been accepted too readily and at face value. Professions have justified their privileged status by exaggerating the exclusive nature of their knowledge and expertise without providing corroborating evidence (Johnson, 1972; Roth, 1974).

This critique of the taxonomic approach owes much to the insights of interactionism, and its premise that socially negotiated labelling has been overly influenced by occupational ideology. Nevertheless, some sociologists claim that micro-sociology, such as interactionism, is too narrow a perspective and fails to give due regard to the large-scale structural forces that bear on human behaviour. This is macro-sociology which itself consists of a number of theoretical orientations. Two of these have played a significant part in scrutinizing the relationship between society and the professions.

18 The boundary between microsociology and macrosociology is more blurred than this might suggest. Dissatisfied with the micro-macro distinction, at the beginning of the 1990s a group of American sociology students, calling themselves MESO, began to meet informally to discuss the middle ground between microsociology and macrosociology: mesosociology (Smelser, 1997:28). Although mesosociology has not been formally defined, in recent years sociologists have inferred its subject area (Evetts, 2003, 2012; Plummer, 2010; Fine, 2012). In the next section, I will explore the discourse of professionalism as a significant tool of occupational change and social control at all three levels (Evetts, 2012).
The first, a neo-Marxist perspective,\(^{19}\) views the role of profession as being party to a collusive relationship with the State whereby, collaboratively or as a hostage to fortune, it is used to further the interests of the capitalist class. In these terms, a profession is understood to be either a willing partner, an instrument of surveillance and control (Ehrenreich and Ehrenreich, 1979; Navarro, 1979), or, alternatively, a victim, its power-base gradually eroded through a process of de-professionalization (McKinlay and Arches, 1985; Braverman, 1998).

The second draws on the work of Foucault who was critical of the assumption made by those promoting a taxonomy-style definition of profession, that scientific progress within institutions such as hospitals, prisons and schools, could be attributed to the knowledge and expertise of professionals (Foucault, 1973). Rather, Foucault conceptualized the professions within a system which he called 'governmentality'. Central to this was his rejection of any idea of the State as a coherent, rational, jurisdictional exercise of sovereign power typical of the medieval period. At that time, political power was exerted through the imposition of law. It was during the Renaissance period that nation States began to employ strategies and tactics to ensure a content and stable society, so rendering a society governable (Jones, Jones and Woods, 2004: 173). Governing became the 'right disposition of things' leading to the 'common welfare and salvation of all' (Foucault, 1979b: 12). A science of government emerged in which institutions, varieties of knowledge, protocols, strategies, and skills were selectively endorsed by a government dependent on the direction that government was intent on pursuing. In other words, a profession is not constituted in terms of its knowledge and expertise per se but instead owes its privileged existence to a political act of assimilation. As a strategic instrument of government, a group of occupations possessing a set of expertise, are specifically selected and used to further the aims and objectives of the State. This Foucault described as the ‘institutionalization of expertise’.

\(^{19}\) Neo-Marxism refers to those social theories or sociological analyses which extend the theories of Marx and Engel, while incorporating other intellectual strands. The neo-Marxist perspective to which I refer here draws on Weber’s wider interpretation of social inequality and his emphasis on status and power.
It was during the eighteenth and, most especially, the nineteenth centuries, that
the political integration of the evolving professions became integral to this
system of governmentality and came to typify modernity (Johnson, 1995: 9), a
very specific albeit complex form of power (Foucault, 1979b: 19). The capacity
to govern rested on expertise in its professionalized form. Sovereignty,
derunderwritten by divine law, gave way to an acceptance that a normative
obedience to the law was the only basis for legitimate rule (Foucault, 1979b:12).
The professions were an integral part of this machinery of normalization, and,
by way of their authority as 'expert', were the means by which the authority of
the State secured its political programmes and policies. Normalization, whereby
legitimate political power depended on the obedience of the citizen-subject,
providing a framework of self-discipline: control was internalized and proactive
rather than external and reactive (Gane and Jones, 1993: 143). I will return to
this theme later (§4.3.3), at which point I will consider the appeal of
professionalism as a disciplinary mechanism in new occupational contexts.

Given the history of this sociological analysis, it is striking that the first
significant critique of healthcare chaplaincy, in terms of its professional
credentials, was left to Woodward (1998) in the late 1990s. This contrasts with
the attention some sociologists gave to the general occupational status of
Church of England clergy from the 1960s onwards (Woolgar, 1960; Coxon,
1965; Towler, 1969; Glasse, 1968; Steward, 1974; Jarvis, 1975a, 1975b, 1976;
Towler and Coxon, 1979; Russell, 1980). Arguably, this interest stemmed from
a perceived crisis. Clergy, in the nineteenth century, were considered to be
archetypical professionals, but by the mid-twentieth century, their occupational
identity was far less clear. Their ministry, for all intents and purposes, was
trapped in a time-warp of nineteenth century attitudes, structures and practices
(Russell, 1980). At the same time, whether in response to this crisis of identity
or because modern chaplaincy was evolving, NHS chaplains were beginning to
write about the distinctiveness of chaplaincy work. Although Swift describes the
years 1958 to 1968 as a period when chaplains were closely attending to the
question of professional identity (Swift, 2014: 42), he does not explain what he
understands by professional identity. I suspect that it was related to the
apparent way healthcare chaplains were beginning to place an 'occupational'
distance between themselves and parish clergy.
Woodward (1998) addresses this applying a broad sociological analysis to chaplaincy. He notes (1998: 41) that, in common with trait models, the professionalization of chaplaincy includes accreditation, efficiency, competence, integrity and altruism. He infers that the Chaplaincy Education and Development Group,\textsuperscript{20} by publishing health care chaplaincy standards was, in a neo-Durkheimian sense, both regulating the work of chaplains and safeguarding society by providing managers with a yardstick by which to appraise, evaluate and train chaplains (HCC, 1993).

From a Weberian perspective, Woodward observed what he interpreted as the impact on chaplaincy of both social closure and professional dominance. Social closure was evident, Woodward (1998: 45) argued, in chaplaincy’s claim to possess a unique knowledge-base and an expertise in areas of practice such as bereavement, death and dying and staff support. Professional dominance, on the other hand, was experienced by its negative impact on chaplaincy. Within the culture of the NHS, the primary model is medical. This means that professional dominance lies with the medical practitioner and as Woodward (1998: 249) wrote, ‘hospitals do not seem to be places dedicated to human health and wellbeing, but instead like places dedicated to medical technical excellence’. The non-empirical pastoral and spiritual care which the chaplain offers is generally little understood and may leave the chaplain feeling marginalized and lacking confidence. Moreover, within the multi-cultural environment of the NHS, Woodward (1998: 48) asks whether chaplaincy ought to be distinctively Christian (as it was then and, arguably, as it remains). In this respect, Woodward appeared to take no account of what others had identified as the gate-keeping role of Christian chaplains promoting, supervising and monitoring the equality of provision within and across faiths (Beckford and Gilliat, 1996; Orchard, 2000): a sure sign of professional dominance.

Overall, Woodward’s sociological analysis was a product of its time and so limited. First, he failed to give sufficient weight to the claim that professions were at risk from the organizational, economic and political changes taking

\textsuperscript{20} This group represented the College of Health Care Chaplains, the Free Church Hospital Chaplaincy Board, the Hospital Chaplaincies’ Council and the Roman Catholic Hospital Chaplaincies.
place in the 1990s (Crompton, 1990; Greenwood and Lachman, 1996; and Reed, 1996). Second, it had become dated in the face of a resurgent interest among sociologists which signalled an era of ‘new’ professionalism (Evans, 2008). In one respect, though, Woodward’s analysis was accurate. He foresaw the effect NHS reforms would have, introducing a new controlling style of management concerned with issues such as accountability and quality appraisal. This was to have a direct bearing on the work of health care professionals. Although Woodward suggests that the medical profession escaped relatively unscathed, retaining status and influence (Elston, 1991; Cox, 1991; Gabe, Kelleher and Williams, 1994; and Witz, 1994), not all agreed (Freidson, 1988; Mechanic, 1991; Allsop and Mulcahy, 1996; and subsequently by Fish and Coles, 1998; Harrison, 1999; and Harrison and Ahmad, 2000). Some anticipated the eventual demise of profession as a unique kind of social institution (Krause, 1996; Broadbent, Dietrich and Roberts, 1997; and Stichweh, 1997). Yet, the fact remains that with few exceptions (Mitchell, 2006), healthcare chaplaincy (Orchard, 2000; Swintons, 2003; Cobb, 2005; Swift, 2014; Ballard, 2010) failed to critically engage with ‘reconceptualised professionalism’ (Evans, 2008) when it appeared at the turn of the twenty-first century.

What would emerge was a ‘discourse of professionalism’, a process by which employees across a range of occupational groups came to accept, adopt and adapt patterns of work to conform to notions of professional and professionalism constructed by employers and managers (Evetts, 2006: 523). By this means, change and restructuring could be introduced into workplace practices (Evetts, Mieg and Felt, 2006: 111). This I will explore in the next section (§4.3.2).

4.3.2 The discourse of professionalism

There is little doubt that in the twenty-first century, the general public has become less deferential, perhaps also more cynical, in its approach to professionals (Evetts, 2006: 516). Even before the 2008 banking crisis and the 2009 UK parliamentary expenses debacle, there were high profile medical scandals in Hyde Manchester, Alder Hey and Bristol which resulted in three public inquiries (The Shipman Inquiry, 2001-2005; The Royal Liverpool Children’s Inquiry, 1999-2000; and the Bristol Royal Infirmary Inquiry, 1998-
2000). As a direct consequence of Bristol and Alder Hey, in 2000 the Department of Health introduced continuous performance review and clinical guidance (Hallowell, 2008: 528f.).

To what extent, then, has professionalism, though damaged, retained sufficient credibility or has it undergone a style make-over or image-change (Evans, 2008: 1)? The labels, professional and professionalism, have evolved into a discourse applied across many different occupational groups. It is a discourse by means of which businesses are marketed, employees are recruited and products are promoted (Fournier, 1999: 294; Evetts, 2012: 4). Has such indifferent generalization rendered the terms ‘professional’ and ‘professionalism’ meaningless? Alternatively, is there more implied by this discourse when non-professional occupations adopt it? Pfadenhauer (2006: 566, 573) makes reference to ‘postmodern’ professionalisms while Hoyle describes a ‘new professionalism’ which is amorphous and lacking shared provenance and content (2001:148). While a postmodern scepticism ensures that no knowledge claims are ungainsayable or uncontestable (Quicke, 2000: 302), it has been argued (Evetts, 2006: 527) that the discourse of professionalism has shown itself to be an effective tool in bringing about occupational change and social control.

Fournier (1999: 281) suggests that this appeal to professionalism is a type of disciplinary mechanism enabling control at arm’s length by means of work identities and practices that are laid down. The context in which she sees this taking place is one of advanced capitalism where economic, cultural and technological changes are underpinned by flexible working practices, e.g. decentralization and delayering. This necessarily entails a degree of occupational discretion and a more flexible approach to strict professional oversight of specific areas of work. By giving workers more autonomy, the expectation is that this will motivate them to be innovative and self-achieving. Placed within a Foucauldian framework of governmentality, liberal government

21 One decorating company markets its services by advising potential customers to ‘Take the stress out of [the work] by using a professional and expert painter and decorator’ (JJC, no date).
22 In 2013, Starbucks, the global coffee house chain, was advertising professional barista apprenticeships (Apprenticeship Vacancy Matching Service, no date).
23 For example, one company advertises a range of ‘trade professional paints’ (Johnstone’s, no date).
and the core idea that all truth claims of expertise are able to govern events and individual behaviour at a distance (Miller and Rose, 1990: 2), Fournier noted that the autonomy of long-established professional practice was dependent on the principle of professional competence determined and regulated at a distance. She explored the implications this might have for new occupational domains, proposing that an appeal to professionalism had become a means of regulating the autonomous practices of employees in what were formerly non-professional categories of work. However, establishing competencies and introducing a professional culture affects not only practice but, an employee’s identity and how they perceive themselves (Fournier, 1999: 296).24

Although Fournier nowhere uses the word governance25, it is implicit in her study of how professional identity and practice have now evolved. A study (Parding, Abrahamsson and Berg-Jansson, 2012) into public sector governance of the teaching profession in Sweden, noted both the complexity surrounding the shaping of professional identity and the part played by NPM: its influence on professional discourse and therefore its influence on how the employees view their organisation, their profession, their work, their own identity, and their professional identity (Parding, Abrahamsson and Berg-Jansson, 2012: 297). In the next section (§4.3.3), I explore how NPM has given rise to new professional scripts, and the relationship between occupational professionalism and organizational professionalism.

4.3.3 Professional Scripts and Renegotiated Identities

While NPM was a global phenomenon, a response both to the worldwide fiscal crisis in the late 1970s (Hood and Scott, 1996) and, some would claim, the bureaucratic failure of the Keynesian welfare state (Baird, 2003: 2), it is an open question whether NPM embodied a coherent approach towards the reorganization of services (see McLaughlin, Osborne and Ferlie, 2002). Pollitt, Birchall and Putman (1998: 34) argue that while ‘the history of public

24 Fournier (1999: 300) does admit that an appeal to professionalism cannot guarantee employee attitudinal change in all cases: for example, a waitress or shop assistant is unlikely to accept that a professional attitude in the workplace is related to personal development; in this instance, factors more likely to influence behaviour and attitudes are management coercion or the fear of being without a job at a time of high unemployment.

25 The term governance, in the field of political sciences, is used to conceptualize the ways in which organizations are systematically managed or regulated.
management reforms... contains its fair share of twists, turns and ex-post rationalization’, there remains ‘a certain consistency and continuity in the objectives’. Whether driven by ideology or pragmatism, in 1979 the newly elected Conservative government gradually dispensed with public administration based on professional judgement, practitioner autonomy and limited managerial involvement and turned to a model based on ‘managers, markets and measurement’ (Worrall, Mather and Seifert, 2010: 120). Even ‘New Labour’, following their UK election success in 1997, adopted ‘a discourse which is familiar as new public management, rather than a radical departure from it’ (Dawson and Dargie, 2002: 43). Private sector management methods were perceived to be the solution to public sector problems across a wide range of services e.g. in both education (Ferlie, Ashburner, Fitzgerald and Pettigrew, 1996; Arnott, 2000; Raab, 2000) and the police (Butterfield, Edwards and Woodall 2007). Nonetheless, it was the restructuring of the NHS which required a proportionately greater commitment of government resources and where change in management style has been most challenging (Ackroyd, Kirkpatrick and Walker, 2007: 10).

NPM-related reform frequently touches upon an organization’s understanding of its aims and role in society and this can lead employees to question the values and principles of change. Change impacts on professional discourse through processes such as self-assessment, shape-shifting and self-marketing, and affects how workers perceive their organization, their role and crucially their professional identity. This is not to ignore what can take place at a personal level, influencing how an individual may present and act socially (Parding, Abrahamsson and Berg-Jansson, 2012), but a significant factor remains a person’s professional identity, a sense of belonging (Baruch and Cohen, 2007), and the perceived threat to this from change brought about by NPM.

When the conditions of professional practice are changed, this can have implications for both knowledge and norm systems which determine answers to questions such as ‘what situation is this?’, ‘what is the action I am required to perform in this situation?’; ‘in what ways can I use professional discretion?’ and, crucially, ‘who am I?’ (Agevall, Jenner, Johnsson, Jonnergard and Olofsson, 2007). The reconstruction of professional identity, from the sole-working
practitioner regulated by a professional association to the team player accountable to an employing organization, has provoked resistance on the part of some professionals. Yet, the professional as discursive subject is beset with contradictory pressures, contingencies and contested representations (Dent, 2008: 8). Even though new scripts of professional identity may become institutionalized, they are still subject to a cycle of encoding, enactment, revision, objectification and externalization (Barley and Tolbert 1997).

Professional identity, therefore, is not fixed. It may be influenced, inter alia, by personal, professional and institutional issues (Eteläpelto and Saarinen, 2006), or by formation, that continuous process of experiences, drawn from professional learning contexts, dynamically interpreted and re-interpreted. One undoubted influence is culture within which stories, standards, and truths are socially constructed (Berger and Luckmann, 1966a, 1966b; Martin, 2002). On assuming a professional or organizational identity, by being inducted into a profession or joining an organization, a person may conform to culturally expected practices and attitudes. A person may also advocate change, questioning aspects of the cultural mores. This highlights the inter-relatedness of identity and culture. When two cultures, the professional and the organizational, come together each can inform and influence the other and modify the profile of an identity. This has been labelled ‘hybridity’, i.e. the co-existence and co-penetration of professional strands and organizational principles that lead to the creation of a hybrid form of professional (Faulconbridge and Muzio, 2008). From traditional professional identities, new forms may emerge (Pritchard and Symond, 2011). Organizational change may lead professionals to emphasise or develop a particular aspect of their professional repertoire, or assimilate an additional competence: from social trustees they have become experts (Brint, 1994), or managers (Liecht and Fennel, 2001), or commercial professional as distinct from professional commercial26 (Suddaby and Greenwood, 2005; Suddaby, Cooper and

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26 Suddaby and Greenwood (2005) canvassed views on multidisciplinary practices (MDPs), i.e. organizations that were composed of various professions (lawyers, accountants, and management consultants) and where the commercial aspects of professionalism stood out (commercial professional) as against traditional notions of profession as a vocation fulfilling some higher social purpose (professional commercial). They argued the existence of two institutional logics containing different professional role identities each with distinct implications for organizational form.
Greenwood, 2007). This development suggests that professionals within the same area of practice do not necessarily receive the same recognition, the standard practitioner losing prestige to the expert practitioner who has gained in standing (Sahlin, 2009).

Returning to the issue of professionalism as a disciplinary mechanism, it was precisely because, conceptually, professionalism is so open-ended, that Fournier questioned its disciplinary logic and concluded it was an imperfect form of governance (1999: 302). Yet professionalism, as a ‘concept-in-use’ (Holroyd, 2000: 39), continues to have popular currency even as it adapts to challenges and opportunities. Evetts locates its appeal in the part it plays in giving credence to work identities, career choices and self-understanding. This she illustrates at macro, meso and micro levels by making a distinction between an appeal to professionalism ‘from within’, by the occupational group itself, as against an appeal to professionalism ‘from above’, by employers and business managers. In present-day service occupations, professionalism is an agenda usually promoted ‘from above’ using a false or selective discourse to implement occupational change and impose mandatory practice. While workers, individually and collectively, may be persuaded by the prospect of enhanced status and financial rewards, equally organizational objectives (which, in the case of the NHS are frequently political) are used to manage practitioner/client relations, and set achievement targets and performance indicators. Organizational professionalism limits discretion and can negate a service ethic. Yet despite this radical overhaul, Evetts maintains that aspects of occupational professionalism can still be discerned; that alongside change there is also continuity. The changes, Evetts (2012: 18) believes, are more structural (e.g. governance, management and external forms of regulation) whereas the continuities (e.g. authority, legitimacy, status, power and dominance) are more relations-oriented. While critics may censure the current form of professional work as commodified (Svensson and Evetts 2003: 11), Evetts makes the claim that professionalism has benefitted from some aspects of organizational *modus*, e.g. the implementation of NPM and employment practices. Her concluding assessment, however, is more cautious for she perceives a threat not only to
the third logic of professionalism\(^{27}\) as an occupational value and expert voice, but to professional judgment which she argues is something worth protecting and preserving (Evetts 2012: 7; see also 2009a; Evetts 2009b).

To my mind, there is little doubt that healthcare chaplaincy has been subject to the influence of NPM and this raises an interesting question: who is driving the professionalization of chaplaincy? Undoubtedly, the professional bodies are e.g. CHCC and UKBHC, but to what extent is this process also being driven by NHS England and, earlier on, by its predecessor, the Department of Health? In a previous chapter (§1.6.1), I referred to Swift’s (2014: 63f.) critique of two Department of Health documents. The first, *NHS Chaplaincy: Meeting the Spiritual Needs of Staff and Patients* (2003), Swift viewed as laying the basis for a remodelled chaplaincy in which identity was located not in credal or theological faithfulness but in the NHS. The second, *NHS Chaplaincy: Caring for the Spirit* (2003), Swift argued was a re-designation of the chaplain as an expert delivering spirituality in a management-style straitjacket. Currently, the UKBHC is seeking the registration of its voluntary register with the PSA (see further in §7.3.4) and this is being underwritten by NHS England. These appear to be three examples of NPM influencing the identity of the professional chaplain. I develop this further in (§4.4.2). However, in the next section (§4.4.1), I will recount and critique two recent experiences of occupational professionalization: first, healthcare chaplaincy in the Netherlands and, second, operating department practitioners in the UK

4.4.1 NHS chaplaincy and the new professionalism

Most reviewers coming from a chaplaincy perspective assume the benefits of professionalization. There can be greater occupational coherence (Swift, 2010: 203), besides which it is a necessary prerequisite if chaplaincy is to be accepted as a serious player on the healthcare field (Ballard, 2010: 194). A more cautionary note, however, emerges in two articles: an assessment of health

\(^{27}\) The concept of a third logic arose from Freidson’s systematic analysis of professionalism, in which he explored the organization of work alongside the logic of the free market and the logic of bureaucracy. In a free market, consumers are in charge and in a bureaucracy managers take control. Professionalism, on the other hand, and in ideal terms, assumes the person who has specialist knowledge and skills will be accountable and responsible for their own work. Each ideal type has its own logic which determines the particularity of education, knowledge, values, regulation and career structure. Furthermore Freidson held that historic and national differences in policy, practice and polity influenced the perception of professionalism (Freidson, 2001).
care chaplaincy in the Netherlands (Zock, 2008), and the experiences of one NHS occupational group as it struggled with the aftermath of professionalization, and the realization that, when competing with other healthcare professions, a level playing field cannot be taken for granted (Timmons, 2010).

Despite the Dutch context of her analysis, Zock’s (2008) observations make interesting reading because healthcare chaplaincy in the Netherlands bears a striking resemblance to NHS chaplaincy in England. Traditionally, the chaplain working in the Dutch healthcare system was a religious functionary, but with secularization and the individualization of religions and worldviews, the chaplain had been re-cast as the *geestelijk verzorger*. Although this translates as ‘spiritual caregiver’, Zock argues that, in reality, the *geestelijk verzorger* is little more than an existential counsellor. With no thought to religion or life-philosophy, the role of the *geestelijk verzorger* is to assist the client, patient or resident to discover personal meaning in their life. This leads Zock to ask whether the work of the *geestelijk verzorger* is any different from that of the psychotherapist or social worker?

Dutch society is in some ways similar to society in Northern Ireland, with communities divided along sectarian lines. Until the 1960s, the Netherlands maintained separate Catholic and Protestant hospitals. When denominational hospitals began to merge, the chaplain became an employee of the health care institution while retaining authorization from a Church or faith institution. This was in order for the chaplain to perform specifically religious duties much like the bishop’s licence for NHS priest-as-chaplain. Later, in the 1980s, humanist spiritual caregivers were employed, and in recent years Muslim and Hindu *geestelijk verzorgers*. An initial problem with this development was the question of who would provide authorization when it was required: the Dutch Humanist Society took responsibility for authorizing humanist *geestelijk verzorgers* (even though it had few members) but the organizational structures of Islam and Hinduism made authorization problematic (as has been the case in England).

Recently, Dutch health care institutions have begun to appoint *geestelijk verzorgers* without requiring authorization from a faith group or worldview
organization. Trainee chaplains no longer tend to seek authorization even if they regard themselves, for example, as Christian or Humanist. Zock points to two further developments she finds troublesome and which, once again, mirror what is happening in the NHS in England. First, financial arrangements now require geestelijk verzorgers to specify the ‘product’ and the ‘outcome’ of any intervention, which in the NHS in England are comparable to audit and coding. Second, the expansion of outpatient services means that, for those patients treated at home, there is a lack of spiritual care provision. The current situation facing Dutch healthcare chaplaincy leads Zock to conclude that the chaplain as spiritual care giver has a split professional identity being both a religious office holder and existential counsellor. What is needed, she claims, is a re-conceptualization of chaplaincy with close attention paid to the explicit aims, methods and key characteristics of the service. Zock’s analysis of the present state of chaplaincy in the Netherlands is indicative of her disquiet.

Disquiet, of a different order, is to be found in Timmons’ retrospective study of Operating Department Practitioners (ODPs) in England during and after they were granted statutory professional registration in October 2004 (Timmons, 2010). Timmons questioned the assumption that professionalization was desirable or, as one person (Butterworth, 2000: 2) put it, a ‘hand on the Holy Grail’. ODPs are similar to operating theatre nurses in the work they carry out, assisting surgeons and anaesthetists in an operating theatre. As an occupational group, they are also similar to healthcare chaplains being few in number.

From a theoretical stance, Timmons brought together two complementary notions. One has been dubbed the ‘professional project’

28 emphasizing the economic and social benefits that professionalization confers (Larson, 1977). The other concerned ‘professional jurisdiction’: that area of activity and

28 The phrase ‘professional project’, first coined by Larson (1977), drew attention to how professionalization was perceived to be the means by which an occupational group could ensure a monopoly in the delivery of a particular service, i.e. occupational closure. This was what Freidson (1994), later, was to term a ‘market shelter’. By laying claim to a distinct knowledge-base and technical skills, an occupational group could argue the need for the state to protect and license its membership. The overall aim was twofold: to secure the economic benefits which are generally thought to accompany professionalization and to receive enhanced status both as an occupation and as individual practitioners.
knowledge regulated and defined by the professions (Abbot, 1988).\(^{29}\) The interrelatedness of professions, to which Abbott drew attention (Abbott, 1988: 33), prompted Timmons to adopt a systemic analysis in which he explored the role not only of the State but of managers, medicine and competing professions. In this he makes a number of salient observations about the process and consequences of professionalization. In general terms, Timmons argued that holding a person to account, professionally, had become a matter for the State rather than for any professional body and that the formation of the HPC was a strategic manoeuvre to make possible State control of healthcare professions. Although it might appear that the HPC was an independent agency, answerable to Parliament and the Privy Council, its principal relationship was with the Department of Health, an executive division of Government.\(^{30}\) With specific regard to ODP professionalization, Timmons judged managers and the medical profession disinterested in the professional aspirations of this small and seemingly insignificant group of healthcare workers. The attitude of the nursing profession was a different matter, especially among operating theatre nurses who considered ODPs professionally inferior (Timmons and Tanner, 2004: 660). Here was the making of a jurisdictional dispute (Timmons, 2010: 345).

ODPs, for their part, already had a voluntary register maintained by their professional body, the Association of Operating Department Practitioners (AODP). After 2001, the NHS Executive Guidance, The Employment of Operating Department Practitioners (ODPs) in the NHS, required ODPs to be on the Association register in order to gain employment in an NHS hospital (NHS Executive, 2001). Effectively, this gave the AODP occupational closure (Witz, 1992). The AODP leadership assumed that, eventually, the Department of Health would give ODPs professional recognition in the same \textit{ad hoc} way

\(^{29}\) Abbott (1988: 13) rejected Larson’s professional project as lacking content. The analysis of professionalization, he believed, had been too preoccupied with structures rather than work. Abbott (1988: 20) went on to develop the idea of a link between a profession and its work which he called ‘jurisdiction’. What intrigued him (1988: 33) was how such a link is established in work, how it is embedded by formal and informal structures and how professions are an interacting system competing with one another.

\(^{30}\) The HCPC (as the HPC is now called) claims to be independent of the Department of Health and UK Government (retrieved from http://www.hpc-uk.org/mediaandevents/pressreleases/faqs/; accessed 24/11/13). However, the Council of the HCPC is appointed by the UK Privy Council, the policy decisions of which are made by the UK Government Cabinet. In addition, changes to the name and remit of the HPC were made by the UK Government and funded by a grant from the Department of Health (retrieved from http://www.hpc-uk.org/aboutus/namechange/; accessed 24/11/13).
other professions had achieved this up until that time. What had not been anticipated was the decision by the Department of Health, in 2001, to use the AODP’s bid for professional recognition to trial the work of the soon-to-be-established HPC. Rank and file membership of the AODP, unlike its leadership, was less than enthusiastic about professionalization. Possibly, delays in launching the HPC compounded this lack of enthusiasm.

Initially, the AODP responded to membership disgruntlement by maintaining that professional registration would raise standards of patient care, advance pay grades, improve career opportunities and place ODPs on an equitable footing with other healthcare professions (AODP, 2000). Yet, for many ODPs, the issue became one of finance (Beavan, 2004: 2). The annual HPC registration fee was expected to be both in excess and in addition to the annual AODP membership fee (Jary, 2002; Chespy, 2002; White, 2003; King, 2003; Smith, 2003). With the benefit of hindsight, it is easy to criticise the AODP as unrealistic in its assessment of the likely benefits and potential pitfalls of registration. The crucial question was what role the AODP might have once professional regulation and registration became the responsibility of the HPC. In answer, Kilvington, a key player in the AODP, alluded to the need for a professional body to validate educational courses, to provide national representation, to publish a journal and advocate on behalf of its individual members (Kilvington, 2004).

The reality was the demise of the AODP following the loss of its registrar role. The National Association of Theatre Nurses (NATN) did a volte-face realizing an opportunity to expand its membership if it could attract ODPs who no longer had to belong to the AODP. The NATN became the Association for Perioperative Practice (AfPP) in the course of which it extended full membership to ODPs. AODP membership declined and, despite cost-cutting measures, it went into administration in 2006. This was a short-lived absence as it was to re-emerge under a new name: the College of ODPs.

There are a number of reasons why the AODP might have pursued

31 Kilvington was Chairman of the AODP between 1991 and 2000, and subsequently its president from 2002 (personal communication, 2013). When the AODP became the College of ODPs, Kilvington remained its president, a position he continues to hold.
professionalization, but neither professional closure nor overall management of ODP education and its development seem likely candidates. Rather, according to Timmons, it may have been motivated by a longstanding jurisdictional dispute with operating theatre nurses. Evidence of this comes from a series of articles (e.g. Cook, 1992; Shields and Watson, 2007; and Kilvington, 2007). Then again, with the implementation of Agenda for Change, there may have been some concern that ODPs would not be given parity with nursing staff.

Fundamentally, though, what Timmons questions is the assumption that professionalization is a desirable end. If his central tenet is accepted, that the State now manages and determines professional boundaries and responsibilities within healthcare, then the kinds of benefits which a previous generation of professional occupations were perceived to enjoy, have been dealt a death-blow. ODPs were particularly vulnerable because they were a small, weak profession. How much more so is that true for healthcare chaplains?

4.4.2 New professionalism: implications for the identity of the NHS priest-as-chaplain

The 1990s reorganization of the NHS incorporated NPM principles and practice (Hannigan, 1998) and, as noted earlier (§4.3.3), NPM touches upon an organization’s understanding of its aims and role in society leading employees to question the values and principles of change. This in turn raises questions about professional identity. With the 1997 change of UK government, the new administration continued the development of NPM within the NHS in a range of areas including quality, standards and efficiency. Again, as I noted earlier (§4.3.3) chaplaincy was not immune to this new emphasis, and for some promoting its professionalization, this presented an opportunity.

In this respect, Caring for the Spirit (CfS) was significant as an NHS employer-led ten year development plan aimed at professionalizing spiritual care. It reflected a developed management model (Swift, 2014: 64) or managerial professionalization (Swift, 2006: 60) intent on modernizing chaplaincy. The chaplain was the expert applying the knowledge and skills of spirituality by means of assessment, care planning, care delivery and review. Its ideology was
modernization e.g. delivering evidence-based practice for patients of all faiths, promoting education, training and care pathways and providing increased career and vocational diversity. Absent was any reference to theology which, for Folland (2006: 15), addresses the ‘edge’ and ‘centre’ role not only of the patient but of the chaplain. The ‘centre’ of chaplaincy was its sought after professional status within the NHS, while its ‘edge’ was that critical distance some viewed as crucial for effective chaplaincy. Folland noted that chaplaincy was preoccupied with self-referential questions concerning identity, definition and professional status but saw this as part of a process: professional identity and development being constructed as a consequence of its primary task laid down by the National Occupational Health Care Chaplaincy Standards (1993, 2002). In contrast, Swift (2014: 65) seems to imply that CfS was the problem not a solution, ‘perceived [by some] to be a coercive force operating upon chaplains rather than with them’. In its attempt to reform the professional practice of chaplains, CfS did raise questions about the nature of spiritual care and its purpose within the NHS. As noted earlier (§4.3.3), this influences questions such as ‘who am I?’ (Agevall, Jenner, Johnsson, Jonnergard and Olofsson, 2007).

Williams (2007), a theologian and one-time theological adviser to the Hospital Chaplaincies Council, counsels against the professionalization of chaplains and bemoans a descent into statistics, questionnaires and managerialism: ‘chaplains to spend a lot of time doing something they don’t believe in, when the things that they do believe in are crying out to be done, and there is less and less time to do them in’ (Williams, 2007). As one chaplain put it, in providing spiritual and pastoral care the professional chaplain may take one view while his alter ego, the priest-chaplain, takes another (Newell, 2005: 37).

Theologically, Swift suggests that one overriding difference, between chaplains and their NHS colleagues, is an understanding of community in which all have needs and healing is characterized by mutuality (Swift, 2006: 59). This, one suspects, has no place in the narrative of NPM, contemporary NHS or new

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32 To ‘enable individuals and groups in a health care setting to respond to spiritual and emotional need, and to the experiences of life and death, illness and injury, in the context of a faith or belief system’ (Chaplaincy Education and Development Group, 1993: 3).
professionalism. Organizational professionalism not only limits discretion, it negates a service ethic. To what extent might theology hold professionalism to account? This I explore in the next section (§4.5.1).

4.5.1 Professionalism: a theological perspective
What has theology to do with a subject like professionalism? Thirty years ago, Campbell asked this question in a paper he wrote for an occasional publication entitled *The End of Professionalism?* Since that time, remarkably little has been written despite the fact that theology possesses an interpretative narrative which does have practical relevance in holding professionalism to account (though see Gula, 1996). As Campbell points out, the failure of a *profession*, a public statement of intent, to match subsequent behaviour has long attracted the attention of the theologian (Campbell, 1985: 33). His own contribution is a theological critique of professionalism by way of three questions addressing power, knowledge and altruism, and while professionalism, thirty years later, is perceived differently, Campbell’s insights remain perceptive.

Professionalism, today, remains absorbed by issues of power, its appropriation and its retention but, as Campbell asks, can such power be justified especially when it is viewed through the lens of vocation? *Vocatio*, Campbell (1985: 34) maintains, is a call from God to undertake a specific task, in fulfilment of which God provides certain skills. It is a call to serve the community rather than an opportunity for self-aggrandisement. If the common humanity, the unmerited gifting of the person in receipt of the vocation is lost from sight, the way is open for idolatry in which the creature becomes the focus of worship rather than the creator.

Power lays claim to knowledge, and yet, within healthcare, the nature of that knowledge can be uncertain, tentative and partial. Incomplete knowledge may lead to unrealistic or unwarranted claims and expectations which, in turn, may become the basis of dependent relationships. It may be the cause of inequitable decision-making and may obviate some adopting a more responsible life-style.

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33 In the main, what little has been written has focused on the demise of professional status among clergy and the implications for pastoral care where practitioners adopt a more professional stance.
If healthcare practitioners were to concede the limits or incompleteness of professional knowledge, this would have the potential to change the nature of the therapeutic relationship from one of dependency to one of mutuality. For Campbell, such a radical change in the nature of the relationship is theologically present in the paradox of the Christian incarnate God: power expressed in weakness and vulnerability, knowledge in foolishness, and hope in apparent failure. While this may appear a theology of despair, Campbell argues that when professionals dare to acknowledge failure, this can have prophetic repercussions, providing hope for a more humane society (Campbell, 1985: 35).

Campbell concludes his theological critique of professionalism by arguing that altruism is not only unrealistic among the ranks of professional caregivers but dangerous when motivated by the egoism of the carer rather than needs of the cared-for. There needs to be a bridge between egoism and altruism by which the carer may enter the world experienced by the one cared-for without being overwhelmed. The self and the self-interest of the carer are safeguarded. In reaching out, emotionally and rationally, to the other person, an act of love becomes possible, but it is an act of valuing another person in his or her own right, while maintaining separation and the independence of one’s own self-interest. The aim of professionalism, Campbell (1985: 36) asserts, is to demonstrate the value of those people society rejects or stigmatizes by striving not only to understand but enabling society to understand those it fears or dismisses. Within the Christian narrative this is associated with the central themes of community and loving service.

Vocation, power and love are also addressed in an appendix to the Church of England’s Guidelines for the Professional Conduct of the Clergy (Archbishops’ Council, 2015). Entitled A Theological Reflection, it again provides a theological summary of professional practice. Its author, Bridger, begins much like Campbell by addressing the principle of vocation which he holds is ‘fundamental to clergy understanding and self-identity’ (Bridger, 2014: 25). Rather than the professionalism associated with technocratic expertise, a comparatively recent

34 Dissatisfaction with the English word ‘empathy’, believing it to have been devalued by ‘pop psychology’, leads Campbell to use the German equivalent, *einfühlung*, borrowed from Scheler (1923).

35 Campbell cites 1 Cor. 13.
construal, Bridger explores how professionalism is relevant to clergy ministerial practice. By way of a theology of vocation, he seeks to re-inject the concept with a transcendent and moral dimension. While profession can be defined sociologically, as people bound by a set of conventions and practices, its origins located in that Latin word *professio*, mean ‘something one affirms’. It is in this sense, profession as value laden, incorporating transcendent values and principles, that a theology of vocation is pertinent. Vocationally, profession is about service primarily directed towards God, although, in its effect, directed towards others by way of human relationships.

Within a theology of vocation sits the idea of covenant. Unlike a contractual relationship in which there are prescribed rights and duties (Gula, 1996: 15), covenant is based on grace perfectly illustrated by the covenant relationship betwixt God and God’s people. Rather than any legal obligation or constraints, there is graciousness reciprocated by a thankful response. It is this which distinguishes ministry: practice embedded in the covenant of God’s love and deeply Christological.

A covenant relationship involves both agape and pastoral care. Agape, love, is given as a gift and incorporates faithfulness and constancy. It is open-ended rather than contractually limited. There are appropriate boundaries but these strive to nourish rather than restrict a relationship. Again, this is not to ignore the unequal distribution of power that is present in a pastoral relationship but to recognize that some expressions of power can be abusive (e.g. exploitative and manipulative power), or uncertain (competitive power) or beneficial in a theology of covenant and agape (e.g. nutritive and integrative power). It is crucial to recognize what kind of power is exercised and for whose benefit.

Finally, a theology of profession encompasses virtue ethics: character which gives unity, definition and direction to a person’s life by forming ‘habits into meaningful and predictable patterns that have been determined by our

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36 So, for example, Phil. 2:5-8: ‘Let the same mind be in you that was in Christ Jesus, who, though he was in the form of God, did not regard equality with God as something to be exploited, but emptied himself, taking the form of a slave, being born in human likeness. And being found in human form, he humbled himself and became obedient to the point of death—even death on a cross’.

37 This typology is the work of May (1972: chapter 5).
dominant convictions’ (Willimon, 1983: 28f.). It is Christian character and virtues which the Church of England priest must deliberately develop, and which encapsulate qualities of trustworthiness (or integrity) and prudence (or discernment) (Labacq, 1985: 166f.). Character, theological convictions and spiritual practices are imperative to professional life because every person is formed by their beliefs, by the way they relate to God and by the way they relate to those communities to which they belong.

4.6.1 Summary
There are clear indications of a tension and a dilemma for the NHS priest-as-chaplain, located vocationally and professionally between two divergent worlds, religion and healthcare, situated within two formidable structures, the Church and the NHS. With their different world views, the Church and the NHS are dependent on a clear rationale to determine their direction (Woodward, 1998: 234; see also Pattison, Hannigan, Pill and Thomas, 2010: 188f.). Even if this was forthcoming, it would be unlikely to resolve the uncertainty and confusion seemingly embedded in the identity of both the C of E priest and the NHS priest-as-chaplain.

While insights derived from the ‘new professionalism’ make a valuable contribution to an understanding of those tensions and dilemmas faced by the NHS priest-as-chaplain, who seeks the professionalization of chaplaincy, an equally important place needs to be given to a theological understanding of personhood and identity, as well as to that priestly identity grounded in ecclesiology. The priest, in whatever context of ministry, needs to remain recognizably, and accountably, the priest.

4.6.2 Developing the Thesis

This chapter, and the two preceding chapters, have grounded my research in the published literature of the social sciences and theology (the customary ‘texts’ of history, scripture, tradition and doctrine). I have surveyed, summarized, and critically assessed the available literature relating to identity in these fields. In the next chapter I will address questions of research methodology to enable
me to scrutinize and interrogate the experience and thinking of the NHS priest-as-chaplain which will be disclosed in the interviews.
Chapter Five: Methodology

5.1 Introduction

This thesis aims to establish whether, in the current ethos of the NHS, the identity of the NHS priest-as-chaplain in England is congruent with the identity of the C of E priest. If the evidence suggests that it is not, then secondary research questions will arise. First, why a dislocation of the two identities might have occurred? Second, what the nature of any perceived dislocation between the two identities might be? Third, how the thinking, experience and practice of the NHS priest-as-chaplain might draw upon, contribute to or challenge contemporary discussions of Anglican priesthood, especially in terms of ontology, function and relationship. These questions require a research methodology that will enable the experience of the NHS priest-as-chaplain to be interrogated and scrutinized.

Consequently, in this chapter, I will explore the methodological building blocks of my research: ‘an analysis of the principles and strategies’ (Schwandt, 1997: 93). I will begin (§5.2.1) by surveying the mid-twentieth century renaissance of Schleiermacher’s practical theology, a dialogue of ‘practice-to-theory-to-practice’, and weigh up the different approaches to working in partnership with the social sciences. I will consider (§5.2.2) the relative merits of quantitative or qualitative methodologies and will explain my decision to place the semi-structured interview with each of the twelve NHS priests-as-chaplains at the centre of my research. I will explain (§5.3.1) my reasons for combining practical theology with Grounded Theory Method (GTM). To this, I will add (§5.3.2) some background information about GTM as well as providing (§5.3.3) a critique of its methods and limitations. Within the interpretative framework of GTM I will explore (§5.3.4) the relationship that is created between the researcher and the participant.

I then will reflect critically (§5.4.1) on the use of intensive interviewing, noting (§5.4.2) its drawbacks as well as acknowledging (§5.4.3) the complex issues surrounding the transcription of interviews. From this, I will go on to trace (§5.4.4) the development of my research questionnaire and those ways in which I piloted it. This leads me (§5.4.5) to outline the stages of the analysis i.e.
immersion, review, reflection, abstraction and synthesis (see Table 5.1). In the next section (§5.4.6), I will set out the criteria by which participants were selected and recruited, and following this (§5.4.7) consider some epistemological issues associated with their selection and recruitment. I then examine the relevance of churchmanship (§5.5.1) and the instrument I use to enable participants to map their perceived churchmanship, noting the conceptual challenge this presents. Lastly, I will explore the ethical context of the research focusing on a number of related issues. This exploration begins at §5.5.1, where I will examine three areas of ethical concern i.e. informed consent, safeguarding the participants' personal and professional information and the interview as a ‘moral enterprise’ (Kvale, 1996: 109). This will lead into a discussion (§5.5.2) about reflexivity and the interplay between the researcher and the research, before I go on to consider the dynamics of power in the researcher-participant relationship (§5.5.3) and its implications for participant transcript checking.

What, however, I will reiterate both in this chapter (§5.3.3), and elsewhere in this thesis, is the interpretative stance of my research. Unlike positivist theory and its search for causes, its emphasis on generality and universality, and its preference for deterministic explanations, the methodology of my research is rooted in imaginative engagement with the interview material, and which assumes the possibility of numerous realities, as well as the connectivity of fact and value. Truth is provisional, and understanding replaces explanation. My research aims to provide a rich, thickened description and makes no claims for reproducibility.

5.2.1 Practical Theology
In that this research was about the experiences and self-perceptions of a group of NHS priests-as-chaplains, the hermeneutical framework of choice was practical theology. It was one from which I would be able to extract theological themes and insights with the expectation that these might contribute to the Church’s developing understanding of priesthood. Earlier, in chapter one (§1.3.1), I offered some introductory comments about the appropriateness of practical theology as a framework for this research project, and these I now develop further.
Although practical theology is a genus that stretches back to the German academies of the eighteenth century and the work of Schleiermacher, the founding father of practical theology (Gräb, 2005:181), it was in the second half of the twentieth century that there was a resurgence and reappraisal of its significance. At first, it was a theology which assumed ‘theory-to-practice’ (Schleiermacher, 1966 [1830]: 91-126) but more recently it has re-emerged as a theological dynamic of ‘practice-to-theory-to-practice’. In part, this owes something to the work of Gadamer, a ‘practical’ philosopher, for whom understanding, interpretation and application is an interactive and ongoing process. ‘Application is neither a subsequent nor a merely occasional part of the phenomenon of understanding, but co-determines it from the beginning (Gadamer, 2004 [1981]: 289). As Bernstein (1983: 38) puts it, for ‘every act of understanding involves interpretation, and all interpretation involves application’. Such thinking challenges past generations of theologians for whom received wisdom dictated that revealed knowledge was self-sufficient, self-determining and self-authenticating, ‘ready to be plugged into a concrete practical situation’ (Browning, 1991: 5). The reality, of course, is more complex. The theologian approaches her brief ‘with questions shaped by the secular and religious practices in which we are implicated – sometimes uncomfortably’ (Browning, 1991: 5f.).

Practical theology is inextricably bound to human experience on which it reflects theologically (Swinton and Mowat, 2016: 6) but it is thoroughly practice-focused because it ‘does not only seek to understand the significance of practice for theology, but also recognizes as a primary goal the guiding and transforming of future practices which will inform and shape the life of faith’ (Swinton and Mowat, 2016: 11). In this sense, a theological dialogue of ‘practice-to-theory-to-practice’ is situated in ‘the experience of the life of discipleship... [as it] seeks to reflect on and serve that faith community’ (Ballard and Pritchard, 1996: 1).

Although it was more than twenty-five years ago that Browning (1991: 3) claimed the rebirth of practical theology, and, more recently, Macallan (2014: vii) confirmed its coming of age, there remains a question. Exactly what is practical theology? No one definition would encompass its wide-ranging remit. ‘It is a discipline among scholars and an activity of faith among believers….: it is
a *method* for studying theology in practice and it is a *curricular area* of subdisciplines in the seminary’ (Miller-McLemore, 2012: 5, italics in the original). Practical theology has not evolved and developed in neat linear movements (Macallan, 2014: 52) and, given its breadth and diversity of methodology and theology, it is not a homogeneous discipline. The common factor is its focus on analyzing human experience through a theological lens: how God is made known or how our understanding of the dynamics of an experience suggests ways in which God engages with the world; ‘with what God is calling us to do and be today; with the being and activity of the Church; with the practice of Christians; and finally with what virtually monopolized the interest of practical theologians for far too long, the activities of the ordained ministry and other ecclesiastical agents’ (Forrester, 2001: 7).

It was Schleiermacher (1966 [1830]) who determined the original direction of practical theology by his focus on the tasks of clerical leadership within the Church. This preoccupation with ordained ministry perhaps accounts for the fact that, over many years, practical theology has been viewed as synonymous with pastoral theology.¹ This, in turn, led to an over-concentration on clerical skills and techniques which provide ‘tools for the job’: what might be called an instrumental view of ministry. Noting this, Dittes coined the phrase ‘the seduction of relevance’ as he observed many 1950s North American clergy abandoning their churches and ordained role in order to become counsellors (Lyall, 2010). Clergy were being seduced by the apparent relevance of counselling *per se* but failed to grasp how the insights of counselling theory might be integrated into pastoral relationships and clerical ministry. Actions or practices became divorced from the fundamental question, who am I called to be in that covenantal relationship with God? In this, personal accountability becomes ambiguous (Hughes, 2003: 101) and personal identity precarious. Possibly the professionalism that counselling offered cloaked a reluctance to be immersed in God’s calling and covenant.²

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¹ Even in recent times, as Woodward and Pattison (2000: 2) acknowledge, ‘Anglicanism... has tended to use the concept ‘pastoral theology’ when talking about theology relating to practical theology.’

² In both these respects, the instrumental view of ministry and the appeal of a professional identity, there is resonance within the context of healthcare chaplaincy. As Bryant (2013: 3f.) succinctly puts it, ‘the rational-instrumental ethos which dominated following the reorganisation
This throws into relief the relationship between the social sciences and practical theology. As Van der Ven (1993: 97-101) has illustrated there are potential pitfalls. First, multidisciplinary partnership in which practical theology draws on the empirical work of the social sciences not only leaves practical theology as the dependent partner, it allows the social sciences to gloss over or ignore questions which for the practical theologian might be pivotal. So, for example, in the last paragraph Dittes posed the question ‘who am I called to be in a covenantal relationship with God?’ is one which the social scientist might disregard. Second, there is partnership based on interdisciplinarity. Each speciality retains its own disciplinary stance, procedures and key questions but is open to the influence of the disciplinary stance, procedures and key questions of a partner discipline. In reality, this may lead to the practical theologian becoming a junior partner in any academic cooperation. Third, there is a partnership which is one of intradisciplinarity. In this, practical theology itself becomes empirical borrowing the concepts, methods and techniques of the social sciences and applying them itself.

An example of intradisciplinarity can be found in the work of Percy (2006: 9ff.) who maintains that environmental and cultural factors, as well as straightforward necessity, have influenced the theological construction of clerical identity over time. Borrowing a concept first proposed by the sociologists Berger and Luckmann (1966), that a person’s perception of reality is socially constructed, Percy argues that, in parallel fashion, there is both the social construction of revelation and the theological construction of reality. This is not to imply that the sacred or theological meanings conferred on objects and actions can be reduced to social or scientific accounts of reality, a capitulation to relativism. Rather, revelation needs to be grounded and constructed in appropriate and relevant social concepts to which other meanings can become attached. Objects and actions may become invested with transcendent understandings beyond their immanent objectiveness. When this happens, ordinary or extraordinary phenomenon of everyday ecclesial or spiritual life needs a language and formulation which recognizes a new status: no longer secular but sacred. By this means reality becomes theologically constructed.

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of the NHS in the early 1990s has increased the pressure for chaplaincy to emulate other departments, develop professionally, prove its efficacy and demonstrate institutional loyalty.’
It was a partnership of intradisciplinarity which guided my own research as I drew on the concepts, methods and techniques of the social sciences while at the same time retaining the priorities and focus of the practical theologian. As I interrogate the interview data, I will weigh up the nature, purpose and intentions behind and within the actions and assumptions of participants. I will deliberate how priesthood is interpreted, lived out and revealed in the character and practices of these NHS priests-as-chaplain. I will evaluate participants’ engagement with the Church in its role as both messenger and missionary presence in and for the world. I will reflect on whether the theories and assumptions which underlie healthcare practice contribute to the development and reshaping of priesthood which might then inform the thinking and practice of the wider Church. I will explore those areas where the practice of the healthcare chaplain is at variance with ministerial priesthood and enquire where orthopraxy lies. I will listen out for fresh questions which emerge from healthcare practice and which might profitably be addressed by the Church.

Swinton and Mowat (2016: 25) refer to practical theology as enabling and developing personal and communal phronesis, practical reason or practical wisdom applied to situations of complexity and ambiguity which might bring about a more God-oriented lifestyle. I will investigate whether this is evident in healthcare chaplaincy. As practical theology is fundamentally missiological, its purpose and motivation derived by way of a share in God’s mission, I will ask what part the context of ministerial priesthood plays within the wider, overarching perspective of God’s ongoing mission of redemption to the world. I will examine those ways in which priesthood practised in the context of healthcare seeks not only to understand the world but to change it. To what extent is healthcare chaplaincy engaged with the fundamental question for practical theology: who is God and how does one know more fully God’s truth?

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3 Phronesis, according to Kinsella and Pitman (2012: 2), is generally defined as ‘practical wisdom or knowledge of the proper ends of life’. They voice a concern that something of moral significance has disappeared from the vision of what it means to be a professional. This they attribute to instrumentalist-rationality which over two centuries has superseded value-rationality (Bourdieu, 2004; Flyvbjerg, 2001). Professional knowledge has been subverted and needs the corrective influence of phronesis.
5.2.2 **Quantitative or Qualitative methodology**

Working from the perspective of practical theology, the initial task was to decide how I would capture the experience and understanding of Church of England priests engaged in full-time National Health Service (NHS) healthcare chaplaincy. The human sciences have long debated the relative merits of quantitative and qualitative methodologies: the former using statistical, mathematical or computational data in order to provide a fundamental connection between social phenomena and general laws or empirical regularities while the latter considers themes and underlying patterns of relationships. Some have argued that the differences between the two methods ‘run deeper than the presence or absence of numbers’ and are located in the philosophical *raison d’être* of each: positivism as against constructivism (Kuper, Reeves and Levinson, 2008: 405) or the primacy of nomothetic as against ideographic epistemology (§5.4.7). Alternatively, others have claimed that ‘[q]uantitative and qualitative methods are only alternative tools, used for different tasks in research (as saws and screwdrivers are alternative tools used for different tasks in carpentry)’ (Paley and Lilford, 2011: 957). Admittedly, the quantitative paradigm is associated with deductive reasoning in contrast to the inductive processes commonly associated with qualitative methodology but, again, it has been argued that ‘[t]hese two research approaches are not bipolar opposites and, in fact, in practice need each other for the development of thorough understanding’ (Swinton and Mowat, 2016: 42).

Whatever the merits of these arguments, there are shortcomings with both designs. A methodology based on data retrieved from a questionnaire has to contend, for example, with questionnaire design issues; sampling and non-response errors; design and wording bias; faulty interpretation; respondent reticence; and errors in coding, processing, statistical analysis (Oppenheim, 1992: 277) as well as what Bryman (2004: 79) claims can be an over-reliance on instruments and a disconnection with everyday life. Similarly, interviews cannot claim to be neutral tools. Data are derived from personal interactions which can be compromised by researcher-participant collusion (Fontana and Frey 2000; Silverman, 2000, 2006). Although interviews afford a context within which participants can ask questions for clarification and expand and explain their views or beliefs using their own words, the interviewer can lead or
influence interviewee responses, either consciously or unconsciously. By its very nature, an interview is a social situation and it has been found that participants may be more likely to respond in ways they think are socially pleasing (Richman, Keisler, Weisband and Drasgow, 1999; Yin, 2009). For these and other reasons, it has been alleged that interview data are invariably manufactured and biased producing deficient understandings of a participant’s point of view (Lankshear and Knobel, 2004). Moreover, as many qualitative studies are based on small sample sizes, replicating or generalizing from the results can be problematic (Bryman, 2008; however, see §5.4.7).

Coding and analysis of the data present further issues. Although it may appear that quantitative data are more objective because of their numeric construction, there can be data manipulation through participant and/or item omission from the data material, the choice of statistical analysis and the interpretation of results are open to researcher bias (Oppenheim, 1992). As for qualitative data, the very process of inductive coding can be skewed by the subjective interpretation the data receives at the hands of the researcher (Bryman, 2004: 197). For that matter, the choice of codes and categories may not necessarily suit the data, and this can be difficult to probe when, as is normal, only brief extracts are provided for reader inspection. However, notwithstanding the limitations of both the quantitative and qualitative methodologies, these remain essential tools for a researcher needing to access a participant’s views, perceptions, mind-sets and opinions.

Given the nature of my research, investigating issues of identity and integrity, I thought it imperative to give as much scope and flexibility to the participants, allowing them to communicate, in their own words and surroundings, how they perceived themselves and how they believed others perceived them, together with the similarities and differences they encountered as Church of England priest and NHS healthcare chaplain. This I decided was best served by means of a semi-structured interview which would encourage participants to share and expand on their experience, insights and understandings. By this means, I sought a more comprehensive picture of each participant’s self-concepts, world views and even loyalties. This also reflects my underlying philosophy, governing the contribution of other people to this research, based on respecting and
valuing each person’s unique and authentic contribution to whatever the research conclusions might reveal.

5.3.1 *Grounded Theory*
Alongside practical theology, I was interested in the application of Grounded Theory Method (GTM) offering, as it does, a systematic, inductive and comparative means of conducting research in order to construct theory. In this respect, it is a fitting partner of practical theology enabling, as it does, theory to emerge from data: ‘unearth[ing] the raw material on which theological reflection must then do its work’ (Green, 1990:11).

GTM was developed by Glaser and Strauss in the 1960s (Glaser and Strauss, 1965; 1967) as they led a research team studying issues around dying with terminally ill patients and healthcare staff. What was particularly novel about this study was their attempt to approach the data without recourse to theoretical suppositions. For Glaser and Strauss, theory followed data and so stood in contrast to grand theory verification. GTM researchers were encouraged to postpone a literature review to avoid being influenced by pre-existing theoretical frameworks. ‘One does not begin with a theory and then prove it. Rather one begins with an area of study and what is relevant to that area is allowed to emerge (Strauss and Corbin, 1990: 23). In common with Charmaz (2006), Bryant (2002) and Clarke (2003; 2005), I accept the principles and practices of GTM but apply them as flexible guidelines and not as a methodological straitjacket.

5.3.2 *Grounded Theory Method: a critique*
GTM has stood up well to evaluation despite the many assumptions that have been made about its method and limitations. Concern has been raised about what some have regarded as the subjective selection of evidence, the value-laden metaphors and the superficial assessment of meanings within participants’ stories (which reflects the tension between constructivist and positivist viewpoints: see further in §5.3.4). Then there can be the fragmentary nature of the analysis which devalues the fullness of the participant’s experience and a reliance on the researcher as expert observer (Denzin and Lincoln, 2000: 521). Much of this may reflect misunderstandings or
philosophical divergence: crucially, whether a person can undertake a research project and not be influenced by prior theoretical knowledge until theory emerges independently from the data. The conduct of research is conditioned by many subtle factors of which the researcher may be unaware: indeed, ‘nowadays, it is rarely accepted that theory-neutral observation is feasible’ (Bryman, 2004: 407). In his defence, it has been claimed that Glaser ‘was not so naive as to think this was possible and that the emphasis should be on his expected emergence or unveiling of a separate entity called data... [in which] the researchers will immerse themselves so as to become more theoretically sensitive’ (Mills, Bonner and Francis, 2006: 4f.). Additionally, there are practical considerations; for example the labour intensive transcribing of audio interviews and analysis of the data. Again, an uncertainty surrounds the precise difference between concepts and categories: is theoretical sampling ‘sampling on the basis of emerging concepts’ (Strauss and Corbin, 1998: 73) or the means ‘to develop our emerging categories’ (Charmaz, 2000: 519)?

5.3.3 **GTM as an interpretative framework**

This research project is interpretative rather than positivist simply because I am listening for hints, clues and pointers which signal a theology of priestly identity emerging from the interviews. For if ‘belief is found within the act' (Swinton and Mowat 2006: 20) what is the nature of the belief which underpins the practice of priesthood and does it have direction (furthering God’s purposes or design) and authenticity (emanating from God’s purposes or design). In contrast to positivist theory, which looks for causes, emphasizes generality and universality, and prefers deterministic explanations, the interpretative approach I am adopting seeks to be an imaginative engagement with the interview material in which I assume the possibility of numerous realities, as well as the connectivity of fact and value. Truth is provisional, and understanding replaces explanation. It is an approach which asks what people assume is real and seeks to understand how people both construct and live with the reality they have constructed. In this respect knowledge, including theories, is 'situated and located in particular positions, perspectives and experiences' (Charmaz, 2006: 127) and 'the ‘discovered’ reality arises from the interactive process and its temporal, cultural, and structural contexts’ (Charmaz, 2000: 524). This respect for the implicit meanings ascribed to values, beliefs and ideologies sits comfortably with the
thrust of practical theology. Moreover, underpinning the relationship between researcher and participant is the assumption that it is the interaction itself which ‘produces the data and therefore the meanings that the researcher observes and defines’ (Charmaz, 1995: 35). In other words, the researcher is co-producer of the data and its subsequent meanings. Consequently, adopting the revisionist approach to GTM as proposed by Charmaz, the research was located in an interpretative grounded theory methodological framework which was constructionist in that ‘realities are social constructions of the mind’ (Guba and Lincoln, 1989: 43).

5.4.1 Qualitative Data Collection: Intensive Interviewing

The research was based on a series of semi-structured interviews, each interview being carried out at the participant’s place of work in a quiet room or space which the participant had arranged. The obvious advantage of a face-to-face interview, besides an improved response rate to research, is the opportunity to delve more deeply, as well as seek clarification in the answers given by interviewees. Admittedly, ‘[a]sking questions and getting answers is a much harder task than it may seem at first... yet interviewing is one of the most common and powerful ways in which we try to understand our fellow human beings’ (Fontana and Frey, 2000: 645). As has been well documented (Fontana and Frey, 2000; Bryman, 2004; and Kvale, 1996), an interview can take different forms, serve different ends and has been variously defined, e.g. as a ‘conversation with a purpose’ (Berg, 2007: 89), ‘a specific form of human interaction in which knowledge evolves through dialogue’ (Kvale 1996: 125) and a ‘technique of gathering data from humans by asking them questions and getting them to react verbally’ (Potter, 1996: 96). For the purposes of the research, the semi-structured interview enabled access to the ‘descriptions of the life world of the interviewees with respect to interpreting the meaning of the described phenomenon’ (Kvale, 1996: 6).

However, a more accurate description of what were exhaustive (and, in some cases, exhausting) interviews is provided by Charmaz when she makes reference to ‘intensive interviewing’. The interviewee is encouraged to describe and reflect on experiences in considerable detail and this is made possible by an interviewer’s stance of ‘active’ listening, empathy and encouragement. In
such a way, the interviewer shows respect and empowers the interviewee to share or withhold, to tell in whatever way they choose, to be experts and to express thoughts and emotions which in casual conversation might be unacceptable. At the same time, within the intensive interview, the interviewer will explore in detail expressed thoughts, feelings and actions, employ interpersonal skills, check out that what the interviewee has said has been correctly understood and take responsibility for the pace and direction of the interview. Fundamentally, the interviewer will ‘validate the participant’s humanity, perspective or action (Charmaz, 2006: 26).

5.4.2 The Interview as the main means of qualitative data collection: a critique

Use of the interview technique as the main source of data gathering still left me mindful of potential problems. Silverman (2005: 238-240) draws attention to the extensive use of the interview as the preferred technique in qualitative research implying that, frequently, it has been used uncritically. Referring to an ‘interview society’, a term some sociologists in the United States have given their country (Atkinson and Silverman, 1997), Atkinson suggests that just because the interview is often the preferred method of data collection, this does not guarantee its integrity. The spoken act is a performance subject to a person’s self-understanding of who they are, the values they profess and, ultimately, what they choose to project about themselves. There is the further influence of cultural conventions and expectations. Personal narrative is a censored understanding of personal experience even if censorship takes place unconsciously or at a low level of consciousness. This is not to deny the value of the interview, but to recognize that as data it requires rigorous and sustained analysis (Atkinson, 2005: 10, 11).

5.4.3 Transcribing the Interviews

Although I do not intend a systematic critique of the epistemological and methodological issues of transcription (though see §5.5.3), I do offer some reflections on the transcription process. Interviews were audio recorded with the permission of the participant and later transcribed by the researcher. Each participant was given a pseudonym in order to anonymize their contribution, especially when incorporating verbatim quotations into the research findings.
Care was taken to avoid naming NHS Trusts or dioceses where this naming might identify a participant. Admittedly, transcripts cannot represent every nuance of the interview e.g. the body language and mood of the exchange. Instead transcripts need to be seen for what they are: ‘interpretative constructions that are useful tools for given purposes. Transcripts are decontextualized conversations; they are abstractions, as topographical maps are abstractions from the original landscape from which they are derived’ (Kvale, 1996: 165).

In transcribing the interviews myself, rather than outsourcing this work to a research assistant, I was able to note those occasions when I detected more in the exchange than the words themselves conveyed or suggested confirming that the process of transcription is indeed an ‘interpretative act’. Rather than a mere perfunctory task of putting the spoken word to paper, transcription is ‘a key phase of data analysis within interpretative qualitative methodology’ (Bird, 2005: 227) and a ‘key moment of choice and the exercise of power in the research process’ (Ross, 2010: paragraph 4).

Clearly there are epistemological and methodological questions which do need to be addressed and which researchers, in the main, have neglected (Ross, 2010: paragraph 6). In Denzin and Lincoln (2005), the authoritative text for researchers using qualitative methodology, transcription receives scant critical scrutiny, ignoring ‘the complexities of transcription, which resemble more the work of translation than that of transference’ (Tilley and Powick, 2002: 292). However, in the social sciences, what has been described as a ‘post-structuralist turn’ has raised an awareness of the complex relationship of language and meaning:

The texts that we produce in interviews... are texts in motion, texts that produce moments of life as it is being lived; they form archives that enable us to study that production. The archive can tell us a great deal about the production of lives... It cannot give us a fixed or fixable truth about particular identities or particular categories or particular social worlds, though it can, paradoxically, tell us about the complex processes of producing oneself, and being produced as ‘having an identity’ and ‘belonging to a particular category. (Davies and Davies, 2007: 1157)
Although there are a number of conventions for transcribing interviews (Edwards and Lampert, 1993; Lapadat and Lindsay, 1999), I decided to adopt the simple guideline of rigorous attention both to verbal content and non-verbal information as I transcribed the interviews. As Ross (2010: paragraph 45) puts it, ‘trying to honour the voices in my interviews on their own terms, even while I am more aware now that what I make of them must, necessarily, be in my own voice. I have not given up on fidelity.’ Then, quoting Spivak (2001: 14), Ross continues ‘not because it’s possible, but because one must try’.

5.4.4 Questionnaire Design

The American architect, Louis Sullivan (1896), wrote:
It is the pervading law of all things organic and inorganic,
Of all things physical and metaphysical,
Of all things human and all things super-human,
Of all true manifestations of the head,
Of the heart, of the soul,
That the life is recognizable in its expression,
That form ever follows function. This is the law.\footnote{The italics are mine.}

The dictum, ‘form ever follows function’\footnote{Often misquoted as ‘form follows function’}, might appropriately describe the thinking which underpinned the development of the questionnaire which structured the interviews. Over the course of twelve months, the questionnaire underwent several stages of development, each informed by planning, reading, design and reflection, focussing on what the questionnaire needed to deliver.

Initially, a postal questionnaire, focusing on ministerial priesthood and canvassing all Church of England priests who were full-time NHS healthcare chaplains in England, was proposed (see Appendix I). The benefits lay not only in the potential sample size but, given the quantitative nature of many of the questions, applying a statistical analysis of the questionnaire responses. For a number of important reasons, however, it was decided that a face-to-face interview was by far the superior means of gaining the views, opinions and insights of research participants (see above: §5.4.1 Intensive Interviewing). In

\footnote{The italics are mine.}
summary, the exploratory nature of the questionnaire was intentionally heuristic, gathering the essential ingredients of GTM in terms of perceptions and beliefs, outlooks and attitudes rather than general statements, facts and statistics.

This decision, to dispense with a postal questionnaire in favour of one that was administered during a face-to-face interview, was just one of many instances when reflection and supervision suggested the need for reassessment, revision or, indeed, a reworking of the research. However, developing the focus and content of the postal interview did provide a first opportunity to formulate key questions which would capture the essence of any grassroots theology of Anglican priesthood and healthcare chaplaincy. In themselves, these questions suggested the substance and shape of a subsequent draft questionnaire intended for face-to-face interviewing (see Appendix J). The revised design incorporated question sequences or modules within the questionnaire. Careful thought was given to why a question was being asked and how a response might contribute to the direction of the research (see Appendix K). Not only was it important for questions to be phrased and ordered in a way that conveyed the value put on the participant’s point of view, but for participants themselves to know that their point of view was valued. Attention was given to the wording of questions, e.g. whether the term ‘priest’ or ‘minister’ should be used as either term might suggest a particular brand of churchmanship and theology. Might the insertion of one or other of these terms unintentionally influence the participants’ self-perceptions and responses?

In 2010, a series of pilot interviews took place with four London-based hospital chaplains (two male and two female). As a result of feedback, the questionnaire was revised. One question was removed because it approached the current delivery of healthcare chaplaincy tangentially from an historical perspective. There was no reason why participants should know about the history of NHS chaplaincy and consequently be able to infer ways in which it has developed. Additionally, the decision was taken to replace the term ‘minister’ with ‘priest’. In part this was because the word ‘minister’ was perceived to be ambiguous. ‘The notion of ministry tends to gobble up everything into itself, so that it becomes impossible to sort out what is not ministry. All are ministers but some are more

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6 In what ways do you think healthcare chaplaincy has changed since 1948?
ministers than others… Unless ministry can be distinguished from something else which is not ministry, it seems hardly worth talking about’ (Oppenheimer, 1979:12). This ambiguity can be detected in the notes to the Ordinal of the Church of England which assert that ‘the Church of England maintains the historic threefold ministry of bishops, priests and deacons. Its ministers [i.e. deacons and priests] are ordained by bishops according to authorized forms of service, with prayer and the laying on of hands’.

In its final form (see Appendix L), the research questionnaire consisted of thirty-one questions covering six areas of enquiry, i.e. the participant’s story; the participant’s understanding of what it means to be an Anglican priest; the participant’s understanding of what it means to be a healthcare chaplain as an Anglican priest; the participant’s understanding of priesthood in terms of theology, liturgy and ecclesiology; the participant’s understanding of the healthcare chaplain in terms of theology, liturgy and ecclesiology; and, finally, the participant’s theology of priesthood in terms of ontology and function.

5.4.5 Stages of Data Analysis: immersion, review, abstraction and synthesis

In designing the semi-structured interviews, I was aware of the need to anticipate the eventual analysis. Initially, I had decided to use the computer software programme NVivo 9.2\(^7\) to analyse each transcript. On the surface, this seemed to provide a commendable objectivity to the analysis. Each line or segment of a participant interview would be summed up in a word or phrase in order to categorize and account for the perceived reality in an interpretative way. This micromanagement of the data concerned me because I did not want to lose a sense of engagement with the participant’s ‘humanity’ (Charmaz, 2006: 26) as well as an ‘awareness of the significance of the present moment’ in which there is sensitivity to the rhythm of the encounter and the uniqueness of an experience (Swinton and Mowat, 2016: 59). The NVivo 9.2 programme would detect an analytic direction and build theoretical categories, but this was already present on the semi-structured interviews with thirty-one questions covering six areas of enquiry.

\(^7\) NVivo 9.2 is a code-based theory builder developed by QSR International that assists the analysis of qualitative data.
My final decision was to dispense with the NVivo 9.2 programme and, in its place, subject the data of the interviews to different stages of analysis i.e. immersion, review, reflection, abstraction and synthesis. This was in keeping with the phenomenological and hermeneutic principles underlying the methodology, emphasizing its interpretative rather than positivist credentials, and favouring understanding over explanation. It is also documented in the literature (van Manen, 1990; Denzim and Lincoln, 2000; Lincoln and Guba, 2000; and Swinton and Mowat, 2016; Ajjawi and Higgs, 2007).

There are five stages to the data analysis which are set out in Table 5.1. The first stage involves my immersion within the text, a concentrated engagement with the data as I listen to and transcribe the recorded interviews, reading and re-reading the transcripts and returning time and again to the voices of the participants. The second stage comprises my systematically reviewing the interviews, gathering the participants’ responses under each question. This I describe as a vertical ordering of the data which enables me to compare and contrast each of the participants’ responses question by question. The third stage is one of reflection as I carry out an initial appraisal of both the primary research question and the secondary research questions based on the systematic review. The fourth stage, abstraction, focuses on the main themes or constructs that I detect in the data. Initially I will search for sub-themes which I will then group into main themes or constructs. These I will revisit and revise a number of times. Following this, I will organize the participants’ responses under each main theme or construct. The fifth stage is one of synthesis in which I correlate the main themes.

Did I make the right decision to dispense with the use of the software programme? The unexpected findings of this research (chapter six) confirm that while computer programmes provide tools to assist with the analysis of qualitative data, it is the researcher’s responsibility to maintain an unequivocal and committed engagement with the data. 'Many researchers have had the hope – for others it is a fear – that the computer could somehow read the text and decide what it means. That is, generally speaking – not the case’ (Weitzman, 2000: 805).
Table 5.1  Stages of Data Analysis

<table>
<thead>
<tr>
<th>STAGE</th>
<th>TASKS</th>
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| 1. Immersion  | • Listening to the recorded interviews  
|               | • Transcribing the recorded interviews  
|               | • Reading and re-reading the transcripts alongside the recorded interviews |
| 2. Systematic Review | • Gathering the participant responses under each question (a vertical ordering of the data)  
|               | • Comparing and contrasting the participant responses to each question |
| 3. Reflection  | • An initial appraisal of the primary research question based on the evidence of the systematic review  
|               | • An initial appraisal of the secondary research questions based on the evidence of the systematic review |
| 4. Abstraction | • Identifying sub-themes in the text  
|               | • Grouping sub-themes into main themes  
|               | • Elaborating and substantiating the main themes  
|               | • Ordering participant responses as these correspond with the main themes (a horizontal ordering of the data) |
| 5. Synthesis   | • Correlating main themes  
|               | • Establishing the presence of a narrative  
|               | • Linking narratives into discourse  
|               | • Refining the discourse  
|               | • Corroborating and legitimating the discourse |

5.4.6  Participant Selection and Recruitment
The selection of research participants presented a considerable challenge. The decision to recruit twelve people was based on the need for interview quality not survey quantity. There are 299 full-time Church of England healthcare chaplains serving NHS Trusts in England as of 31 December 2010 (Church of England, 2011: 46), but matching this population group across a range of variables considerably reduced the pool in respect of which participants might be drawn. The variables, in which some element of control was exercised, were as follows: gender, age, period of time in priestly ministry, period of time in stipendiary
parochial ministry, period of time in deacon’s orders, context of ministerial training, churchmanship, period of time in healthcare chaplaincy and current appointment in healthcare chaplaincy. The relevant information about participants was identified from their entries in Crockford’s Clerical Directory 2010-2011 (2009) and this provided a population group of men n=73 and women n=8 from which the twelve participants were to be chosen.

1) **Gender:** the decision to recruit equal numbers of male and female participants was tacit recognition that the experience, insight and understanding of Anglican priesthood may not be gender-neutral. Although there is a biological basis for gender, equally critical is society’s own perceptions of gender which contribute to what many claim is its social construction (Hacking, 1999: 21-24). Moreover the relationship between religion and gender comprises a complex web of social interactions and teachings which span, among other areas, human sexuality, gender relations and ecclesiology. The history of women in the Church is a witness to their exclusion from positions of responsibility, authority and power. In 1994, the Church of England admitted women to the order of priest, but it was a further ten years before General Synod decided that women might be ordained to the episcopate. The first appointment was made in January 2015. Arguably, gender remains a ‘costume, a mask, a straitjacket in which men and women dance their unequal dance’ (Lener, 1986: 238). By giving women an equal voice in this research, the intention was not to minimalize or gloss over what may emerge as distinct differences in their experience, insights and understandings of Anglican priesthood. Rather, it is to give recognition to the validity of their contribution on its own merits.

However, for completeness it should be noted that among Church of England priests, women represent 32.09% (*n* = 3650) of diocesan licensed ministers as of 31/12/12 (Church of England, 2012: Table 3). Among healthcare chaplains who are ordained Church of England priests, women represent 41.82% (*n* = 115) as of 31/12/12 (Church of England, 2012: Table 9).

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8 This figure includes full-time stipendiary clergy, part-time stipendiary clergy, self-supporting clergy, and ordained local ministers.
9 I refer to 2012 as this was when the interviews were conducted.
2) **Age** (as at 2011): based on an analysis of year of birth, ranged from 1960 to 1971 (men) and 1954 to 1971 (women). The average age was 45.83 years (men) and 47.83 years (women). This can be compared to the average age for non-parochial diocesan clergy (which includes healthcare chaplains as well as other non-parochial appointments): 51 years (men) and 50 years (women); and the average age for all stipendiary diocesan clergy: 52 years (men) and 51 years (women) (Church of England, 2011: 49).

In 1996, Louden and Francis factored age into their research exploring the views of nearly fifteen hundred Roman Catholic priests in England and Wales across a range of twenty-two key areas: these included the theology of priesthood conceptualized as ‘theologically motivated practices that give shape to the priestly way of life’ and the experience of priesthood conceived, in part, in terms of ‘the expectations and demands of parishioners and of society as a whole’ (Louden and Francis, 2003: 9). They presented their findings by age group (under 45; 45-59; and over 60) in order to capture generational differences based on pre- and post-Vatican II seminary experiences (Louden and Francis, 2003: 22). A more recent study of Roman Catholic clergy in the USA (Gautier, Perl and Fichter, 2012) adopted a similar approach claiming that the age groups it incorporated mirrored mirrored generational differences which were ‘influenced by the prevailing cultures of the time’.

Given the overall age profile of potential participants who matched the other research criteria, I decided not to attempt to control for age in building my sample. However, I would draw attention to the fact that the age group of the participants reflects a generation embattled on a number of fronts, including an intense debate on the nature and meaning of Anglican episcopacy prefigured by an equally intense debate about the nature and meaning of priesthood. ‘The possibility of women being admitted to the orders of deacon, priest and bishop has been on the Church of England’s agenda since at least 1966 when *Women and Holy Orders* was produced for the Church Assembly. Over the succeeding two decades, the General Synod followed up with *The Ordination of Women to the Priesthood* (1972), *The Ordination of Women* (1978) and *The Ordination of Women to the Priesthood: Further Report* (1984)’ (Archbishops’ Council, 2012: paragraph one). Furthermore, the participants belong to generation which has
witnessed the resignation of Anglican priests, both in the aftermath of the 1994 ordination of women to the priesthood and more recently with the creation of The Personal Ordinariate of Our Lady of Walsingham, in order to become ordained as Roman Catholic priests. Undoubtedly, such upheaval in the Church of England, reflecting as it does a prevailing culture questioning the very identity of Anglicanism has had and will continue to have a particular impact on that generation from which the participants were recruited.

3) **Period of time in priestly ministry** (as at 2011): the number of years participants were in priestly ministry ranged from 12 years to 16 years (men) and 7 years to 17 years (women). The mean was 14.33 years (men) and 12.3 years (women). Again, this variable relates to the decision by the Church of England in General Synod and in Convocation, to permit women to be ordained as priests when on 11th November 1992, it received the necessary two-thirds majority in the three Houses of Bishops, Clergy and Laity. In fact, all twelve research participants began ordination training after General Synod gave general approval to the draft legislation permitting women to be ordained priests in July 1988 and were ordained from 1994, the year that women were first ordained priests. In this respect, the population sample met the two criteria I established. First, participants were ordained priest in or after 1994 and second, participants had spent at least five years in priest’s orders. This was acknowledgement that the process of clerical identity and integrity, while it begins during ordination training, is grounded in the experience and practice of priesthood in the years following ordination to the priesthood. This might be described as the internalization of priesthood: ‘a process of personal deepening and transformation; ... [i]ntegration, then, is the key – and integration not merely on an intellectual level, but on that of the soul and spirit’ (Countryman, 1999: 157).

4) **Period of time in stipendiary parochial ministry**: to understand the reasons why it was decided that participants should have served a stipendiary parochial ‘title’, it is necessary to consider the implications of stipendiary and

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10 This was established in 2011, by Pope Benedict XVI, to allow Anglicans to enter into full communion with the Roman Catholic Church while preserving some vestiges of Anglican heritage and tradition.
non-stipendiary ministry.

Before the 1960s, every Church of England priest was selected on the basis that they would be employed by the Church (or, if in sector ministry, by a secular employer) in a paid, full-time ministerial capacity. On ordination as a deacon, a person would ‘serve a title’: this was a usually a full-time, paid three year placement in a parish other than the person’s ‘sending’ parish, i.e. where a person had worshipped, discerned a priestly vocation and been supported in testing this vocation. At the end of the first year, it was customary for the person to be ordained a priest. The ordination of non-stipendiary priests in 1969, following the creation of the Southwark Ordination Course in the 1960s, changed this. A person could now be ordained to a part-time and unpaid ‘title’ in the ‘sending’ parish. In 1996, Church of England bishops accepted the recommendations of the report, *A Review of Selection Procedures in the Church of England*, one consequence of which was that people offering themselves for ordained ministry were placed in one of two categories: ordained stipendiary and non-stipendiary ministry or ordained permanent non-stipendiary ministry (Sentamu, 2001:115). The distinguishing feature was that candidates selected for the first category might move, at some future date, between stipendiary and non-stipendiary ministry, whereas candidates in the second category would remain permanently in a non-stipendiary ministry (Hodge and Mantle, 2001:220).

The situation has now changed again. Selection for ordained ministry is not made on the basis of stipendiary and non-stipendiary ministry. Instead, candidates are sponsored as ‘incumbent’, ‘assistant’ or ‘ordained local ministers/locally deployed’. The question of a stipendiary appointment is a separate issue. Theoretically, a person could have a stipendiary post as an assistant, although the expectation is that only those sponsored as incumbent will receive a stipend. However, an incumbent’s ministry might be self-supporting. Moreover, if, during training or as an assistant in training (Initial Ministerial Education 1-7), a person requests ministry as an incumbent, the candidates are sponsored as ‘incumbent’, ‘assistant’ or ‘ordained local ministers/locally deployed’. The question of a stipendiary appointment is a separate issue. Theoretically, a person could have a stipendiary post as an assistant, although the expectation is that only those sponsored as incumbent will receive a stipend. However, an incumbent’s ministry might be self-supporting. Moreover, if, during training or as an assistant in training (Initial Ministerial Education 1-7), a person requests ministry as an incumbent, the

11 ‘Initial Ministerial Education (IME) for the clergy comprises the two or three years before ordination to the diaconate and the four years of the initial curacy.’ The Church of England http://www.churchofengland.org/clergy-office-holders/ministry/ministerial-education-and-development/initial-ministerial-education.aspx (retrieved 24/02/12).
Candidates’ Panel has to be approached for a decision. If a person has completed their training, it is at the bishop’s discretion, and he may or may not seek a decision from the Candidates’ Panel. Finally, if an assistant wants to apply for a paid post in sector ministry, it would need to be agreed by the licensing bishop, who may or may not seek the advice of the Candidates’ Panel or the Ministry Division (Ison, 2012).

Clearly, there has been, and continues to be potential for wide variation and, in part, this has been the reason why completion of a stipendiary ‘title’ post was a criterion for participation in this research. The dynamics between training incumbent and curate-in-training is sufficiently complex without the additional issues of a part-time training, an unpaid appointment (or honorary curacy) and, possibly, a concurrent full-time secular appointment. Furthermore, according to Crockford’s (2009), there are clergy in post who were ordained to a ‘title’ parish and, at the same time, appointed to an NHS Trust as a healthcare chaplain. In such instances, the formation of priestly identity would have taken place in the dual ‘work’ context of parish and hospital. For these reasons, research participants were selected on the basis of having completed a stipendiary parochial post.

The period of time participants were in stipendiary parochial ministry (as at 2011) ranged from 12 years to 16 years (men) and 3 years to 11 years (women). The mean was 14.33 years (men) and 5.83 years (women).

5) **Period of time in deacon’s orders**: before 1987, and since 1994, it has been common practice for a person to be ordained deacon and, a year later, ordained priest. This practice can be varied, at the discretion of the diocesan bishop, but this would be the exception rather than the rule. In 1994, women were admitted to the order of priest in the Church of England, some of whom had been deacons since 1987 when ordination of women to the diaconate had been allowed. Again, ministerial formation would have been undertaken within the context of an extended period in the diaconate. What influence this might have had on the formation of a priestly identity is uncertain. Consequently, I decided that all healthcare chaplains interviewed as part of this research would have served the customary one year in the diaconate before being priested.
6) **Context of ministerial training**: the Hind Report (Archbishops’ Council, 2003), endorsed by the Church of England General Synod at its meeting in July 2003, paved the way for a mixed economy of training for priesthood. According to Crockford’s, there are eleven residential theological colleges, fourteen non-residential regional courses and eleven local ministry schemes (Crockford’s, 2009: 1237f.) The 1970s and the 1990s witnessed the closure of many residential colleges due to a significant decline in candidates for the Church of England priesthood. It has been argued that the traditional seminary environment, setting people aside for training and education, is not appropriate for the future practice of ministry (Pickard, 2009: 165). But non-residential training is not without its critics. ‘It is possible to argue that though more and more people are being trained for ministry, fewer and fewer are being helped to grasp in any real depth the building blocks that will help them engage with a sophisticated and fragmented society’ (Mantle, 2000: 278). Elsewhere the advocates of residential training perceive it to offer ‘full-time preparation for ministry with a strong emphasis on contextual learning through an extensive range of placements, deep immersion in the rhythms of daily prayer’ and ‘the joy and challenge of living and working together’ (Westcott House, 2012). Whatever the merits of either view, residential and non-residential theological preparation for ordained ministry offer a different context which is influential in the formation process. Consequently, I decided to select participants who had received a residential rather than non-residential training. My premise was that experienced healthcare chaplains were more likely to have received a residential theological education, so this choice would lead to a larger potential sample. In addition, churchmanship may influence choice of residential theological college (see the next section which explores the variable, churchmanship).

7) **Churchmanship**: as this research focused on the ontological and functional interpretations of priesthood, a noteworthy ‘bone of contention’ between high and low church, I noted possible indications and influences of churchmanship bias within the participant sample, although I decided that it was

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not feasible to attempt to control for churchmanship.

Traditionally, theological colleges have been noted for a particular brand of ‘churchmanship’ (c.f. Homan, 1995: 14). Research participants attended one of eight theological colleges. Male healthcare chaplains attended Queen’s Birmingham (n=1), Lincoln (n=1), Westcott House, Cambridge (n=1) and Ripon College, Cuddesdon (n=3). Female healthcare chaplains attended St Stephen’s House, Oxford (n=1), Ripon College, Cuddesdon (n=1), St John’s College Nottingham (n=1) and Cranmer Hall, Durham (n=3).

From the websites of seven of these theological colleges, not including Lincoln which closed in 1995, the following statements reflect or intimate churchmanship: ‘the college is chiefly set in the catholic tradition’ (Alison Craven, Westcott House); ‘[a]s a community we are rooted in the tradition of Catholic spirituality’ (St Stephen’s House); ‘[o]ur strength comes from the acceptance of diversity and we have students from across the breadth of church traditions’ (Ripon College); David Hilborn, the new Principal, ‘strongly embodies the charismatic evangelical Anglican values for which St John’s stands’ (St John’s College); ‘Queen’s works collaboratively with a number of denominations’ (The Queen’s Foundation); and ‘an Anglican theological college, rooted in the evangelical tradition but hospitable to a wide range of Christians from a huge range of denominations’ (Cranmer Hall).

On the basis of these statements, one may infer that the residential formation that participants experienced as they trained for ordination, and which would have influenced their liturgical and theological understanding of the nature of priesthood, placed them within specific churchmanship contexts. These, then, were catholic (Westcott House and St Stephen’s, n=2); evangelical (St John’s College and Cranmer Hall, n= 4); and liberal13 (Ripon College, Lincoln and Queen’s College, n=6).

13 In the second half of the nineteenth century, the term ‘broad church’ was used to describe those ‘who objected to positive definition in theology and sought to interpret the Anglican formularies and rubrics in a broad and liberal sense’ (Cross and Livingston, 1974:202). Its twenty-first century equivalent might be the term ‘liberal’ understood as ‘a habit of cultural sensitivity and intellectual flexibility that does not seek to close down unexpected questions too quickly’ (Williams, 2006: paragraph 3).
Few would deny that churchmanship is an artificial construct difficult to define, articulate and specify. However, in recognizing the legitimate contribution of churchmanship to the methodology of this thesis, I use it as a means of deepening an awareness of participants as individuals rather than as members of an ecclesiastical caucus. Further discussion of issues relating to churchmanship will be found below at §5.5.1.

8) **Period of time in healthcare chaplaincy:** what an individual does, in terms of day-to-day employment, is often integral to how they construct a sense of self which ultimately provides a person with meaning and purpose (Alveson, 2001). As Steers and Porter observe: ‘from a psychological standpoint, [work] can be an important source of identity, self-esteem, and self-actualization’ (Steers and Porter, 1991: 574). The conceptual grounding of work identity is drawn from theories of identity (see Postmes and Branscombe, 2010) and self-categorization (Turner and Oakes, 1986). Over a period of time, people internalize the work experience and an interaction takes place between the individual and their experience of work: ‘while work helps to define an individual’s identity, so an individual’s identity impacts on and helps shape their work and their relationships with their employer, fellow employees, and the occupation group with which they work’ (Brown, Kirpal and Rauner, 2007: vii).

Taking this into account, I decided that participants selected for the research sample had to have worked for at least two years, full-time, in healthcare chaplaincy.

In that NHS healthcare chaplains in England, who are priests of the Church of England, are responsible to a healthcare manager and accountable to a diocesan bishop, an aspect of this research was concerned with the perceived relationship and interaction between the two identities: healthcare chaplain and priest. Participants had been ordained priests far longer than they had been healthcare chaplains: the number of years participants were in healthcare ministry (as at 2011) ranged from 6 years to 12 years (men) and 2 years to 11 years (women). The mean was 9.17 years (men) and 7.17 years (women). So, one of my research questions was this: to what extent did day-to-day employment as a healthcare chaplain shape a person’s interpretation of
priesthood or was it more that priestly formation shaped the experience and practice of healthcare chaplaincy?

9) **Current appointment in healthcare chaplaincy:** it had been the original intention of the research to recruit participants who managed NHS chaplaincy departments. This would have provided an opportunity to explore the influence of an NHS culture which is driven by financial constraints and politically motivated policies e.g. those reflecting equal opportunity and diversity. To what extent do such constraints and policies require the chaplain to negotiate an identity which promotes the needs of the manager over and above those of the priest? However, the limited population of female healthcare chaplains enforced a compromise. Rather than selecting only those chaplains at Agenda for Change\(^{14}\) (AfC) band 7, a pay scale banding rewarding management responsibility, chaplains at AfC band 6, a pay scale banding without management responsibility, were accepted into the research group.

An initial letter inviting participation in the research was posted to each healthcare chaplain (see Appendix M). On agreeing to take part in the research, each healthcare chaplain was sent the interview questionnaire (see Appendix N) together with a paper briefly outlining the nature of the research (see Appendix O).

5.4.7 **Participant Selection: epistemological foundations and assumptions**

As has been noted earlier, the population group matched across a range of variables identified 73 male healthcare chaplains and 8 female healthcare chaplains from which twelve research participants might be drawn. There was a sufficient number of male healthcare chaplains to permit a randomized selection of male participants but this was not the case for female participants. The limited size of the matched population group of female healthcare chaplains (n=8) was further compromised by the decision of one person not to participate in the research while another was on extended sick leave. The matched population group of female healthcare chaplains was able to provide the

\(^{14}\) AfC is the current NHS grading and pay system for all NHS staff with the exception of doctors, dentists and some senior managers. It was agreed in December 2004.
required number of female research participants (n=6) but no more. The only avenue forward was the non-randomized selection of those female healthcare chaplains remaining in the matched population group, what has been described as a forced selection. Given this situation, what were the implications for the veracity of this research?

Generally speaking, the main purpose of identifying a sample from a population group is to enable researchers to draw common conclusions about the scrutinized population as a whole. An equal probability sampling method, the strongest research design, ensures that every member of the population under study has an equal probability of being included in the study sample and will have the same characteristics as the population group from which it is chosen. This permits the researcher to generalize the research findings to the population group as a whole. The representative nature of the sample is based on the fact that it resembles the larger population. Any differences between the population and the sample cannot be attributed to researcher bias but will be due to chance. Alongside this premise of generalizability there are two further related criteria: falsifiability and replicability. These are the three pillars of a particular model of knowledge-seeking, nomothetic knowledge, by which truth and fact are identified and defined. It is also the acknowledged epistemology of quantitative analysis.

Reliant on rigorous scientific method, nomothetic knowledge is the bedrock of post-enlightenment Western culture within which hard science opposes ‘such things as narrative, experience and emotion [as] modes of ‘soft truth’ which are, to a greater or lesser extent, excluded from the realm of ‘public truth’ that has relevance beyond the experience or opinion of the individual’ (Swinton and Mowat, 2016: 37). Such a view has not gone unchallenged for as one social psychologist observed, ‘although we may theorize or even dream in a nomothetic world, we never live in it’ (Gorsuch, 2002: 1824).

As an alternative epistemological model, there is ideographic knowledge which provides the rationale for qualitative methodology and ‘presumes that meaningful knowledge can be discovered in unique, non-replicable experiences’ (Swinton and Mowat, 2016: 41). To describe ideographic knowledge as an
alternative is not to imply an inability to co-exist alongside its nomothetic counterpart. The two can, and often do, complement one another within a research project. However, for the purposes of this research, drawing on the unique experiences, insights and understandings of individuals and recognizing that a person’s perception of reality might also be theologically constructed, the handling of data reflected an ideographic epistemology: ‘the authenticity and reality of ideographic truth’ (Swinton and Mowat, 2016: 42).

This issue of epistemology, in the context of sampling, is pertinent here in that there was a forced, non-randomized selection of female research participants which threatened the integrity of the population sample for purposes of generalization. Few would deny that [s]ampling is a major problem for any kind of research... Every scientific enterprise tries to find out something that will apply to everything of a certain kind by studying a few examples, the results of the study being, as we say “generalizable” to all members of that class of stuff. We need the sample to persuade people that we know something about the whole class. (Becker, 1998: 67, italics in the original)

But this research has also highlighted an additional if related concern about generalizability. Exploring Anglican priesthood by reference to a population sample of healthcare chaplains begs a crucial question: is there a common profile among Anglican priests who minister as healthcare chaplains which is different to Anglican priests who minister in other settings?

A survey carried out in 2007 (Hancocks, Sherbourne and Swift, 2008) suggested that many Anglican priests who are healthcare chaplains experience a sense of alienation from the institution of the Church. Of male participants, 20% revealed that they were in same-sex relationships, while of all chaplains 27% were married to or in a relationship with another ordained person and the personal circumstances of a further 80% made it easier to work in this sector of ministry. The survey found that a significant number of so-called ‘refugees’15 were liberal and high church, and experienced the Church as theologically and

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15 The term ‘refugee’ was used by one respondent to the survey who commented, ‘I consider myself to be a “refugee from the church”. I had a reasonably good curacy and a very supportive bishop but a truly appalling experience when a priest in charge... I feel relatively safe in the NHS’ (Hancocks, Sherbourne and Swift (2007: 173).
pastorally at variance with their own position and thinking. The point is made by the authors that it seemed the problem was not with ministry but with the institution. Only 25% of chaplains had perceived themselves as valued by the Church, while as healthcare chaplains more than 60% felt valued by the NHS. This survey might suggest that taking a sample from any specific clergy group is going to face potential bias given the very characteristics of those people who choose and are chosen for a particular ministerial setting? Generalization, which gives credence to the findings of a quantitative survey, might seem to undermine the credentials of a qualitative study by its absence. Then again, ‘[g]eneralization is... (a) word... that should be reserved for surveys only. What can be analyzed instead is how the researcher demonstrates that the analysis relates to things beyond the material at hand... extrapolation better captures the typical procedure in qualitative research’ (Alasuutari, 1995: 156-7).

Embarking on this research, the initial supposition had been that the findings would shed light on the nature of any correspondence or disparity that exists between theologies of priesthood on the one hand, and the experience, insights and understanding of those who live and practice the priestly craft on the other. However, what emerged addressed more the ‘transferability’ of the findings rather than their generalizability. In other words, ‘a resonance with people outside of the immediate situation who are experiencing phenomena which are not identical, but hold enough similarity to create a potentially transformative resonance’ (Swinton and Mowat, 2016: 45). This closely relates to what has been described as ‘theoretical generalizability’, a logical or conceptual comparability rather than one based on statistical representativeness (Sim, 1998: 350). The premise of the research findings, which are presented in a later chapter, is that transformative resonance and theoretical generalizability support the decision both to allow the non-randomized population sample of female participants and to deploy healthcare chaplains as the population group for exploring Anglican priesthood. More crucial still has been a researcher characteristic, identified by Strauss and Corbin, which I would hold has influenced this research, theoretical sensitivity which refers to a personal quality of the researcher. It indicates an awareness of the subtleties of meaning of data... [It] refers to the attribute of having insight, the ability to give meaning to the data, the capacity to understand, and
capability to separate the pertinent from that which isn’t. (Strauss and Corbin, 1990: 42)

5.4.8 Churchmanship
As mentioned earlier (§5.4.6), because this research focused on the ontological and functional interpretations of the priest, a point of difference and dispute between high and low church, it seemed pertinent to record the participants’ perceptions of their churchmanship during the interview. Unfortunately, ‘[a]s the history of the Anglican Church has revealed, churchmanship is an emotive and emotional concept. In attempting to measure churchmanship by applying a quantitative index to it, the researcher is likely to encounter ecclesiological, philosophical and methodological issues’ (Randall, 2005: 57).

In its 1986 report entitled *The Priesthood of the Ordained Ministry*, the Church of England Board for Mission and Unity acknowledged that ‘[t]he priestly character of the special, ordained ministry has long been a source of contention between different sections of the Anglican Communion’ (Board for Mission and Unity, 1986: 3). Elsewhere, it has been worded more diplomatically. ‘A feature of the Church of England is that Anglicanism has been capable of embracing a variety of frequently diverse theological standpoints... [which] have persisted with considerable force (Ranson, Bryman and Hinings, 1977: 41). This is what is generally referred to as ‘churchmanship’.

The debate has never been one solely between Catholic (for whom the priest is the incumbent of a divine office and ontologically set aside) and Evangelical (for whom the universal necessity of ‘conversion’, ‘justification by faith’ and *sola Scriptura* are more important). Nor, in recent years, has it been one solely between modernist (pursuing a ‘progressive’ form of theology especially in relation to the Church and its ministry in the world) and traditionalist (with an emphasis on preserving the Christian faith as it has been passed down). There have been, and continue to be, numerous shades of churchmanship: a complex matrix. ‘The deficiency of the labelling approach is the lack of refinement it offers for the range and subtlety of churchmanship self-designations’ (Randall, 2005: 57).
As was noted earlier in this chapter (§5.4.6), a 2007 survey of Anglican healthcare chaplains found that 20% of male participants were in same sex relationships while 27% of all chaplains reviewed had partners who were in ministry (married or same sex) (Hancocks, Sherbourne and Swift, 2008), two statistics which suggested (and was confirmed elsewhere in the study) that healthcare chaplains are more likely to be found on the ‘progressive’ wing of the Church.

In order to record the healthcare chaplains’ perception of their churchmanship, and given the multifarious shades of churchmanship as well as the reluctance of many clergy persons to be pigeon-holed, I used what I thought was a novel approach. Instead of churchmanship labels, I proposed an orthogonal representation (Appendix P), a graph with two axes (x-axis: Traditional/Liberal; y-axis: High Church/Low Church) on which a clergy person might plot their churchmanship in one of four quadrants, i.e. Traditional High Church, Liberal High Church, Traditional Low Church and Liberal Low Church). Only later did I learn that a graph, identical in schema, was proposed in 1967 by Daniel (reproduced in Randall, 2005: 48): the x-axis Evangelical (Bible-based)/Catholic (Church) and the x-axis Conservative (tradition)/Liberal (human reason). In a more recent study, a further axis has been added by Randall (2005), i.e. positively influenced by the charismatic movement/negatively influenced by the charismatic movement. In part, this is based on the findings of a study by Francis, Lankshear and Jones (1998) which suggested that an ‘Evangelical’ identity could be further refined by considering the influence of charismatic spirituality. Earlier evidence from the Church Rural Project, a major study of church and religion in rural England for the Church of England, demonstrated that clergy across the Catholic/Evangelical spectrum acknowledged a charismatic component to their spirituality (Davies, Watkins and Winter, 1991). Randall used other measures of churchmanship and religious experience to test his three-dimensional model and subsequently argued that there is ‘a strong indication that the measure is satisfactorily mapping the content as well as the labels of churchmanship’ (2005: 75).

However, in the pilot study I conducted in 2010, I was met with a significant degree of ambivalence, often expressed with humour, when participants were
presented with the two-dimensional churchmanship instrument I had devised. To my mind, what were straightforward categories still presented some participants with a conceptual challenge. To include Randall’s third dimension would not only have added a further and unnecessary layer of complexity. This aspect of enquiry sought churchmanship orientation rather than definitive content for, as has been suggested, ‘measures of semantic space and conceptual structure... supply dimension of meaning to the subject rather than eliciting them... [and] pays little attention to the subject’s own personal meaning system or to the possibility that the dimensions supplied may not be applicable to the concepts under study for a particular individual’ (Winter, 92: 65).

5.5.1 Ethical Issues
The freedoms and privileges that academic researchers enjoy, and which underwrite the independence of the higher education research community, come with significant responsibilities including the need to ensure that research involving human participants conforms to a rigorous code of ethical practice (cf. Department of Health, 2005; Economics and Social Science Research Council, 2012). Key among these are honesty, integrity, objectivity, accountability and openness (cf. the ‘Nolan Principles’ from Standards in Public Life, 1995: 14), as part of methodical inquiry, systematic analysis, and conscionable professionalism. In compliance with the regulations of the University of Exeter, an application was made for ethical approval in April 2011 (renewed in March 2012) and a Certificate of Ethical Approval was issued by the College of Humanities (see Appendix U).

My preliminary thoughts about the ethical implications of the research focused on two methodological issues. First, I needed to consider how much research information it was appropriate to share with participants in order for them to be in a position to provide informed consent. This is not straightforward for as King and Horrock (2010: 110) point out, ‘when obtaining informed consent participants will only be in possession of fuller knowledge of what participation entails when they have experienced the interview.’ ‘Process consent’, ensuring at regular intervals during the interview that the interviewee continues to give informed consent (Richards and Schwartz, 2002: 137), offers one solution
although it has shortcomings, primarily that it interrupts the cognitive and emotional development of the interview.

More positively, what a participant learns about the research before being interviewed can itself demonstrate the extent to which a researcher is willing to be open and transparent, imperative for a relationship of trust and mutual respect such as that which needs to be established between the two parties. For my part, I chose to be quite candid about the purpose of the research accepting the view that ‘narrative research reports are not co-constructions of meaning between participant and researcher, but points in a conversation between the researcher and a group of colleagues who share interest in a particular conceptual or theoretical frame’ (Josselson 2004: 19). On agreeing to take part in the research, each participant was sent the interview questions (see Appendix N) and a briefing paper outlining the nature of the research (see Appendix O).

Second, and related to this need to build trust and respect between researcher and participant, I thought carefully about how to safeguard the personal and professional information of each participant. Plainly, this requires both researcher confidentiality and participant anonymity. Each of these was written into the research proposal and consent form that participants received and signed prior to interview (Appendix U): the form stated that ‘where specific reference is made to content in a transcript, this will be non-attributable to ensure that no participant can be identified in any way. Anonymity is guaranteed and will be rigorously enforced.’ This was reiterated in the questionnaire (the basis of the semi-structured interview) which participants received once they had agreed to take part in the research project. Similarly, in order to safeguard the personal and professional information of each participant audio recordings and transcripts of the research interviews were securely stored and interviewees identified only by number.

Aside from these preliminary thoughts, the ethical oversight of a research project calls for a process of continuous review. I realized that in the dual roles of interviewer and researcher, a not uncommon feature of qualitative research (Karnieli-Miller, Strier and Pessach, 2009: 280), it was important to retain a
sense of role balance. This, however, was not easy. As a researcher, my relationship with participants was delineated and asymmetric or, as Reason (1994: 42) describes it ‘mutually exclusive: the researcher alone contributes the thinking that goes into the project, and the subjects contribute the action or contents to be studied.’ Yet, as an interviewer my aim was to establish a welcoming, safe atmosphere, displaying ‘a feeling of empathy for informants’ that encourages ‘people [to] open up about their feelings’ (Taylor and Bogdan, 1998: 48). Unfortunately, such warm, caring, and seemingly empowering features of the qualitative interview may mask significant power differences. Within the dialogue of an interview, it is the interviewer who will invariably exercise the greater power.

In the face of this reality, the interview needs to be recognized for what it is: a ‘moral enterprise’. It is unavoidable that all qualitative research based on interviews will be ‘saturated with moral and ethical issues’ (Kvale and Brinkman, 2009: 62). Power, by and large, resides in the hands of the interviewer who initiates, guides and formally concludes the interview: ‘[t]he research interview is not a dominance-free dialogue between equal partners; the interviewer’s research project and knowledge interest set the agenda and rule the conversation’ (Brinkmann & Kvale, 2005: 164). Participants may try to assert their control over the interview by adopting behaviours which are intended to distract the interviewer, such as flattery and flirtation (Collins, Shattel, & Thomas, 2005), or by steering the conversation (Hutchinson & Wilson, 1992), or simply by withdrawing from the interview but, even so, ethical responsibility for the interview lies with the interviewer.

Similarly, open-ended interviewing can lead participants into areas of personal or professional revelation that are neither anticipated nor contracted (Borbasi, Jackson and Wilkes, 2005: 497; Shaw, 2003: 15), while the use of empathy to encourage participant disclosure and trust needs to be weighed against the risk of accentuating participant vulnerability or distress (Karnieli-Miller, Strier, and Pessach 2009: 283). I was particularly conscious of this as I listened to ‘Mary’, who assumed that God’s call to priesthood required the sacrifice of her marriage, ‘Barbara’ who felt coerced into relinquishing her Church Army commission and ‘Rita’ who, in part, experienced ordination as a burden. Self-
revelation and introspection may be cathartic, containing latent opportunities for transformation in self and identity (Ortiz, 2001: 193), but they can also blur what needs to distinguish research from therapeutic counselling (Dickson-Swift, James, Kippen and Liamputtong, 2006).

What this makes apparent is that, from an ethical point of view, researchers need to have sufficient self-awareness that their own subjectivity becomes part of the research process. This will ensure, for example, that researcher-participant relationships are transparent and open to scrutiny, taking into account such issues as power and integrity. Without this, the ethical probity of the research may be compromised. Thus, the researcher needs to look inwards, to ‘bring their preconceived beliefs into the dialogue’ (Harry, Sturges and Klinger, 2005: 7) and to assume a reflexive approach. This I investigate further in the next section.

5.5.2 Reflexivity
For the most part, qualitative researchers are so closely engaged with research participants that they may overlook another equally important aspect of the research: recognizing and evaluating researcher subjectivity. The personal, biographical, professional, social and cultural characteristics of the researcher may well shape the management of the research affecting what the researcher decides to investigate: ‘the angle of investigation, the method judged most adequate for the purpose, the findings considered most appropriate, and the framing and communication of conclusions’ (Malterud, 2001: 483f.). This awareness of the interplay between the researcher and the research, how this relationship effects and even transforms research (Finlay, 2002: 210), has figured prominently in the development of qualitative research, making reflexivity pivotal to methodological thinking (Seale, 1999: 160).

While reflexivity is a key dynamic (Swinton and Mowat, 2016: 56) if not ‘the defining feature’ of qualitative research (Bannister, Burman, Parker, Taylor and Tindall, 1994 cited by Finlay, 2002: 211), finding a definition that captures what reflexivity means and how it can be achieved, is problematic (Colbourne and Sque, 2004: 297). Reflexivity itself is a contested term (Gough, 2003: 32). Nonetheless, for Swinton and Mowat (2016: 57) reflexivity is essentially that
‘critical self-reflection carried out by the researcher throughout the process that enables her to monitor and respond to her contribution to the proceedings’. It is however, more than just reflection for it is a ‘process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes’ (Finlay, 2003a: 108). For Finlay and Gough (2003: ix), reflection and reflexivity are at opposite ends of a continuum. While reflection may entail self-observation or self-examination, perhaps nothing more than ‘benign introspection’ (Woolgar, 1988: 22), reflexivity promotes a dynamic and recursive approach to the process of reflection. Critically and explicitly it interrogates the assumptions, the positionings and the human relationships that impinge on the research (Chamberlain, 2015: 165ff.). While reflexivity should be ‘neither an opportunity to wallow in subjectivity nor permission to engage in legitimised emoting’ (Finlay, 1998: 455), it does provide a springboard for the development of a range of interpretations and insights not immediately apparent.

How reflexive research is conceptualized and organized will be dependent on ‘the aims and functions of the exercise at stake and the theoretical and methodological traditions embraced’ (Finlay, 2003b: 16). So, for example, Macbeth presents a twofold distinction between positional reflexivity, ‘a disciplined view and articulation of one’s analytically situated self’ (Macbeth, 2001: 38), and textual reflexivity, ‘studies and discourses that directly address the work of writing representations’ (Macbeth, 2001: 41). Alternatively, Lynch (2000) advocates a layered approach to reflexivity in which he notes six variants i.e. mechanical, substantive, methodological, meta-theoretical, interpretative and ethnomethodological. At the same time, he denies the claim that reflexivity is some theoretical or methodological virtue (Lynch, 2000: 34): [s]tudies of 'our own' investigative practices may, in some cases, be interesting, insightful and cleverly written, or they may come across as tedious, pretentious and unrevealing’ (Lynch, 2000: 47).

Swinton and Mowat (2016: 57), who directly address the contribution of qualitative research to practical theology, draw attention to the work of Willig (2001: 10) and her two categories of reflexivity: epistemological and personal.
Epistemological reflexivity takes account of researcher assumptions which, perhaps unwittingly, underpin and influence the direction of the research and its conclusions. Personal reflexivity addresses those ways in which the researcher's values, experience, interests, beliefs and social identities shape the research and the changes this may introduce to the way the research is conducted. Additionally, it recognizes the possibility that the researcher herself can be changed both as a person and as a researcher. These two types of reflexivity, it is claimed (Swinton and Mowat, 2016: 57), illustrate how, in different respects, the researcher is not a detached observer but a participant, either intentionally or unintentionally. This, in itself, might suggest that all research is, to a degree, autobiographical. In addition, what epistemological reflexivity emphasizes is the set of presuppositions the researcher has about the world and the construction of knowledge. ‘How has the research question defined and limited what can be ‘found’? How has the design of the study and the method of analysis ‘constructed’ the data and the findings? How could the research question have been investigated differently? To what extent would this have given rise to a different understanding of the phenomenon under investigation?’ (Swinton and Mowat, 2016: 57).

Even though Finlay (2002: 212) acknowledges that attempts to conceptualize reflexivity are ‘perilous’ and ‘full of muddy ambiguity and multiple trails’, she provides a helpful overview of how reflexivity has been interpreted in contemporary research. This, Finlay summarizes as one typology with five variants: introspection; intersubjective reflection; mutual collaboration; social critique and, finally, discursive deconstruction. These are not bounded categories, for Finlay (2002: 212f.) recognizes that researchers may draw on different aspects of reflexivity. Neither does she suggest that her mapping of reflexivity in contemporary research is the final word. Rather, Finlay seeks to provide a map by which researchers may make an informed choice that is consistent with their epistemological and methodological commitments.

What then were my own epistemological commitments? Initially, in formulating the research question, I was influenced by two factors. First, I had become increasingly aware of a disconnection between the respective values, priorities and direction of the NHS and the Church of England, which left me with a sense
of being marginalized, if at times unintentionally, by both institutions. Second, I wanted, theologically, to articulate an account of Anglican priesthood which, personally, I would find both credible and authentic. This was my ‘passionate concern’ which called out to me (Moustakas, 1990: 27). As the research progressed, I came to recognize that the theological preconceptions I had, concerning priesthood, were too narrowly framed within a catholic tradition derived from Thomism, in which an ontology of priesthood rests on the claim that, at ordination, a profound or metaphysical change occurs in a person’s ‘spiritual identity’. Such introspection, what Finlay (2002: 213f.) refers to as a variant of reflexivity, enabled me to be open to alternative constructions.

As for my methodological commitments, these prioritized the contextual voice of the Church of England priest ministering in the NHS. As explained in an earlier chapter (§1.6.2), I chose to 'listen attentively to the voices of a group of Church of England priests as each shared a theology of both priesthood and healthcare chaplaincy... less concerned with whether those voices were articulate or struggling to find appropriate words, whether they expressed cogency or were still searching for meaning... [rather] learning from their experience and interpretation of priesthood.' To some limited degree, it could be argued that the participants became self-reflexive co-researchers for it was their comments and observations which confronted, modified and informed my own thinking (Mulkay, 1988, cited in Smith, 1994: 259). Perhaps I could have gone further and allowed participants to view and comment on the transcripts of their individual interviews, clarifying their material to ensure accuracy and completeness. This I will explore further in the next section (§5.5.3).

Although there is an inherent risk that reflexivity can become a conduit for self-indulgent revelation, an ‘infinite regress of excessive self-analysis and deconstructions at the expense of focusing on the research participants and developing understanding’ (Finlay, 2002: 212), reflexivity offers both opportunities and challenges. Some may misconceive reflexivity as ‘researcher confession’ in order to reinforce the 'accuracy' or 'authenticity' of their research (van Maanen, 1988: 73f.), but as Gough (2003: 30) points out, ‘researchers need to take some responsibility for producing an analysis which can be applied to support a particular view of the world, whilst recognising researcher
involvement in the production of the account.’ Earlier in this section I referred to Willig’s (2001: 210) claim that reflexivity may lead to the recognition that the research itself can affect and change the person conducting the research. In this, I would readily admit that my own doctoral research has affected and altered my practice as a healthcare chaplain, as a priest and as a researcher.

Having earlier referred to Finlay’s description of reflexivity as a process by which the researcher ‘move[s] beyond the partiality of our previous understandings and our investment in particular research outcomes’ (Finlay, 2003a: 108), I am aware that my own presuppositions, preconceptions and prejudgements did play a part in determining the development and direction of this research, for example, narrowing the scope of its methodological design (cf. Swinton and Mowat, 2016: 57). Merely the fact that I am an Anglican priest and healthcare chaplain means that ‘in being too close and familiar with the subject matter, there is a possibility that certain aspects may be overlooked’ (Bhopal, 1995: 160). In the next section I further reflect on this and how my presuppositions may have limited a more equitable distribution of power between myself and participants and, in particular, whether sharing interview transcripts with participants might have had a more levelling effect on how power was communicated and experienced.

5.5.3 **Sharing interview transcripts with participants**

In the main, the purpose of the research interview is to elicit the participant’s story and, in the context of this research, the focus was on the experience and interpretation of both priesthood and healthcare chaplaincy. The management and organization of the interview, for data analysis purposes, needs the spoken language of the interview to be transcribed into written text notwithstanding the fact that spoken language has its own set of rules different to those governing the written word (Kvale, 1996: 165). This is one of a number of quandaries which arises in research based on interviews. So, for example, taking dynamic, oral, performative speech, contextualized within a specific time, place and relationship, and concretizing it into a static and permanent form (Lapadat, 2000: 204) involves, some would claim, an interpretative and political act which subtly alters meaning (Green, Franquiz, and Dixon 1997: 173). Again, the transcriber may be unfamiliar with the research topic and its language and
where the recording is ambiguous, the transcriber may ‘guess’ what has been said on the basis of what appears to make sense (Poland, 1995: 292). These illustrate the pitfalls of transcription, which may affect not only the quality but the objectivity of the text (Green, Franquiz, and Dixon 1997: 172).

To mitigate these and other potential drawbacks, some argue that participants should have an active role in the transcription process so improving, among other things, transcript credibility (Lincoln and Guba, 1985: 314), accuracy (Polit and Beck, 2007: 71), validity (Bloor, 1997: 41) and trustworthiness (Davidson, 2009: 28; Carlson, 2010: 1102). While few would dispute the need to ensure that ‘the participants’ own meanings and perspectives are represented and not curtained by the researchers’ own agenda and knowledge’ (Tong, Sainsbury and Craig, 2007: 356), it is essential to be clear about what function the interview transcript has within the overall purposes of the research. Many would agree that a ‘hit and run’ encounter with participants, taking data never to return, is ethically unacceptable (Greed, 1990: 145; Forbat and Henderson, 2005: 1125). Thomas (2017), in carrying out a narrative review of published articles which describe, consider or propose participant feedback, identifies four themes which reflect underlying assumptions about what purpose the research serves: theory development and generalization, representing participants’ experiences and perspectives, participation as an on-going research strategy, and the initiation of participant change either on a personal or social level. While concluding that ‘member checks’ were unlikely to the useful in theory development and generalization, Thomas thought that in research where feedback might be worthwhile, such as in representation and participation, this could be based on research summaries rather than verbatim transcripts (Thomas, 2017: 38; see also Creswell, 2009: 191; Carlson, 2010: 1111).

However, in his claim that some researchers who engage in participatory research endeavour to equalize power between themselves and participants, and to facilitate the empowerment of participants, Thomas directly addresses a wider issue: the distribution of power between researcher and participant. Citing various researchers who have studied this issue of power (from Winter, 1991, to Karniel-Miller, Strier & Pessach, 2009), Mero-Jaffe (2011: 239) acknowledges that the asymmetric division of power between both parties can never be totally
eradicated though its effect may vary from one interview to the next. While the researcher chooses what topics will be discussed, what questions will be asked, how much research information will be shared with participants as well as how the data will be analysed, interpreted and presented, an interviewee can decide what will and will not be divulged (Bhopal, 1995: 160).

Similarly, when a transcript is returned to an interviewee to enable corrections and clarification of a text, any changes introduced post-interview may affect data analysis. In their study of fifty-one interviewees, who were invited to review their own transcript, Hagens, Dobrow and Chafe (2009: 50) found that among the twenty-two interviews who accepted the invitation, sixteen made changes and ‘the majority of interviewees who revised their transcripts did so in such a way that the transcript no longer reflected accurately the verbal exchange during the interview’. In which case, as Mero-Jaffe (2011: 244) points out, when interviewees rephrase large sections of their transcript, any quotations from the revised texts are no longer verbatim ‘since these were not the things that the interviewee said, but rather things that he or she adapted to the rules of standard written text grammar... and in fact wrote them’ (italics in the original).

Despite this, there is also evidence that returning transcripts to interviewees for them to amend, clarify, refine or append supplementary information can be a cause for empowerment, building trust and showing respect (Mero-Jaffe, 2011: 244). In one study, where a hearing-impaired researcher used a ‘participant-as-transcriptionist’, the researcher commented that ‘[t]he collaborative nature of the relationship between the interviewer [i.e. researcher] and participant-transcriptionist allowed a participatory and inclusive approach to the research project. The collaboration extended to the point where the participant-transcriptionist became a co-author for this article’ (Grundy, Pollon and McGinn, 2003: 28).

16 Interestingly, as Forbat and Henderson (2005: 1120) and Thomas (2017: 36) observe, analysis of feedback from interviewees, who viewed their own transcript, is more likely to occur in methodological articles rather than in those which report substantive research findings.
Set against this, as Hagens, Dobrow and Chafe (2009) discovered, not all participants will respond to an invitation to review the transcript of their interview even though they gave prior consent (see also Hagens, Dobrow and Chafe, 2009: 50). Thomas (2017: 36) suggests that this may be due to participant indifference or disinclination to re-engage, but this means that, potentially in a research project, some interviewees will have revised their transcript and others not, resulting in two different sets of data (Hagens, Dobrow and Chafe, 2009: 50). Elsewhere (Mero-Jaffe, 2011: 240), there is acknowledgement that reading a written transcript of spoken dialogue may cause embarrassment and anxiety as well as concern about how it will be used e.g. placing quotations in published papers. Participants may have ‘moved on’ in life making the transcript less relevant (Forbat and Henderson, 2005: 1118), or in reading it a participant may judge its style and content according to conventional standards of writing and therefore perceive it to be incoherent or illiterate (Tilley and Powick, 2002: 304).

Whatever the advantages or disadvantages of returning the transcript to the participant for their scrutiny and review, my epistemological premise steered me towards a traditional research hierarchy of power with the role of researcher and participant fixed: ‘the researcher alone contributes the thinking that goes into the project, and the subjects contribute the action or contents to be studied’ (Reason, 1994: 42). It is an interesting to speculate whether incorporating some form of participant checking in the process of data gathering, so ‘minimiz[ing] the distance and separateness of researcher-participant relationships’ (Karnieli-Miller, Strier and Pessach, 2009: 279), might have influenced the conclusions I drew. However, as Josselson (2004: 17) argues, ‘[t]he participants themselves have no privileged claim to knowing whether the analysis is right or wrong – much as the author of the text, in a framework of deconstructionism, has no privileged knowledge of the meaning of a text.’

5.6.1 Summary
As has been shown, there were three key components within the philosophical and methodological framework of this research: practical theology, GTM, and grounded theory ethnography. Each complemented one another, and complemented the overall aim of the research, which was to closely scrutinize the theological conversation or dialogue arising from the experience and
practice of Anglican priests working as chaplains within the context of an NHS healthcare facility in England.

The strength of this research lies in its philosophical and methodological framework, although, as has been recognized, some procedural compromise was unavoidable given, for example, the limitations imposed through the choice of criteria for the selection and control of the participant group. Drawing on Winnicott’s concept of the ‘good-enough mother’ (Winnicott, 1973: 17, 44), this chapter highlights the need for ‘good-enough research’ which does not shy away from asking difficult questions in its critique of methodological features such as interviewing and transcription.

This does not detract from my research goal which is to provide a rich and thick description of the thinking of twelve NHS priests-as-chaplain, and which makes no assumption about reproducibility. It will be for others to test generalizability where their own experience, resonating with the research findings, leads them to a sense of identification with the conclusions I draw. There may be a degree of transferability but this is where the issues raised and the insights offered are thought, by others, to extend beyond the margins of twelve participants thinking aloud.

5.6.2 Developing the Thesis
Having established the philosophical and methodological framework of this research, I now turn to the analysis of the data. The first stage is my immersion within the data and the slow, labour-intensive task of faithfully transcribing the interviews. Once this is completed, I move on to the second stage, systematically reviewing the interviews, gathering the participants’ responses under each question. This is a vertical ordering of the data enabling me to compare and contrast each of the participants’ responses question by question. This is reported in Appendix Q. The third stage is one of reflection as I carry out an initial appraisal based on the systematic review and in which I link the participants’ responses to the primary research question and the secondary research questions. This is reported in Appendix R. The fourth stage, abstraction, focuses on the main themes or constructs that I detect in the data. Initially, I search for sub-themes which I group into main themes or constructs.
These I revisit and revise a number of times. Following this, I organize the participants’ responses under each main theme or construct. This is reported in Appendix S.

The next chapter reports the crucial fifth stage, one of synthesis, in which I correlated the main themes and established what I discerned to be a series of narratives. These were not independent of one another but formed what I determined was a discourse of narratives, which I eventually refined into two discrete discourses. These are corroborated and legitimated within the theoretical framework of Wenger’s (2010) community of practice.
Chapter Six: Interrogating the Data

6.1.1 Introduction
The semi-structured interviews provided a great deal of information. The shortest interview lasted one hour and twenty-one minutes and the longest interview extended to two hours and thirty-seven minutes. Potentially I faced information overload which has been variously described as data asphyxiatiation (van Winkle, 1998), data smog (Shenk, 1998) and information fatigue syndrome (Lewis, 1996). Too much information is as challenging as too little information (Ruff, 2002: 4). Organizing the information is crucial so that what is significant can be readily retrieved.

The methodological framework by which I chose to organize the data, as explained in the last chapter (§5.3.3), was a version of GTM influenced by the constructionist approach of Charmaz (2000: 521) and based on her premise that ‘people create and maintain meaningful worlds through dialectical processes of conferring meaning on their realities and acting within them... [and thus] social reality does not exist independent human action.’ Recalling my earlier reference (§5.2.1) to Percy’s (2006: 9ff.) view that there can be a theological construction of reality which corresponds to its social construction, I wanted to be alert to the theological meanings participants might confer on their perception of reality. While what follows is a revisionist approach to GTM, my first step is typical of GTM in its many guises (Bryman, 2004:401): to ‘label, separate, compile and organize the data’ (Charmaz, 1983: 86).

The method of analysis described in chapter five (§5.4.5) enabled me to sift the data through five stages (see Table 5.1). The first stage involved my immersion within the text, a concentrated engagement with the data as I listened to and transcribed the recorded interviews, reading and re-reading the transcripts and returning time and again to the voices of the participants. The second stage comprised my systematically reviewing the interviews, gathering the participants’ responses under each question. This I describe as a vertical ordering of the data and enabled me to compare and contrast each of the participants’ responses question by question (Appendix Q). The third stage was one of reflection as I carried out an initial appraisal of both the primary research
question and the secondary research questions based on what I had retrieved from the second stage, the systematic review (Appendix R). The fourth stage, abstraction, focused on the main themes or constructs that I detected in the data. Initially I searched for sub-themes which I grouped into main themes or constructs, revisiting and revising these numerous times (Appendix S). Following this, I organized the participants’ responses under each main theme or construct.

In this chapter I concentrate on the fifth stage, synthesis, in which I correlated the main themes and established the presence of certain narratives. These, I refined into two discrete discourses of paired narratives, using the theoretical framework of Wenger’s (2010) community of practice to provide corroboration and legitimation.

6.2.1 A discourse of two narratives
Having identified the main themes from the interviews (Appendix S), and grouped the participants’ responses under each of the themes, I identified a relationship between these narratives. Initially, this led me to conjecture a discourse consisting of two narratives: the one narrative of someone who is not fully engaged with the Church\textsuperscript{1} nor fully engaged with ministerial priesthood\textsuperscript{2}, and a second narrative of someone who is not fully engaged with the NHS\textsuperscript{3} nor fully engaged with the concept of the chaplain as an allied healthcare professional.\textsuperscript{4}

\textsuperscript{1} Example: ‘[N]ow I barely feel that I’m part of the Church of England and I don’t actually miss the Church of England. I don’t get any church press because I find it utterly depressing. I don’t care, any longer, about the dividedness of the church on so many issues because I just think they’re irrelevant and stupid. I don’t have enough energy left at the end of the day to want to be part of any struggle, really. So I don’t really feel any great sense of great comradeship with the church. I find the church to be quite narrow and quite conservative. What one of the patients here once said that when they go to church they find that there’s so much stuff about the goodness and love of God that there’s very little place for the people who don’t feel themselves to be good or loved by God and who feel themselves to be in a place of darkness’ (‘Sarah’).

\textsuperscript{2} Example: ‘[A]s my, you know, theology, my whole spiritual journey has moved, you know, I’ve even been at the point of thinking ‘Can I with integrity remain a priest in the Church of England’, and have thought of doing whatever you do, saying ‘Have it back again’ [Laughter]; whoever would want it back, [Laughter]’ (‘Claire’).

\textsuperscript{3} Example: ‘Chaplains aren’t quite of the NHS, that we bring something different and we have a certain freedom and sometimes I think there is a genuine appreciation of that freedom to act. And sometimes I think it’s because people don’t quite know what we do’ (‘Hugh’).

\textsuperscript{4} Example: ‘[P]atients, I think, will quite often accept care from the church, from a chaplain, but they might well refuse something that they perceive as being more professional... I’m not suggesting that what we offer is not professional, but I think in their perception it’s not professional in the way that... psychological support would be’ (‘Andy’).

Those participants more closely allied to the first narrative seemed to view their identity primarily through the prism of the NHS and healthcare chaplaincy. The clerical collar is abandoned because of what it represents and the part played by the Church of England is understated. A greater emphasis is placed on spirituality as well as on the NHS and its values. In contrast, those participants more closely allied to the second narrative seemed to view their identity primarily through the prism of the Church, broadly understood, and through ordained ministry. Ordination was regarded as the hallmark of the professional minister irrespective of denomination. The clerical collar was a sign of ministerial identity, a Church representative standing in persona Christi or alter Christus.

In summary, the healthcare chaplain is betwixt and between two institutions, the Church and the NHS, and between two roles, the healthcare chaplain and the ministerial priest. Negotiating this tightrope, participants adopt a primary attachment to one of the two institutions and the role it incorporates.

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5 Example: ‘I even now actually have a bit of a revulsion around the idea of having to put a dog-collar on, and I never wear one... symbolism, authority, priesthood. I don’t want to do it anyway’ (‘Claire’).
6 Example: ‘I would see myself less as being representative of the Anglican Church no matter how the established Church of the nation it may be’ (‘Sarah’).
7 Example: ‘...connecting with their spiritual being, because a lot of people have had bad experiences of the Church on the outside’ (‘Barbara’).
8 Example: ‘it means being very much a part of a different institution, but the institution that is the NHS; being very much part of an organisation, and very much part of the care that that organisation is trying to offer; so, very much part of a holistic approach to people... to ensure that there are opportunities for people to explore or draw strength from whatever might be the spiritual side of their lives’ (‘Claire’).
9 Example: ‘[Ordination] is a sort of professional badge of office (‘Andy’).
10 Example: ‘I don’t think it... necessarily starts from being a priest. I think it starts from your role as a professional minister, and starts from being visible as a clergyman around the place. I don’t think you need to be an Anglican priest for that to be the case, for that to work... (‘Andy’).
11 Example: ‘The dog-collar that denotes the religious church professionally, if you like. Yes’ (‘Andy’).
12 Example: ‘I think for a lot of people [the fact that I am an Anglican priest is] actually quite positive. I’m careful about wearing my dog collar’ (‘Hugh’).
13 Example: ‘[A]s soon as somebody sees the collar, they think religious stuff and the church. They think God... So that’s the context... your representative role. Clearly you represent the Church, yes, so there’s a sense in which you represent God to the people in that sense’ (‘Andy’).
14 Example: ‘[Y]ou, as chaplains, are no less than the focus of the presence of Christ to the people to whom you minister. That is an awesome responsibility. Chaplaincy is not simply a professional skill. It is not simply the exercise of the collection of religious functions. It is being present, as Christ, to those in need’ (‘Mary’).
15 Example: ‘A lot of the NHS are not really sure that it wants me here [and] so don’t understand me. A lot of the Church don’t know why I’m here and certainly don’t understand me either. So I feel we’re on the edge of both’ (‘John’); ‘... a sense of being of two institutions, but not really fully, perhaps, of either’ (‘Andy’).
6.2.2 Reappraisal: one discourse becomes two

On closer scrutiny, the pattern of narratives was more complex. As the evidence unravelled what became apparent was not one discourse but two related discourses, each with their own paired narratives. One was a discourse in which the more significant reference point, from which a participant was inclined to draw their *vocational* sense of identity, was either healthcare chaplaincy or ministerial priesthood (Figure 6.1).

![Figure 6.1 The disciplinary discourse](image)

The other was a discourse in which the more significant reference point, from which a participant was inclined to draw their *institutional* sense of identity, was either the NHS or the Church of England (Figure 6.2).

![Figure 6.2 The institutional discourse](image)

Cobb (2004) is on similar ground with his contextual model focusing as it does on the location and identity of healthcare chaplains. Cobb argues that the
identity of the chaplain is socially negotiated, to my mind a sustained dialogue between those who hold different perceptions of what constitutes the identity of the chaplain. In Cobb’s analysis this involves four parties: the chaplain and those communities to which the chaplain relates i.e. the healthcare community, the professional or disciplinary community and the faith community (Figure 6.3).

Because each of these communities provides validation and determines what Cobb conceives as the location and identity of chaplains, a complex interrelation of identities and associations is produced which can prove confusing for some healthcare professionals, but which may also allow for the chaplain’s ‘unique and creative contribution to healthcare’ (Cobb, 2004: 14).

Cobb’s analysis is undoubtedly helpful though, from the evidence of my research, incomplete. There are four not three communities to which the NHS priest-as-chaplain relates, and it is Wenger’s theoretical model encompassing communities of practice which provides an effective means by which to interpret the inter-relationship of these four communities composed of two disciplinary communities i.e. healthcare chaplaincy and ministerial priesthood and two institutional communities i.e. the NHS and the Church of England. I am not suggesting that a chaplain locates herself within a particular community of practice. It is, as Wenger (2010: 186) describes it, a journey across a trajectory of landscapes of practices which influences the shape an identity takes (§2.3.3). In the next section, I assess the advantages of Wenger’s ‘community of practice’ as a hermeneutic model for my own research.
6.2.3 Wenger’s theoretical model of community of practice

Singling out four communities to which the chaplain relates confirms that the identity of the NHS priest-as-chaplain is more nuanced than I had first envisaged. As I noted previously (chapter two passim), social learning theories in general, and socialization theories in particular, provide a persuasive account of how identity and identity formation are at the centre of the learning process (e.g. Parsons, 1962; Berger and Luckmann, 1966; Berger, 1969; Van Maanen and Schein 1979; Cohen, 1981; Hall, 1992; Kramer and Miller, 1999; Wenger, 1998). To this there is a caveat, for the identity of the Church of England priest is not solely the product of social learning. I would maintain it is also dependent on the theological or revelatory story which ‘apparently or allegedly privileges holy orders as being ‘by God established’ (Percy, 2006: 8). There are theologies of priesthood which in some ecclesial traditions envisage ministerial priesthood as sacramental, sacrificial or indelible in character. While priesthood encapsulates an identity which has evolved through social learning, its theological legitimacy is established in a language and conceptualization that reaches beyond the secular to the sacred (Percy, 2006: 10).

That point made, Wenger’s ‘communities of practice’ does provides a useful hermeneutic tool by which to understand those ways in which the two identities of priest and chaplain are forged. His approach focuses ‘on the person without assuming the individual is a point of departure’, and uses the concept of identity ‘as a pivot between the social and the individual, so that each can be talked about in terms of the other’ (1998: 145). Individual identity, Wenger claims, reflects a landscape of communities through which a person journeys, inhabiting some and experiencing others. To this, he adds three corollaries: there is a trajectory of identity whereby identity is influenced and evolves within and across communities of practice; there is a nexus of multi-membership that reflect the range of locations which construct identity; and multi-membership is sequential as a person passes through the landscape and carries an identity across contexts. As a person belongs to multiple communities at any one time, the process is concurrent. A person may experience a number of identities whether they simply co-exist or whether they complement, enhance or conflict with each other.
Incorporating the insights of Wenger’s theoretical model, I now outline those themes arising from the interviews which are associated with the vocational discourse.

6.3.1 The vocational discourse: the narrative of the NHS healthcare chaplain

In proposing the presence of a vocational discourse in the interview material, two related narratives that I detected from the patterning of the interview themes, I found that in the first narrative the more significant community of practice, from which participants were inclined to draw their vocational sense of identity, was located in the role and work of the NHS healthcare chaplain as a disciplinary group. In contrast, the second narrative signalled a different community of practice from which participants were inclined to draw their vocational sense of identity, one which was located in the role and work of the ministerial priest of the Church of England as a disciplinary group. In this section I present and investigate the former of these two narratives in which the more significant community revolves around the role and work of the chaplain.

(a) Healthcare chaplaincy as a specialist ministry

The narrative of healthcare chaplaincy as a preferred disciplinary community is characterized by a number of claims. Chaplaincy is perceived to be a distinct vocation in which the chaplain has to learn, assimilate and employ the language of the NHS. Her role is to champion spirituality and spiritual care, to deliver pastoral care and to safeguard religious practice in the secular context of the NHS. While there are organizational frustrations job

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16 Example: ‘It’s when I came into healthcare chaplaincy that I felt I could start talking about vocation’ (‘Claire’).
17 Example: ‘I live out my life as a priest in this healthcare setting’ (‘Rita’).
18 Example: ‘Becoming a healthcare chaplain is another vocation within a vocation. I think it is something specific that perhaps you’re called to do’ (‘Rita’).
19 Example: ‘I’ve got to learn that language and talk the managerial language and produce things that they might read in their language’ (‘Phil’).
20 Example: ‘Chaplaincy is the lead profession for enabling and empowering spiritual care within the NHS’ (‘John’).
21 Example: ‘the other professionals are meant to fix things... the patient is diagnosed, the healthcare professionals have to fix the diagnosis. The chaplain is one who accompanies, to discover where that journey is going to. So the fixing isn’t the priority. The priority is the being with, the experiencing with, to wait upon what’s emerging. And that seems to me… to be an extraordinary mirror of the passion narrative’ (‘Nigel’).
22 Example: ‘We’ve reclaimed the word religion because that had been thrown out. So we’ve reclaim it. We deliver spiritual and religious care’ (‘Phil’).
satisfaction was evident. In fact, at one remove from both the discipline of the Church of England, and its canonical rules and regulations which at times inhibit pastoral and liturgical sensitivity, healthcare chaplaincy was recognized as more person-centred and person-led than the bureaucracy of parish life might allow. Conspicuously, however, it is a narrative in which the significance, relevance and value of priesthood is ambiguous.

(b) The professional status of the healthcare chaplain

I found a similar ambiguity when participants addressed the professional status of chaplaincy, a subject which continues to divide opinion. The national chaplaincy organizations, such as the UKBHC and the CHCC, have been keen to promote a professional agenda, but this is against a backdrop of uncertainty and ambivalence within the rank and file of chaplains (§4.2.1). Among the participants, ‘John’ spoke of chaplaincy as a ‘kind of craft’ in which a key component is theological reflection. More generally, however, arguments in support of chaplaincy as a profession reflected the dated, disputed and generally discarded trait model which, as noted earlier, has been criticized as a

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23 Example: ‘counting lamp posts’ (‘John’).
24 Example: ‘But of course we’re in a world now where we’re having to play along, or games most of which I like. I like exploring the stuff we’re having to look at now, like recording data. I may not agree with it but I’m interested and enjoy exploring all these things: going to management meetings. So that’s part of the richness of the job’ (‘John’); ‘We’ve got a liberal Muslim and a much more strict Muslim and then we’ve got a female Muslim now as well. We’ve got a Sikh... And then we’ve got Christians of various persuasions on the staff; got a liberal Hindu priest, you know we’ve got such a... the thought of holding in... trying to hold together... quite exciting...’ (‘John’).
25 Example: ‘[A]nd I haven’t got the Church saying ‘You can’t do that’’ (‘Phil’).
26 Example: ‘[W]hat’s that canon, one of the canons that allows you to change different bits, set liturgies for pastoral purposes, in there: B21 or something? Is it B21? I’ve no idea... And probably, as the years have gone by, I’ve taken it further... always for genuine... I genuinely... I don’t believe I’m being naughty. I believe I use it for pastoral reason... but how I found myself, as the years’ gone by for pastoral reasons, pushing the limits. Whether having that ordination gives one a certain confidence – with experience – I’m not saying I would have done it ten years ago but to... to just push the boundaries a bit for pastoral, and indeed for missionary ends’ (‘John’).
27 Example: ‘Being [a] healthcare chaplain is to be alongside somebody... journeying with that person as long as that person is involved, that person’s care is carried out by the Trust that one’s working for. So it’s about [being an] accompanist on the journey wherever that journey goes... and that journey is led by the... by the patient...’ (‘Nigel’); ‘... as an Anglican priest in a parish, you’re sometimes more concerned with buildings, meetings and the people get lost’ (‘Barbara’).
28 Example: ‘[I]f there are sort of challenges, expectations that are more about me as an Anglican priest, you know, I suppose my response can always be about, you know, that’s not primarily why I’m here. Because that bit isn’t the bit that’s foremost in enabling to be a healthcare chaplain’ (‘Claire’).
29 Example: ‘James Woodward, Stephen Pattison, Emmanuel Lartey: that whole movement where practice and experience have an equal weighting in the theological equation... when you come into hospital chaplaincy... if you don’t do it that way I don’t know how you do it’ (‘John’).
vehicle of professional ideology (§4.3.1). It was claimed that chaplaincy benefits from a career structure, a specialist body of knowledge and professional registration but this is a matter of debate. Career progression is limited, a specific body of knowledge is difficult to determine, and professional registration will continue to be administered on a voluntary basis even if it is regulated by the Professional Standards Authority. Besides which, the Roman Catholic Church has voiced its own opposition to any professional register (McManus, 2014: 5). Predictably, some participants were reluctant to describe themselves as professional healthcare workers or qualified their understanding of professionalism.

What seemed to be at issue was the character of the professional relationship. Unlike medical and nursing colleagues and those in allied health professions whose role gives right of access to the patient, it is arguable that a chaplain cannot assume this. Best practice might suggest that a chaplain negotiates her involvement in the care of the patient, wherever possible gaining the patient’s agreement. This would be a reasonable expectation in a relationship which is person-centred and in which the chaplain is the accompanier, listening and encouraging patient self-reflection and self-determination.

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30 Example: ‘[A]t the moment it happens to be that most [chaplains] are ordained and that we’re working in an environment in which nurses have, nurses and other healthcare professionals, have particular set career ladders that they go up. That needs to be reciprocated within… the ‘profession’ of the healthcare chaplain as seen by a Trust, and… that’s more easily fulfilled by people who are ordained because they’ve gone through particular set processes’ (‘Brian’).
31 Example: ‘…but, you know, I think that chaplaincy is a profession with its own work, and our own environment, and our own speciality’ (‘Hugh’).
32 Example: ‘I’m not sure where I sit on this thing about developing a UK Board for Healthcare [Chaplaincy]’ (‘John’); ‘I haven’t thought this through, so it’s thrown into my mind, but I think if people are - it’s [the UK Board of Health Care Chaplaincy] isn’t it, where people don’t have to be registered if they choose not to be registered - some kind of professionalism, qualification, I think is important’ (‘Barbara’).
33 At 2016, McManus is the Vice-Chair of the influential Health and Social Care Advisory Group of the Catholic Bishops’ Conference of England and Wales.
34 Example: ‘We’re invited into the space of the bed unlike other health professionals where they have to go in to ‘do’ things. We go by invitation into their space. We... wait to be invited. We don’t assume we can go in... and I think, certainly within the hospice, where we have conversations which... go deeper and last longer, there’s a building up of trust’ (‘Vanessa’); ‘and sometimes it’s permission of entering that person’s space, because that is their space, isn’t it?’ (‘Barbara’).
35 Example: ‘...other professionals are meant to fix things. The patient is diagnosed. The healthcare professionals have to fix the diagnosis. The chaplain is one who accompanies, to discover where that journey is going to. So the fixing isn’t the priority. The priority is the being with, the experiencing with, to wait upon what’s emerging’ (‘Nigel’).
36 Example: ‘...helping that person find a sense of identity being, meaning, understanding, belonging, in whatever their community is’ (‘Phil’); ‘that sense of [the chaplain] who is able to listen and to accompany, and go into some of the dark places... that they don’t feel they can...’
‘Brian’ talked about creating semi-professional friendships with patients who are regularly admitted into hospital as a result of chronic ill-health. Periodic episodes of in-patient treatment give the chaplain an opportunity to build deeper relationships. I sounded out ‘Brian’ to discover what he meant by a friendship which was semi-professionalized. What he shared, by way of illustration, was a pastoral encounter which seemingly went beyond the normal bounds of what a professional person might accept, or even tolerate, from a patient. In the example he gave, it was as if he became a receptacle for the patient’s feelings. In psychodynamic literature, this is conceptualized as projective identification, a mechanism which, in its most serious form, may cause the recipient of the patient’s feelings to lose a sense of their own identity (Laing, 1969: 37) becoming a passive carrier of the patient’s projections (Pitt-Aitken and Ellis, 1989: 120; 133). However, in this instance, it seemed to me that what Brian surrendered was not his identity but what another participant described as the power of the priest. It might be argued that this kenotic self-emptying of power enabled empathy with the patient’s feelings of both depression and rejection at a far deeper and costlier level, demonstrating traits which ‘Sarah’ considered more important than professional status: traits of compassion and self-awareness. Once again, this reveals the chaplain’s person-centred and share. And we can’t prescribe any medication, we can’t do that. We’re professionals but we can’t. All we can do, in a sense is actively listen and support’ (‘Hugh’).

37 Example: ‘I share an office with a psychologist, and there’s a particular patient who comes in. She is a chronic respiratory patient. She is a practising Anglican, a sort of high Church variety [who] has Communion every time she comes to Sunday services, but is very difficult personality-wise’ (‘Brian’).

38 While based on Freud’s concept of psychological projection, projective identification adds something further. ‘The one person does not use the other merely as a hook to hang projections on. He/she strives to find in the other, or to induce the other to become, the very embodiment of projection’ (Laing, 1969: 111).

39 Example: ‘You know, if somebody here feels that they’re being punished by God for their sins and that’s what’s caused their depression, schizophrenia or whatever, they want to hear it from a priest that they’re not being punished by God and that God loves them... [T]hat power is one heck of a responsibility’ (‘Sarah’).

40 Example: ‘To me, it would be down to what the person was actually like, and the depth of their compassion would matter actually more to me, and their sense of being integrated around their own experiences of suffering. You know, aware of them but integrated with them. And about their capacity to love and value people for who they are and not for who the person wants them to be. Those things would matter to me way more than somebody’s accreditation, if you like’ (‘Sarah’).

41 Example: ‘that my focus has to be on the person in front of me and what’s helpful to them, and anything to do with like any rightness by the Church would come way second to that’ (‘Sarah’); ‘It’s that not knowing who you’re going to meet but the value of every encounter that you have...’ (‘Vanessa’).
person-led approach, focusing primarily if not entirely on the needs of the other person. The chaplain journeys alongside and accompanies; the chaplain has time and holds, and the chaplain fosters a relationship of trust which reflects the presence of Christ.

(c) An expendable priesthood

As a narrative, what stood out was an apparent indifference towards ministerial priesthood. Some participants questioned the assumption that a Church of England NHS chaplain had to be an ordained person possibly because, within the NHS, priesthood seemed to have only marginal relevance. Even what participants shared about their own spiritual journey gave the impression that priesthood was no longer a significant factor. ‘Andy’ had resigned as a vicar after a ‘difficult’ twelve months, and thought he would never resume ministry. Five years later, he became a healthcare chaplain. In retrospect, he concluded,

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42 Example: ‘... it's just meeting a person where they are and letting them lead wherever they want to go, be that getting no further than what's happening in the news’ (‘Vanessa’).
43 Example: [Drawing on the story of Jesus and the Gerasene demoniac in which Jesus asks ‘Who are you?’] The first thing I do when I go to see somebody, no matter how excitable they are, I just find out who they are’ (‘Phil’).
44 Example: ‘So [the] healthcare chaplain is a bit like being an accompanist; a musical analogy is quite a good one; so a pianist accompanying a singer has to listen carefully to the singer... while following the notation, but actually it's about being attuned to the singer, so that it, so that it is actually the piano supporting the voice rather than dominating’ (‘Nigel’).
45 Example: ‘it’s the listening, it’s the stopping, you know, and I think chaplaincy it is about that, you know, that we hear what the needs are and we actually stop and make ourselves available and then, and then ask what it is we can do’ (‘Claire’).
46 Example: ‘... it can be a way of holding the loss, as a way of waiting to see what emerges from the loss. That’s a bit like being a midwife, you know, waiting for the emergence of this new being through the loss of what’s being held in the womb... the womb has to lose the child in order for the child to be born... [T]he healthcare professionals have to fix the diagnosis. The chaplain is one who accompanies, to discover where that journey is going to. So the fixing isn’t the priority. The priority is the being with, the experiencing with, to wait upon what’s emerging. And that seems to me... that seems to me to be an extraordinary mirror of the passion narrative’ (‘Nigel’).
47 Example: ‘Chaplaincy is not simply a professional skill. It is not simply the exercise of the collection of religious functions. It is being present, as Christ, to those in need’ (‘Mary’).
48 Example: ‘I don’t think my being an Anglican priest is particularly significant for people [in hospital] (‘Andy’); ‘some of the confusion [about priesthood]... is that that feels very much geared to a series of tasks called function for the church say, rather than the NHS or anywhere else, you know, and I think that’s sometimes where the, the confusion comes’ (‘Claire’).
49 Example: ‘I’ll be really honest here – I don’t need to call myself an Anglican priest; that label doesn’t... I don’t need that label. I suppose what’s happened since being ordained is a recognition that actually in God – and that ordination is a part of that journey, a very important part – there is ultimately a freedom from that label, and so those labels actually become very problematic for one’s sense of freedom in God. So Anglican priest is a kind of problem because I don’t really want to be... I suppose I don’t want that limitation which is what the... what it tends to stipulate... kind of limiting’ (‘Nigel’).
his vocation had been to a pastoral ministry and not to a priesthood of Eucharistic presidency, preaching and parish office work.\textsuperscript{50}

Other participants expressed their own disquiet. Filled with doubts, ‘Claire’ wanted to rid herself of priesthood because her ‘spiritual journey had moved on’. She imagined that the way she lived her priesthood, as a healthcare chaplain, would not meet with her bishop’s approval. ‘Claire’ felt a fraud.\textsuperscript{51} ‘Nigel’ spoke about the narcissism of priesthood\textsuperscript{52} and ridiculed the need for ordination.\textsuperscript{53} ‘Phil’ was simply bewildered.\textsuperscript{54} Mundanely, choosing to wear\textsuperscript{55} or not to wear\textsuperscript{56} a clerical collar\textsuperscript{57} could be itself a statement of identity and a rejection of what priesthood might represent.\textsuperscript{58}

\textbf{(d) A summary of the narrative}

The evidence of the ‘healthcare chaplaincy’ narrative suggests that among the participant group, there were those who derived a greater sense of vocational identity from their role and work as a healthcare chaplain, and so were drawn towards chaplaincy as their preferred community of practice. Notwithstanding this, and despite the profession-conscious world in which the NHS chaplain exercises a ministry, the professionalization of healthcare chaplaincy remains a contentious issue even among this group. Why this should be is difficult to

\textsuperscript{50} Example: ‘I came to realise that during that time what I really missed about ministry was not the priestly stuff at all, it wasn’t saying Mass or preaching or certainly not any of the administrative stuff, (that I desperately needed to get away from), but was really the pastoral stuff’ (‘Andy’).
\textsuperscript{51} Example: ‘I’ve even been at the point of thinking, ‘Can I with integrity remain a priest in the Church of England?’ And have thought of doing whatever you do, saying ’Have it back again’. [Laughter], Whoever would want it back’ (‘Claire’).
\textsuperscript{52} Example: ‘I think priesthood is very dangerous. I think that it can add vanity... it can add all sorts of trapping which one has to be very wary of.’ (‘Nigel’).
\textsuperscript{53} Example: [E]very culture needs somebody who’s actually keeping that symbol [of the soul growing into a relationship with God] alive. But we hope that other people grow into it without having to go through the ridiculous route of ordination in the Church’ (‘Nigel’).
\textsuperscript{54} Example: [T]he whole thing is, why am I a priest in this role? And actually I don’t have to be. It may be that I happened to be a priest, that I’ve got particular skills to do the job, but it doesn’t mean I have to be a priest to do it, and so it has made me think about that actually, and I’ve not come up with the answer yet’ (‘Phil’).
\textsuperscript{55} Example: ‘I’m careful about wearing my dog collar. I’ve got it half on. No, I haven’t. I’ve got it more or less hidden – dear me!’ (‘Hugh’).
\textsuperscript{56} Example: ‘when I first began as a healthcare chaplain it was about being an Anglican priest in a different context. Now it’s not, I don’t wear a dog-collar’ (‘Sarah’).
\textsuperscript{57} Example: ‘I still wonder why I wear a dog collar, why am I a priest, and perhaps always wonder that... maybe that’s healthy’ (‘Phil’).
\textsuperscript{58} Example: ‘[I] have a bit of revulsion around the idea of having to put a dog-collar on, and I never wear one. And I have a few in my bottom drawer which people think is very funny. But, yes, I don’t know. Symbolism? Authority? priesthood? I don’t want to do it anyway’ (‘Claire’).
explain. Perhaps it reflects a disquiet with a professionalism still be associated with prestige, privilege and power (see further in §4.3.1). Then again, perhaps there is a wariness given the cynicism and diffidence that professions have attracted in recent times (see further in §4.3.2). Undoubtedly it merits future research. That aside, what I would draw attention to is a tendency among those drawn to this narrative to be more circumspect about an identity formed around Anglican priesthood.

6.3.2 The vocational discourse: the narrative of the Church of England priest

In the second narrative associated with the vocational discourse, I detected a greater emphasis on the work and role of the ministerial priest of the Church of England. This leads me to propose that here ministerial priesthood is the more significant community of practice from which some participants drew their vocational sense of identity. This is not to imply that within this theoretical community of practice participants share one definition or description of priesthood. How a person conceives priesthood probably owes more to each person’s unique spiritual journey, a journey in which the meaning and expression of priesthood will have developed and evolved.

(a) The meaning of priesthood

In this narrative, the contextual influence of the NHS was obvious. Kirk, drawing on his experience of healthcare chaplaincy in the United States, points out that the secularity of an institution has implications for someone whose ministerial priesthood has been influenced, at least initially, by assimilation into an ecclesial community (Kirk, 2011:2f.). Participants readily accepted that their understanding of what it meant to be a priest had altered over time.\textsuperscript{59} In retrospect, some recognized that during training and in the initial years following ordination, they had tended to abide by the teaching of the Church\textsuperscript{60} and the

\textsuperscript{59} Example: ‘[I]t's going back nearly twenty years [to my ordination]... me evolving and becoming more confident in, in who I am. And being more confident in who I am as opposed to what I perhaps thought the Church expected of me. It's a much more freeing thing’ (‘Vanessa’).

\textsuperscript{60} Example: ‘I think what we do at that point of formation of ourselves, especially at that age when I was at early twenties, is that you try and fit yourself into boxes more easily, rather than actually allowing yourself to be more at home with who you might be in your own history’ (‘Brian’); ‘To be honest, I mean, probably if I’d been answering these questions ten years ago, twelve years ago, I’d, I’d have different answers, to a certain extent, but that might have been more me giving the... what I think I should say answer [Laughter]’ (‘Claire’).
norms of an ecclesial tradition. Exposed to the freedom that chaplaincy offers, freedom from the demands, constraints and expectations of the local church, as well as freedom from ecclesial discipline, the opportunity had presented itself to reflect, review and rethink what priesthood might mean and how it might, or might not, be incorporated into the life of an NHS priest-as-chaplain.

‘John’ spoke of his work as chaplain being rooted in a discourse of spiritual care. This he characterized as Anglican priesthood alluding both to the modus by which the Anglican priest delivers spiritual care and the training that the priest has undertaken. While he considered this comparable to any other model of healthcare practice, his underlying concern was that in the hospital context more dominant models such as business management, medicine and nursing were disinterested in the contribution and insights of spiritual care.

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61 Example: ‘I think that when I was... first ordained... I think I might have been full of myself really, and, you know, the young curate and I... probably quite liked being called father and that kind of thing. And I think, particularly since I’ve been here, I’ve really rather shunned that and I certainly would never invite anyone to call me father ... I think I’m very anxious to increasingly sort of reject that... stuff really... [T]hat doesn’t mean that the role of itself is necessarily grandiose of course. It certainly isn’t. But I’m anxious about that stuff’ (‘Andy’); I think that when I was first ordained, I was quite keen to be more of an Anglo-Catholic than the Anglo-Catholics I trained alongside [Laughter] (‘Sarah’).

62 Example: ‘It is such a joy not having to think to raise £20k for a new toilet in the, within a listed building and there's that sort of... it's incredibly liberating freedom of ministry’ (‘Vanessa’).

63 Example: ‘anybody can take communion, it really doesn't matter because that's about the grace of God, in my view, and I haven't got the church saying you can't do that. Yes of course they can’ (‘Phil’).

64 Example: ‘[A]t an earlier point in my ministry I wouldn’t have... I would have been very sceptical about [the] interchangeability of ministries, put it that way, and I would have found some difficulties with that. Increasingly a bit of me doesn’t really think that that’s important’ (‘Brian’);

65 Example: ‘[M]y focus has to be on the person in front of me and what’s helpful to them, and anything to do with like any ‘rightness’ by the Church would come way second to that’ (‘Sarah’).

66 Example: ‘John O’Donaghue, the Irish priest and philosopher, who sadly died, and in one of his poems he writes about a river; he says, ‘Carried by the surprise of its own unfolding’ and that’s been my... you know, I am constantly surprised at where I find myself and, you know, it does feel like an unfolding. But it’s felt like a very natural unfolding and I think that’s why healthcare chaplaincy felt so natural, because it was, it was a place where I felt I could hold together the fact that I was an Anglican priest [Laughter] with doing what I wanted to do and... and having the freedom to be who I needed to be...’ (‘Claire’).

67 Example: ‘I bring a qualification in spiritual care. I bring that. You know. I try -- no nurse ever gets this when I try to explain this to them -- but I always say there are different models of nursing, different models of occupational therapy, and you work from the basis of one or more of those models. I work from the basis of a model of spiritual care and we call it Anglican priesthood. But I just think it’s a model of spiritual care just like there are many models of medicine and nursing’ (‘John’).

68 Example: ‘[R]eligious care or spiritual care [make] a fully-fledged contribution to healing, health and discharge and all that kind of thing’ (‘John’).

69 Example: ‘But overall the institutional feel is a bit, you know, for me, [chaplaincy is] tolerated...’ (‘John’); ’I’m just a different discourse in society, like nurse discourses and medicine
However, as Ryan has pointed out (Ryan, 2015:55), the impact of chaplaincy is often dependent on the availability, the non-judgemental attitude and the personality of the chaplain. It has been argued (Galashan, 2015: 107) that what needs to be demonstrated is what qualifies someone, in this instance the NHS priest-as-chaplain, to deliver spiritual care to people of all faiths and none. Given that a principal tool of spiritual care in healthcare chaplaincy is reflective practice (Cobb, 2005: 29f), the critical analysis and evaluation of ministerial processes, perhaps it needs to be accompanied by an equally critical analysis and evaluation of the relevance of priesthood. Although not alone in his inability to offer a theological account of priesthood, ‘John’ did propose a metaphor of hospitality as a means of articulating something about the person and the work of the NHS priest-as-chaplain. Hospitality, he explained, consists of presence and availability: an awareness of sacred space, underpinning person-centred care and addresses spiritual, pastoral and religious needs.

(b) The authority of the priest
A significant theme within this narrative in which the work and role of ministerial priesthood had particular meaning was the authority of the priest: an authority for safeguarding the development and transmission of the faith; an authority for administering the sacraments; an authority which accompanies the delegated duties of priesthood and an authority which places the priest in a...
particular relationship with those who are part of the worshipping community. It was an authority which could be used to some advantage. So, for example, while ‘Andy’ acknowledged that ordination straightforwardly confers an authority to work within the local church and, so he claimed, nothing more, he subsequently admitted that as a ‘churchman’, and therefore as a representative of the Church, comments and observations he might make were taken seriously within his NHS Trust. It was an authority which he believed stemmed from a view among NHS colleagues that he was, in a sense, independent of the NHS, and so assumed to have an authoritative impartiality or neutrality. He regarded this as a privileged position which needed to be exercised responsibly. Other participants were also conscious that ordination gave them an authority which NHS managers recognized and which allowed them to engage with senior staff or with patients who might invest the priest with a type of ‘therapeutic authority’ more particularly on mental health units.

Nonetheless, among the participants there was also an uneasiness that the

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78 Example: ‘[I]t puts you in a different relationship to the community that you’re given to serve’ (‘Sarah’).
79 Example: ‘priesthood confers an] authority to minister in a particular church community, and... that is all it confers’ (‘Andy’).
80 Example: ‘I certainly find here that my being a churchman gives me a certain authority and respect in the institution and people look to me as somebody who is, as it were, slightly to one side of the institution. So it gives you the possibility to comment from the outside, though obviously that, that, that, has to be used with immense caution’ (‘Andy’).
81 Example: what ordination does do, it does, it gives you authority... so I suppose the Church has given you authority and then that, that authority is recognised within the healthcare context: that authority is something which is then recognised in a reciprocal arrangement with, with, with the Trust. So you need to have some form of a religious community, saying, ‘Right, this person has gone through a particular form of training which allows them to do XYZ’. So the value that ordained ministry brings to this context, I think at present that is to do with simply the authority, or maybe authority is the wrong word because maybe that’s a more ecclesial word, but certainly the fact that their trust is able to recognise that you’ve been recognised by the Church and therefore you are able to do something’ (‘Brian’).
82 Example: It opens doors because it, it’s, rightly or wrongly, but I think, dare I say it, the collar gets you places you wouldn’t get otherwise; which I don’t like but it’s such a hierarchical institution and it thinks in a very hierarchical way, so I, I can certainly think of examples where I’ve managed to have conversations with people at board level or round about there. I wouldn’t have been able to get a conversation with otherwise but I think they recognise something of... well they see authority, however they perceive that. I think they see something about authority so that’s okay’ (‘Phil’).
83 Example: ‘You know, if somebody here feels that they’re being punished by God for their sins and that’s what’s caused their depression, schizophrenia or whatever, they want to hear it from a priest that they’re not being punished by God and that God loves them. They don’t want to hear it from somebody not in a dog-collar (‘Sarah’); again, ‘Vanessa’ claimed that it can be positive for patients to see the chaplain as one ‘who has authority from the Church of England’.

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priest was associated or endowed with authority, especially given its implied sense of hierarchy. Rather than an elite cadre, there were those who spoke about priesthood needing to embody and promote a Church which is inclusive and in which all are equal. A striking fact was the absence, by and large, of any reference to priestly authority in the interviews I conducted with female participants. Might this, in itself, reflect a more inclusive, conciliatory understanding of priesthood from a cohort of women only recently admitted to ordination after centuries of exclusion?

(c) The nature of priesthood

Aside from this issue of authority, participants were diffident when I canvassed their views about the nature of priesthood. Asked whether they thought a profound or metaphysical change accompanied priestly ordination, participants responded with reservation and uncertainty. Their comments inferred that priesthood was abstruse and, for some, a formational process still being worked out. Even so, what emerged were ideas bearing a marked similarity to those which the literature review (§3.3.3) identified as alternative models of ontology: e.g. ontology as lifestyle, as a life of sacrifice, as a life of voluntary

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84 Example: When speaking about the theological difference between the lay person and the priest, ‘Mary’ acknowledged that it was ‘to do with the sacramental authority... for want of a better word. I don’t like the word authority...’.
85 Example: ‘I’m totally turned off by a notion of hierarchy in the ministry’ (‘Andy’).
86 Example: ‘I think it that some clergy think that priests are separate?’ (‘Sarah’); ‘I have always sort of wanted to sit with the fact that I am a priest but I also do believe in the priesthood of all believers and, and I’m very, by nature I want to be inclusive and I want to be included and, and that’s very important to me. And, like I was saying earlier, this, this idea that priests are somehow special and, and above other people or set apart in an exclusive way, I can’t do with any of that’ (‘Claire’).
87 ‘Sarah’; ‘Claire’; ‘Rita’; ‘Mary’.
88 Example: ‘I’m just becoming less and less… doctrinally anchored (‘John’); ‘I do have a sense of being a priest, and it’s really difficult to say what that is’ (‘Hugh’); ‘there’s a mystery that [I’ll] probably, at some time, unpack. It will probably be in retirement... [I] just go along with it now (‘Vanessa’).
89 Example: ‘drawing close to death, there may be an opportunity to glance back and see distinctive moments [such as ordination] in kind of naked clarity’ (‘Nigel’); ‘there’s a mystery [to priesthood] that [I’ll] probably at some time unpack. It will probably be in retirement. [I] just go along with it now’ (‘Vanessa’).
90 Example: ‘an ongoing process’ (‘Nigel’); ‘that I’m moving towards... as part of my identity’ (‘Hugh’).
91 Example: ‘Commissioned to be’ I think’ (‘Barbara’); ‘being present and practising being present...’ (‘John’).
92 Example: ‘I think ordination to the Anglican priesthood was a call by God to sacrifice everything to serve him, because it went against everything that I ever thought I would ever do in life. In a sense it cost me my marriage... but I wouldn’t have it any other way’ (‘Mary’).
and involuntary renunciation'; as overtly spiritual; as self-giving; as sacramental (being both the sacrament and the one who performs sacramental acts); and as the priest formed into the image of Christ, modelling and representing to the church its own vocation. Some did regard priesthood as infusing a person’s identity; an enduring attribute, but not necessarily in any metaphysical sense claimed by Catholic theology, i.e. a distinctive character permanently imprinted on the soul of the priest which transcends this life into the next. Rather, any lifelong changes accompanying priestly ordination might be psychological or relational. There were also misgivings. Priesthood was described as dangerous. There was the risk that the priest would be regarded

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93 Example: ‘If you were ordained… after 1997, you could not keep your [Church Army] commission. If you were ordained before that you could. So, for instance, I was commissioned in 1989 and I went for ordination… [and] I was asked to... send everything back... Bye-bye!’ (Barbara).

94 Example: ‘the process of ordination, has clearly led me to explore much further the whole nature of [the] relationship with God, the nature of God, the nature of being, life, universe and everything else, that I perhaps wouldn’t have done without that process of training and ordination (Phil).

95 Example: ‘I’m still me with… all the whole baggage of stuff …; what has been quite noticeable is how other people have treated me and some people, who were very close friends have found it quite difficult and we aren’t as close any more, and I think other friends had certain expectations of who I had become and so would only phone me if they had a prayer request. It was never ‘How are you?’ or ‘Let’s go out for a drink’. It was all ‘Could you pray for so-and-so?’ (Rita).

96 Example: ‘ministry [is] about the living out of the sacraments you celebrate as a priest’ (Sarah).

97 Example: ‘[T]he priest is a physical representation of... what the whole of the Church is called to in Jesus Christ, and in that sense it’s... priesthood is sort of like maybe the poetry where the rest of the Church is a bit prose’ (Brian).

98 Example: ‘It’s all of my being, not just when I’m wearing clericals. And I think that’s one thing I really struggled with, first off, when being ordained. Because people used to say ‘Oh, you’re a priest now because you’re wearing your outfit’ and I’d say ‘Well I’m a priest anytime’, you know, not just ‘cause I’m wearing the badge of identity’ (Barbara); ‘[B]eing ordained is a new identity and it’s not something you think, ‘Oh well, I won’t bother about that today’ or ‘I can leave that behind’ (Rita).

99 Example: ‘I have a sense of being a priest... that is something which is quite integral and I don’t quite know what that means... It’s more than just having a job; and if I was unemployed I would still be a priest’ (Hugh); ‘I feel... you are a priest and that’s something that can’t be taken away from you [although] it may be that you’re not in a position..., or the Church doesn’t authorise you, to carry out those priestly responsibilities’(Rita).

100 Example: ‘there’s a sort of psychological change that happens in that, because, there is, I mean if you then go through someone’s traumatic event, you change, you know, and if you go... I’m not saying that ordination is a traumatic event, but it changes, it changes us’ (Hugh); ‘for my role and personhood... it has been that completeness and vulnerability and acceptance and also willingness [to engage in ministry which] I would never, in my human frailty, would do’ (Barbara).

101 Example: ‘in a sense, it puts you in a different relationship to the community that you’re given to serve’ (Sarah).

102 A number of participants (‘Nigel’; ‘Andy’; ‘Brian’; ‘Sarah’ and ‘Claire’) used the word ‘danger’ or ‘dangerous’ to describe their uneasiness.
as superior and holy,\textsuperscript{103} or succumb to feelings of misguided self-importance\textsuperscript{104} and conceitedness.\textsuperscript{105}

(d) \textit{Priesthood as ministry: being and doing}

However, in marked contrast to the hesitancy and awkwardness produced by questions focusing on a systematic theology of priesthood, participants found it easier to engage with questions about ministry.\textsuperscript{106} When asked to compare which of two propositions was more important, who they were as against what they did, a question designed to ascertain the relative merit of vocational character over against ministerial performance, and to tease out what spiritual, social or psychological change might have occurred at ordination to priesthood, one thing became obvious. Participants were, for whatever reason, disadvantaged in that they appeared not to have the theological language or appetite to engage with an ontology of priesthood. The most they were willing to concede was a distinction between priesthood as \textit{being} and ministry as \textit{doing}, at the same time claiming that vocational character and ministerial performance were, nonetheless, inexorably linked. The \textit{being} of priesthood informed the \textit{doing} of ministry, and the \textit{doing} of ministry authenticated the \textit{being} of priesthood.\textsuperscript{107} It was left to ‘Andy’ to propose an alternative view: that while \textit{being} is important, it stems from who the person is \textit{per se} and not the fact that he or she is a priest.\textsuperscript{108} This corresponds with the observation to which I referred earlier that, as ‘Sarah’ put it, what mattered was an individual’s personality irrespective of any notion of professionalism.\textsuperscript{109} All participants,

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  \item \textsuperscript{103} Example: ‘I feel the danger of going down the sort of [whispers] you’re somebody very special because you’ve been ordained’ (‘Claire’).
  \item \textsuperscript{104} Example: ‘I think there’s quite a lot of danger, isn’t there, attached to the business of saying God has called me to do this or to do that’ (‘Andy’).
  \item \textsuperscript{105} Example: ‘I’m not sure whether any of that [i.e. the possibility of spiritual change at ordination] was sheer arrogance’ (‘Nigel’); ‘I think that one big danger of ordination is the fact that lots of clergy lose sight of their humanity and lose sight of what it is to be them[elves]’ (‘Sarah’).
  \item \textsuperscript{106} Example: ‘I definitely moved into a place of thinking in terms of ministry rather than priesthood… particularly in this context (‘Andy’); ‘I find it very difficult to think about, actually, or even to explain, express [priesthood]’ (‘Brian’).
  \item \textsuperscript{107} Example: ‘[H]opefully what you do flows out of who you are’ (‘Sarah’); ‘The doing has to come out and be informed by the being’: ‘how much you can tease one… or separate from the other – the ‘being’ from the ‘doing’ – I don’t know’ (‘Rita’); ‘I do what I do because of who I am. I can’t separate the two. If I wasn’t who I am, I wouldn’t be able to do what I do. And the other way round…’ (‘Mary’).
  \item \textsuperscript{108} Example: It ‘starts from who you are. I don’t think it starts from being… a priest’ (‘Andy’).
  \item \textsuperscript{109} Example: ‘To me, it would be down to what the person was actually like, and the depth of their compassion would matter actually more to me, and their sense of being integrated around their own experiences of suffering. You know, aware of them but integrated with them. And
though, were agreed that ministry was not the sole prerogative of those in priest’s orders even though, for a number of participants, it seemed that priesthood was merely synonymous with ministry.\textsuperscript{110}

What then did participants make of the relationship which exists between the ordained and the non-ordained? The recognition that the laity has an equal share in ministry or, as the 1958 Lambeth Conference succinctly put it, ‘[m]inistry and laity are one...’ (Cox, 2004: 135), might, at least in part, account for why participants found it difficult to articulate a theology of ministerial priesthood which differentiated the priest from the licensed lay minister. While it was claimed that, in some respects, the priest was no different from the lay person authorized for a ministerial role by the bishop,\textsuperscript{111} it was claimed that a priest’s professionalism, formation and self-identity e.g. as president of the Eucharistic community, did somehow set them apart. ‘Brian’ maintained that priesthood had nothing to do with leadership in the Church but instead showcased a relationship which God seeks to establish with everyone.\textsuperscript{112} ‘Nigel’ voiced a similar view, anticipating a time when everyone, lay and ordain alike, might grow into that relationship without the need to be ordained.\textsuperscript{113}

When the question specifically focused on healthcare chaplaincy and what, theologically, might be the relationship between the NHS priest-as-chaplain and a chaplaincy colleague who might be an Anglican lay minister, a minister in one of the Free Churches or a Roman Catholic priest, it was evident that this had

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\textsuperscript{110} Example: ‘[G]oing into ordination training... it felt quite functional for me. It was because I wanted to go and do the work in a church and help lead a church’ (‘Claire’); ‘I knew when I went through ordination it was to the ministry – not necessarily the priesthood’ (‘Vanessa’).

\textsuperscript{111} Example: ‘It’s a minefield... I wouldn’t want to say there is a difference in quality between one and the other’ (‘Hugh’); ‘I don’t think there’s [as] much difference as some people want... or perceive there to be’ (‘Phil’).

\textsuperscript{112} Example: ‘[T]he priest is a physical representation of sort of what the whole of the Church is called to in Jesus Christ...; the dangers in the priest thinking about priesthood are precisely to do with cutting certain people off from other people in the Church’ (‘Brian’); ‘The whole thing about Church leadership... is we are not leaders in the Church because we are priests. And priests are something which is to do with not just the Church. It’s to do with creation. And theology of priesthood has to be embedded within the doctrine of the Christian rather than within the doctrine of the Church if it’s to be of any use to anybody’ (‘Brian’).

\textsuperscript{113} Example: ‘... without having to go down the ridiculous route of ordination into the Church’ (‘Nigel’).
been given little thought. Invited to consider the case of a full-time NHS lead chaplain who is not ordained but, as an Anglican, is in licensed ministry, ‘Andy’ thought that what was lacking was the professionalism priesthood conferred. He made no mention of the professionalism that might undergird the role of the healthcare chaplain. Perhaps, this was unsurprising since, during the course of his interview, ‘Andy’ had referred a number of times to the chaplain as the religious rather than the healthcare professional. ‘Rita’ wondered whether a difference existed in the theological relationship the chaplain, as a priest, had with the Church and with the bishop. She seemed to ignore the reality that a non-ordained Anglican chaplain does have a theological relationship with both the Church and the diocesan bishop. By implication, albeit I suspect unintentionally, Rita might here be pointing to an ontological difference. For other participants the concern was a more practical one; that a non-ordained chaplain would be unable to provide a sacramental ministry which most participants regarded as vital.

(e) *The priest as sacramental minister*

Nine of the twelve participants judged the Eucharist to be central to their identity as a priestly and offered various reasons for this: the Eucharist as a spiritual community in which all are equal before God, as the sacrament in which all are spiritually nourished and restored, as the sacrament which heralds

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114 Example: ‘It’s… one of those I-wouldn’t-start-from-here kind of questions’ (‘Andy’).
115 Example: ‘I think it would be very odd to have a senior chaplain who wasn’t an ordained Christian minister of some kind, because you’re looking for that kind of professionalism… and that kind of experience’ (‘Andy’).
116 Example: ‘ordination is a professional badge of office’; ‘[the chaplains’] professional role is religious’; I think, [as a chaplain], it starts from your role as a professional minister, and starts from being visible as a clergyman (sic) around the place (‘Andy’).
117 Example: ‘I suppose that you have a particular relationship with the Church or with the bishop, if you want to, in theory or in theological terms, even if it’s not always worked out in practice’ (‘Rita’).
118 Example: ‘… the ordained bits… Presiding at the Eucharist’ (‘John’); ‘Well clearly sacramental ministry’ (‘Nigel’); ‘… that kind of sacramental role’ (‘Phil’); ‘… there should be a priest accessible for Christian patients who wish to receive a sacramental ministry’ (‘Sarah’); ‘We obviously have the sacramental… ministry’ (‘Vanessa’); ‘Again, it’s got to be that sacramental element’ (‘Barbara’).
119 Example: ‘more and more my own journey has [shown me] the centrality of the sacrament… that person who presides at the Eucharist’ (‘Vanessa’).
120 Example: ‘Anywhere else there’s this real sense of hierarchy, but actually [in the Eucharist] no’ (‘Phil’).
121 Example: ‘[I]t’s where we are fed and where as priests we feed others, or Christ feeds others through us’ (‘Rita’).
God’s reign\textsuperscript{123} and, interestingly, as the sacrament in which the priest, separated from God in the turmoil of his own life, might once again be found by God.\textsuperscript{124} In all of this there was also the dilemma that, in the secular setting of the hospital or mental health unit, the presence of a Eucharistic community over which the priest could exercise presidency, was neither realistic nor achievable.\textsuperscript{125} Even where the Eucharist was a regular feature of the chaplain’s Sunday ministry, ‘Mary’ revealed that, over time, the number of hours available to her team to provide a Sunday Eucharist had been appreciably curtained. This now meant that there was only one Sunday Eucharist a month. If the Trust was to go further and completely withdraw the Sunday Eucharist, she was anxious that her priesthood would be further marginalized if not fatally compromised.\textsuperscript{126} The value of the Eucharist in the life not only of the chaplain but of the hospital, was captured by ‘Brian’ who called it a ‘wonderful nonsense’. Reflecting on the hospital as a place which is frequently death-denying, Brian recognized the paradox of the chaplain presiding over the central drama of the Eucharist, a celebration of brokenness which reframes death not as an ending but as a beginning.\textsuperscript{127}

Brian also readily admitted that at times he experienced a sense of separation from God in the turmoil of his own life. This underlines the reality that the chaplain is not a detached observer of the brokenness of those on the wards and units of the healthcare facility. Not only is the ministry of the priest drawn to suffering,\textsuperscript{128} but the notion of brokenness and personal loss was thought by Mary to be bound up in who the person is as a priest, authenticating priesthood

\textsuperscript{122} Example: ‘It is the sign, par excellence, which we have been given to show that God has come among us and that we feed on him, and know his healing in every aspect of our lives’ (‘Andy’).

\textsuperscript{123} Example: ‘[T]he Eucharist being a sign of the transformative power of God in the whole of Creation so that particular liturgical acts, that we do, are simply signs of the in-breaking and the fullness of God’s reign. It’s about the transformation of all things’ (‘Brian’).

\textsuperscript{124} Example: ‘when maybe I was finding it difficult to find where God was, even in my own life, never mind anybody else’s life, or the life of the world, that actually putting on a chasuble, and being at the altar was where God found me’ (‘Brian’).

\textsuperscript{125} Example: ‘… in any other context, [on] some Sundays at least, [I would be] president of the community… But in this context I don’t think that quite works… I’m not absolutely sure that my priesthood does mean very much in this context’ (‘Andy’).

\textsuperscript{126} Example: ‘[S]acramentally, my role has diminished from when I first started ten years ago, with regard to Eucharistic ministry. If they stopped having a celebration of the Eucharist, altogether, there’s a question raised about my integrity as a priest here’ (‘Mary’).

\textsuperscript{127} Example: ‘[A]t the heart of that Christian story is that death is not an annihilation, but that death is in the end something which gives in to life itself and that death is not a defeat’ (‘Brian’).

\textsuperscript{128} Example: The priest ‘attending to his or her being will be naturally pulled into situations of human suffering and that’s... where we need to be you know’ (‘Nigel’).
itself. The point was made a number of times that priesthood is less a
sinecure and more a burden. Chaplains needed to be self-aware of their own
personal, intimate and unique brokenness which, as Sarah put it, was more
important than the fact that a person was ordained, although it does determine
the shape of priestly character. ‘Sarah’ paraphrased a prayer taken from the
Roman Catholic ordination rite which poignantly acknowledges the expectation,
and indeed acceptance, of the brokenness which will accompany the journey of
the priest and which is at the heart of the priest’s identity.

(f) The relationship of the NHS priest-as-chaplain to ordained ministers or
priests of other Christian denominations
Given the importance of sacramental ministry among the majority of
participants, and the Eucharist as a defining characteristic of Anglican
priesthood, I was interested to learn whether participants might discern a
difference of ministerial theology between themselves and their Free Church
colleagues for whom sacramental ministry, in particular the Eucharist, does not
always carry the same significance. This might reveal something more about
Anglican ministerial theology. Nonetheless, many participants seemed
unwilling, or simply unable to perceive what might distinguish their ministries
apart, that is, from the sacramental aspect of their work. The delivery of
spiritual and religious healthcare means that, frequently, chaplains work across
boundaries of ordination, denomination and faith affiliation and this allows
personal relationships to grow and a broader outlook to develop.

Example: ‘I think ordination to the Anglican Priesthood was a call by God to sacrifice
everything to serve him, because it went against everything that I ever thought I would ever do
in life. In a sense it cost me my marriage, but I wouldn’t have it any other way (Mary)’
Example: ‘… ordination takes quite a lot from you, too. I don’t think it’s all about being given
stuff (Sarah); ‘I think people who aren’t ordained can’t always understand the challenge of it
sometimes, and the burden of it’ (Rita).
Example: ‘To me, it would be down to what the person was actually like. And the depth of
their compassion would matter actually more to me and their sense of being integrated around
their own experiences of suffering, you know, aware of them but integrated with them’ (Sarah).
Example: ‘May you become like the mystery that you celebrate. May you be taken blessed,
broken and shared’ (Sarah).
Example: ‘I don’t feel superior to others (John); ‘I think there might be a difference of order,
not a difference of theology, and not anything I would lose sleep over. That probably isn’t really
helpful [Laughter] (Andy); ‘We like to see the differences instead of the uniqueness that
complement each other (Barbara).
Example: ‘I would have to read their ordinal… but I think it would certainly be the case that...
the ordination prayers, if such a thing exists for Baptist ministers or URC ministers or whatever,
would be a very different kind of thing from the Anglican or the Catholic ordinal (Andy).
Example: ‘At an earlier point in my ministry, I would have been very sceptical about [the]
interchangeability of ministries… in a hospital context those things do break down quite
differences may not be ignored neither do they necessarily intrude,\textsuperscript{136} and this is possibly a factor which led many participants to affirm the ministry of their Free Church colleagues.\textsuperscript{137}

Less in evidence was a collegiality in the relationship with Roman Catholic priest-colleagues.\textsuperscript{138} In part, it appeared to hinge on the absence of any mutual affirmation of ministerial orders. While a number of participants held that there was no theological difference between Anglican and Roman Catholic priest orders, they were equally conscious that the Roman Catholic Church does not reciprocate this position. Some Roman Catholic priests, individually, might be gracious in their invitation to Anglican priest colleagues to receive communion\textsuperscript{139} and even imply a tacit recognition of their orders\textsuperscript{140} but, more generally, it was a strained relationship both theologically and, occasionally, personally.\textsuperscript{141}

(g) A summary of the narrative

The foregoing evidence suggests that among the participant group there were those who did derive a greater sense of vocational identity from their role and work as ministerial priests, and so inclined to this as their preferred community of practice. What the evidence also suggests, however, is the difficulty or reluctance of participants to offer or to engage with a theological account of priesthood. It was the ministry of the priest rather than priesthood per se which formulated a narrative of priesthood. A number of reasons might account for this. One might be the emphasis, within healthcare chaplaincy, on practical theology and reflective practice, in which situations and relationships the

\textsuperscript{136} Example: ‘[T]hrough the difference you can create a collegial friendship, because there are distinct difference[s]’ (Nigel)

\textsuperscript{137} Example: Interviewer: ‘[D]oes Dave [the Pentecostal pastor] figure as [part of] the College of Priests, even though he belongs to another church, or … is Dave part of the lay-people?’ ‘Mary’: ‘No. He’s very much part of the College of Priests as well’ (Mary).

\textsuperscript{138} Example: ‘There is a much greater tension there [in the relationship with the Roman Catholic priest] than there is between myself and the Free Church’ (Phil).

\textsuperscript{139} Example: ‘I purposely didn’t go up to the rail [to receive communion] and [the Roman Catholic priest] beckoned me and gave me the sacrament’ (Phil).

\textsuperscript{140} Example: ‘For a male Roman Catholic priest to bring, as a gift [to a female Anglican priest], a piece of sacramental garment [it was a stole], was just so humbling’ (Mary).

\textsuperscript{141} Example: ‘I don’t feel terribly hurt by being rejected by certain kinds of Catholicism’ (John); ‘I do think it’s an authority issue… The Roman Catholic priest [is] under the authority, from an institutional point of view, of an Anglican. But that I think is a big tension…’ (Phil)
chaplain encounters are interrogated against a backdrop of theory, practice and experience in order to develop self-awareness and self-knowledge (Cobb, 2005: 29). A further contributory factor might be the absence of systematic theology from chaplaincy programmes of Continued Professional Development.

Questions about how ministerial priesthood relates to the priesthood of all believers, or the nature of the theological relationship with Free Church, Roman Catholic and lay chaplain colleagues, or how priesthood might be interpreted from an ontological, relational or functional perspective, tended to evoke protestations that theology was a throwback to pre-ordination studies now long forgotten. In fact, Cobb, a senior voice in healthcare chaplaincy, argues that chaplaincy is neither propositional nor conceptual but formational (Cobb, 2005: 28). I would differ in that I believe an understanding of priesthood necessarily involves all three components. Although the theological character of priesthood did present something of a challenge to the majority of participants, it was still the case that among the participants there were those for whom priesthood did provide vocational meaning.

6.4.1 **The institutional discourse: the narrative of the NHS**

Alongside the vocational discourse, there also stood an institutional discourse which I detected among the themes of the interviews. This consisted of two narratives. In the first narrative, the more significant community of practice from which participants seemed inclined to draw their institutional sense of identity, was delineated by the NHS. In the other narrative the more significant

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142 Example: ‘I’d quite like to have this conversation because...this is not something I’ve thought about for donkey’s years really, so I think it’s... a question that’s worth asking (‘Andy’).

143 Example: ‘I just decided, only this morning, the answer to this one because I was struggling’ (‘Andy’).

144 Example: ‘I’m struggling with that one... probably because I don’t understand the theology of Roman Catholicism’ (‘Phil’).

145 Example: ‘...if you’re going to be sat in an office, delegating tasks, I don’t think there’s really much need for someone to be ordained. But out there, doing the business, yes, I do think people should be ordained.’ [Interviewer: ‘Why?’] ‘I don’t know... [Laughter] a mass of inconsistencies’ (‘Sarah’).

146 Example: ‘I’d quite like to have this conversation because this is not something I’ve, you know, as is probably perfectly obvious to you, is not something I’ve thought about for donkeys years really, so I think it’s, you know, a question that’s worth asking’ (‘Andy’); ‘I remember the big discussions at college about ontological change... I didn’t quite know what the word means, but... I was trying to think back to whether I ever thought that something was really... kind of happening’ (‘Claire’).

147 ‘…my interpretation of priesthood is all up in the air’ (‘Claire’).

148 Example: ‘It means being very much a part of a different institution but the institution that is the NHS; being very much part of an organisation and very much part of the care that that
community of practice, from which participants seemed inclined to draw their institutional sense of identity, was delineated by the Church of England. In this section I present and explore the former of these two narratives in which the more significant community revolves around the NHS as an institution.

(a) The NHS context

According to the evidence of the interviews the NHS can present a challenging working environment for healthcare chaplains. Their role can be misconstrued, and their work underestimated or overlooked (except when there is urgent need for religious rites) paving the way for marginalization and an uncertain future. The parish priest model of the workhouse chaplain, which the NHS inherited, has evolved over nearly seven decades into what many chaplains regard as a discrete ministry which no longer corresponds to its parish counterpart. Yet, in some quarters, management retains an outdated view of chaplaincy which has little in common with twenty-first century chaplaincy practice and models of service delivery. With scant knowledge of contemporary chaplaincy, managers may appear begrudging in their acceptance of a service which they do not understand and for which they have little time.

organisation is trying to offer.’ (‘Claire’); ‘I live out my life as a priest in this healthcare setting’ (‘Rita’).

Example: ‘[W]e are a missionary frontier of the Church’ (‘John’).

Example: Discussions in a policy-making group left ‘John’ seething, ‘God that lot! Still caught up in the old view where chaplains are religious functionaries’. Significantly, this was a meeting of an Equality and Diversity Steering Group. As ‘John’ went on to say: the ‘one part of the organization that I would hope to be more sympathetic than most in an official sense – not what people really think but kind of officially’ (‘John’).

Example: ‘that’s exactly what senior management want... they [only] want those emergency things covered’ (‘Brian’).

Example: ‘[T]here’s also the feeling that someone could say... ‘why are we employing these people?’” (‘Hugh’).

Example: ‘I think they perceive us... I have termed this kind of role as the kind of ‘bumbling vicar role’. I think we are perceived as the bumbling vicar. You know, it’s nice to have you around, you can bumble around and go and be can be nice to people and have lots of tea, and people like you, and that's lovely... end of story when my model is not that at all. I mean far from it’ (‘Phil’); ‘I think that how chaplaincy is perceived, then, within this Trust and managers, is quite out-dated in the sense that... the model of outsourcing to local parishes still existed only four years ago and still exists in how we operate with our Catholic chaplaincy, essentially’ (‘Brian’).

Example: ‘I don’t think [management has] got a clue what I do [Laughter]. I don’t think they have any idea’ (‘Sarah’).

Example: ‘[M]y experience here... [is] that we are seen as a need that they perhaps could do without, but they've got to have it...; a box that somewhere says we must provide this care’ (‘Phil’).
Nonetheless, this is not a complete picture. Certain specialist areas of healthcare do work in partnership with chaplains and so have a better awareness and appreciation of what chaplaincy is able to contribute. Given its holistic approach, palliative care medicine has generally worked cooperatively with chaplaincy, while the chronic nature of respiratory illness naturally lends itself to the long-term supportive relationships which chaplains are able to offer.156 A number of the participants reported a positive attitude on the part of their Trusts, each valuing the contribution made by chaplaincy,157 even if this may have been due, in part, to their perceived representative role, acting on behalf of the Church.158

(b) Integration and assimilation

Whatever the attitude of an NHS Trust towards its chaplaincy department, among the participants were those whose comments indicated an overriding commitment to the NHS,159 working jointly with healthcare colleagues,160 carrying responsibility for a broad-based spiritual and religious care service in which the presence of Church of England is negligible,161 and being so integrated at every level of the NHS162 that the exercise of ministerial priesthood becomes indistinguishable from the practice of healthcare chaplaincy.163 Even

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156 Example: ‘[P]alliative care knows what chaplaincy is all about and the chronic respiratory side does as well’ (‘Brian’).
157 Example: ‘I think our Trust perceives us as an important part of what this Trust is trying to do and what this Trust stands for’ (‘Claire’); ‘[W]e have the complete trust of the hospital management’ (‘Vanessa’); ‘[H]ow they see us as a team? I think very highly’ (‘Barbara’); ‘I feel... in a more secure position to what management think of us and how they value us’ (‘Rita’); ‘They love us; they absolutely love us’ (‘Mary’).
158 Example: “[S]o I suppose the Church has given you authority and then that... authority is recognised within the healthcare context. That authority is something which is then recognised in a reciprocal arrangement with... the Trust’ (‘Brian’).
159 Example: ‘So, yeah, I don’t think I any longer see being a healthcare chaplain as being about being an Anglican priest in a different context’ (‘Sarah’).
160 Example: ‘I think some patients think that you’re never going to tell anyone what they’ve said to you and unfortunately, in the NHS, that can’t be true...’ (‘Sarah’).
161 Example: ‘The world we’re working in, you know, is not just Anglican but ecumenical, and not just ecumenical but multi-faith not just multi-faith but the NHS, and capacity-wise and energy-wise, you know, I just don’t feel that that [the Church] is the body that I should be spending my time relating to because it’s one small aspect of the context which is healthcare chaplaincy...’ (‘Claire’).
162 Example: ‘It means being very much a part of a different institution but the institution that is the NHS... that might be anything from being involved in the structures and strategies of the Trust, to... seeing people in that care role and support role, and everything in between’ (‘Claire’).
163 Example: ‘Nigel’, whose comments suggest that the NHS is his dominant community of practice, stated: ‘I don’t really have [a] strong demarcation between this bit of theology is for healthcare chaplaincy, this bit is for my priesthood’ (‘Nigel’); ‘When I was looking at this last night, it was really funny because I could only really think of my experience as a healthcare...’
where NHS managers fail to understand the organizational relevance of chaplaincy, a chaplain’s readiness to engage with the organization by learning its language and its style of communication can itself be a measure of a chaplain’s commitment to the NHS. By contextualizing ministry and shaping the provision and profile of spiritual care to meet the specific needs of the NHS, a chaplain may signal her recognition that the NHS has a prior claim over that of the Church. By proactively championing the role and purpose of chaplaincy within the NHS, using the apparatus of the organization, such as policy directives which require Trusts and healthcare professionals to have due regard for spiritual, religious and belief needs, a chaplain engages in more than just raising awareness of service provision. It builds a case for recognizing chaplaincy as a specialism relevant to the needs of a secular healthcare organization, and that a chaplain is prepared to be accountable in the same way that other services and departments are accountable to the NHS as employer.

(c) NHS values
Participants also acknowledged that chaplaincy will inevitably reflect those values promoted by the NHS but which can be a source of friction within the Church. Paradoxically, it is these selfsame values which may have

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Example: ‘[W]hat I do is important because the institution needs to recognize what chaplaincy does; it’s not very good at that. So in one respect I’ve got to learn that language and talk the managerial language and produce things that they might read in their language’ (‘Phil’).
Example: ‘[I]f you want to get that message over to an NHS director, there’s a... there’s a different communication skill set than [that used with patient-centred care]’ (‘Nigel’).
Example: ‘[M]y salary is paid by the Trust, who has a very particular understanding of what I’m here to do. So I suppose I see I have two, two sort of chains of command in a sense. And although the diocesan bishop one is perhaps a more, perhaps the more implicit thing, it’s something that’s more part of who I am and how I work as a priest, the healthcare one is perhaps more in my face because that’s the one that, you know, I’m having meetings with my manager and setting targets, initiating projects and “How’s this going and how’s that going?” So [the NHS] on the month-to-month basis is perhaps more important in some senses than the bishop’ (‘Rita’).
Example: ‘I’ve written a Spiritual Care Strategy for the Trust, just quite recently, which is currently with my line manager so they sure as heck will know shortly what gets done and how it can be developed. But at the moment I don’t think they know. To give... her credit, our Chief Executive asked me to write the Spiritual Care Strategy, so I’m not trying to say I don’t think they’re interested, it’s just I don’t think that they really know’ (‘Sarah’).
Example: ‘So part of my role at the moment, I think, is trying to train some of the managers to think... chaplaincy is different now, you know. Now, we are a professional... we are clinical’ (‘Phil’).
Example: ‘I find the Church to be quite conservative and quite narrow’ (‘Sarah’); ‘I sometimes do feel we’re not that connected [with the Church of England]. Of course, but also you’re
encouraged certain participants to realize that their vocation was one best served within the NHS. Principal among these is inclusiveness demonstrated by chaplaincy’s engagement with different faith and belief groups, and which bears out the NHS commitment to equality and diversity. Additionally, there are those values which are integral to a person-centred and person-led ministry, such as non-directive pastoral care and respect for spiritual autonomy.

(d) Ecclesial estrangement

Another theme within this narrative minimised the need for a chaplain to be an ordained person. Rather than faith accreditation e.g. Anglican ordination and licensing, more weight needed to be given to the personality and aptitude of the chaplain. This did not necessarily imply that participants had lost confidence in their ordination or priesthood, or that the Church had no part to play in the life of the chaplain. For example, while ‘Sarah’ was critical of God, the Church...
and priesthood,\textsuperscript{177} she admitted she was unable to rid herself of either the Church or priesthood.\textsuperscript{178} Among other participants, the evidence of a more distant relationship with the Church of England seemed to be a source of anguish and grief.\textsuperscript{179} It was less that participants actively sought a sense of vocational identity from the disciplinary community of healthcare chaplaincy. Rather, systemic and structural issues within the Church of England had caused them to doubt whether as an institutional community of practice, the Church of England was one from which they could satisfactorily derive a sense of identity.\textsuperscript{180} Participants were fretful,\textsuperscript{181} irritated\textsuperscript{182} or simply resigned to institutional anxieties,\textsuperscript{183} priorities\textsuperscript{184} and demands\textsuperscript{185} from a Church which seemingly had lost its way.\textsuperscript{186} Although these concerns may have led some to re-locate their ministry into the NHS, for others it became noticeable on entering chaplaincy and experiencing the Church from a different ministerial perspective. This may have persuaded some that the NHS was the preferred community within which to assume a new institutional identity.

\begin{itemize}
\item Example: ‘I felt like a hypocrite to be, seeming, to represent an institution which was basically there to defend God when I felt that some of God’s actions were indefensible’ (‘Sarah’).
\item Example: ‘I think no matter how much I think I might sometimes try to run from it, and I kind of think I’ll run from it and kind of think ‘Oh, you know, the Church is this strange and peculiar institution’, I genuinely think that once you say yes to it, then that’s it; that you can’t escape from it then’ (‘Sarah’); ‘So I can’t kind of go ‘Oh no, being an Anglican priest brings nothing to being a healthcare chaplain’ because that would be seeking to escape from reality of the situation ‘I mean being an Anglican priest is part of who I am, for better or worse’ (‘Sarah’).
\item Example: ‘the healthcare chaplain… has a sort of semi-detached relationship with the Church’ (‘Brian’); ‘I don’t really feel that sense of connectedness to the Church that once I did’ (‘Sarah’); ‘to be side-lined, which is how I feel’ (‘Vanessa’).
\item Example: ‘I think to have a… positive, good relationship, I think, you know, the structures of the Church would need changing’ (‘Claire’).
\item Example: ‘As an Anglican priest in a parish, you’re sometimes more concerned with buildings, meetings, and the people get lost’ (‘Barbara’).
\item Example: ‘Jesus doesn’t want us to be Christians and God doesn’t want us to be Christians; God wants us to be Christ-like… [P]riesthood always has to be kept within that much wider horizon, and… seen as actually a terribly temporary ironic and paradoxical thing that is only necessary because we are so stupid and actually then we mess it up anyway’ (‘Brian’).
\item Example: ‘[I][l]t’s responding to decline of churches, and the need to manage buildings and money and income and all that’ (‘Brian’).
\item Example: ‘I mean as a parish priest in a busy parish, it can be… too easy to get caught up in the church as a self-perpetuating institution, however open… you hope that things are. At the end of the day the Church is not the be-all and end-all of things’ (‘Sarah’).
\item Example: ‘[in] my last parish church… the mission was to keep the church building going’ (‘Vanessa’).
\item Example: ‘[W]e don’t know where we are or what we are or what is the greater whole of which we’re [a] part. I don’t quite know what [the Church] is. I don’t understand what’s happened to that Church’ (‘Hugh’).
\end{itemize}
In what follows, I now trace themes of ecclesial estrangement gathered under three headings: dysfunctional relationships, mission priorities and negative experiences of parochial ministry.

(e) Dysfunctional relationships

Among the institutional or structural relationships which shape the identity of the priest, one that carries particular weight is that which exists between the diocesan bishop and the priest. It was a relationship which many participants experienced as deficient in one way or another.\(^\text{187}\) Within his or her diocese, the bishop is supposedly a focus of unity\(^\text{188}\) and, within the catholic tradition of the Anglican Church, the presbyter vicariously exercises the ministry of the bishop who is, in effect, the proto-priest.\(^\text{189}\) In describing the leadership, vision\(^\text{190}\) and pastoral support a ‘good bishop’ might be expected to offer,\(^\text{191}\) the metaphor of shepherding was used: the bishop as someone from whom the priest might seek pastoral care\(^\text{192}\) and who listens and attends to the inner life of a fellow minister.\(^\text{193}\) Yet, many comments revealed a different picture; that such expectations do not necessarily match with reality. The bishop was someone with whom it could be difficult to engage, perhaps because healthcare chaplaincy is a marginal ministry,\(^\text{194}\) although other reasons were cited.

So, for example, diocesan and healthcare catchment areas invariably do not coincide, and consequently NHS priests-as-chaplain may live and work across several dioceses making episcopal responsibility, oversight and support problematic as well as confusing.\(^\text{195}\) Given that the NHS priest-as-chaplain is

\(^{187}\) Example: ‘We’re on the very edge of their consciousness and ownership and understanding’ (‘John’); ‘[A]t its worst... it’s worse than useless’ (‘Andy’).

\(^{188}\) Example: ‘Oh God, I was going to say the focus of unity or disunity within the diocese’ (‘Brian’).

\(^{189}\) Example: ‘My ministry is the bishop’s ministry’ (‘Brian’)

\(^{190}\) Example: ‘[A] good bishop... [has] a kind of shepherding, leading role...; I look at the relationship of Jesus and his disciples...; in Jesus, [there were] particular gifts or [a] particular understanding or [a] particular vision that [the disciples] hadn’t got, and they learn from him. That’s how I look to a bishop’ (‘Phil’).

\(^{191}\) Example: ‘[S]hepherding: and that means both overseeing us and supporting us’ (‘Vanessa’).

\(^{192}\) Example: ‘[T]he pastor of the pastors’ (‘Vanessa’).

\(^{193}\) Example: ‘[H]ow spiritually, physically, mentally, emotionally intact are they? Are they well? Are they keeping their spiritual journey alive...?’ (‘Nigel’).

\(^{194}\) Example: ‘[I]n terms of building any meaningful relationship... my experience is that you’re off the radar and one learns not to have any expectations’ (‘Nigel’); ‘i suppose we would only really see him... at [the] Chrism Mass’ (‘Barbara’).

\(^{195}\) Example: ‘All these boundaries... don’t really work... to have a good relationship, the structures of the Church need changing’ (‘Claire’).
employed by a Trust and does not receive a stipend from the Church, the
relationship between a bishop and a healthcare chaplain may feel contrived.\textsuperscript{196} Predictably, a bishop’s primary concern is for those parishes under his or her
care,\textsuperscript{197} and this can leave the NHS priest-as-chaplain conscious that their own
ministry is marginalized.\textsuperscript{198} A bishop will often lack familiarity with healthcare
chaplaincy issues which makes serious engagement and collaboration unlikely
and, in the main, unachievable.\textsuperscript{199} A bishop is required to investigate clergy
accused of misconduct, which may make an NHS priest-as-chaplain wary,
especially as the two institutions of Church and NHS may not agree about what
constitutes professional misconduct.\textsuperscript{200} This is not to deny that some
participants spoke of their bishop as supportive and the relationship
constructive (§6.4.2). Nonetheless, the overall impression was that it was left to
the NHS priest-as-chaplain to take responsibility for pursuing and maintaining
this relationship.\textsuperscript{201}

A further set of key relationships, again part of the institutional structure of the
Church, is located within the deanery chapter. This, theoretically, serves as a
forum providing mutual support for licensed clergy. There is the opportunity for
its members to discuss parish, deanery and diocesan matters of common
interest but while the chapter does include sector clergy, its principal agenda, as
was confirmed by a number of participants, is primarily, sometimes exclusively,
dominated by parish matters.\textsuperscript{202} In this way, it not only effectively excludes
those ministering beyond parish boundaries, it can promote a sense that the
only legitimate expression of priesthood is one exercised within the

\textsuperscript{196} Example: ‘I am still questioning the [bishop’s] authority… because, in my role here, I’m
actually employed by a healthcare Trust’ (‘Rita’).
\textsuperscript{197} Example: ‘[T]he diocesan bishop went round to visit all his clergy… who were in parishes,
and has not done one-to-one visit on his chaplains in healthcare, prisons or anything like that
because he hasn’t got the time. His focus is on the mission of the Church’ (‘Vanessa’).
\textsuperscript{198} Example: ‘[I]n terms of building any meaningful relationship (with bishops), my experience is
that you’re off the radar and one learns not to have any expectations’ (‘Nigel’).
\textsuperscript{199} Example: ‘[H]e doesn’t have a clue [about] what I do and doesn’t really want to know’ (‘Phil’).
\textsuperscript{200} Example: ‘[T]he most relationship I had [with the bishop] in recent years was when I was off
on maternity leave and I’d let the diocese know… and I actually got a phone call from the
bishop’s secretary saying… “Would you care to tell us what date you got married on?” [as if to
say] “Just to make sure there’d been a marriage before the baby”’ (‘Claire’).
\textsuperscript{201} Example: ‘[H]e will see me at all the diocesan events even if it’s just to jog his memory
(‘Mary’).
\textsuperscript{202} Example: ‘A waste of time because… understandably their agenda is dominated by parish
matters; they also don’t understand us’ (‘John’); ‘I tried to sort of get involved in chapter,
deanery, but it’s just never quite worked because there’s so much emphasis on parish’ (‘Claire’).
parochial system\textsuperscript{203} and the NHS chaplain as someone who has failed this litmus test of authentic ministry.\textsuperscript{204}

(f) Mission

Mission was a further contentious issue. Participants claimed that, while healthcare chaplaincy is at the forefront of mission,\textsuperscript{205} an increasingly mission-conscious Church of England has, to all intents and purposes, failed to take advantage of this. In recent years, the rhetoric of the Church of England has focused on mission. Pioneer priest-ministers have been recruited and ordained as part of the Churches mission-shaped strategy, while the report, \textit{Mission-Shaped Church}, recognizes that that the Church of England has allowed itself to drift away from society (Archbishops’ Council, 2004: 13), an observation echoed in the experience of participants.\textsuperscript{206}

Greenwood (1994:6) writes that ‘before anything can be said of individual priests, a great deal has to be worked out regarding the being of Godself, the passionate mission of God for the salvation of the created order, and the role of the Church as a vehicle of that mission’. Be that as it may, among the participants there was discernible cynicism that instead of being an opportunity for a radically new approach to ecclesiology, one that healthcare chaplaincy was well positioned to support,\textsuperscript{207} Church-directed mission was little more than the parish priest tasked to do more of the same: to evangelize and thus grow

\textsuperscript{203} Example: ‘We’re a sort of servant to the parochial ecclesiology’ (‘John’); ‘[S]o someone asked me, ‘Are you a priest? I didn’t think, you know, a hospital chaplain would be a priest.’ And I said: ‘Oh. I’m every inch a priest’ (‘Hugh’); ‘So they’re only seen to be a proper priest is to be within the parish system’ (‘Barbara’).

\textsuperscript{204} Example: ‘[A] priest came up to me and said that... their curate wasn’t coping in the church [or should this be Church?] Would you think about them... have a chat with them... to see if they... because healthcare chaplaincy might be better for them’ (‘Vanessa’).

\textsuperscript{205} Example: ‘[W]e are a missionary frontier of the Church. It’s just that hardly anyone recognizes it’ (‘John’); ‘[W]e’re pretty much having to be at the cutting edge of how we respond to society’s sense of the sacred, and we have to listen to that and respond’ (‘Hugh’); ‘I think the healthcare chaplain is at the cutting edge of mission because we’re meeting people who are in huge need. The majority of them don’t have anything to do with Church; lots of staff we meet don’t have to do with Church’ (‘Nigel’).

\textsuperscript{206} Example: ‘I think, sometimes what’s happened, is that the Church per se, the diocese or whatever, hasn’t quite cottoned on to... the fact that we’re out there doing, in some ways, much more direct work than often people in churches get to do [be]cause they’re waiting for you to come through the door of the Church’ (‘Claire’).

\textsuperscript{207} Example: ‘I’m right at the forefront of meeting non-Christians, ex-Christians, fringe Christians, lapsed Christians... and then Muslims of all sorts of shades, and Hindu, and Sikh, and Rastafarian, ... the odd Buddhist, you know; people who claim to be Pagan and Wiccan... What an opportunity’ (‘John’).
208 ‘Brian’ was far more sceptical about the mission programme in his diocese, convinced that it was motivated by a fear of ‘Islamification’.209 In the main, however, participants saw mission as an opportunity which an insular Church was failing to recognize and exploit,210 a vision of community which must look beyond the narrow structures of the Church211 energized by a focus on the reign of God.212

(g) Negative experiences of parochial ministry

Estrangement from the Church is perhaps inevitable when parish ministry is embraced as the bedrock of the Church of England. Yet, as was evident from some of the interviews, there are clergy for whom parish ministry is an overwhelmingly negative experience. All the participants had spent a minimum of three years in a parish, in accordance with Church of England practice. This requires a person to be ordained to a title parish in which they will be trained as a curate. Following this apprentice-style posting, a number of participants had gone on to other parochial appointments as a team vicar or a priest-in-charge, in which they were to gain additional experience and responsibility. Perhaps because ‘the parish is the heart of the Church of England’ (Church of England, n.d.), some participants assumed they would remain in parish-based ministry

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208 Example: The ‘mission of the church becomes much more about… trying to be viable [and] so getting bums on pews [Laughter] and… that’s when I think we… part company…; healthcare chaplaincy is… one way of ‘being Church’; a different expression of church but very valid’ (‘Claire’).

209 Example: ‘[T]he increase of Christian numbers is set up in competition against what some people, … senior figures in the diocese, see as the Islamification of [blank] and I think that’s really difficult… because I think there’s an implicit [and] complicit religious competitiveness which is coming into how the mission of the Church is seen in this diocese, which I think is contrary to the teaching of Jesus in the synoptic gospels’ (‘Brian’).

210 Example: ‘I’ve become a bit cynical about the mission of the Church… it’s ultimately about getting people into buildings at certain times in the week… and I don’t think that’s what it’s all about personally’ (‘Nigel’); ‘The Mission of the Church? … I think we should be helping people to identify whatever it is that gives them hope and meaning and understanding in the greater scheme of life. So I think we’re about growing a much larger community than just a Christian community’ (‘Phil’); ‘[I]n broad terms the mission of the Church is simply to help in the extension of the full reign of God… [H]ealthcare chaplaincy helps extend God’s reign by caring for people at extreme points in their life, at the vulnerable points in their life. That’s what’s going on and that’s what is going on in my ministry, and that’s what’s going on in the fullness of chaplaincy here’ (‘Brian’).

211 Example: ‘What it’s about, I feel, is about people catching something of the presence of God in their being, where they are right now, and allowing that to capture them and to lead them, wherever it chooses to, whichever way the Spirit moves them, whether it’s in Church or out of Church, you know… Church with a capital C – has got so fixed with the idea that it monopolises the Spirit. And that’s complete and utter rubbish, you know, and the sooner the Church wakes up to that, and can live that, the better’ (‘Nigel’).

212 Example: ‘Growing a healthy community’ (‘Phil’); ‘[I]t’s not about just being Church and making Christians. It’s about something much broader… focused on the reign of God which is different’ (‘Brian’).
and continue to learn more about the expression of priesthood and the shape of ministerial practice. Some recalled trying to adapt themselves, to accommodate a particular understanding of priesthood which, in retrospect, made no allowance for their own story and for the positive contribution this story might make to their priestly identity. For others, the additional responsibilities, expectations and frustrations that accompanied a more senior parish post, produced feelings of ambivalence when it involved the maintenance and security of what might be listed church buildings which were hardly fit for purpose. Then there were financial pressures as well as the expectation, if not requirement, to grow the congregation. For some participants, this was too much, even abusive, and resulted in episodes of serious ill-health. As chaplains, marginal to the needs of the Church, perhaps it was indeed inevitable that instead of promoting the Church, some participants would entertain an alternative vision: a vision focusing on the presence of God in people’s lives, in their suffering as well as in the world; one focusing on extending God’s kingdom rather than growing the Church; and one focusing on society’s creative and illimitable awareness of the sacred.

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213 Example: ‘[M]y understanding of priesthood then, I suppose was a lot more positive, or maybe it was a bit clearer, and it probably was quite a functional understanding’ (‘Claire’).
214 Example: ‘[Y]ou try and fit yourself into boxes more easily rather than actually allowing yourself to be more at home with who you might be in your own history’ (‘Brian’).
215 Example: ‘seeing the mission in a grade one listed building - in a very small village, not prosperous - ... to keep the church building going’ (‘Vanessa’).
216 Example: ‘I mean… not having to worry about the church that’s seven, eight hundred thousand years old where the lead’s being stolen every week’ (‘Hugh’).
217 When buildings are listed they are placed on the statutory list of buildings of ‘special architectural or historic interest’. These are compiled or approved by the Secretary of State under the Planning (Listed Buildings and Conservation Areas) Act 1990. All buildings built before 1700 which survive in anything like their original condition are listed, as are most of those built between 1700 and 1840 (see https://historicengland.org.uk/listing/what-is-designation/listed-buildings/).
218 Example: ‘It is such a joy not having to think to raise £20k for a new toilet in… a listed building… It’s [an] incredibly liberating freedom of ministry’ (‘Vanessa’).
219 Example: ‘we don’t have to worry about paying the quota’ (‘Hugh’).
220 Example: ‘I think the Church is getting caught up in some of this mission-shaped, fresh expressions theology, about doing stuff and ticking boxes and Church growth and numbers’ (‘Brian’).
221 Example: ‘[I] it turned out to be a complete nightmare’ (‘John’); ‘I left that parish after only about a year and it had been a very difficult time… [A]t that stage I thought I wasn’t actually even going to be going back to ministry at all’ (‘Andy’); ‘I’d dealt with all these problems in the parish and fell ill and I was diagnosed with reactive depression’ (‘Phil’).
222 Example: ‘I’m re-reading Original Blessing, at the moment, by Matthew Fox. He notes this kind of distinction between the Church and the Kingdom. And I would say that now I would definitely be more sort of Kingdom-centred than Church-centred’ (‘Sarah’).
223 Example: ‘Whereas we are having to pretty much be… at the cutting edge of how we respond to society’s sense of the sacred, and we have to listen to that and respond’ (‘Hugh’).
A summary of the narrative

A review of this narrative suggests that among the participant group there were those who did derive a sense of institutional identity within the NHS, and so inclined to this as their preferred institutional community of practice. Although the NHS remains an environment within which chaplaincy can be marginalized due to misperceptions, misunderstandings, indifference and individual prejudice, there are departments, such as palliative care, which value its contribution. There was evidence to suggest that some participants were highly committed to the NHS and to its values of equality and diversity. Alongside this, the systemic and structural organization of the Church of England which left some participants feeling neglected and discounted by the Church’s attitude and priorities, was in itself enough, I would argue, to prompt some participants to search for acceptance and identity within the NHS. A negative experience of parish ministry undoubtedly encouraged some participants into sector ministry, but for others a vocation to healthcare chaplaincy exposed them to what ‘Sarah’ described as the self-perpetuating and self-consuming institutional Church.

6.4.2 The institutional discourse: the narrative of the Church of England

This, the second of the two narratives which form an institutional discourse, contains themes which demonstrate a greater attachment to the Church of England. It is a narrative which suggests that the more significant community of practice, from which this group of participants were inclined to draw their institutional sense of identity, was located in the Church to which they belonged.

(a) The Church within the NHS

What was remarkable about this narrative was the admission, by a number of participants, that they regarded themselves as the Church within the NHS.
and as an outpost of mission. They might bend the rules or introduce liturgical innovation but, beyond the critical eye of parishioners, this was justified on the grounds of pastoral care or mission. For those participants who regarded themselves as being on the edge of the institutional Church, it was sacramental ministry which grounded them and made it possible to retain some sense of belonging to the Church. In other conversations, there was a feisty determination to resist marginalization and to ensure the Church of England appreciated and valued the contribution of the NHS priest-as-chaplain. ‘Vanessa’ spoke about her need to be an advocate for chaplaincy within the Church because in the intense person-centred work of the NHS, in which the chaplain listens and follows, it was crucial to preserve her own sense of spiritual identity as an Anglican priest. This was a view shared by ‘Mary’. Once

chaplaincy and the role of a healthcare chaplaincy is... one way of ‘being Church’; a different expression of church but very valid (‘Claire’).

Example: ‘[W]e are a missionary frontier of the Church...what an opportunity; and the State pays for me to be here and the church doesn’t pay a penny... actually you’re a Trojan horse in the NHS and at the forefront of mission’ (‘John’); ‘Although we have an established place and we are paid by the establishment... we’re still on that Missio Deo. We’re finding God... we’re going out into the world and we’re meeting the people where they are and who they are and how they are, as opposed to waiting for them to come to the Church for a reason’ (‘Vanessa’).

Example: ‘[W]e’ve got a Muslim on one of the wards, a youngish man, who comes along, and he has communion’ (‘Hugh’); ‘I mean, our Sunday services we ask no questions about the Eucharist, who receives it’ (‘Vanessa’).

Example: ‘I’m less prescriptive. I’m more open, which does lead to a bit more vulnerability... [W]hen you baptise somebody or anoint somebody, you’re told in the rubrics, what exactly you should do... And I spooked somebody out, who was being trained by us, when I told him that when... I anointed somebody and they had their family present, I gave the oil to the relatives to do the same. And he said we are not allowed to do it. Well I think, you know, it’s like being invited to a meal, isn’t it, it’s best to be participative’ (‘Barbara’).

Example: ‘I suppose my experience in one or two parishes was... were the first to pick you up on anything they didn’t quite like or [you] didn’t do what they been doing for the last 20 million years sort of thing’ (‘Phil’); ‘[I]n a parish setting you wouldn’t be able to do that’ (‘Barbara’).

Example: ‘push[ing] the boundaries a bit for pastoral and, indeed, for missionary ends’ (‘John’).

Example: ‘Although I feel quite separate from... the Church, it’s that sacramental side of things that keeps me connected to it really’ (‘Sarah’).

Example: ‘I think I am a little bit of a thorn in [the bishop’s] side, but I think I need to be, because it’s not that I want to be in his face but purely because I think our ministry is as vital to the whole ministry [of the Church] as the parish’ (‘Vanessa’).

Example: ‘[Y]ou change with every person that you meet because... they have their own understandings. And that’s where you’re meeting people. So you’re listening to people from all edges... And it’s not losing who I am, but it’s enabling them to be them... [S]piritual care is what makes me unique and each individual unique, and ensuring that that uniqueness is not lost in illness... but in order to do that, you’ve got to know who you are because otherwise you can be lost in the situation. So I’ve got to be rooted and that’s what I long for, and hope for, in that I still feel rooted both within [the ministry of NHS chaplaincy], but also within the priesthood of who I am; which is why I value and fight for recognition within the Church... it is a battle, that somehow you’re seen to be a loose cannon within both, if you’re not careful and that’s where the rootedness goes’ (‘Vanessa’).
again, what was particularly striking was that, in one way or another, every participant alluded to the tenuous relationship between the chaplain and the Church. Nonetheless, the perceived failure of the Church to engage with and support chaplaincy did not necessarily affect the resolve of some to retain an acknowledged place within the Church. Although there were those who might choose to cut themselves off from the Church others clung tenaciously.

(b) Episcopal support and a mission-based ecclesiology

However, for the sake of balance, I need to reiterate that while some participants claimed they had little, if any, pastoral support from their bishop, confirming a suspicion that compared with parochial ministry chaplaincy was the poor relation, others deemed it a more positive relationship, even if this was sometimes qualified. While it was helpful and well-meaning and fundamental for a theological understanding of priesthood, it could be obscured by the nature of a bishop’s managerial and disciplinary responsibilities.

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Example: ‘I want to stay under the care of my diocesan bishop, and I want him to always be aware of what is going on in my priestly ministry as chaplain. And so he will see me at all the diocesan events, even if it’s just to jog his memory’ (Mary).

Example: ‘I think we’re often pioneers, but I think we don’t have a way of feeding [that] back into where the Church is’ (Hugh); ‘[the healthcare chaplain] is essentially employed by the NHS, and has a sort of semi-detached relationship with the Church’ (Brian);

Example: ‘I struggle to know, in some ways, what the Anglican Church is. I think... it is important to me. I am part of it. I’m in various... one or two committees within, you know, the diocese, and that’s deliberately so because I wanted to renew my connections with the diocese’ (Hugh).

Example: ‘Actually, it suits some healthcare chaplains to forget the Church exists and forget that they are ordained ministerial priests within that particular Church and that their ‘authority’ comes from that whole history and tradition’ (Brian).

Example: ‘I think our ministry is as vital to the whole ministry [of the Church] as the parish. And as one who’s done both lay and ordained ministry, my life has been in the diocese of my passion for this area is so great that to be sort of side-lined which is how... I feel... you know perhaps the strength of the rock on [the Church] side of the bridge isn’t as great as the strength actually in the hospital... is worrying. And, yes, I keep battling, I keep attending deanery chapters which is all about the parishes, but I keep attending and putting my two-penneth in... I don’t ever expect to become a canon but as long as I don’t become canon-fodder [Laughter]’ (Vanessa).

Example: ‘I found the connection with my bishop very positive... I think probably at the moment we’ve got it the right way that actually the bishop is there very much a supporting person... and somebody we can appeal to if there are problems and he is generally interested. And does rather more than, sort of, ‘Oh well you might see me once-a-year or once every one-and-a-half years or something’. Does more than that. But I think probably it’s erring on the right way, rather than being over-involved’ (Hugh); ‘[The bishop] is certainly... keen to support us in any way that we tell him to, if you see what I mean. I don’t think he’s got much imagination for [chaplaincy] because we don’t really fit in to his understanding of mission, you know which is because he is very much from the evangelical charismatics stable. But, he is definitely trying to be supportive and to get to know us, the lot of us, so one should give him credit for that, I think’ (Andy).

Example: ‘Sometimes I look at the relationship of Jesus and his disciples... There’s equality amongst them, and in another sense, one of them, in Jesus, has particular gifts or particular
In addition, my earlier comment, that the Church’s interpretation and engagement with mission excluded the part healthcare chaplaincy might and does play, again needs to be qualified. There were participants who placed a more positive emphasis on the ministry of the healthcare chaplain as part of the Church’s mission-focus.243 This, though, is not the final word. Some went further and claimed that mission required a broader understanding of ecclesiology. ‘John’ spoke about the mission opportunities of dialogue with people of other faiths244 which, in part, had led him to reappraise his understanding of ecclesiology. Similarly, ‘Brian’ claimed that mission has little to do with making Christians. It is about making God known, encouraging people to be more Christ-like and being a voice for the marginalized.245 These comments, by ‘John’ and ‘Brian’ undoubtedly have implications for an understanding of the Church of England as a community of practice but not straightforwardly so. For example, ‘Brian’ was committed to extending the reign of God rather than growing the Church of England which suggested that, for him, the institutional Church carried little weight as a meaningful community of practice. Yet, equally, ‘Brian’ was vociferous that while the Church of England remains insufficiently understanding or particular vision that they hadn’t got, and they learn from him. That’s how I look to a bishop... for that kind of leadership or that authority, insight. But at the same time we should be equal as well... the bishop’s an extension of what we do or what I do, or I’m an extension of what he does’ (‘Phil’).

242 Example: ‘[W]e tend to think that relationship with bishops is not theological it’s more organisational’ (‘Phil’); ‘So the bishops I’m experiencing currently are far more managerial, they’re a bit like the band 8A, whether they want to be or not. They’ve got very caught up in that kind of managerial institution’ (‘Phil’).

243 Example: ‘[A]nother arm of the mission of the Church... an integral part’ (‘Vanessa’); ‘I see [my ministry as] part of, I suppose, the wider mission of the Church... I very much see myself as an extension, I suppose, of what my parish colleagues are doing, it’s just I’ve been called to minister in this setting rather than in a Church community’ (‘Rita’); ‘I very much keep strong links and network with the deanery and the chapters... I just exercise my priesthood in a different place other than a church building... we’re all involved in the same ministry for God and the same mission for God’ (‘Mary’).

244 Example: ‘[I]t helps us to have a much broader understanding of ecclesiology... [as] a missionary frontier of the Church... I’m right at the forefront of meeting non-Christians, ex-Christians, fringe Christians, lapsed Christians... and then Muslims of all sorts of shades and Hindu and Sikh and Rastafarians (‘John’).

245 Example: ‘[M]y sense of ecclesiology would say that I am here not just to promote the interests of the Church, because... my conception of the priesthood and ecclesiology and mission would be that we are always in the business of trying to make known the God who is already present, rather than make present the God who is not there. And detecting that God and drawing attention to that God in the places where God is found. Now that means that actually I’m not in the business of making people Christians and I don’t think I would even say that in a parish context because I’m not really interested in people being Christians or becoming Christians. I’m interested in people being Christ like and therefore that means that within a context like this, that whole Christian inheritance of following Christ is to do with actually making visible the marginalised, being a voice for those who don’t have any voice and being a voice for those who have other ways of which they relate to God. So actually, you know, working in a multi-faith context, I sit very easily with that, completely easily’ (‘Brian’).
committed to chaplaincy and to wider engagement with public institutions, its credibility to speak to national issues is in danger of being lost. Clearly, perhaps paradoxically, for ‘Brian’ the Church does have some significance.

(c) A summary of the narrative

The evidence from the interviews suggests that among the participant group there were those who did derive a greater sense of institutional purpose and direction from the Church of England, and so inclined them to this as their preferred institutional community of practice. However, even among these participants, there was genuine concern about what was perceived to be the Church’s indifference and disinterest in healthcare chaplaincy. There was little sense of partnership ministry or any substantive recognition of the contribution chaplains make to the spiritual well-being of the unchurched.

6.5.1 Summary

In this chapter I have presented a detailed analysis of the interview data, what I earlier described (§5.4.5) as stage five of the analysis, the synthesis (see Table 5.1). Having correlated the main themes from the interviews (Appendix S), I identified four narratives which I conceptually framed using ‘communities of practice’, Wenger’s theoretical model, as a hermeneutical tool by which to engage with each of the narratives. This enabled me to assemble the structural schema of the narratives. First, the vocational discourse consisting of two narratives, one aligned with the disciplinary community of the healthcare chaplain and the other aligned with the disciplinary community of ministerial priesthood. Second, the institutional discourse, again, consisting of two narratives, one aligned with the NHS and the other aligned with the Church of England. I do not claim that a chaplain locates herself within a particular community of practice. Rather, it is from one or more of these communities that the chaplain shapes a sense of identity, for as Wenger asserts (2010: 186), a person journeys across a trajectory of landscapes of practices which sculpts identity (§2.3.3).

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246 Example: ‘[the Church of England’s] relationship to public institutions is really important. If the Church in the future does not invest in chaplaincy within public institutions then the Church will lose the ability to actually talk at any level within national life with any authority’ (‘Brian’).
6.5.2 Developing the thesis

Having presented the detailed and final analysis of the interview material, which illustrates the complexity of deciphering the identity of the NHS priest-as-chaplain, in the next chapter I consider what may be learned from this analysis and its findings. In this, I return to the primary and secondary research questions. Although I make no claims for the reproducibility, generalizability and transferability of this research, the thickened descriptions of each participant’s experience of living an identity shaped by the interaction of different vocational and institutional narratives does signal where a discussion needs to begin. For although the interview material revealed twelve distinct and different accounts of identity, what has emerged is a collegial experience of healthcare chaplaincy which sets it apart from parochial ministry. What does this imply and what might it contribute to an understanding of priesthood?
Chapter Seven: Discussion of the Research Findings

7.1 Introduction

The primary research question sought to determine whether, in the rapidly changing ethos of the NHS, the identity of the NHS chaplain in England remains congruent with the identity of the Church of England priest. Although not presupposing the research findings, I planned for the possibility that the evidence would suggest an incongruence and so give rise to secondary research questions: namely, why a dislocation of the two identities had occurred; what the nature of any perceived dislocation might be; and how the thinking, experience and practice of the NHS priest-as-chaplain might draw upon, contribute to or challenge contemporary discussions about the ontology of Anglican priesthood.

As laid out in chapter five, the methodology of this research brought together Practical Theology (see further in §5.2.1) and grounded theory (see further in §5.3.1) in a qualitative study (see further in §5.2.2) which encompassed the thinking, experience and practice of twelve NHS priests-as-chaplains in order to construct a theological model which authentically engages with the Church of England priest. It was research that aimed to provide a rich, thickened description while making no claims for its reproducibility. However, the issues raised and the insights offered extend beyond the margins of twelve participants thinking aloud (see further in §5.4.7). I reflect, in this chapter, on what may be learned from the analysis of the interviews (chapter 6) in order to build a theological model within which the priesthood of the NHS priest-as-chaplain may be framed and interpreted.

As I noted earlier (§5.2.1) it is not only the thinking, experience and practice of participants that has a bearing on theological identity but an interaction of revelation and context. A person's perception of reality is socially (Berger and Luckmann, 1966) and theologically constructed (Percy, 2006: 10) inasmuch as certain objects and actions are given transcendent meanings beyond their immanent objectiveness.
This principle, that reality is socially constructed, drew me to Wenger’s communities of practice (§2.3.3). He maintains that a community of practice is the simplest social unit possessing the general characteristics of a social learning system such as self-organization, dynamic boundaries and on-going negotiation of identity and cultural meaning. What I found appealing was its emphasis on learning taking place by way of discourse and dialogue (chapter two, footnote 32). Applying Wenger’s understanding of communities of practice as a hermeneutic tool enabled me to locate four communities in the interview material: the disciplinary community of the healthcare chaplain and the disciplinary community of ministerial priesthood (chapter six, figure 6.2: The vocational discourse) and the social community of the NHS and the social community of the Church of England (chapter six, figure 6.3: The institutional discourse). The chaplain does not locate herself within a particular community of practice to the exclusion of others but, as Wenger (2010: 186) describes it, there is a journey across a trajectory of landscapes of practices which contributes to shaping an identity (§2.3.3). While the analysis reveals twelve accounts of that journey, twelve distinct and individual accounts of what identity means in terms of healthcare chaplaincy and Anglican priesthood, the idea of a journey across a trajectory of landscapes of communities of practice highlights something else: the chaplain as ‘betwixt and between’.

Betwixt and between conveys the idea of the chaplain’s ministry as atypical, somehow set apart from a ‘received’ account of ministry which for the Church of England is the parish church (§1.6.2). The atypicality of chaplaincy resonates with Slater (see further in §7.2.1) who finds, in other research, evidence of a dualism that marginalizes chaplaincy as a specialist ministry set apart from the parochial model of ‘Church’ (Slater, 2015: 114). Her proposal is that the many and varied expressions of contemporary chaplaincy are indeed distinct and can be regarded as a genre of ministry (Slater, 2015: xvi). This is an innovative reappraisal of what Oppenheimer (1979:12) calls the greedy concept of ‘ministry’, so described because she claimed it is difficult to distinguish what does, and does not come under the orbit of ministry (§5.4.4).

Nonetheless, I will argue (§7.2.1) that Slater’s grouping of all expressions of chaplaincy into one genre is itself too broad. It would be more accurate to
describe healthcare chaplaincy as a subgenre of Slater’s overall category of chaplaincy. Healthcare chaplaincy has a singular context and a growing depository of research. While Slater acknowledges a narrative of marginality among chaplains, a theme that is replicated in my own analysis (§7.2.2), I will consider (§7.2.3) whether there exists an association between marginality and the reasons which have drawn participants into this specialist ministry. This will focus, in particular, on some participants’ perceived sense of rejection by the Church as against other participants’ perceived calling to engagement with a non-Church context.

Rejection as against engagement brought to mind a comment by one participant, ‘Brian’, about exile and this leads me to reflect on rejection and engagement in terms of exile and diaspora (§7.2.3). There are those healthcare chaplains who are living, figuratively, as priests-in-exile alongside those who are diaspora priests drawn to a ministry in a foreign or alien culture. I go on to explore a difference in attitude between exile and diaspora in Hebrew scripture. Exile emphasizes the enforced nature of the relocation and a tortured longing to return home (Goldstein, 2002: 75), while diaspora is a positive engagement with a new, if alien, environment. Where exile implies loss of home, diaspora suggests a home-away-from-home (Reimer, 2010: 15), an unsettled relationship between where-I-live and where-I-belong (Reimer, 2010: 17). Clearly, it would be mistaken to suggest that those participants who felt driven out of the institutional Church yearned for a return. Nonetheless, the presence of four communities of practice in the participant narratives underlines the complex relationship between ‘where-I-live’ and ‘where-I-belong’, a live issue for all the participants whatever their initial reason for becoming healthcare chaplains.

I go on to explore the relationship between where-I-live and where-I-belong and its bearing on the meaning of marginality (§7.2.4). From its earliest days as a missionary diaspora, Christianity evolved into a series of settled churches which, within the Church of England, gave rise to the parish-based model of Church. Chaplaincy, it has been argued, marks a return to a diaspora or dispersed Church (Slater, 2015: 90). As Epp Weaver describes it: ‘[t]he church in diaspora is called to be a witnessing church, a church that builds houses and
plants trees in the cities of its dispersion even as it remembers Zion and dreams of a future return. Genuine return, meanwhile, is not ultimately a departure from diaspora, the restoration to a pure origin, but instead involves a homecoming in which exile *shapes the meaning of home*’ (Epp Weaver, 2008: 18; my italics). The claim, that chaplaincy has more in common with a dispersed form of Church than with the parish-based model of the Church of England, leads me (§7.2.4) to frame this in the language of modality and sodality (Winter, 1974), a vocabulary familiar to those researching missiology (Metcalf, 2015: 122). The task of modal Church, operating in a settled place, is to sustain what already exists while the task of sodal Church, mobile and deployable, is to grow the Church where it has yet to emerge (Lings, n.d.). I propose that healthcare chaplaincy is an expression of sodal Church and explore, in two particular areas, differences in theological emphasis between the settled, modal Church and the dispersed, sodal Church.

First, drawing on the work of Steddon (2010), I maintain that a modal form of Church incorporates a host theology (‘come and join us doing what we do’) unlike a sodal form of Church which is more likely to practise a guest theology (‘may we join you and be part of what you do?’). Second (§7.2.4), taking Moody’s thesis that, in general terms, pastoral care tends to be motivated by one of two theologies, either redemptive or incarnational, I go on to note that the redemptive-influenced model of pastoral care seems to correspond more closely to a modal approach. The incarnational-influenced model of pastoral care, while seemingly corresponding to a modal approach, may prove to have sodal characteristics. It is Moody’s third way (§7.2.4), his wilderness model, which I will suggest is theologically more disposed to sodal Church, God leading his people into the world-cum-wilderness in order for others to disclose his presence. Here, God is beyond what is already known so making the disclosure of God’s presence unpredictable. This, I will argue, offers fertile ground for the study of healthcare chaplaincy and a theology of priesthood.

However, I will note and critique (§7.2.4) the participants’ use of incarnational language and what this implies about the relationship between the chaplain and the Church. A person who appropriates the vocabulary of incarnational presence does so only insofar as her ministry emanates from and through the
Church, the Body of Christ and Christ’s continuing incarnational presence. Yet, as I will highlight (§7.2.2), some participants talked about marginality and detachment from the Church.

What this marginality might mean and imply I go on to clarify, given the confused way marginality and liminality have been used interchangeably in the literature. In drawing a distinction between the two concepts, I will argue (§7.3.1) that liminality opens up new directions and possibilities in determining the identity and ontology of the NHS priest-as-chaplain. Acknowledging van Gennep’s original study of ritual passage (1960 [1909]), I will expound Turner’s development of liminality and the liminal world as a catalyst for change. For my purposes, what is particularly relevant is the idea of *communitas* as well as the dialectical tension of structure and anti-structure and the precarious place of liminality. As I go on to explore (§7.3.1) the correspondence of liminality and the experience of the healthcare chaplain, I will argue that the chaplain inhabits jurisdictional liminality (Galashan, 2015: 106) which is both a permanent or persistent state and experimental in character (here mindful of the comments made by participants such as ‘John’ who spoke about re-centring or re-working his understanding of ecclesiology).

I go on to elucidate liminality in terms of the healthcare context, exploring four areas. First, there is religious pluralism which typifies the delivery of healthcare chaplaincy (§7.3.2). Liminality is an ambiguous and unstructured state that may make the boundaries of faith more tentative and the proximity of other faiths disarming. This is evident from the comments of a number of the participants and their recognition of commonalities across different faiths. ‘Rita’s’ assertion that God is incarnate in other faiths leads me to scrutinize the spermatikos principle outlined in the Church of England report, *Mission Shaped Church*, and Hull’s criticism (2006:11) of the Report’s authors for their failure to pursue the implications of spermatikos in the context of other faiths and cultures. I will also contend that the Church of England’s Presence and Engagement programme provides chaplains with inadequate guidance.

Second, chaplaincy promotes itself as primarily responsible for spirituality, under which religion is subsumed (§7.3.3). I will question this, drawing on the
evidence of the interviews to demonstrate that participants’ engagement with spirituality is superficial and narrowly couched in their own religious language, beliefs and assumptions. I will claim that spirituality, as a social construct, predictably lacks consensus but that it shares common characteristics with liminality in that it is enigmatic, subtle, intangible, vague and unquantifiable. From the interviews I will argue that what appears to be vitally significant is the spiritual relationship fashioned by the chaplain, and that this bears a marked similarity to the therapeutic relationship which has been shown to improve the patient’s experience (The King’s Fund, 2011). Current research interest focusing on a link between the therapeutic relationship and emotional intelligence will lead me to explore multiple intelligences and, in turn, consider the process model of chaplaincy developed by Mowat and Swinton (2005) which identifies emotional intelligence and spiritual intelligence as core chaplaincy skills. This prompts me to examine whether there might be a link between what I term the spiritual relationship and what Trebilcock (2012) has proposed is ‘liminal intelligence’.

Third, I will consider liminality in terms of healthcare chaplaincy as a professional discipline. I will note the distinctive way participants interpret their professional interactions, which touches on softer, less tangible skills that draw on emotional and liminal intelligence as captured in the idea of semi-professional friendships (§7.3.4). I will suggest that both chaplain and patient share an experience of liminality which provides each with a mutual sense of resonance. I acknowledge that the professionalization of chaplaincy, encouraged by NHS England, has not been without its critics (Moorhead, 2014). I speculate that one driver for the professionalization of chaplaincy has been an awareness among chaplains of the liminality of being ‘outside the established cadres’ (Waaijmann, 2002:214).

Fourth, in recognizing that some participants spoke about being detached from the agenda and priorities of modal Church, and are attempting to refashion an ecclesiology which addresses numerous world-views and identities contained within the NHS, I will ask whether participants are disengaged from mission as the modal Church envisages it (§7.3.5). This will lead me to consider whether the liminal place which the chaplain inhabits is one which prompts the chaplain
to challenge, even defy, the perceptions and conduct of the settled, modal Church, which stands accused of forgetting its own liminal past (Holmes, 1971: 224).

In the final sections of this chapter, I will consider what liminality, *communitas* and sodality contribute to furthering an understanding of the theology, identity and integrity of the Church of England priest. Conceptualizing the identity of the healthcare chaplain as liminal, ministering in *communitas* or sodal Church, offers a hermeneutic framework for developing an understanding of the marginal place of the chaplain, a key theme that emerged from the participant interviews (§7.4.1). On the basis that ordained ministry embodies the identity of the Christian community (Hannaford, 1996: 40), I will explore the association of liminality and the Church as the Body of Christ. I will demonstrate that the Christian roots of liminality lie in a countercultural gospel of self-denial, servanthood and a call to discipleship, which requires transformation in order to be fashioned into a new creation. I will note the corporate life of the early Church with Christians living together and sharing what they possessed (§7.4.2). I will examine the claim by Mason (1992: 70) that the structured, institutional, modal Church is measured by the standards of *communitas* and what this might imply for ministerial priesthood (§7.4.3). I will propose that the vocation of the ministerial priest is to symbolically embrace the liminal life of ambiguity, dissonance and conflict as a person who is in the world but not of the world (cf. John 17). In this way, I claim, the priest serves to recall the Church to its roots in the liminality of the gospel, which requires of the priest a commitment to life-long formation.

In conclusion, I will argue that congruence lies not in an identity but in an ontology which marks the priest as liminal. I draw on the work of Mason (1992: chapter nine *passim*), among others, as I outline what characterizes this ontology of liminality in shaping the priest and her ministry. It is an ontology which is thoroughly Christological in that Christ himself was wholly immersed in the human experience of liminality which, according to the author of the Book of Hebrews (Hebrews 2:17) qualifies him to be High Priest. Liminal intelligence complements and enhances the ministry of the priest not in terms of what the priest does, but who the priest is, what the priest represents and what the priest
brings to life. Priesthood is, as Green (2010: 119) notes, a mobile category capable of re-signification and transformation but, whatever form it takes, I maintain that it is shaped by the liminal experience of divinely-inspired imagination and creativity. As such, there is no formulaic ontology of liminality. Rather, it is an ontology of priesthood which authenticates the courageous, if somewhat precarious, embrace of the unknown.

7.2.1 Ministry and ministries: chaplaincy as a genre of ministry
The literature review revealed the extent to which identity, as a concept, has fascinated psychologists, sociologists, anthropologists, philosophers and theologians although this has produced a contested arena of competing interests and frames of reference. Analysis of the interviews I conducted with NHS priests-as-chaplain, uncovered an interrelationship of vocational and institutional narratives which I interpreted using Wenger’s community of practice as a conceptual and hermeneutic model (chapter six passim). This reinforces the view that identity is an organic phenomenon. Wenger describes a person journeying across a trajectory of landscapes of practices. There is engagement, using both imagination and affiliation, out of which an identity gradually emerges as ‘personalized reflections of the landscape of practices’ (Wenger, 2010: 186). In the participant conversations there were common themes which correspond to the self-meaning or self-understanding which shapes a community of practice and draws others under its influence.

As I immersed myself in the twelve assorted accounts of who and what it means to be a healthcare chaplain, I realized that there were twelve different interpretations of ministry. Each was tailored to a particular healthcare context as well as incorporating a participant’s strengths, skills, experience, theology and models of chaplaincy. Swift (2009: 159) comments that, ‘chaplains have the least systematized form of working of any group in the health service’ despite the fact that chaplaincy is one of the smallest professional disciplines within the NHS. Healthcare chaplains assume responsibility, to some degree or other, for developing their own working practices within the NHS, and this encompasses their values and vision as well as their engagement with language, systems, assessment, audit, learning and collaborative ministry. A job description and person specification merely provide the basic parameters. According to Slater
(Slater, 2015, 99), a chaplain acting with theological and professional integrity needs to have a ‘responsive, proactive entrepreneurial approach’. Although Slater is addressing the wider field of chaplaincy, her comment resonates with my own experience of healthcare chaplaincy, that the professional persona of the NHS priest-as-chaplain is frequently a highly personalized account. There is no one identity which characterizes the NHS priest-as-chaplain. Legood confirms as much when he writes that ‘just as it might be seen as problematic to talk about issues in parochial ministry as if this were a single, homogeneous whole, talking about ‘chaplaincy’ generically is even more complicated, given the wide range of provision’ (Legood, 2001: 256). However, a study carried out by Slater (2013) argued that across a wide range of social contexts such as nursing and care homes, the police, courts, emergency services, the retail industry, the commercial sector and sports clubs, chaplaincy does indeed represent a distinct genre of ministry (see also Threlfall-Holmes and Newitt, 2011: 36).

By genre, Slater has in mind chaplains who ‘are embedded in a particular social context, seeking to understand that context from within while still maintaining their identity as representatives of a faith community and their capacity for prophetic witness alongside pastoral care and service’ (Slater, 2015: 93). Chaplaincy is a specialist area of ministry, and I strongly support Slater in her assertion that chaplaincy, both as a place and identity to inhabit, is complex: ‘not everyone is called to exercise this genre of public ministry and not everyone has the skills or capacity to do so’ (Slater, 2015: 93). Where I would part company with Slater is in her overarching definition of chaplaincy as a genre of ministry. It is too general and too broad. As she recognizes (Slater, 2015: xii), the word ‘chaplain’ has become an umbrella term for anyone undertaking a faith-based ministry in a secular context, referring ‘to informal part-time pastoral visiting at one end of the spectrum to a formalized ‘professional’, contracted and accountable services at the other’ (Slater, 2015: xvi). Within the overall ministry of chaplaincy there are dissimilarities, as well as similarities.

This leads me to propose that, within the general category of chaplaincy, there are subgenres or subcategories, and what informs the practice and identity of these different subgenres of chaplaincy, theologically, may differ. In the context
of healthcare, as the participant interviews illustrate, there may be a focus on health, healing and well-being; on suffering and theodicy, therapeutic practice and Christian ethics, mortality and pastoral care, as well as ‘wounded healers’ and reflective practice. For many healthcare chaplains, there will be no worshipping community because if patients ‘are well enough to attend the chapel service then they are probably well enough to be discharged’ (Threlfall-Holmes and Newitt, 2011: 36). However, one theme which emerged from the interviews and persists across many expressions of chaplaincy is marginality. This will be explored in the next section.

7.2.2 Marginalizing the healthcare chaplain

In tracing the participants’ journeys through a trajectory of four communities of practice, as described above (§7.2.1), there is one common theme: marginalization. As chaplains, some felt they were unfavourably compared to other allied health professions and denied complete recognition as fellow professionals. As priests, some felt that compared to their parish-based colleagues they were derided as ‘failed vicars’ or, in some sense, not ‘proper priests’. As NHS health workers, some believed that, organizationally, their contribution was discounted or overlooked, and even as representatives of the Church of England some considered that the Church treated them with indifference and disinterest.\(^1\) Marginality, in some sense or other, appears to be bound up in the identity of the NHS priest-as-chaplain.\(^2\)

In the literature there is frequent reference to the marginalized chaplain, (Newitt, 2013: 104; Bryant, 2013: 1; Franz, 2011: 124; Threlfall-Holmes, 2011: 138; Ballard 2010: 190; Davies, 20010: 45; Carr, 2001: 25; Orchard 2000: 46;

\(^1\) Jackson, a one-time member of Springboard, the Archbishop of Canterbury’s initiative to encourage, renew and mobilize the Church of England for evangelism, and subsequently an archdeacon, argued for cuts in chaplaincy when he wrote that ‘[t]he core business of the diocese… is the ministry of the parishes. When retrenchment has to happen, then any sensible organization protects its core business where its revenue is raised, and looks to cut its marginal, non-contributing operations’ (Jackson, 2005: 184). Although not directed at healthcare chaplaincy, it demonstrates the priorities of one senior church person and a disregard for the value of chaplaincy.

\(^2\) This is not to ignore the contribution chaplains themselves can make to this sense of marginalization within the NHS. As Swift comments: ‘chaplains have been slow to enter and develop a meaningful presence in the culture of research and development. Most chaplains have a background in the humanities and they are faced with the challenge of working in a culture where a premium is placed on clinical qualities and quantitative processes of enquiry. This is an important consideration within the politics of the hospital as chaplains vie with other staff groups to be a recognised interpreter of the patient’s experience’ (Swift, 2013: 249).
Arbuckle, 1999: 158; Woodward 1998: 91), a marginality which can be ‘communicated in multiple ways, from the structural (e.g. spatial arrangement of hospital space and staff hierarchies that limit chaplain contact with patients) to the ideological (e.g. staff stereotypes and assumptions of chaplains and chaplain[cy] work that limit their inclusion in hospital routines)’ (Norwood, 2006: 16).

For Ballard, this marginality is characterized in the language of the metaphor of the embedded journalist working alongside military personnel in a war zone. These journalists not only accompany a military unit, they live as part of the detachment. Their task, however, is different to those whose lives they record and whose dangers they share. They have a dual allegiance: on the one hand to the military which provides access to news stories and, on the other hand, to those news corporations which provide the means for their stories to be published. This exposes journalists to a range of pressures and responsibilities. During the Iraq and Afghanistan wars, embedded journalism was severely criticized because correspondents, considered independent, ingenuously accepted sometimes absurdly optimistic information about the course of the war from their military minders (Cockburn, 2010).

Negotiated presence does require an element of compromise. For the healthcare chaplain, as an employee, this may potentially jeopardize that prophetic freedom to challenge the priorities, policies and procedures of an NHS Trust or, as ‘Phil’ saw it, to ‘help an institution realize that we are still human... because there’s a stunning sense, in the health service at the moment, that that’s kind of disappearing.’ The chaplain needs to be able to stand back from the immediacy of the context and offer a theological commentary, ‘at times alternatively embrac[ing] or distanc[ing] themselves from competing discourses of religion and medicine’ (Norwood, 2006: 5). It can be too easy to succumb, uncritically, to the expectations and the mores of an organization and to ‘go native’. Striving to meet different sets of expectations in both the NHS and the Church of England epitomizes the dilemma of ‘serving two masters’ (Matthew 6:24).

Living on the edge, as ‘Claire’ described it, can be a place of vulnerability,
insecurity, personal risk-taking and loss. As noted earlier (§6.3.2), chaplains are not detached observers to the brokenness that surrounds them, nor insensitive to institutional estrangement. In what follows, I examine what may have drawn participants into this lonely and challenging role and how this informs their sense of identity.

7.2.3 Marginality understood and interpreted as exile and diaspora
Exploring the nature of marginalization and, in particular, its impact on the identity of the NHS priest-as-chaplain, I turn to the biblical theme of exile. On asking participants about scriptural passages which resonated with their experience of healthcare chaplaincy, ‘Brian’ spoke about exilic literature from the Hebrew Bible. He likened episodes of illness, including his own, to exile. This left me wondering whether, at some unspoken level, the identity of the healthcare chaplain is predominantly one of exile from the institutional Church: a chaplain who has been driven out of stipendiary ministry by the demands and expectations of the local Church; or while practising in the context of the NHS, a chaplain who experiences the Church’s indifference or apathy towards a healthcare ministry, and perhaps elects to distance themselves from the oversight or jurisdiction of the Church in so far as this is possible. Bryant (2013: 36) considers exile a primary trait of the healthcare chaplain while Swift attributes this sense of exile among chaplains not only to the Church’s preoccupation with issues related to human sexuality, but to a shift in the Church’s focus from pastoral care to one of mission (Swift, 2014: 182), a trend that has been gathering momentum over a number of years. Swift believes that this change in emphasis is yet another indication of the Church’s disengagement from the theological and pastoral demands and ambiguities that the healthcare chaplain faces on a day-to-day basis.

There are, of course, additional reasons. As mentioned earlier (§2.3.2), a survey carried out among Church of England healthcare chaplains in 2007 revealed that many of them, so-called ‘refugees’ from the Church, felt estranged not only because of their liberal or radical views but because of their personal

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3 In 1995, the Church of England’s National Officer for Evangelism was critical of the Church’s tendency to operate in pastoral mode when what was needed, in computer terminology, was a mission-focused operating system to open up what he foresaw to be new possibilities (Warren, 1995 cited by Castle, 2004: 14; cf. §2.3.4).
vulnerability or exposure given the Church’s stance on issues of human sexuality (Hancocks, Sherbourne and Swift, 2008). As Swift comments, ‘it is not surprising that a group of clergy which sees itself as largely disadvantaged by the churches’ exemption from employment law (regarding equality) should be doubtful about the wisdom of leaving the fate of chaplaincy in the hands of an institution about which they feel so ambivalent’ (Swift, 2014: 74).

Among those I interviewed, it was plain that chaplaincy had provided a route out of the institutional Church but I was left wondering whether this was an exodus or a self-imposed exile. Comments about parish ministry demonstrated variable degrees of anger, disappointment, frustration and ambivalence similar to Woodward’s findings noted in his research (1998: 155). For ‘John’, the job of team vicar had been a complete nightmare while ‘Phil’ believed parish life was responsible for his diagnosis of reactive depression. After only one year as an incumbent, ‘Andy’ was so crushed that he never envisaged a return to ministerial priesthood. There was also criticism, resentment and despair directed at the Church more generally, an indictment which ‘Hugh’ attributed to the Church having lost its way, and which others ascribed to the structural and systemic problems that, in their view, had left the Church dysfunctional. A significantly different perspective was offered by ‘Sarah’ who declined to be held accountable or regarded as an apologist for God’s ‘indefensible’ actions. In fact, ‘Sarah’ was not alone in voicing what might be described as a dissident approach to Christianity. Along with ‘Phil’ and ‘Claire’, ‘Sarah’ was drawn to Buddhist teaching and practice, ‘John’ was prepared to accept a ‘less rigid sort of dogma’, ‘Nigel’ confessed to having ‘lost the plot’ while ‘Brian’ was content to live with ‘inconsistencies’. All this may seem to reflect a more relaxed attitude to faith, but as Kirk argues, ‘[p]astoral identity emerges from the source to which one adheres and is the foundation from which one makes decisions about life and functions. Identity is in peril if one loses confidence in one’s system of convictions and values (Kirk, 2011: 40). I was left to conclude that among certain participants, it was self-imposed exile, although the extent to which this was ‘largely constructed by the Church’ (Swift, 2014: 182) would require further investigation.
Then again, not all participants perceived themselves to be refugees from the Church. There were others for whom a *diaspora* model more accurately describes their decision to transfer into the NHS.\(^4\) The difference between exile and *diaspora* in Hebrew scripture is one of attitude. Exile emphasizes the enforced nature of the relocation, which more closely reflects the experience of those chaplains who find ‘the tone and direction of the Church to be at odds with their theological convictions and pastoral priorities’ (Swift, 2014: 74). At the same time, it also features a tortured longing to return home (Goldstein, 2002: 75). Clearly, it would be mistaken to suggest that those participants who felt driven out of the institutional Church necessarily yearned for a return although this sense of longing might be still present.

In contrast, living in *diaspora* is not necessarily a negative experience. Driven into exile in Babylon at the beginning of the sixth century BCE,\(^5\) the ideological crisis for the kingdom of Judah cannot be overstated. The pillars on which the identity of the people rested, i.e. king, temple and land, had been destroyed (Römer, 2000: 117). The conditions and challenges of exile in Babylon, and the realization that this would not be a brief sojourn meant that there was a need to reinvent an identity as a community detached from an ancestral homeland living in *diaspora* (Nicholson, 2014: 50f.). Over the next five centuries, Palestinian Judaism was notable for its ‘apocalyptic dreamers, messianic claimants, zealots, revolutionaries and mystics’ (Cohen, 2008: 23) while in Babylon and elsewhere, ‘Judaism thrived in engagement, encounter, emulation, competition and the cut and thrust of religious and intellectual debate’ (Cohen, 2008: 24). Cohen argues ‘that though the word Babylon often connotes captivity and oppression, a re-reading of the Babylonian period of exile can be shown to demonstrate the development of a new creative energy in a challenging, pluralistic context outside the natal homeland’ (Cohen, 2008: 24).

Consequently, some of those in *diaspora* came to forge a new self-identity as

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\(^4\) The word *diaspora*, is taken from the Septuagint translation of Deuteronomy 28:25. The last phrase of this verse reads ἔσῃ ἐν διασπορᾷ ἐν πάσαις ταῖς βασιλείαις τῆς γῆς which is generally translated ‘you shall be dispersed into all kingdoms of the earth’. Judaism, it may be argued, adapted to *diaspora* (by creating synagogue worship) in a way that the psalmist exiled to Babylon found impossible cf. Psalm 137, a bitter prayer of resistance.

\(^5\) Besides a brief reference to the first capture of Jerusalem, in 597 BCE, found in the Babylonian Chronicles (Wiseman, 1956: 73), the only source material is the Hebrew Bible where there is disagreement over the number of victims as well as the number of deportations. 2 Kings reports two deportations and the Book of Jeremiah reports three (Moore & Kelle, 2011: 357f.).
well as a new religious identity based on a theology of salvation rather than a theology of judgement.\textsuperscript{6} The exiled community faced marginalization, but, as a diaspora community, cultural accommodation enabled them to survive and even flourish while retaining a distinctiveness (Halvorson-Taylor, n.d.). Exile implies a sense of loss while diaspora suggests a home-away-from-home (Reimer, 2010: 15), an unsettled relationship between where-I-live and where-I-belong (Reimer, 2010: 17).

This is a helpful analogy for a number of reasons. First, it reinforces the point I made earlier, that the disciplinary community of healthcare chaplains is not a homogeneous group. It comprises those who are living, metaphorically, as priests-in-exile alongside those who are diaspora priests. Second, the presence of four communities of practice in the participant narratives underlines the complex relationship between where-I-live and where-I-belong, a continuing issue for all the participants whatever their initial reason for becoming healthcare chaplains. Third, the relocation from parish ministry into NHS chaplaincy was, for some participants, a positive response to God’s call to live a ministry that signals a diaspora or sodal ecclesiology, and this I now explore in the next section (§7.2.4).

7.2.4 Healthcare chaplaincy: a sodal ecclesiology

The early Church experienced its own diaspora when, facing the challenge of persecution in the first century CE, it became scattered, initially throughout the countryside of Judea and Samaria, then to the great cities of Damascus and Antioch.\textsuperscript{7} Thus, the pattern of a dispersed Church was born.\textsuperscript{8} The Church of

\textsuperscript{6} What I mean here by a theology of judgement is that exile is cast within the biblical narrative of sin, the consequential banishment of humankind from the Garden of Eden and the expulsion of Israel from its land (Alexander, 2008: 32). In contrast, I understand a theology of salvation to be a positive narrative signifying Israel’s ultimate vindication and restoration (Hiers, 1992: 82-83).

\textsuperscript{7} Acts 8:1, 4-8; 11:19-21.

\textsuperscript{8} The Church in Jerusalem comprised both Jews and Hellenists and, according to Bruce (1964: 8), the first persecution and Christian diaspora following Stephen’s death (Acts 8:1) was probably directed at the Hellenist faction to which Stephen had belonged. In dispersion, it was this Hellenist faction which began to engage in a programme of active Gentile evangelisation. When the Jewish revolt against the Roman authorities, in 66 CE, led to the dispersion of the Jewish faction (who, in Jerusalem, had been tolerated by the Jewish authorities) in diaspora they were perceived as apostates by orthodox Jews and as theologically deficient in relation to orthodoxies developing in Pauline and Johannine communities (Bruce, 1964: 11). Living in the Transjordan and Egypt, these Jewish Christians continued to call themselves the Jerusalem Church before, by the seventh century CE, being absorbed into Jewish or Christian orthodoxy, or succumbing to the spread of Islam.
England, for its part, is shaped by a different ecclesiological model, one which it inherited from the pre-Reformation Church. It is the settled faith community which is geographically located and reflects the historic Christianity of European Christendom: a partnership of Church, State and society symbolized by the parish church at the centre of every village, town and city. It is an ecclesiological model that has enabled the Church to retain a position of privilege and protection, a position that has profoundly affected its institutional and intellectual character and, in its wake, has left a history of cultural compromise, and even captivity (Heron 1980: 168; Guder, 2015: 80). It is a model which, as the evidence of this research demonstrates, does not readily accommodate the subgenre of healthcare chaplaincy.

Nonetheless, while the mind-set and attitudes of Christendom still flourish in many churches, as well as in national ceremonial occasions and public culture, it is claimed by some that the age of Christendom is drawing to a close (Murray, 2004; Guder, 2015: 78). Christianity has been pushed to the margins of a culture that is increasingly secular, pluralistic and disconnected from the institutional Church. The latest statistics from the British Social Attitudes survey for 2015 reveal that of those questioned, forty-eight per cent identified with no religion. The percentage of Anglicans has fallen from twenty-six per cent in 2005 to seventeen per cent in 2015 (Wyatt, 2016). The parish model of ministry has failed to halt this decline.

Chaplaincy, however, is a style of ministry which defies this negative analysis, having developed and grown (Ryan, 2015: 8; Pattison, 2015: 14). It has proved itself adaptable to a variety of secular contexts and has extended the social reach of the Church. Steddon (2010) attributes this to the fact that chaplaincy is rooted in a different ecclesiology. It is a way of ministering which reflects a dispersed model of Church engaging with post-Christendom attitudes and with people who have little inclination for institutional church life? Rather than what

9 There is no settled account of what shape an ecclesiology of the dispersed Church might take. Heywood’s reference to the dispersed Church (Heywood, 2011: 110) is, like many, lacking clarity. Slater is a little more specific when she writes that chaplains ‘can be understood as the dispersed Church, intentionally fulfilling its vocation as people called and sent to serve and witness in the world’ (Slater, 2015: 89f.). My own view is that the concept of the dispersed Church has much in common with the diaspora which took place in the five centuries following the Babylonian exile especially, as I wrote earlier (§7.3.2), in its need to reinvent an identity as a
Steddon (2010) caricatures as a ‘host’ theology, which ‘Vanessa’ may have had in mind when she talked about ‘waiting for [people] to come to the Church for a reason... them searching us out’, arguably a dispersed model of Church has more in common with a ‘guest’ theology which attends to where God is present and active in Creation. A dispersed Church, in discerning God’s presence in the world, looks for ways to partner God’s creative and redemptive purposes. This resonates with two comments from ‘Brian’: that as a chaplain he had been ‘called to be faithful to something which is beyond the Church’ and was in the business of ‘trying to make known the God who is already present’. It is a perspective which is further developed in Moody’s wilderness model (1992: 12ff.) to which I will turn later in this section.

Heywood believes that there is ‘the need to re-evaluate and perhaps re-write traditional ecclesiology, the doctrine of the church. Whereas traditional ecclesiology tended to focus on the life of the gathered church, an ecclesiology of our time and context will balance this with a focus on the dispersed church’ (Heywood, 2011: 110). Unfortunately, terms such as ‘gathered’ and ‘dispersed’ present their own conceptual difficulties. So, for example, the ‘gathered Church’ has been associated, historically, with a Church polity of Congregationalism. Emphasis is laid on the autonomy and independence of the local Church with final authority for decision making resting within the gathered congregation. Anglicanism, for its part, knows a different form of Church governance which ‘does not lend itself to the gathered church model but to the ‘church in community’ type of ecclesiology’ (Avis, 2007: 71). Again, while the term ‘dispersed Church’ seems straightforward, and indeed connects to the experience of the early Church, it is problematic. In an earlier footnote (fn. 8), I described how the dispersion of the early Church was less than straightforward, and arguably this remains the case for contemporary understandings of ‘dispersed Church’. So, for example, Moynach (2012: ix-xiii) writes about the development of what he calls ‘new contextual church’. This includes church plants, emerging church, fresh expressions and communities in mission, as well

community detached from its ancestral homeland. I would hold that its ecclesiology remains a work in progress.
as new monasticism which ‘as a whole defy easy definition’ (Moynach (2012: xiv).

For this reason, I prefer to use a different ecclesiological language, one which is both anthropological and missiological. Developed by Winter (1974), it introduced the vocabulary of modality and sodality. Together, these provide a ‘wonderful tool which works elegantly with the twinned dynamics of continuity and change that are rooted in the Incarnation and Christology’ (Lings, no date: paragraph 2). Modal Church is settled in place and temperament: pastorally supported and mutually supportive it demands little by way of commitment from its membership. In many ways it is a form of ecclesial community which conforms to how most people understand the Church. Complementing this is sodal Church (from the Latin, sodalis, which translates as intimate, companion, comrade). Mobile and deployable, it expects a greater level of commitment from a much smaller group in its task of growing the Church where the Church has yet to emerge (Lings, n.d.). Sodal Church might appear exclusive and even blinkered, but it can assist and enable the wider Church to re-discover and re-express its true missional nature, calling and ministry. Each is fully and properly part of the Church. Indeed, functionally, each can be traced back to the first century CE (Winter, 1974: 6). The organization and worship of the early Church was developed out of Jewish synagogue life and, functionally, is a modal model. Alongside this, Christian missionary activity was based on the khevra, a Jewish proselytizing band (cf. Mt. 23:15): functionally, a sodal model. The two partner one another. Sodality pioneers what modality then sustains and modality provides those resources which enable sodality to flourish and be sustained. It is a bi-focal vision and an example of the mixed economy of Church provision to which Williams (2011) has drawn attention.

As I studied the characteristics of sodal Church, I became conscious of a partial correspondence with liminality and communitas which I explore later in this chapter (see §7.3.1). Sodality is a call to risk-taking which can strain its relationship with modal Church. If the two are unable to manage this tension, there is the threat of imposed heterodoxy and severance. Alternatively, if the tension can be constructively negotiated, sodal Church may act to renew and to reinvigorate the life of modal Church. As Walls has written:
From age to age it becomes necessary to use new means for the proclamation of the Gospel beyond the structures which unduly localize it. Some have taken the word ‘sodality’ beyond its special usage in Catholic practice to stand for all such ‘use of means’ by which groups voluntarily constituted labor together for specific Gospel purposes. The voluntary societies have been as revolutionary in their effect as ever the monasteries were in their sphere. The sodalities we now need may prove equally disturbing. (Walls, 1996: 253f.)

Healthcare chaplaincy, then, may appear to conform to a sodal style of Church and a guest theology, but there is a further distinguishing mark and this relates to the delivery of pastoral care.

In his critique of the pastoral role exercised by church leaders, Moody (1992: 7-12) believes that pastoral care, as a ministry, lacks clarity and that it tends to stem from two different theological models: redemptive and incarnational. The redemptive model, which has more in common with modal Church, operates on the premise that the Church is the saved community at work in a fallen world which consists of those who are unsaved.\(^\text{10}\) The Church is the focus and agent of God’s gracious activity intent on redeeming and restoring humanity. Its evangelical work is intent on leading people to Christ for the salvation of their souls. In contrast, while the incarnational model recognizes the Church as the sign of God’s presence, most especially in its worship, God’s presence and providence is not confined to the Church. The role of the Church is to reveal the presence of God in the mundane and everyday aspects of human life, both personal and communal, through pastoral ministry and prayer. This is an approach which still seems aligned to modal Church thinking though incorporating sodal features.

Both models have strengths but are also susceptible to distortion. So, for example, the redemptive focus on pastoral care, as an instrument of pre-evangelism, may undermine the integrity of the pastoral relationship because, in a sense, it is offered conditionally: what some pejoratively call ‘rice Christianity’. A further complication is that membership of the Church, as the saved community, may become an end in itself. In other words, this may signal an

\(^{10}\) Cf. John 17: 14-15.
over-realized form of eschatology (Dodd, 1935; von Wahlde, 2013) which regards the purposes of God as fulfilled in the Church of the present day (MacDougall, 2015) rather than the Church being ‘both an instrument and sign of the promise of the Kingdom and an anticipation of its fulfilment’ (Hannaford, 1996: 47; italics in original).

Equally, an incarnational focus may draw too sharp a distinction between pastoral care and other aspects of the Church’s mission, such as evangelism, as was evident from my participants’ comments. Insufficient attention may be given to revelation; that under God’s providence, creation is moving towards the restoration of its true nature and, for humanity, God is met in the Risen Christ, the Lord of the Church. The pastoral image of the suffering Christ may divert attention away from the revelatory image of the exalted Christ. The crucial observation that Moody makes (1992: 9), certainly evident from my own research, is that the incarnational model becomes more prominent the greater the distance separating ministerial practice from the institutional church. In every interview, participants either specifically mentioned an incarnational model of chaplaincy guiding their ministry or, more obliquely, identified themselves with the ministry or person of Christ.

This presents a further complication. Adopting an incarnational model of ministry, one in which the spiritual care giver identifies with Christ, may reflect an internally-driven need to legitimize a ministry practised on the margins of the Church. ‘Mary’ spoke about ‘Being present as Christ in any given situation.’ It is, undoubtedly, a powerful image but one which may be self-serving. For example, it may act as a defence mechanism against the powerlessness a chaplain may experience in the presence of severe illness, injury, death and bereavement. The power and credibility of Christ may defend against feelings of personal vulnerability, whereas an authentic incarnational model of ministry acknowledges that it is the Church which is the body of Christ and which serves as Christ’s continuing incarnational presence. A person, such as the NHS priest-as-chaplain, who appropriates a model of incarnational presence, does so only inasmuch as it is a ministry flowing out of God’s continuing and incarnational presence in and through the Church (Anderson, 1984: 241f.).
The deficiencies in these two models, the redemptive and the incarnational, lead Moody (1992: 12ff.) to propose a third, the wilderness model, which explores the relationship between the world and the Church. Moody likens the world to the wilderness, a place of conflict and disclosure, home to the demonic and the divine. The world-cum-wilderness is where human leadership is tested, as Jesus himself learned,\(^\text{11}\) and where it can be found wanting, as Moses discovered.\(^\text{12}\) Human leadership is for discerning and disclosing the presence of God. Any authority it may exercise is only ‘lent’ by God: ‘spiritual authority hovers over particular people and particular functions, but it is not exclusive to them. They are foci, not containers, for an authority which God shares with his people as they obey his summons to come with him into the wilderness of the world’ (Moody, 1992: 14).

God’s call to evangelism and pastoral action is, as Moody interprets it and I describe it, a paradox. God leads his people into the world-cum-wilderness in order for others to disclose his presence.\(^\text{13}\) There are no clues in the world-cum-wilderness as to God’s whereabouts other than those which have been learned within the community of faith. God is beyond what is already known, which means that any disclosure of God’s presence will incorporate the unexpected. As a pilgrim Church growing in faith and knowledge, Moody insists that the goal of evangelism and pastoral care is ‘not to gather people in and keep them in one place, but to nurture them and keep them on the move’ (Moody, 1992: 13), which seems indicative of sodal Church.

In this, Moody seems set on energizing and radicalizing the modal Church in order that it may provide the necessary resources that enable an accompanying sodal style of Church to flourish and be sustained. It is a five step programme. First, re-envisioning leadership, and the spiritual authority accompanying leadership, as vested not in the hierarchical structures of the Church or in personal attributes, experience or professional standing, but in the people who respond to God’s call to accompany him into the world-cum-wilderness where they share God’s authority as God determines (Moody, 1992: 14). Second, re-

\(^{11}\) Matt. 4:1-11.
\(^{12}\) E.g. Num. 20:2-13.
\(^{13}\) This calls to mind a description of pastoral care as a conversation that proceeds from the Word of God and leads to the Word of God (Thurneysen, 1962: 101).
directing the Church’s attention to the world-cum-wilderness as the place where God discloses himself in ways which are unforeseen and unexpected (Moody, 1992: 13). Third, redrawing the demarcation line which separates organized and non-organized religion (Moody, 1992: 110). Fourth, reasserting the faithfulness of the parish priest to her own calling over and above professional identity and function’ (Moody, 1992: 46). Fifth, reaffirming that the effectiveness of the ordained person is dependent on the recognition bestowed by a community of faith, and crucially ‘the context created by shared belief. If belief is not present, the pastor’s role disappears or is distorted’ (Moody, 1992: 49).

In this section, I have developed parallels between chaplaincy and *diaspora* which I introduced in a previous section (§7.2.3). As I further develop this in the next section, drawing on the language of liminality and *communitas*, a comment by Epp Weaver, to which I referred earlier (§7.1.1), seems particularly apposite: ‘[t]he church in diaspora is called to be a witnessing church, a church that builds houses and plants trees in the cities of its dispersion even as it remembers Zion and dreams of a future return. Genuine return, meanwhile, is not ultimately a departure from diaspora, the restoration to a pure origin, but instead involves a homecoming in which exile *shapes the meaning of home*’ (Epp Weaver, 2008: 18; my italics).

**7.3.1 Liminality and *communitas***

Earlier in this chapter (§7.2.2), I discussed the marginal place the healthcare chaplain occupies, located at the edge of the communities to which they relate. This led me to explore why participants might have been drawn into the field of healthcare ministry. As exiles from modal Church or as entrepreneurs of a dispersed or sodal Church, chaplains are displaced people. They are at one remove from the structures and governance of the Church of England and from the collegiality of parish-based clergy. They are employed by the NHS but, in language reminiscent of Hauerwas, the NHS might be described as ‘a culture which would not merely be unable to contemplate a visible Christian presence such as chaplaincy as a central goal but, indeed, stands opposed to the values of the Christian ‘colony’ (Ward, 2003: 40).
In published literature there is frequent mention of the marginality and liminality of the healthcare chaplain but, as Threlfall-Holmes and Newitt (2011: xv) point out, there is often a failure to draw a distinction between the two words, which are regularly used interchangeably. Marginality focuses on the experience of the chaplain ministering at the periphery of a community, be it the Church or the NHS. Liminality has a different and distinct meaning which has not been fully explored or, in some cases, understood in the literature on chaplaincy. This is regrettable because I think the concept of liminality opens up new directions and possibilities in any discussion about the identity and ontology of the NHS priest-as-chaplain. A brief but necessary digression will explain this.

Liminality, as a concept, was introduced into early twentieth century anthropology by van Gennep. His interest in transitions led him to single out *rites de passage* as a distinct ceremonial type consisting of three stages: separation from the community (preliminal), rites of transition (liminal) and rites of reincorporation (postliminal). It was the middle stage, which van Gennep delineated liminal (1960 [1909]: 11) that, more than fifty years later, caught the attention of Turner when he stumbled across van Gennep’s work and realized the potential of the concept of liminality. Not only does liminality highlight the importance of transitional or ‘in-between’ moments, it provides a way of understanding human reactions to liminal experiences e.g. how personality can be shaped by liminality, the crucial part played by human agency, and the sometimes dramatic interrelationship of thought and experience. Liminality does not, and cannot, offer an explanation, nor does it specify a particular outcome, but it is a latent force for impending change in what will be the postliminal experience. The liminal world is one of contingency in which events, ideas and even reality itself can be carried in sundry directions. Recalling my earlier comments (§2.3.3) about the dialectical relationship between structure and agency, with the one acting upon the other, in liminality the relationship between structure and agency is not easily characterized or necessarily understood. Liminality focuses attention on that moment of transition from one structured

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14 The distinction between marginality and liminality is examined more closely later in this chapter (§7.4.1).
15 Starkloff (1997: 646) observes that the complexity of Turner’s ethnological and philosophical ideas, published over the course of many years and in a non-chronological order, can make their unravelling a challenging endeavour.
pre-liminal world-view to another post-liminal world-view. Liminality acts as a catalyst for change and provides potential for fresh modelling in the field of social theory (Thomassen, 2009: 5).

Liminality can also engender communitas. In his study of Christian pilgrimage, Victor Turner (working in collaboration with his wife, Edith) believed it to demonstrate a shared sense of liminality (Turner and Turner, 1978: 105). When pilgrims separate themselves from the everyday structures and the social identities of their pre-pilgrimage lives, and take on a common status as pilgrims, it is then that they create communitas, a corporate liminal space: a ‘direct, immediate and total confrontation of human identities’ (Turner, 1995: 132).16 Communitas enables people to interact in an unrehearsed, instantaneous and tangible way as opposed to the rule-governed, institutionalized, abstract social structures.17 It represents a release from structure and can be exploratory, generating metaphors, symbols and philosophy (Turner, 1995: 133). To those who have a vested interest in preserving the structural status quo, communitas will be regarded as dangerous and anarchical, necessitating prescription and prohibition (Turner, 1969: 109). However, over time, communitas may develop its own ordering characteristics (Jorgensen, 2008: 57) in which the spontaneous and forthright exchange between individuals is converted into rule-governed relationships18 though without the status and hierarchy found in more settled structure. This does not imply that communitas is unstructured. Rather, it is a state of anti-structure (cf. Turner, 1994: 45) in dialectical tension to structure. While communitas is ‘the fons et origo of all structures’ (Turner, 1978: 250), its primary role is to critique (Turner, 1994: 233) and revitalize (Turner, 1995: 129) the structure from which it has emerged.

Liminality, as that phase within which questions of ‘who am I?’ and ‘what am I for?’ occur, strikes a chord with the countercultural nature of the Christian

16 Turner (1974: 97) held that communitas was not only a state of liminality but encompassed ‘outsiderhood’ and structural inferiority. These will be addressed later in this chapter.
17 This understanding contrasts with the work of another anthropologist, Lévi-Strauss, who conceived structure to be an internal cognitive process.
18 Turner identifies three stages of communitas. Chronologically, these are existential or spontaneous communitas; normative communitas (whereby, given time, resources are marshalled and organized, social control among participants is exerted which leads to an enduring social system) and ideological communitas which are utopian models of societies based on existential communitas (Turner, 1969: 132).
gospel. Mason asserted (1992: 69) that as anti-structure and liminality are not co-terminous, there is the potential for every institution, including the Church, to be both structural and anti-structural. The structure of the Church, Mason maintained, is followed, shadowed and haunted by the anti-structure of Christian *communitas*. The Church would appear to conform to the Turners’ definition of structure: ‘the patterned arrangements of role sets, status sets, and status sequences consciously recognized and regularly operative in a given society and closely bound up with legal and practical norms and sanctions’ (Turner and Turner, 1978: 252). The anti-structural demand of the Christian faith, Mason insists, ‘must be seen as pointing to a fruitful *union* of structure and anti-structure if it is in fact taken as a demand laid upon the church’ (Mason, 1992: 70). For the Church, it is not only the case that ‘[t]he ultimate desideratum... is to act in terms of *communitas* values while playing structural roles’ (Turner, 1978: 166), the Church needs to be judged by *communitas* standards (cf. §7.4.3).  

This might be interpreted as implying ‘the suspension of social differences, the abandonment of hierarchy, mutual subjection, mutual obedience, the willing acceptance of pain and disadvantage, the stripping off of marks of distinction even to the point of actual nakedness, isolation from daily life, homelessness, hunger, uncertainty as to past or future... the nothingness out of which new substance is to be created’ (Mason, 1992: 71).

What bearing, then, does this have on those references to liminality which appear in the literature on chaplaincy? What does it mean to suggest that the chaplain operates in the liminal space both between Church and medicine and between life and death (Swift, 2014: 127)? In what way might pastoral supervision enable the chaplain ‘to inhabit and embrace their liminality’ (Paterson, 2015: 149)? What sense is to be made of the claim that ‘healthcare chaplaincy resides in a state of jurisdictional liminality which is derived from the fact that it has detached itself from its origins within the sphere of religious control, but has yet to find secure moorings in secular frameworks of organisation’ (Galashan, 2015: 106)?

19 An interesting paper by Lemons (2015) explored the way Jesus used a meal as a ‘*communitas*’ experience to redefine who was included within God’s reign, recapturing the original understanding of the Abrahamic covenant to be a blessing to the margins of society.
Turner writes explicitly about liminality as some kind of ‘original state’ out of which everything is born, a formless reality out of which forms emerge. It is the beginning of everything (1967: 97) in which nothing can be assumed save uncertainty. As for liminal personae, threshold people, they are by nature ambiguous because they ‘slip through the network of classifications that normally locate states and positions in cultural space’ (Turner, 1969: 359). To this, Waaijman adds:

It is no unmixed blessing to be in this phase, since those who are in it are literally nowhere; outside the established cadres, outside of any time frame. Death, darkness, and nothingness prevail here. Liminal entities are tabulae rasaee, without possessions, passive. Yet there is a current of life here: creativity, community, equality, vital energy, insight and imagination, wholeness, naturalness. Liminality is marked by the continual alternation between death and life. Liminal entities experience the extremes of being valued and the most intense experiences of being devalued. (Waaijman, 2002: 214)

This is a description which, alongside the idea of liminal personae, appears to mirror the experience and self-identity of participants and characterizes chaplaincy. So, for example, ‘John’ discloses that ‘being in the NHS and a sort of representative of a faith community... can be a place of uneasy tension, but also a place of creativity.’ That balance between stressful uncertainty and imaginative resourcefulness is a feature of liminality. Immersed into the ‘formless reality’ which constitutes liminality, it is almost inevitable that a chaplain will scavenge for a safe mooring especially in the light of ‘the clearly dangerous or problematic aspects of liminality’ (Thomassen, 2014: 83). Nonetheless, insecurity itself ‘can breed renewed self-awareness and questioning which, if it is not paralysing, can lead to ministry which is fruitful, relational, adaptive and compassionate’ (Swift, 2014: 172).

However, I am particularly engaged by Galashan’s depiction (above) of chaplaincy inhabiting jurisdictional liminality for I consider this goes to the heart of my thesis. Having argued that healthcare chaplains are closer in theology and practice to a model of sodal Church (§7.2.4), I think Turner’s concept of liminality captures the sense of dislocation that participants, and indeed
chaplaincy as a disciplinary community, experience. They are ‘betwixt and between’ the modal Church, a model of Christian witness centred on the settled life of a parish, and some future Church which is yet to emerge.\textsuperscript{20} Galashan’s notion of jurisdictional liminality is characteristic of the disciplinary community of healthcare chaplains and resonates with both Turner’s notion of \textit{communitas} and Winter’s concept of sodal Church. What I would maintain differentiates the \textit{communitas} of chaplaincy from the \textit{communitas} of sodal Church is that in the existential \textit{communitas} of chaplaincy the threshold person i.e. the chaplain, finding common cause with other threshold people i.e. other chaplains, forms a disciplinary relationship of \textit{communitas}. In the \textit{communitas} of sodal Church, a ready-formed group may intentionally re-locate itself in a liminal place i.e. where the Church is absent, and the relationship of \textit{communitas} (reminiscent of the \textit{communitas} of the early Church and thus normative) may begin to evolve before the group separates itself from its ‘parent’ root or group (cf. Starkloff, 1997: 665).\textsuperscript{21} Nonetheless, as a corporate liminal space, both the existential \textit{communitas} of chaplaincy and the normative \textit{communitas} of sodal Church build on the insights offered by Wenger’s model of communities of practice and, as I will demonstrate (§7.4.1), deepen an understanding of the identity of the healthcare chaplain.

The genre of chaplaincy is part of a sodal or dispersed Church (Slater, 2015: 89f.) and the theology and practice of healthcare chaplains does signal this (Heywood, 2011: Steddon, 2010; Hough, 2010: 110; Shaw, 2004: 92f.; Strudwick, 2001). As a genre of ministry, chaplaincy offers a vision of being Church which, as ‘Claire’ put it, is different from [modal] Church but is still an authentic and faithful representation of Church. It invites a fresh appraisal of ecclesiology

that relie[s] less on religious establishment and more on entrepreneurial public engagement... in order to discover and articulate where God is at work in civil society (as well as where God’s grace is frustrated by human action, or inaction). This would in turn require an active suspicion of some of the dualisms at work in contemporary church and society – distinctions between:

\textsuperscript{20} As Rohr (1999: 132) describes it ‘betwixt and between [where] the old world is left behind, but we’re not sure of the new one yet.’

\textsuperscript{21} However, see my later comment (§7.4.1) in which I suggest that this is an unnecessary distinction.
public and private; religious and secular; sacred and profane; spiritual and material... It would also involve a seriousness about dialogue and cooperation; about making common cause with others committed to the good of society, including those of other faiths and beliefs. (Todd, 2011: 14)

As for Turner’s claim that ‘sustained manifestations of *communitas* must appear as dangerous and anarchical’ (Turner, 1969: 109), I would cite Swift’s observation that ‘it is hard to avoid the impression that the Church does not want to hear the experience of the chaplains: it is too difficult, too marginal and too raw’ (Swift, 2014: 182). Healthcare chaplains, liminal pilgrims at one remove from the immediate discipline and authority of the Church of England, pose a challenge, if not a threat, to those whose role it is to maintain the integrity of modal Church, ‘for those striving to present uniformity and ecclesiastical cohesion’ (Swift, 2014: 159).

It is even more contentious if, in its accommodation of faith diversification, healthcare chaplaincy transcends specific religions and, instead, ‘embodies and commends many of the sacralities of contemporary society’ (Pattison, 2015: 18). Galashan describes this as ‘the unique paradox of the contemporary chaplain: a person identified by her faithful adherents to one particular religious tradition, tasked with ministering to the spiritual needs of a multitude comprising of all faiths and those with no (and no traditional) faith’ (2015: 103). The literature review confirms this (§1.6.1); that chaplaincy has reconfigured itself around two key issues: an inclusive multi-faith philosophy and an all-embracing spirituality. To what extent, then, has liminality, in the guise of *communitas* or sodal Church, played a part in determining the direction of chaplaincy and influenced the identity of the healthcare chaplain? In answering this question, I will investigate four key areas: religious pluralism, spirituality, professionalization and mission. The next section investigates the first of these: liminality and religious pluralism in the work of the healthcare chaplain.
7.3.2 Liminality and the context of religious pluralism in healthcare chaplaincy

In the interviews, all but one participant spoke about the importance of multi-faith care. This ranged from a general awareness and readiness to respond to multi-faith need through to close working relationships with colleagues and patients of other faiths. In liminality, the boundaries of a person’s faith may become tentative and proximity to other faiths disarming. Kollar (2016: 18) goes further arguing that anyone who engages in interfaith dialogue will, in all probability, undergo a series of identity-changing events. Earlier (§7.3.2), I referred to ‘Phil’, ‘Claire’ and ‘Sarah’ who had developed an interest in Buddhist teaching and practice. When I asked ‘Rita’ about the nature of the theological relationship which, as a chaplain, she had with her Roman Catholic and Free Church colleagues, she wondered why I had failed to ask the same question with regard to her Muslim colleague. I deferred this to the end of the interview when I learned that ‘Rita’ was conscious of much that they shared, especially in the Imam’s description of his servant role. What was particularly striking was her comment that ‘people tend to look at the differences... and fail to recognize that we share an awful lot too...I mean in the broader context of being children of God rather than thinking of St Paul’s term of the Body, with Christ at the head of the Body... I would see that we’re all there together’.

‘Rita’ would find an ally in Marsh, who argues that the Church needs to be seen less as the Body of Christ and more a Body of Christ (Marsh, 2007: 106); this is a radical ecclesiology. Using Wenger’s ‘community of practice’ model, Marsh identifies five specific communities, i.e. work, education, family, friends and church, in which he believes people are formed and able to flourish. His allusion to the church as a community of practice refers to the local expression of church, social, tangible and perceptible, rather than the Church universal. His thesis is that the local church is not the sole place in which Christ is made known and the Christian story told but that it plays a strategic and explanatory role, equipping its members to recognize Christ’s presence in other communities of practice (Marsh, 2006: 156f.).

22 1 Corinthians 12:27.
Here, there is common ground with Moody (1992) who, as I noted earlier (§7.3.3), maintains that God is to be discovered in the unexpected, beyond the Church as well as within the Church. However, both Moody and Marsh are patently ecclesiocentric and Christocentric. In ‘Rita’s’ proposition, I detect a far more radical thought: God incarnate in other faiths. More in sympathy with ‘Rita’s’ view would be Hull who, in his theological assessment of the Church of England report, Mission Shaped Church, goes further. The report cites the principle of spermatikos, seeds of the Word, planted before the coming of Christ, the Logos spermatikos or Word-bearing seed (Archbishops’ Council, 2004: 87). This concept, possibly borrowed from Stoicism, was developed by Justin Martyr to win over his Greek audience by proposing that human reason is a fragment of the Logos spermatikos and that, therefore, the metaphysics of Greek philosophy were a legitimate source of Christian metaphysics (Goodenough, 1923: 207). Accordingly, this source of truth prefigures the later incarnation of divine truth in Christ. Hull’s contention is that the authors of Mission Shaped Church fail to apply the principle of spermatikos more widely, ignoring the possibility of God’s incarnate presence in other cultures and faiths. Any mention of diversity in the report is restricted to comments about diverse patterns of Church, whereas a broader understanding of diversity of religions, values and lifestyles is dealt with ‘negatively’ (Hull, 2006: 11). What the report advocates is the conversion of other cultures, proselytization in all but name, with the sole intention of enriching the cultural life of the Church.

In the liminal space of healthcare chaplaincy, the beliefs, practices and texts across the different religions, as well as the wisdom and insights each tradition has to offer, are accorded equal status. ‘Sarah’, ‘Barbara’ and ‘Rita’ spoke

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23 The Christian apologist of the second century CE.
24 A teaching document on interreligious dialogue produced by the Roman Catholic Bishops’ Conference of England and Wales adopts a similar interpretation: ‘The Catholic Church today... recognises the presence of what is true and holy in other religions as being ‘rays of the Truth’ and ‘seeds of the Word’; but the Church is also cautious about identifying those ‘rays’ and those ‘seeds’ too hastily’ (2009: 15).
25 Mumisa and Kessler (2008: 3) investigated Jewish, Christian and Islamic seminary education in the UK focusing on the provision of courses about religions (other than the seminary’s own religion). Among theological colleges training and preparing students for Christian ministry in mainstream Protestant, Anglican and Roman Catholicism denominations, they observed that ‘[t]he more evangelical colleges tend to prefer courses taught from a Christian-centred theological perspective with the primary purpose of evangelising; on the other hand, more liberal colleges prefer to teach other religions with the primary purpose of promoting understanding and dialogue.’
about having prayed with and ministered to patients of other faiths and, in such situations, chaplains can gain awareness of what may be shared and what is proscribed. Partnerships between the faiths can provide creative and imaginative ministry opportunities especially in situations where people affiliate to more than one faith tradition. 26 Chaplains whose religious attachment is to a faith other than Christian may be willing to share ministerial responsibility, and this reflects the way some religions have adapted to the socio-religious context in which they now work. So, for example, Islam is not required to look beyond its own faith community but, as Pattison (2015: 20) observed, instead of simply instructing people on the basis of religious teaching, as an imam would do in a mosque, Muslim chaplains have ‘learned to listen to individual people and [have begun] to highly value non-directive, person-centred counselling and pastoral skills and attitudes.’ Additionally, Pattison maintained (2015: 18), ‘chaplaincy seems to have become a new umbrella religion [to] which members of specific religious communities are or have to be converted’.

For Anglicans, including NHS priests-as-chaplain, who minister in religiously diverse settings, there is no official guidance from the Church of England regarding the parameters of working relationships with ministerial colleagues of other world faiths. No code of practice appears on the website of the Church’s ‘Presence and Engagement’ programme. 27 Instead, under the general heading of ‘ guidelines’, there are nine documents from a variety of sources dealing with everything from New Religious Movements to Countering Racist and Far-Right Groups. Among these, and possibly the most helpful, is a teaching document of the Roman Catholic Bishops’ Conference of England and Wales, Meeting God in Friend & Stranger: Fostering respect and mutual understanding between the religions, which clarifies interfaith dialogue as ‘not only discussion, but also... all positive and constructive interreligious relations with individuals and communities of other faiths which are directed at mutual understanding and enrichment’ (Roman Catholic Bishops’ Conference, 2009: 13). It is the only

26 As I wrote this, I was mindful of two patients who were in the hospice where I work as chaplain. The one identified herself as Jewish and Roman Catholic, and the other as Muslim and Greek Orthodox.
27 ‘Presence and Engagement is the Church of England’s national programme equipping Christians for mission and ministry... focusing on the importance of the Church both remaining present in multi religious areas and engaging positively with communities of other faiths’ (Presence and Engagement, no date).
document on the Presence and Engagement website which specifically addresses the question of interreligious boundaries in healthcare chaplaincy (Roman Catholic Bishops’ Conference, 2009: 96f.), although obviously its focus is the ministry of the Roman Catholic chaplain.\textsuperscript{28}

Depending on local demography, however, the NHS chaplain may be called upon to work closely with people of other faiths, be they colleagues, patients or families. Ministerial partnerships of this kind do raise questions of theology and best practice but this appears to be left to individual initiative and personal boundary setting. In conversation with the Presence and Engagement National Programme Coordinator, there was recognition that healthcare chaplaincy is at the leading-edge of multi-faith co-operation (Kat Brealey, 2016: personal communications). Elsewhere this is described as building ‘positive and constructive interreligious relations with individuals and communities of other faiths which are directed at mutual understanding and enrichment’ (Secretariat for Non-Christians, 1984: 3).

The importance of the chaplain’s contribution to this partnership with people and communities of other faiths cannot be underestimated especially in the light of the Casey Review (2016). Among other things, the Review noted that ‘[p]olling in 2015... showed that more than 55% of the general public agreed that there was a fundamental clash between Islam and the values of British society, while 46% of British Muslims felt that being a Muslim in Britain was difficult due to prejudice against Islam’ (2016: 12f.).\textsuperscript{29} Religious pluralism is a feature of modern healthcare delivery in contemporary England. Yet, it would appear that the Church of England does not draw on the experience of, or adequately support chaplains in this area of their ministry so leaving them, as a liminal community, with what I referred to earlier (§7.3.1) as the ambiguity of a threshold people (Turner, 1969: 359). In the next section, I continue my investigation of liminality and the ministry of the chaplain, focusing on the place

\textsuperscript{28} Although not guidelines, the websites of both the Church of England and the ‘Presence and Engagement’ programme mention a diocesan network of interfaith relations advisers who are available ‘to provide specialist advice and encouragement for church leaders and members seeking to develop good relations with members of different faiths’ (Archbishops’ Council, n.d.)

\textsuperscript{29} ‘Muslims make up the largest non-Christian religious population in the UK at 2.8 million in total, compared with 0.8m Hindus, 0.4m Sikhs, 0.3m Jews and 0.3m Buddhists’ (Casey, 2016: 9).
of spirituality. In this I detect further ambiguity and introduce the novel idea of liminal intelligence.

7.3.3 Liminality and the delivery of spiritual care in healthcare chaplaincy

As I discussed in a previous chapter (§1.5.3), the emphasis now given to spirituality as part of holistic care has largely supplanted the exclusively religious role the chaplain once undertook. Religion and belief needs are now subsumed under the general category of spiritual care. To appreciate why this has happened, it is necessary to acknowledge the way 'spirituality', its language and its different manifestations, now competes with Christianity in the public domain of English culture.

Helas & Woodhead (2005: 1) note that for over a century the declining influence of religion, especially Christianity, has been a matter of scholarly debate. It may be claimed that religion is no longer a primary 'source of significance' in western societies (Taylor, 2007: 509). The fact that a growing number of people choose to define themselves as spiritual, rather than religious, begs a number of questions. Whether this marks the erosion of the sacred in the West (Bruce, 2002) or a tectonic realignment of the religious landscape, such as took place at the time of the Reformation in the sixteenth century, there are those who would assert that spirituality has eclipsed Christianity (Luckmann, 1967, 1990; Campbell 1999). All the more remarkable then, that the term 'spiritual' lacks conceptual clarity (McGuire, 1997: 8) despite, or perhaps because of, a surfeit of competing definitions (Bender and McRoberts, 2012:2).

Against this backdrop, Heelas and Woodhead (2005: 2) undertook empirical research focusing on Kendal, a Cumbrian market town in the UK. Their aim was to explore what Taylor (1991:26) perceived to be 'the massive subjective turn of modern culture' and which others have interpreted as the defining cultural feature of contemporary western societies (Hobsbawm, 1995; Inglehart, 1997; Taylor, 1989, 1991; 2002). Heelas and Woodhead (2005: 2) conjectured that this 'subjective turn' might account for what appeared to be the demise of traditional forms of religion and the growth of new expressions of spirituality. In other words, they argue that society has begun to distance itself from congregational religion within which a person sacralises transcendent meaning,
goodness and truth. This they describe as ‘life-as’. In its place, so their argument continues, society has embraced an ‘alternative’, ‘holistic’ style of spirituality in which a person sacralises personal authority, self-direction and individual autonomy. This they describe as ‘subjective-life’.

Intriguingly, Heelas and Woodhead (2005: 5) argue that the influence of the ‘subjective turn’ is patent in the institutions of social-cultural provision. So, for example, in healthcare the authority of the doctor has been displaced by the subjective well-being of ‘patient-centred’ care. They are not suggesting that ‘subjectivization’ is the same as ‘individualization’, i.e. the ‘self-in-isolation’. Rather, ‘subjectivization’ is a ‘self-in-relation’ or, as McCullers (1973:39) phrases it, the ‘we of me’. Their evidence for this (Heelas and Woodhead, 2005:136) comes from the fostering of subjective-lives within group settings: ‘[w]ith the expansion of subjective well-being culture during the last decade or so, spiritual practitioners have been able to cater for an increase in the number of people interested in associational, holistic, quality of life provisions.’ They cite (2005:156) over fifty forms of holistic activities, ranging from acupressure to yoga, which, at the time of their research, were offered in and within five miles of Kendal.

However, while Heelas and Woodhead maintain that there is nothing to suggest a wholesale transformation of the sacred landscape, their research does demonstrate that the ‘subjective turn’ has stimulated the growth of subjective-life spirituality which, they argue, will continue to increase and so gain a greater cultural hold. While recognizing the uncertainty which accompanies any prediction, they foresee (2005:149) that in around forty years’ time the congregational domain and the holistic milieu of Britain will be similar in size to one another. However, they make plain that the importance of their research lies less in any prediction but in the evidence which illustrates current trends and the longer term significance for the sacred landscape of Great Britain.

This digression into the work of Heelas and Woodhead (2005) is not only about mapping the lay of the land. It has a particular relevance to modern day chaplaincy for, as Billings suggests (2015:34f.),
the contemporary chaplain is faced with a complex kaleidoscope of traditional
religion, new spiritualities, many faiths, non-believers and aggressive
secularist within a public institution that has its own ethic, the ethic of the
welfare… Ministering to people who would come from any of these
backgrounds might seem like mission impossible, but over the years
chaplaincy has evolved to do exactly that.

The evolution of chaplaincy, to which Billings refers, has placed a particular
emphasis on the delivery of spiritual care, but while the weight given to
spirituality is understandable in the light of the research of Heelas and
Woodhead, there may be other drivers.

So, for example, in becoming the spiritual ‘consultant’ or ‘expert’, the one who
leads on ‘spirituality’ within the framework of holistic care, it may be that the
chaplain is responding to the need to establish personal credibility in the
uncomfortable zone of liminality where there is no privileged status, no
protected (ecclesial) rights and no inherent authority. Given the importance that
chaplains now attach to spiritual care, it is surprising that a reading of the
research interviews conveys the impression that some participants had given
little thought to what spirituality might mean. ‘John’ reckoned that spirituality was
what animated a person’s life and gave it meaning.30 This seemed a promising
definition, but then he gave, as an illustration from his own life, the smell of cut
grass heralding the cricket season. In terms of the instrumentalization of
spirituality, there was scarcely a mention of tools, strategies or checklists. ‘Mary’
commented that her Trust had incorporated spiritual assessments into its
implementation of the Liverpool Care Pathway,31 while ‘Brian’ considered
assessments unworkable in larger Trusts. Another participant, ‘Sarah’, did
reveal that she had recently drawn up a spiritual care strategy at the specific
request of her Trust’s chief executive.

30 ‘John’ attributed this definition to McGrath (2006: 51) but clearly he has misunderstood it. For
McGrath, spirituality revolves around a life of faith: what drives and motivates it as well as what
people find helpful in sustaining and developing it.
31 During the course of this research, in July 2013, the Department of Health stated the use of
the Liverpool Care Pathway should be ‘phased out over the next 6-12 months and replaced with
an individual approach to end of life care for each patient’ (Department of Health, 2013).
More generally, however, when participants did address ‘spirituality’, they seemed to struggle not only with the concept itself but with the separation of the spiritual and religious domains. Spirituality, for example, was a journey into God’s being (‘Nigel’) and God present in the pain and healing of Christ (‘Hugh’) while for ‘John’ his model of spiritual care was based on Anglican priesthood. This raises the possibility that the delivery of spiritual care by the chaplain is, in effect, the clandestine delivery of religious care which would bear out Swift’s observation that ‘scratch below the surface and the reality of what chaplains do appears to remain resiliently religious – albeit in a more fragmented and less prescriptive manner’ (Swift, 2014: 148). Spirituality becomes a category of convenience (Cobb, 2005: 40) detached from conventional religion: a ‘formless religiosity’ (Billings, 2015: 34), the ‘commodification of religion’ (Carratte and King, 2005: 15), and ‘religion-lite’ (Pattison, 2013: 200). So this significant ‘rival’ to Christian faith in England still lacks clarity. McGuire’s declaration, twenty years ago, still applies: ‘we do not yet have the language or conceptual apparatus for refining our understanding of spirituality (1997: 8).

Even where research has developed tools to systematize and categorize spirituality using, for example, spiritual care assessments and spiritual care strategies, there is uneasiness. So, for example, it is alleged (Hunt, 1994: 3) that such ‘tools’ only mirror the rational-instrumental world of hospital medicine and its dependency on procedural interactions which can be taught, defined, monitored and developed, and that these needlessly objectify both the nature of spirituality and the patient in order for the chaplain to assume an air of technical proficiency and professionalism. Other issues prevail. If spirituality is a social construct, then its interpretation will be culture-dependent and context-specific (Carratte and King, 2005: 83; van der Veer, 2009: 5). Presumably, then, there can be little consensus on what constitutes ‘spiritual need’ let alone prescribing how it might be met. Perhaps spirituality and religion do share common ground if spirituality is less a rejection of religion, but rather a rejection of religion as an institution (van der Veer, 2009: 9). Then again, it may be that spirituality is judged to provide a more flexible and socially-acceptable approach to transcendence in a society cynical of meta-narratives.
The criticism (Pattison, 2001: 37) that spirituality ‘functions like intellectual polyfilla, changing shape and content conveniently to fill the space its users devise for it’ may be too harsh. Liminality is a discomforting place in which there are no answers. The very suggestion that ‘spirituality needs definition, but it doesn’t need a definition’ (Rowson, 2014: 14; my italics), confirms the equivocal nature of spirituality as unknowable, subtle, intangible, vague and unquantifiable. These are the distinguishing marks of liminality. Revisiting the evidence from the interviews, what stands out is the quality of the relationship some participants sought to stimulate; a ‘relationship of trust’ (‘Vanessa’); ‘the beyond and otherness in relationships’ (‘Claire’) and a ‘semi-professional friendship’ (‘Brian’). This corresponds to what has been reported elsewhere, although from a patient perspective (Snowden et al, 2013: 26), that the focus of the chaplain’s intervention is ‘on the relationship with the person as an end in itself’. Indeed, the Scottish Executive Health Department (2002) identified the non-religious yet essential role of the chaplain as relational. If the essence of the relationship is spiritual and, as such, unknowable, subtle, intangible, vague and unquantifiable, perhaps it bears useful comparison with that other relationship which is difficult to quantify, the therapeutic relationship. The report of an independent inquiry commissioned by The King’s Fund into the quality of care in GP practices (The King’s Fund, 2011) found that although the subtle and intangible elements that underpin a strong therapeutic relationship are difficult to define and to measure, there was evidence to support the conclusion that a good-quality therapeutic relationship improves the life of the patient. In the professional environment of the NHS, what is subtle and intangible, vague and unquantifiable may not qualify for a seat at the high table, but it may embody the person of the priest, re-imaging priesthood, retaining what is helpful from traditional beliefs and practices while, at the same time, engaging with those sacred forms that have found their place in contemporary British life (Pattison, 2015: 22). I would speculate, however, that what is subtle, intangible, vague and unquantifiable signals something else: liminal intelligence.32

32 Exploring the liminal space between humans and other animals in what might be regarded as the benchmarks of human uniqueness i.e. reason, freedom, moral virtue, language, socialisation and justice, Deane-Drummond (2014: 316) refers to the wisdom ‘that cries out in the dark space of unknowing’.
Theories of multiple intelligences has developed over the last few decades broadening the concept of intelligence to embrace emotional, creative, practical, social, existential and spiritual intelligences (Bar-On, 2000; Gardner, 1983, 2000; Emmons, 1999; Halama & Strizenec, 2004; Goleman, 2001; Mayer & Salovey, 1997; Sternberg, 1997a, 1997b). In their study, reported in an earlier chapter (§2.2.1), Mowat and Swinton (2005) outlined a process model of chaplaincy based on their interviews and case studies. Having identified the core task of chaplaincy as meeting spiritual needs, they proposed a three stage process of seeking people who are in need, identifying the nature of the need and responding to the need through theological and spiritual praxis. The middle stage, in which the nature of the need is identified, requires, as Mowat and Swinton envisaged it, emotional and spiritual intelligence. They cited Vaughan (2002: 16) who suggested that spiritual intelligence involves multiple ways of knowing (e.g. sensory, rational and contemplative), as well as the integration of the inner life of mind and spirit with the outer life of work in the world, and is the basis of discernment necessary in making spiritual choices that contribute to psychological wellbeing and overall healthy human development. To this, Vaughan (2002: 17) adds the caveat that in the absence of an agreed definition of spirituality, discussion of spiritual intelligence has to be exploratory rather than definitive. Similarly with liminal intelligence, any discussion is necessarily exploratory given the inexact, even ambiguous status of liminality.

It was Trebilcock (2012: 8ff.) who advocated liminal intelligence, developing a framework based on the philosophy of Ricoeur (1974) and Lonergan (1973; 2004). From Ricoeur, Trebilcock took a methodology of interpretation derived from his study of exegesis, although for Ricoeur this was a root metaphor, text-interpretation being a paradigm for interpretation in general: a 'hermeneutic based on the problematics of the text’ (Ricoeur, 1988: 155). The essential element was Ricoeur’s hermeneutic circle33 within which there are three arcs: a first arc or naïveté from guessing to explanation; a second arc from explanation to understanding; and a third arc, a postcritical naïveté from understanding to appropriation. Trebilcock (2012: 9) claimed that intellectual liminality occurs

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33 Browning (2006: 86) refers to ‘the many happy formulas Ricoeur provides to unify the complex texture of his thought and guide us through his many methodological detours.’ So, for example, explanation, understanding and appropriation (Ricoeur, 2001: 112ff.) and prefiguration, configuration and refiguration (Ricoeur, 1984: 56ff.).
when that second movement from explanation to understanding collapses into a void of shapeless unknowing. Transitioning through this void requires a particular type of critical skill found in liminal intelligence. To this, Trebilcock adds work by Lonergan (1973: 15) on the conceptualization of meaning, a three stage model: a realm of undifferentiated consciousness (found in the concrete immediacy of daily life), then through the realm of theoretically differentiated consciousness (in which there is the sifting of analytical causes, correlations, frequencies and probabilities), and concluding with the realm of interiority, which resembles theoretical differentiation but features ‘a heightening of intentional consciousness, an attending not merely to objects but also to the intending subject and his acts’ (Lonergan, 1973: 83). For Trebilcock (2012: 9), it is the second realm which has a direct bearing on liminal intelligence. This is an intellectually busy time ‘experimenting with amalgams of critiques and constructs, piecing them together to see whether the shape fits. Liminal intelligence is not yet systematic, it is chaotic, spontaneous, dynamic – like all the best conversations where the questions are of more interest than the answers!’

Lonergan’s modelling led Trebilcock (2012: 9) to propose four tasks within liminal intelligence: first, experiencing one’s experiencing, understanding, judging, and deciding; second, understanding what unites and connects one’s experienced experiencing, understanding, judging, deciding; third, asserting the reality of one’s experienced and understood experiencing, understanding, judging, deciding; and fourth, deciding to act in accordance with those norms that naturally and spontaneously arise from the associations of what one’s experienced, understood, affirmed experiencing, understanding, judging, and deciding (Lonergan 1973, 15). These tasks which Trebilcock attributes to liminal intelligence are not dissimilar to those principles which underlie reflective practice in chaplaincy (see further in §6.3.2). From this one example alone, it might be argued that the critical skills of liminal intelligence are already deployed by chaplains.

This concept of liminal intelligence clearly requires further investigation, but I would rank its importance, in determining spiritual need, alongside that of emotional and spiritual intelligence which Mowat and Swinton (2005: 29) cite as
the particular skills of chaplaincy. In an earlier chapter (§ 2.2.1), I explored the perception of the healthcare chaplain as a mediator between disconnected or parallel realities. The chaplain as ‘translator’ is located in that space between subject and object which Winnicott (1971: 53) labelled ‘transitional space’, an ‘in-between’ area of experiencing where inner reality and external existence co-exist. For Macritchie (2001: 209), the chaplain as translator is the person who enables the discovery of meaning in this transitional space, meaning being uncovered and recovered by a process which I believe requires the chaplain to possess and apply liminal intelligence. An equally powerful metaphor with which chaplaincy has been associated, as mentioned earlier (see further in § 2.2.1), is that of midwife alongside people in their labour as they negotiate what I now perceive to be the transitional experience of liminality. In this, the midwife draws on liminal intelligence to navigate the risks, uncertainties, and vulnerabilities as well as a ‘current of life’ (Waaïjman, 2002: 214). As Turner puts it, some kind of ‘original state’ out of which everything is born. This leads me to propose that not only is liminal intelligence a core skill for developing that spiritual-based relationship which at the heart of the ministerial practice of the chaplain, but it is indicative of the essence of priesthood (cf. § 7.4.3).

In this section, I have discussed ways in which spirituality, in the ministry of the healthcare chaplaincy, reflects the ambiguity of liminality and this led me to investigate the concept of liminal intelligence. In the next section, I address this same issue of ambiguity but with regard to those calls within healthcare chaplaincy to professionalize the disciplinary community.

7.3.4 Liminality and the professionalization of healthcare chaplaincy

Working alongside the evidence-based, rational-instrumental professionalism of the NHS, participants clearly wrestled with the implications and expectations of what it means to be a healthcare professional. What emerged was a narrative of professionalism formed by the ambiguous situations and the provisional relationships a healthcare chaplain inhabits in liminality. While the urge to be recognized as a professional, in an organization which rates professionalism so highly, is understandable, nonetheless chaplains, NHS colleagues and patients alike recognize the professionalism of the chaplain as qualitatively distinct. ‘Brian’ spoke about how the chaplain is perceived to be a ‘lesser professional’.
For ‘Nigel’, whereas ‘other professionals are meant to fix things... the chaplain is one who accompanies, to discover where that journey is going to. So the fixing isn’t the priority’. Such comments are perhaps indicative of a chaplain’s use of softer, less tangible skills, those which draw on emotional, spiritual and liminal intelligences. In the hospital, where norms are so embedded as often to be beyond perception, a chaplain may be a countercultural presence establishing a person-centred relationship based on accompanying, listening and encouraging self-reflection. This, indeed, may bring to mind the idea of friendship, as in ‘Brian’s’ notion of the semi-professionalized friendship, but which, arguably, is the very antithesis of what many would accept as professional.

Perhaps, at times, the liminal experience of the chaplain resonates with the liminal experience of the patient. What constitutes a friendship, however, are the shared experiences of the past and shared hopes for the future, the preliminal and postliminal dimensions of life which risk being consumed by illness but which are an essential part of a person’s identity (Boyd, 2001: 84).

Certainly, the idea of friendship may raise concerns about blurred boundaries, the place of objective distance and the danger of over-involvement. Yet friendship is a fundamental human need and a primary means by which people communicate their spirituality and are re-humanized (Swinton, 2000: 127). For some chaplains, a professional agenda threatens the nature of what a chaplain does or presumes to offer to those receiving spiritual care. Such care is about loving people and ‘[y]ou cannot be a professional lover’ (Haig, 2010: 7). For others, humanity and professionalism are not necessarily incompatible and, actually, may complement one another allowing the possibility of the ‘professional lover’ (Nelson, 2011: 44).

Clearly, this narrative of professionalism is ungainly and, as was recognized in a previous chapter (§4.2.2), is subject to a wide range of views among healthcare chaplains. At the same time, it is important to recall Evett’s (2012) cautionary observation that professionalism, while giving credence to work identities, may be used ‘from above’ to implement occupational change and impose mandatory practice (§4.3.3). So, for example, over the last couple of years it appears that NHS England has revised its position over the professionalization of chaplaincy. As recently as 2015, Pattison thought that NHS Trusts were unconcerned about the need for a professional and ‘demonstrably effective’ chaplaincy workforce.
Yet, NHS England appears now to be actively supporting the process of professionalization. Evidence of this comes from two projects it has endorsed. First, the *NHS Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual & Religious Care*, in which there is acknowledgement that ‘chaplains are professional staff’ (NHS England, 2015: 7). In fact, as part of the contract with NHS England, NHS Trusts in England are now required to give ‘due regard’ to these *Guidelines*. Second, NHS England has underwritten the UKBHC’s application for its voluntary register of healthcare chaplains to be accredited by the Professional Standards Authority. NHS England’s collaboration is possibly part of a wider agenda. Fraser, chair of the UKBHC since 2009, believes it may be influenced by the Government’s Prevent Strategy as well as issues of data protection and patient care (Fraser, 2016: personal communications).

This drive towards the professionalization of chaplaincy, however, has not received an unequivocal welcome. The Roman Catholic Bishop Tom Williams commented that the *Guidelines*, which he read in draft form, sought to ‘nationalise’ hospital chaplaincies, requiring a ‘professionalism of health-care chaplaincy which may be incompatible with a denominational approach’. He went on to say that ‘[t]his document is clearly intended to establish an NHS Chaplaincy as a single professional entity, leaving little room for local religious and faith communities’ (Moorhead, 2014). For different reasons, Heywood, a former director of pastoral studies at a Church of England Theological College, also rejected the need for professionalization believing that ‘the professional model of ministry is long past its “best before” date’ (Heywood, 2010: 9).

However, McCarthy, a policy adviser to the Church of England, stated that ‘NHS chaplains are healthcare professionals who, recognised and supported by their respective faith communities, are uniquely qualified and trained to deliver spiritual and religious care to patients, clients and staff (McCarthy, 2010: 1; my italics). Behind this on-going debate, there is the question of whether those calling for the professionalization of healthcare chaplaincy are in retreat from liminality, and seeking shelter in what is perceived to be the regulated security

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34 Bishop Tom Williams is Chairman of the Health and Social Care Advisory Group at the Catholic Bishops’ Conference of England and Wales.

35 McCarthy, working in the Church of England’s Mission and Policy Division, advises on medical ethics as well as health and social care policy.
of professional associations. To take a Weberian perspective (§4.3.1), this is where monopoly and social closure prevail and where professionalization acts to safeguard the vested interests of those who have structural power.

For these reasons, Galashan (2015) is critical of those who would professionalize chaplaincy. She questions the assumption that the chaplain who subscribes to a specific religious faith is qualified to meet the spiritual needs of people of all faiths and none. Instead, she argues, spiritual care needs to be inclusive, underwritten by a theory, practice and competency-based model of non-religious spiritual care, and, by implication, provided by non-religious carers. Pastoral care would be separated from sacramental ministry which, then, would be provided by ‘representative clergy’ (Galashan, 2015: 107).

However, Galashan (2015: 113) is concerned that there are those who would prevent this: the ‘ruling class’ or leadership of chaplaincy’s professional bodies ‘whose race, gender, religious identification and class are, arguably, far from representative of the demographics of the populations they serve’. Potentially, for this ‘ruling class’, professionalization becomes an opportunity ‘to secure and enhance its privileged access to rewards and opportunities in the labour market’. Whatever the merits of Galashan’s case, she is doing precisely what is to be expected of a chaplain in liminality: ‘unafraid to question or even throw away the mould and to challenge the established way of doing things’ (Galashan, 2015: 120) and ‘to confront the vertigo of the radically historical character of our identities’ Beaudoin (2008: 107).

Then again, would Galashan’s proposal for a non-religious spiritual care service compromise the integrity of the Church of England priest who is an NHS chaplain? Possibly not, for if spiritual care in the NHS was non-religious, the position of the NHS priest-as-chaplain might be viewed as comparable to the situation of the self-supporting priest in secular employment. Holmes’ (1971: 223) view, based on his premise that the parish church has become subjugated to secularism, is pertinent:

it is a gross inaccuracy to say that if a priest leaves St Stanislaus by the Steam Plant to become a probation officer that he is “entering a secular ministry.” My belief is that more likely he is leaving a secular ministry for one
that is far more powerful, that is, more open to God’s grace, because it is liminal (not of the structures, nonsecular).

In this section, I have surveyed the implications, expectations and motivations behind moves to professionalize healthcare chaplaincy. Some chaplains have reservations. This theme of doubts and misgivings is also apparent in their response to the mission agenda of the Church of England which I investigate in the next section.

7.3.5 Liminality and the contribution of healthcare chaplaincy to mission

While participants considered their ministry to be at the forefront of mission, many felt this remained unacknowledged by the Church. Threlfall-Holmes and Newitt (2011: xv) remark that ‘[i]n the context of the increased focus on mission and outreach, of fresh expressions and ‘mission-shaped’ church, it seems perverse that chaplaincy remains so commonly characterized as marginal.’ Some participants thought that their view of mission was out of step with the missiology of an inward-looking Church focused, as it is, on an evangelistic agenda of Church growth. In contrast, perhaps reflecting the liminal place of chaplaincy where there is a disposition to take contrary positions, mission was regarded as misconceived. Among the participants were those who wanted to re-envision ecclesiology and engage with a vision of community beyond the narrow structures of the Church; to focus instead on the reign of God (‘Brian’ and ‘Sarah’). Yet, many participants struggled to articulate what mission might mean. For example, while ‘Phil’ was disgruntled with the way his diocese interpreted mission in terms of Church growth, I was left wondering what he meant when he referred to mission as ‘growing a much larger community than just a Christian [one].’

The report Mission-Shaped Church (Archbishops’ Council, 2004) highlighted the Church’s need to respond to three areas of concern: to an evolving culture, to a changing spiritual climate and to the promptings of the Holy Spirit. Yet, although healthcare chaplaincy has demonstrated its readiness to respond to an evolving

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36 This is demonstrated in the Church of England’s Renewal and Reform programme which states that ‘one of the clear and intended outcomes of this work is to reverse the decline of the Church of England so that we become a growing church, in every region and for every generation’ (Archbishops’ Council, 2016).
culture and changing spiritual climate, the Church has directed much of its
attention and resources to Fresh Expressions and Pioneer Ministry (Slater,
2015: 82). As a report, Mission-Shaped Church was ecclesiologically
conservative applying itself to evangelisation rather than a more broadly
conceived missio Dei. As I noted earlier (§7.3.2), Hull’s critique was scathing:
that it was about ‘church shaped mission’ rather than ‘mission shaped church’.
‘The church is not the fulfilment or flowering of mission. The flowering of mission
is the Kingdom’ (Hull, 2006: 2), a sentiment echoed among the participants in
my survey.

Ten years later, a report prepared for the Mission and Public Affairs Council of
the Church of England, The Church of England’s Involvement in Chaplaincy,
(Todd, Slater and Dunlop, 2014) demonstrated that little had been done to
engage chaplains with anything mission-shaped, and that healthcare chaplains
during the intervening years had continued to be marginalized by the
institutional community of the Church: ‘One of the most important messages to
emerge from this report is that chaplaincy is a resource whose potential is not
fully realized’(Todd, Slater and Dunlop, 2014: 37).

In the Report, the authors urge the development of an ecclesiology that
integrates chaplaincy with what I describe as modal Church: ‘integrating
dispersed modes of ministry with those that are more focused on the gathered
life of the Church’ (Todd, Slater and Dunlop, 2014: 34). Using the missional
vocabulary of modality and sodality provides one means of understanding and
even negotiating the dynamic that exists between the two, for while each has its
place and each needs the other, there can be suspicion, misunderstanding and
concerns (Steddon, 2010). Church leaders need to know how to work across
the two modes of being Church for each to work well and constructively. New
Testament evidence and contemporary research emphasize the value of a
constructive relationship between modal and sodal Church which then promotes
a healthier Church (Lings, n.d.) building on the strengths of a mixed economy to
which I referred earlier (see further in §7.2.4). The operative phrase, of course,
is ‘constructive relationship’. Are the two Church modes like water and wine
which can be perfectly and inextricably mixed or like oil and water, mingling but
not mixing? There is no one template for a ‘constructive relationship’. What it

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does require, however, is ‘the formation of disciples who are able to recognize and live with inescapable undecidability and uncertainty in all aspects of their faith, including how that faith is manifested in their approach to ecclesiology’ (Mason, 2008: 86).

Mason (2008: 85) described this as ‘living in the distance between a community of character’ and a community of the question which highlights a rift between sodal and modal forms of ministry. To counter this, Ling (n.d.) proposed a continuum of ministry in which there is first, pioneer-starters, skilled at initiating new ideas but who might become easily bored and move on; second, pioneer-sustainers, who wait for initiatives to become bedded-in before handing over leadership; third, sustainer-innovators, who develop mission-focused schemes within traditional Church structures; and fourth, sustainer-developers who effectively nurture the slower pace of traditional Church life. It is interesting to speculate whether an NHS priest-as-chaplain can find any place on this spectrum of ministry as she is a liminal persona (§7.3.1) living in the distance between ‘a community of character’ and ‘a community of the question’, and perhaps vacillating between both. More provocative is Arbuckle (1999: 160f.) in claiming that ‘chaplains, in their role as prophetic liminal or refounding leaders in chaos, must inter alia be grief leaders, calling fellow Christians and churches to let go the familiar and historically irrelevant in order to risk the unknown’.

I have now examined four aspects of ministry, central to the work of the healthcare chaplain, i.e. multi-faith collaboration, spirituality, professionalization and mission. In the sections that follow, I turn my attention to the wider question of what my research might contribute to a theology of ministerial priesthood.

7.4.1 Liminality and its contribution to a theology of priesthood
Throughout this chapter, I have demonstrated that marginality is a recognized characteristic of healthcare chaplaincy both in the literature and the participant

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37 This phrase was coined by Hauerwas (1981) to depict the Church as a distinct society living within the continuing narrative of the Christian story.

38 This phrase is derived from Derrida who described the community of philosophers as ‘a community of decision, of initiative, of absolute initiality, but also a threatened community, in which in which the question has not yet found the language it has decided to seek, is not yet sure of its own possibility within the community. A community of the question about the possibility of the question’ (Derrida, 2001 [1967]: 98).
interviews (§7.2.2). However, as noted earlier (§7.3.1), marginality and liminality are sometimes used interchangeably, or marginality is mistaken for liminality. The difference between the two is important and can be illustrated by considering the idea of nothingness which is at the root of both. In the framework of structure and anti-structure, the nothingness of marginality refers to the perception or reality in which an individual or group feels disempowered and regards themselves as being of little or no significance to those who are structurally in control and dispense structural power. Organizationally, they can be easily dismissed. The nothingness of liminality, however, challenges those who have a vested interest in preserving the structural status quo, requiring them to justify this (Mason 1992: 69). Liminality is ‘a time of enchantment when anything might, even should, happen’ (Turner, 1979: 465); it is a sacred place in time and space, a kind of symbolic ‘social limbo’, loaded with promise, potential and the unknown (Turner, 1969).

A distinctive contribution of my research is the re-designation of marginality as liminality and its application to Christian communitas. Earlier (§7.3.1), I drew a distinction between the disciplinary communitas of chaplaincy and the normative communitas of sodal Church. Taking Steddon’s (2010: 11f.) spectrum of engagement with culture, ranging from a ‘host’ theology typical of modal Church to a ‘guest’ theology typical of sodal Church, I would maintain that there is a difference between the disciplinary communitas of chaplaincy and the normative communitas of sodal Church; that the communitas of sodal Church can, in some instances, harbour elements of ‘host’ theology while the communitas of chaplaincy is more embedded in a ‘guest’ theology. In this respect, both highlight what the dyad of structure and communitas points to: ‘a need situated deep within human nature for both social stability and creative regeneration’ (Starkloff, 1997: 665).

My attention, however, has focused on jurisdictional liminality which I maintain offers a hermeneutic framework for developing an understanding of the identity of the healthcare chaplain and for critiquing and augmenting a theology of priesthood.
For example, in liminality, the NHS priest-as-chaplain is the ‘stateless’ or ‘institution-less’ person who may then demonstrate a disregard for the Church and the NHS as top-down institutions structured by regulated relationships, hierarchies, chains of command, grades of authority and status. The freedom that liminality offers may lead the chaplain to identify with values and attitudes which, for different reasons, are at variance with those associated with the NHS and the Church. The Church may be discomforted by values and attitudes associated with the NHS and endorsed by the chaplain in relation, for example, to issues of diversity, equality and opportunity. The NHS may be discomforted by values and attitudes associated with the Church and, similarly, endorsed by the chaplain, for example, the non-rational and non-instrumental claims of spirituality and religion to enhance health and well-being. Liminality, unsettling as it may be for the NHS priest-as-chaplain, does provide the theological and ecclesial freedom to engage in lateral thinking and transformative practices through experimentation and inquiry, as well as in the adoption or rejection of new identities, ways of acting or frames of reference.

As for what liminality might add to a theology of contemporary ministerial priesthood, little has been written. Leech (1994: 78), an Anglican, who developed a theology of the inner city, called for priesthood to be exercised in shadow places where people ‘come to discover their identities, needs and future’. Priests, as a ‘liminal people’, minister between structure and chaos living as aliens, sojourners and pilgrims. Holmes (1971: 178), an American Episcopalian and academic, offered a cautionary word about professional skills and techniques as he regarded these as ‘peripheral to the core of the definition of a priest’ (Holmes, 1975: 178). The priest is liminal and charismatic, ‘contagious, spontaneous, mysterious and essentially eschatological’ (Holmes, 1975: 248). Nearly forty years later, in a sermon directed at priests in self-supporting ministry, Croft (2013), an Anglican bishop and missional theologian, spoke about the way liminality shapes the priest ‘living permanently on the edge and between two or more worlds’: a ‘precious gift to the wider church’ with ‘many lessons for a church in mission’, but a ministry which is

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39 The point I am making here has a more extensive reach. Engelhardt (2003: 140) refers to ‘chaplaincy tak[ing] on an identity independent of and hostile to traditional Christian concerns.’

40 This was a sermon was preached during a service marking the fiftieth anniversary of the first ordinations of those trained on the Southwark Ordination Course in 1963.
complex and demanding. Rohr, an American Roman Catholic Franciscan, (2002) revealed something about the nature of liminality in his frank admission that much of his life as a priest has been less liminal and more ‘liminoid’: ‘a false transcendence in just enough dosage to inoculate people from Real Encounter. It takes away one’s sense of aloneness and one’s sense of anxiety – and for most people this feels like “God”.’ Another Roman Catholic priest and theologian, Witherup (2012: 89), inferred liminality from the celibate role of the priest, especially in the light of the Jesus’ saying about eunuchs: this, he believed, calls attention to the unique status of priests as people who live on the edge (Witherup, 2012: 78). Finally, there is Mason (1992: 161), another Anglican theologian, who implicitly addressed the liminality of ministerial priesthood in his claim that the priest’s institutional function is ‘to occupy the social space that humankind leaves empty for God to fill but which God (it seems) insists on having filled by [the priest]’.

These six theologians portray different aspects of the priest living in a state of liminality: an ‘edge’ person who ministers to those who live in the hazardous twilight zone between structure and anti-structure, who captures within herself what others perceive as emanating from God, who is challenged by the complexities of ministry and frequently falls short of self-expectations, and who believes herself called to occupy for others that vacant place only God’s chosen person can satisfy. This is the ‘betwixt and between’ of the priest but, I would argue, there is more to be learned about the liminality of priesthood in relation to Israelite cultic religion and the person of Jesus. It was in an earlier chapter (§3.2.1) that I reflected on the liminal place of the cultic priest in Israelite

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41 Matt. 19:12: ‘For there are eunuchs who have been so from birth, and there are eunuchs who have been made eunuchs by others, and there are eunuchs who have made themselves eunuchs for the sake of the kingdom of heaven. Let anyone accept this who can.’

42 Holmes wrote: ‘Some people would deny that in the priest we ‘see’ God, but I think we do. When a parishioner comes to talk with his priest he perceives this as a conversation with God through the priest. This is because the priest as symbol evokes the expectation of the shaman in our unconscious. It is the shaman who talks with the spirit. This unconscious association is very much at the root of asking a priest to pray for you, when logic would say that you could do it just as well for yourself’ (Holmes, 1975: 86).

43 It is interesting to note that the newly installed priest of cultic Israelite religion was required to wait seven days in a liminal condition of isolation, humility and sacrality (Lev. 8:33-36; 10:6-9; 14:8-9), which, perhaps, is mirrored today in the mandatory retreat the Anglican priest undertakes before ordination. Avis (2003: 144) referred to the liminal state of this silent retreat, with the ordinand ‘cut off from their families and communities and each other’.

44 Cf. Lk. 9:58 ‘Foxes have holes, and the birds of the air have nests, but the Son of Man has nowhere to lay the head’ (see Jacobson, 2005 [1992]: 135).
religion, so in the next section I consider liminality in four further respects: in terms of the person of Jesus, the essence of the gospel, the call to discipleship and the authority of the apostles.

### 7.4.2 The liminality of Jesus, the gospel and the *communitas* of the early Church

Male celibacy was not unknown in Judaism although sufficiently unusual that it would have cast Jesus as a liminal figure (Witherup, 2012: 86). His liminal place in society would have been confirmed by the itinerant lifestyle he adopted and what this implied about family and household. These were central institutions in ancient Israel. As the eldest son, Jesus was expected to demonstrate filial loyalty and obedience by following in the steps of his father, so securing an honoured and respected place in the community (Moxnes, 2003: 70). In these respects, Jesus was atypical. He was denounced as a drunkard and a glutton; he kept dubious company; and he was a person of questionable character (Witherup, 2012: 86). Even what he said, in his criticism of family and household, was divisive.

Jesus describes himself as the Good Shepherd but, as Turner points out (1991: 49), the liminal status of the shepherd, widespread in religious antiquity, signalled a figure mediating between the purity of the divine world and the confusion and corruption of the human world. The eschatological hope for Israel’s redemption was located in the person of the messianic shepherd. Into this context, or so the Church holds (Kinnison, 2016: 56), Jesus entered history.

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45 Cf. Jeremiah.
46 Cf. Q 9:58 ‘Foxes have dens and birds of the sky have lodgings but the son of man has nowhere he may lay the head’ (Jacobson, 2005 [1992]: 135)
47 Cf. Mt. 11:19; Lk. 7:34.
48 Mt. 9:11; 11:19; Lk. 5:30; 7:34; 15:1
49 From the Gospel of Thomas, 55 is arguably among the earliest versions of these sayings: ‘Jesus said, “Whoever does not hate his father and his mother cannot become my disciple. And whoever does not hate his brothers and sisters and take up his cross in my way will not be worthy of me”’ (Patterson, 2013: 194).
50 Cf. Mk. 3:31-15; Mk. 10:28-29.
51 Jn. 10:11, 14.
52 The use of the shepherd as a metaphor is like any other metaphor, it is a linguistic device designed to say something novel and productive about its subject drawing on real-life knowledge and human experience. Here, Turner’s reference to the liminal status of the shepherd needs to be read cautiously. It has been claimed that the shepherd was a social outcast (Tooley, 1964: 23; Huntzinger, 1999: 66-69; Kinnison, 2016: 56) but this has been contested (Groteau, 2015). Although rejecting the stereotype of social outcast, Groteau (2015: 18) is prepared to admit that the shepherd was from the lower rung of society.
53 Ezek. 34:24; Ezek. 37:24-25; Zech. 10.
as the incarnate God, fully divine and fully human. In his claim to be the ‘Good Shepherd’ of Israel, Jesus identified himself with YHWH, Shepherd of Israel. The metaphor of the shepherd works well with the role of someone who identified with the marginalized underclass or the socially reviled. Not only does Jesus, as shepherd, protect those who risk being consumed by a liminal world, over time he re-directs his ministry towards more liminal places.

This is most noticeable halfway through the synoptic gospels when Jesus is no longer found in the synagogue but moves into the ‘public square’ of the seashore, the lake, the open road, the wilderness and mountains. This is also the moment when Jesus gathers around him people who are already in communitas (the sick, ‘sinners’ and tax collectors), as well as those who, in response to his call, willingly become liminal or sodal disciples. They are leaving ‘a place of social identity, a place that defines and structures that identity... the workplace, the property, and the social basis for a place in the village’ (Moxnes, 2003: 96). It was a call to self-denial, servanthood and the abandonment of everything, it was directed at turning the world upside down; it would be an apostleship marked by nakedness, hunger and suffering in order to be fashioned into a new creation; it would create a communitas of believers living together and sharing what they possessed with one another. In terms of the leadership of this communitas, the first five chapters of Acts draw a definite connection between the ministry that Jesus exercised and the ministry of the apostles (Russell, 2013: 186). Opposition comes from the Temple leadership, its own authority emanating from the cultic structure of Israel as against the anti-structural credentials on which the authority of the apostles relies; not a personal authority but one derived from Jesus and delegated to them as his witnesses (Russell, 2013: 172).

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54 Jn. 10:11.  
55 Mark 8.34  
56 Mark 10.44  
57 Luke 5.11, 28  
58 Acts 17.6  
59 1 Cor. 1:26-28  
60 2 Cor. 5.17  
62 The author of Acts uses the introductory chapters to settle a number of matters over and above the anti-structural basis of the apostles’ authority; first, to illustrate that the people of God were a liminal community awaiting the final consummation of God’s purposes; second, to make evident that they were God’s people not by the structural criteria of the old covenant, but by the anti-structural criteria of the new covenant in obedience to Christ and the gospel; and third, to
Thus, from the evidence presented in this section i.e. the liminal character of Jesus, the liminal essence of the gospel, the call to liminal discipleship in *communitas* and the authority of the apostles derived from the liminal authority exercised by Jesus, I would argue that the essence of the Church and priesthood, be it ministerial priesthood or the priesthood of all believers, presupposes a disposition of liminality. In the next section I consider what liminality means for both the Church of the twenty-first century and its theology of priesthood.

7.4.3 Ministerial priesthood recalling the Church to its liminal roots

Despite the anti-structural and liminal foundations of the Christian faith, set out in the previous section (§7.4.2), the Church of England today is an institution shaped by the social-structural principles which characterize the way Western society is organized. Earlier (§7.3.1), I referred to Mason’s claim (1992: 69) that, as anti-structure and liminality are not co-terminous, there is the potential in every human institution for there to be both structure and anti-structure, and that structure may be followed, shadowed and haunted by anti-structure. In my view, the structural institution of the Church is most credible when it is followed, shadowed and haunted by a sodality which authentically expresses the anti-structural Christian *communitas* i.e. liminality which ‘calls people to discover status actually in their lack of status, riches in their poverty, security in their loss, health in their suffering, or… through the action of God upon those who are in such conditions’ (Mason, 1992: 70). It is to the standards of the anti-structural *communitas* that the structural institution of the Church needs to be held accountable though, paradoxically, it is the sociological inevitability of the institutional Church which provides the means by which *communitas* is kept alive. ‘Structure on its own is mechanical. Anti-structure on its own is chaotic. Only together can they provide that order within freedom and freedom within order which is essential to true humanity’ (Mason, 1992: 74).

From a North American and Baptist perspective, Roxburgh (1997: 39) maintains that the concept of liminality is a model for missional engagement and the eventual reconstruction of the Church. He draws a parallel, from the book of

demonstrate that the people were bound by the Spirit which provided a common identity (Russell, 2013: 175).
Hosea in Hebrew Scriptures, in which the prophet speaks of the people’s return to the desert, the definitive place of liminality where there is the opportunity to rediscover what it means to be the people of God. This is the opportunity that now presents itself to the Church ‘awakening to life at the margins and yearning for the past detente. Reflection on where God may be leading and shaping the Church for a new future remains to be done. The Church stands at the threshold of the liminal’ (Roxburgh, 1997: 33). There is, however, a predicament. In liminality, Roxburgh argues, there can be the inclination to move in two opposing directions at one and the same time: the safer option of turning back to recover a lost identity or the more hazardous option of moving forward. The first option leads to marginalization and, as Mason points out (1992: 69), those who are marginalized are ‘small change’, ignored by those who have structural power. The second option leads to liminality where ‘you can challenge, with as much daring as you can muster, the emperor’s claim to be wearing clothes, provided, that is, you are ready to admit that you have no clothes yourself’ (1992: 68). Christianity entered history as ‘a new social reality formed out of a liminal experience that created the _communitas_ of a new peoplehood’ (Roxburgh, 1997: 54). It was a _communitas_ for the ‘there and then’ that needs to be revisited, refreshed and reinterpreted for the ‘here and now’. This requires ministerial leadership which is prepared to live with ambiguity, dissonance and conflict.

Yet some church leaders have wanted to reconceptualise ministry using secular occupational models drawn, for example, from business and therapy. Liminality, Roxburgh insists (1997: 58), requires a different kind of leader: the

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63 Phyllis Tickle (2008) argues that Christianity, and before that Israelite religion, renewed itself every five hundred years. The cultural changes facing the contemporary Church might be understood as a major transition into a new era of Christianity in which established forms of Church are questioned and dominant forces lose their influence. Trebilcock (2012: 7) regards this as definitive of liminality entailing ‘the loss of social status; the end of one era without orientation into another; deconstructed roles and responsibilities’.

64 Leech (2005) refers to a book by Kuhrt (2000), formerly head of the Church of England’s Ministry Division, as ‘a kind of 1950’s managerial Evangelicalism, with little attention to priesthood, diaconate, sacraments, or the world.’ To this, I would add the question posed by the theologian Guder (2015: 157): ‘What is happening to... ministries that equip the saints for the work of service when we adopt the language and values of the corporate world and describe ministers as Chief Executive Officers, Heads of Staff, Executive Pastors, Directors of this and that?’

65 In North America (and elsewhere), there is Clinical Pastoral Education and, in the UK, the Clinical Theology Association (now the Bridge Pastoral Foundation). The original aim of each was to provide therapeutically-styled ministerial training.
poet able to interpret experience and recall the tradition; the prophet able to recognize that the Word of God does have applicability in the life of the world (Roxburgh, 1997: 60), and the apostle ready to lead ‘in lands where the old maps no longer work’ (Roxburgh, 1997: 61). These leaders are not ‘functionaries and organisers’ (Mason, 1992: 72) but, as poets, prophets and apostles, signal a new communitas which is faithful to the Church’s liminal roots while reinterpreting it afresh for a new generation. This is the vocation of the ministerial priest. It is the ‘Church liminal’ ‘that transitions individuals and groups from one point to another as they grow in their life, faith, and work, often in ways that surprise those involved’ (Orton and Withrow, 2015: 41), for it is the place of the unexpected.

To enable the priest to live with the ambiguity, dissonance and conflict typical of liminality, a process of life-long formation is necessary to supplement initial training. While a person can be taught technical knowledge and people skills, important as these are, a life of liminality requires a priest to be instilled with qualities of ‘being’ rather than ‘doing’ because, as Mason (1992: 160f.) makes clear, ministry is not about what the priest does, but who the priest is, what the priest represents and what the priest brings to life or, in Moody’s words (1992: 14), discloses about God. Formation is primarily ascetical: the acceptance of an inner discipline and a ‘taste for God’. Mason is adamant: ‘[a]scetical theology, not management or strategy, is the basic pastoral science’ (Mason, 1992: 160).

What then of the NHS priest-as-chaplain? Can there be congruence between the identity of the healthcare chaplain and the identity of the Church of England priest when there is no prevailing identity for either one? Congruence, I would maintain, lies not in an identity but in the essence or ontology of priesthood. As I discussed in an earlier chapter (§3.3.3), there are different interpretations of priestly ontology. The contention of my research is that priesthood is founded on and authenticated by an ontology of liminality, a revised ontology of priesthood which marks the priest as liminal: ‘contagious, spontaneous, mysterious and essentially eschatological’ (Holmes, 1975: 248).

Although Mason (1992: chapter nine passim) nowhere refers to an ontology of liminality, I regard him as chief among its architects. His call for priestly askesis,
a process of formation which is principally ascetical and built on the disciplines of prayer, repentance and vibrant faith, is liminal in that it assumes nothing save uncertainty. Personal agency is relinquished. It is liminal in that within the transitional space of spiritual transformation everyday structures and social identities count for nothing, and the questions ‘who am I?’ and ‘what am I for?’ count for everything. To cross the threshold of priestly liminality is to experience an ontological shift ‘letting God have his way, at the point where ideas are questioned, attitudes are challenged, feelings are exposed in their confusion, motives in their immaturity.’ (Mason, 1992: 160). The liminal priest, in whom God does have his way, is likely to have an ambivalent relationship with the institutional Church, and this was certainly evident among some participants in my own research. It is the liminal priest who is prepared to take risks and push boundaries, again as was evident among some participants in my research.

Predictably, this may mark the liminal priest as troublesome, unsafe, disobedient, unmanageable or unreasonable; someone the institutional Church may want to keep at ‘arm’s length’. Arguably, however, the Church needs to heed the liminal voice for unless the life of the Church listens ‘its worship becomes desiccated and it loses the ability, as well as the will and intelligence, to touch the heart and imagination’ (Moody, 1992: 132). As Avis (2003: 146) acknowledged, ‘in the worship and sacraments of the Church, liminality is curbed and controlled’, while Rohr (2002) lamented the absence of ‘shared liminality which transforms rather than merely sustains.’

Moody’s imagery of wilderness (1992: 12ff.) is a reminder that the world itself is a liminal place of ‘ambiguities and pitfalls’ where ‘God is always moving beyond what we already know about him’. The alter Christus of priesthood arises from a Christology not based on some abstract union of divine and human natures but, as Mason (1992: 164) pointed out, on the basis that Christ fully engaged in the human experience of ‘ambiguities and pitfalls’. Christ ‘had to become like his brothers and sisters in every respect’, he had to immerse himself in the human condition of liminality in order to ‘be a merciful and faithful high priest in the service of God.’ Priesthood shaped by such a Christology will be a priesthood rooted in liminality for ‘[n]o one can help to open up a situation to God who does

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66 Hebrews 2:17.
not perceive that he is in that condition himself, who cannot acknowledge his
own shame and guilt, grief and perplexity when he offers himself, in God’s
name, as a resource to those who share in those conditions’ (Mason, 1992:
166).

To what extent, then, does the notion of liminal intelligence contribute further to
a theology of priesthood? To address this, it is necessary to recall Mason’s
comment about askesis (1992: 160) that, in its original context, it described the
preparation an athlete makes before a competitive sporting event. Priestly
askesis, Mason argued, is different. Rather than being a preparation for
ministry, it is ministry itself. While accepting this, I would add that it is ministry
deepened by an engagement with liminal intelligence (see further in §7.3.3), a
liminal sensing brought into conscious intelligence by a process of critical
questioning, scrutiny, insight, conception, naming, reflection, checking and
judging (Lonergan, 2004: 39). In her innovative account of liminal intelligence,
Trebilcock, (2012: 9f.) illustrated what she envisaged by turning to Louth (1985)
and his mystical approach to intelligent theology. This he described (1985: 136)
as ‘[a] division between the rational, communicable but superficial, and the
intuitive, which moves us and determines our will, but which is incommunicable
– a division between the objective and the subjective as Kierkegaard
understood that distinction – resolved at the level of the saint, or more exactly at
the level of the saintly life, resolved not in a concept, but in a life, or an act, or a
succession of acts, acts which are lived not in a clarity they attain to, but
through a darkness and confusion of ‘dim apprehension’. As Mason (1992:
160f.) commented, ministry is not about what the priest does, but who the priest
is, what the priest represents and what the priest brings to life. Priesthood is, as
Green (2010: 119) described it, a mobile category capable of re-signification
and transformation. It is crafted by divinely-inspired imagination and creativity,
both of which reflect the experience of liminality. In summary, an ontology of
liminality does not provide a formulaic ontology of priesthood. Rather, it
authenticates the courageous, if somewhat precarious, embrace of the
unknown.
7.5.1 Summary
The research presented in this thesis sought to determine whether, in the rapidly changing ethos of the NHS, the identity of the NHS chaplain in England remains congruent with the identity of the Church of England priest. Twelve individual accounts of healthcare chaplaincy confirmed that there is no common identity among the participants other than the fact that each works within this specialist sector of ministerial practice. That led me to examine Slater’s (2015: xiii) claim that the many different expressions of chaplaincy represent a genre of ministry. There is much to commend her proposal especially given Oppenheimer’s (1979:12) criticism that ‘ministry’ is so all-encompassing that it is devoid of meaning. Where I parted company with Slater was over her classification of all chaplaincies as one genre of ministry. This was too broad, and led me to argue that healthcare chaplaincy is a subgenre of an overall genre of chaplaincy.

A detailed analysis of the participant interviews, and using Wenger’s model of communities of practice, enabled me to locate four communities: the disciplinary community of the healthcare chaplain and the disciplinary community of ministerial priesthood (the vocational discourse) and the social community of the NHS and the social community of the Church of England (the institutional discourse). From this, emerged the idea of a journey across a trajectory of landscapes of communities of practice and the chaplain’s sense of being ‘betwixt and between’ them all.

It was here that the theme of marginality began to take shape as I noted that some participants had turned to healthcare chaplaincy in order to escape the institutional Church while others experienced a vocation to this specialism within ministerial priesthood. An analogy from Jewish history, of exile and diaspora, provided me with the further insight of differing attitudes: exile being the enforced relocation into an alien environment and diaspora, a positive decision to seek engagement irrespective of its alien nature. In this, I observed the complex relationship between where-I-live and where-I-belong.

The notion of diaspora brought to mind the diaspora of the early Christians and the way in which the healthcare chaplain shares a sense of this diaspora.
ministry practising, by choice, in the alien environment of the NHS rather than in the normative parish setting of the Church of England. Avoiding the language of dispersed and gathered Church, I decided to use the missional vocabulary of modal Church and sodal Church suggesting that healthcare chaplaincy reflects sodality. In questioning differences of theology underpinning modal and sodal models of Church, I drew on Steddon’s notion of host and guest theologies and Moody’s analysis of pastoral theology by way of redemptive, incarnational and wilderness theological models.

Still focusing on what bearing marginality might have on healthcare chaplaincy, I realized the importance of clarifying what distinguished liminality from marginality, given that the two terms are frequently used interchangeably. This introduced me to the work of Victor and Edith Turner who developed ideas first found in van Gennep’s anthropological studies and later introduced the novel concept of *communitas*. Liminality, I then argued, captured the sense of dislocation that the participants, and chaplaincy more generally, reported. However, I was engaged by Galashan’s notion of jurisdictional liminality and drew together Turner’s idea of *communitas* and Winter’s concept of sodal Church. I went on to provide examples of how liminality has contributed to an understanding of healthcare chaplain in four areas of ministerial practice i.e. religious pluralism, spirituality, professionalization and mission in the course of which I explored the notion of liminal intelligence.

Finally, I considered ways in which liminality provides further opportunities to critique and extend a theology of priesthood. Although little has been written on the liminality of ministerial priesthood, I noted the comments of six theologians before investigating the legacy of liminality in the person of Jesus, the essence of the gospel, the call to discipleship and the authority of the apostles. From this, I argued that the credibility of the institutional Church is affirmed when it is followed, shadowed and haunted by Christian *communitas* to which it needs to be accountable. What is required of Christian leadership, when liminality and *communitas* are taken seriously, led me to consider the insights of Roxburgh and his recognition that a Church standing at the threshold of liminality can turn in two directions simultaneously: turning back in search of a lost identity which will only serve to marginalize the Church further, or engage with liminality: a
ministerial priesthood prepared to live with ambiguity, dissonance and conflict. This, I maintained, would require a process of formation rather than the acquisition of professional techniques and skills.

In conclusion, I argued that congruence lies not in an identity but in an ontology which marks the priest as liminal. Mason’s writings (1992: chapter nine *passim*), among other theologians, enabled me to characterize this ontology of liminality and the part it plays in shaping the priest and her ministry. Its Christological roots I illustrated from the Book of Hebrews (Hebrews 2:17). In addition, I argued that liminal intelligence complements and enhances the ministry of the priest not in terms of what the priest does, but who the priest is, what the priest represents and what the priest brings to life. While Green (2010: 119) considered priesthood to be a mobile category capable of re-signification and transformation, I foresaw that whatever its form priesthood owed something to divinely-inspired imagination and creativity. However, I acknowledge that in this there is no formulaic ontology of liminality. Instead, it is an ontology of priesthood that authenticates the courageous, if somewhat precarious, embrace of the unknown.
Chapter eight: Conclusion

8.1 Research findings

My research was prompted by the recognition that over the course of nearly seventy years the identity of the NHS chaplain had changed to such an extent that it might no longer be congruent with the identity of the Church of England priest. If this was demonstrated then it would be important to identify why a dislocation of the two identities had occurred, what the nature of the dislocation might be and what the thinking, experience and practice of the NHS priest-as-chaplain might contribute to contemporary discussions of Anglican priesthood focusing on ontology, function and relationship. In what follows I summarize the findings of my research.

1. Analysis of the interviews I conducted with NHS priests-as-chaplain, uncovered an interrelationship of vocational and institutional narratives which I interpreted using Wenger’s community of practice as a conceptual and hermeneutic model (chapter six passim). This enabled me to identify four communities: the disciplinary community of the healthcare chaplain and the disciplinary community of ministerial priesthood as well as the institutional community of the NHS and the institutional community of the Church of England. The chaplain, I determined, does not locate herself within one particular community to the exclusion of all others but journeys across what Wenger (2010: 186) portrays as a landscape of practices. It is this notional journey which uniquely shapes identity. By conceptualizing it in this way, I was able to account for the absence of an identity common to all the participants and the chaplain, journeying betwixt and between the different communities, as someone who experiences a sense of marginality, a significant theme common within all the participant interviews.

2. Although there is no common identity among healthcare chaplains, I considered Slater’s claim (2015: xvi), that all expressions of chaplaincy represent a genre of ministry, as having merit. In principle I concur but my own research suggests that healthcare chaplaincy, with its discrete theological and ministerial focus, its ‘marginal’ status and its specific
body of knowledge is more appropriately a sub-genre in Slater's wider classification of chaplaincy.

3. The recurring issue of marginality I initially explored analogously as exile, but the interviews revealed that ‘exile’ from the institutional Church was not characteristically representative of how all participants perceived the relationship with the NHS or the Church. Exile conveys a sense of enforced relocation from the institutional Church, and this was undoubtedly the case for some participants. For other participants the analogy of *diaspora* was more appropriate, implying a sense of purposeful vocation beyond the institutional Church. What this underlines is the complexity of the relationship between ‘where-I-live’ and ‘where-I-belong’ as well as the status of healthcare chaplaincy as part of the dispersed Church.

4. To understand those ways in which chaplaincy is part of the ‘dispersed’ Church, it was necessary to clarify how the ‘dispersed’ Church differs from the ‘gathered’ Church. Steddon (2010) describes these differences as ecclesiological. The ‘dispersed’ Church adopts a ‘guest’ theology, searching out and partnering God’s presence and activity in the world. In contrast, the ‘gathered’ Church practises a ‘host’ theology which expects the outsider to take the initiative, searching out the Church and becoming an insider. The evidence of the interviews clearly situated chaplaincy within the ‘dispersed’ Church in its calling “to be faithful to something beyond the Church”, and striving ‘to make known the God who is already present’ (‘Brian’). However, the terms ‘dispersed’ Church and ‘gathered’ Church come with theological preconceptions. To circumvent this, I opted to use the missiological language of ‘sodal’ and ‘modal’ Church.

5. A further difference between chaplaincy, as an expression of sodal Church, and modal Church was one derived from Moody's scrutiny of the theological motivation which drives pastoral care (Moody, 1992: 12ff.). While the pastoral care undertaken within modal Church is typically influenced by a theology of redemption, Moody maintains that the more removed a ministry of pastoral care is from modal Church the more likely
it is to be influenced by an incarnational theology. This was certainly borne out by my research in which every participant spoke about or implied an incarnational interpretation of their ministry. However, Moody claims that both redemptive and incarnational theologies of pastoral care have their deficiencies. This leads him to propose a ‘wilderness’ model of pastoral care: to locate God in the world-cum-wilderness where there are no clues as to God’s whereabouts save those learned within the community of faith. Moody’s world-cum-wilderness might be assumed to share common ground with the ministerial context of healthcare chaplaincy but it is what Moody expects from modal Church in its resourcing of ministry in this world-cum-wilderness that resonates with the themes of the participant interviews: that leadership and the spiritual authority accompanying leadership should not be vested in the hierarchical structures of the Church (Moody, 1992: 14); that the Church’s attention should be redirected to the world-cum-wilderness as the place where God discloses himself in ways which are unforeseen and unexpected (Moody, 1992: 13); and that the demarcation line which separates organized and non-organized religion should be withdrawn (Moody, 1992: 110).

6. Moody’s world-cum-wilderness might be described as a marginal place, but from those themes arising out of the participant interviews, I realized that there was more to be learned about this apparent sense of marginality, that it might more accurately be interpreted as liminality in which the healthcare chaplain is the threshold person accompanying others as they negotiate transitional moments such as that between life and death. Galashan’s observation (2015: 106) that the chaplain is located in jurisdictional liminality led me to explore and confirm her insight from four key areas of chaplaincy practice.

7. First, the NHS context is one of religious pluralism in which the beliefs, practices and texts across the different religions, as well as the wisdom and insight each offers, are accorded equal status. This might be regarded as confirming Pattison’s (2015: 18) claim that chaplaincy seems to have become a ‘new umbrella religion.’ My investigation
revealed that the Church of England offers insufficient guidance to those practicing alongside colleagues of different faiths and beliefs, leaving the NHS priest-as-chaplain exposed and without formal support, a feature of jurisdictional liminality.

8. Second, NHS chaplaincy promotes itself as the lead discipline for assessing spiritual needs and delivering spiritual care. Yet my research demonstrated that participants had a narrow understanding of spirituality which retained religious overtones. What was apparent, however, was their awareness of what I termed the ‘spiritual’ relationship. This bore marked similarity to the ‘therapeutic’ relationship considered important for clinicians to establish with their patients. As part of the therapeutic relationship, recent research has explored the place of emotional intelligence, and more generally multiple intelligences. The suggestion by Mowat and Swinton (2005) that emotional intelligence and spiritual intelligence are core chaplaincy skills led me to consider the feasibility of liminal intelligence (Trebilcock, 2012) and the part it might play in a spiritual relationship.

9. Third, amid moves to professionalize healthcare chaplaincy some chaplains and the Chair of the Health and Social Advisory Group of the Catholic Bishops’ Conference of England and Wales have been critical, believing that this challenges the basis of chaplaincy. Within the research interviews, I found that participants’ interpreted professionalism by reference to softer, less tangible skills that drew on emotional and liminal intelligence captured in the notion of semi-professional friendships (§7.3.4). While their ‘professional’ narrative was ungainly and contentious it implied liminality in its challenge to assumptions, expectations and customary practice.

10. Fourth, my research found that the mission agenda of the Church of England presents the chaplain with a quandary. Most participants perceived themselves to be at the forefront of mission and yet, by and large, were critical of the Church’s narrow interpretation of mission. Mission, as the Church interpreted it, was regarded as misconstrued and
inward-looking. Given that some participants expressed resentment that the Church had failed to recognize their contribution, there remains a need to implement a missiology that endorses and blends modal and sodal expressions of Church. In a spectrum of ministerial practice recognizing that modal Church and Sodal Church each has a place, it is not clear where the NHS priest-as-chaplain is located. It could be living in the distance between a ‘community of character’ (Hauerwas, 1981) and a ‘community of the question’ (Derrida, 2001 [1967]: 98) or, as Arbuckle (1999: 160f.) maintains, ‘a prophetic, liminal, grief leader who calls the Church to vacate its accustomed and historically irrelevant past in order to risk the unknown.

11. The key theme to emerge from my research has been the liminality of the chaplain’s practice and this prompted me to explore what liminality might contribute to contemporary discussions of Anglican priesthood. The evidence of the interviews suggests a ministerial priesthood that signals the influence and impact of the liminal Jesus, the liminal gospel, liminal discipleship and an authority which mirrors that same liminal authority associated with Jesus. The priest who embraces a liminal ministry is disinclined to emulate occupational roles derived from the secular world. The liminal priest is neither a functionary nor an organizer but remains faithful to the Church’s liminal roots, reinterpreting it afresh for each new generation.

12. The contention of my research is that priesthood is founded on and authenticated by an ontology of liminality which marks the priest as liminal and charismatic. This owes much to the writings of Mason who calls for priestly askesis, a process of formation which is principally ascetical. To cross the threshold of liminality is to experience an ontological shift ‘letting God have his way, at the point where ideas are questioned, attitudes are challenged, feelings are exposed in their confusion, motives in their immaturity’ (Mason, 1992: 160). Such a person is likely to have an ambivalent relationship with the institutional Church, as was evident among some participants in my research; someone who is prepared to take risks and push boundaries, again as
was evident among some participants in my research. The Church needs to heed the voice of the liminal priest for the sake of its worship and to ensure the authenticity of its relationships with those who live in Moody’s world-cum-wilderness (1992: 12ff.). The ministry of the liminal priest is deepened with liminal intelligence, a liminal sensing brought into conscious intelligence by a process of critical questioning, scrutiny, insight, conception, naming, checking and judging (Lonergan, 2004: 39).

13. The findings of my research lead me to argue that pre-conceptions of what ministerial priesthood might or might not encompass need to be set aside. There can be no pretence of homogeneity in the expression of priesthood for it is not about what the priest does. Rather, it is about who the priest is, what the priest represents and what the priest brings to life (Mason, 1992: 160f.). The priestly life is lived through the liminal darkness and confusion of ‘dim apprehension’ (Louth, 1985:136) and is, as Green (2010: 119) portrays it, a mobile category capable of re-signification and transformation, and crafted by divinely-inspired imagination and creativity, both of which reflect the experience of liminality. An ontology of liminality does not provide a formulaic ontology of priesthood but, instead, authenticates the courageous, if somewhat precarious embrace of the unknown.

8.2 The contribution of this research
The originality of this research lies in the fact that it is the first to be undertaken exploring the theological interface of two specific identities, the NHS chaplain and the Church of England priest. In addition, the distinct and significant contribution it makes to current knowledge lies in its engagement with and its analysis of the ministry of the NHS priest-as-chaplain and, arising from this, its implications for a theology of priesthood. While Slater (2015) maintains that the many varied expressions of chaplaincy form a specific genre of ministry, this research provided the rationale for understanding healthcare chaplaincy as a discrete sub-genre of ministry.

A novel feature was its critical engagement with the theological self-understanding and self-interpretation of research participants as they described...
their sense of identity both as Church of England priests and as healthcare chaplains. This research demonstrated that healthcare chaplains are not solely the exiled figures some have made out (Pattison, 2015: 23). There is also vocational choice that motivates the ordained person to relocate into the diasporic ministry of healthcare chaplaincy.

In scrutinizing the sense of marginalization which many of the participants claimed was a significant factor in their ministry, this research has ascertained that liminality may in the past have been mistaken for marginality. This possibility has not been recognized or acknowledged. Tracing the conceptual development of liminality from van Gennep (1960 [1909]) to Turner (1969; 1978; and 1995), what has been demonstrated, for the first time, is the presence and importance of jurisdictional liminality (Galashan, 2015: 106) in four key areas of chaplaincy practice, i.e. in the context of religious and belief pluralism, of spirituality, of professionalism and of mission. The result is a thicker account of what the identity of the healthcare chaplain might comprise.

In addition, this research introduces the novel hypothesis that, in the ministry of the healthcare chaplain generally, and more specifically in establishing a spiritual relationship with the recipient of ministry, there is a need for liminal intelligence (Trebilcock, 2012).

The main thrust of this research has been directed towards understanding the liminal place of the healthcare chaplain both in terms of ministry and identity. This lends itself to the realization that the essence of priesthood necessarily includes what is described as liminal ontology. This is a revised ontology of priesthood, hitherto unacknowledged, which accounts for the often ambivalent relationship a priest has with the institutional Church as well as her willingness to take risks and extend boundaries. The innovative observation that arises from this is that the Church needs to heed the voice of the liminal priest if its worship and call to discipleship is one that transforms rather than merely sustains (Rohr, 2002).
8.3 The future direction of related research

The role of the healthcare chaplain has changed fundamentally since the inception of the NHS in 1948 and reflects foundational changes to the provision of State-sponsored healthcare. Nonetheless, as the participant interviews revealed, while the disciplinary community of healthcare chaplaincy does not possess or share a single identity, there is a common theme across the many expressions of its identity which I associate with liminality. This, I believe, needs to be the focus for further research more especially in two principal areas.

First, the Turners’ work on liminality has found wider application both in academic and popular culture and its value as a conceptual tool has been acknowledged elsewhere in this thesis (see further in §7.3.1). What would benefit from further research is the proposition that among the conjectured examples of multiple intelligence (Gardner, 1983) there exists what has been described as liminal intelligence. The exploratory model of liminal intelligence put forward by Trebilcock (see further in §7.3.3) raises other interesting research questions. While liminality is clearly transrational, is liminal intelligence more experiential than conceptual? In what respect does it contribute to the relationship between the chaplain and the recipient of ministry (see further in §7.3.3); and, furthermore, what is the relationship between liminal intelligence and two other previously noted forms of intelligence, spiritual and emotional?

Second, the healthcare chaplain offers a very generative pointer to the importance of liminal intelligence for future understandings of priestly ministry and mission in a postmodern, plural, multi-faith society. However, the chaplain operates largely as a lone practitioner; she is not the nucleus of a community as parish ministers must be. Therefore any further exploration of liminal intelligence needs to take place in both parochial communities and those communities arising from ‘fresh expressions’.

Third, unlike the Roman Catholic Church, the Church of England does not have one ontology of priesthood but allows for a number of differing, descriptive exemplars of ontology (see further in §3.3.3). This research has provided one
more: the ontology of liminality. If, as some hold, the ministerial priest has by virtue of ordination received a configuration of character to enable her to act in the person of Christ (\textit{alter Christus}) then it might be thought that the liminality of Jesus (see further in §7.4.2) would make an ontology of liminality a principal feature of any theology of priesthood. This begs a question. To what extent have Church of England priests, whatever their ecclesiological tradition or ministerial context, engaged with a theology of priesthood? Given that some participants to this research did not consider a theology of priesthood important or necessary, what does this imply about priesthood as an identity, let alone one which some might believe is indelible?

Finally, given the dislocation that this research maintains does exist between the NHS priest-as-chaplain and the Church of England (see further in §7.3.1) an important area of research would investigate those ways in which healthcare chaplaincy can be accommodated within the structures of the institutional Church to ensure its equal status with parish-based ministry and provide a framework for support, accountability and representation. As part of this line of research, there would be a need to clarify the relationship between diverse styles and contexts of ministry.

8.4 Final observations

‘For me, there can be no going back; I must finish what I've started, even if, inevitably, what I finish turns out not to be what I began’ (Rushdie, 2011: 230)

This chapter has served a threefold purpose. The research findings have been presented; the contribution my research makes, extending the boundaries of what is already known, has been established; and the direction of future research has been signaled. More remarkable, though, are the twists and turns my research has taken along the way. When I embarked on this research, I thought I knew the direction it would take and, for that matter, the presuppositions I would eventually corroborate. In this I was mistaken. The twin concepts of ‘identity’ and ‘ontology’ seemed demonstrably straightforward. Again, I was mistaken. What I finish turns out to be neither what I began nor where I intended to go, which makes the journey of this research even more extraordinary and worthwhile. As a person clothed with the identity of both
priesthood and healthcare chaplaincy, this research allows me to live ‘not in a clarity they attain to, but through a darkness and confusion of ‘dim apprehension’’ (Louth, 1985: 136), a liminal place which the priest is called to occupy and to proclaim.
Appendix A: Hospital Chaplaincies Council Job Description template
(HCC, 1978a: 9-10)

1. To make provision for the spiritual needs of patients, staff and where applicable students within the hospital, particularly for those people who are unable to remain in contact with their normal place of worship. A chaplain is pastor of all patients and staff of his own denomination and has a concern for those of other Churches though they are principally the responsibility of the chaplain of their own Church tradition.

2. To conduct services of public worship regularly in the chapel and/or other suitable place for worship, and to administer the Sacraments. Times of services should be arranged by the chaplains of the hospital in consultation with Administration so that the most suitable times can be arranged to enable staff and patients to attend.

3. To visit patients and staff in the wards and departments regularly, and when requested to give special ministrations to the seriously ill or dying. According to his denomination, a chaplain should have experience of hearing confessions and in the ministry of healing such as the laying on of hands and holy unction. The full co-operation of medical Consultants and nursing staff should be sought before such services take place on the ward or in private rooms.

4. To meet and welcome new members of staff as soon as possible and to be readily available where opportunity arises to co-operate in the training of students and in Induction courses.

5. To co-operate with medical, nursing and administrative staff wherever possible in departmental meetings as and when his attendance is considered necessary. Many hospitals now have multi- or inter-disciplinary meetings, professional executive and/or heads of department meetings. Chaplains should readily accept invitations to attend when invited to do so.
6. To be available wherever possible to relatives of patients, particularly to those bereaved.

7. To be available to parish priests and ministers in order to assist and advise them in the pastoral care of their people when in hospital.

8. To make public (preferably by leaflet) information about times of hospital religious services and other such facilities for patients and staff.

9. To keep records of all services and, when asked, to write reports for the Area Health Authority (or Chaplains’ Advisory Committees where such committees exist).

10. To ensure that chapels, places of worship and mortuary waiting and viewing rooms are suitably furnished.
Appendix B: Hospital Chaplaincies Council Job Description template
(HCC, 1998: 6-7)

Job Title
Whole-Time Anglican Chaplain [Chaplain’s Assistant]

General
The Anglican Whole-Time Chaplain is responsible for the pastoral care of patients and staff in the ................. NHS Trust and has a concern for those of other denominations, as well as for those of other faiths or of no faith. He/she should be seen as the principal point of reference for religious and ecumenical matters within the Trust. He/she will belong to his local Chapter and Synod, and will need to work closely and in cooperation with the local clergy.

[The Assistant will be under the supervision of the Senior Whole-Time Chaplain. He/she will learn and share in the following:]

1. To make provision for the spiritual needs of patients, staff and where applicable students within the hospital and departments of the ............ NHS Trust, particularly for those people who are unable to remain in contact with their normal place of worship. A chaplain is pastor of all patients and staff of his own denomination and has a concern for those of other Churches though they are principally the responsibility of the chaplain of their own Church tradition.

2. To conduct services of public worship regularly in the chapel and/or other suitable place for worship, and to administer the Sacraments. Times of services should be arranged by the Chaplains of the hospital in consultation with management so that the most suitable times can be arranged to enable staff and patients to attend.

3. To visit patients and staff in the wards and departments regularly and, when requested to give special ministrations to the seriously ill or dying. According to his/her denomination, a chaplain should have experience in hearing Confessions and in ministry of healing, such as the Laying on of Hands and Holy Unction. The full co-operation of medical Consultants
and nursing staff should be sought before such services take place on
the ward or in private rooms.

4. To meet and welcome new members of staff as soon as possible and to
be readily available where the opportunity arises to co-operate in the
training of students and to take part in Induction Courses.

5. To co-operate with medical, nursing and management staff, wherever
possible, in departmental meetings as and when his attendance is
considered necessary.

6. To be available, wherever possible, to relatives of patients, particularly to
those bereaved.

7. To be available to parish priests and ministers in order to consult with
them on the pastoral care of their people when in hospital, and to receive
information from those priests and ministers, always remembering rules
of confidentiality by which every NHS employee is bound.

8. To make public (preferably by leaflet) information about times of hospital
religious services and other such facilities for patients and staff.

9. To keep records of all services and, when asked, to write reports for the
Trust.

10. In cooperation with other staff responsible, to ensure that chapels, places
of worship and mortuary waiting and viewing rooms are suitably
furnished and properly maintained and sustained.
Appendix C: A Person Specification for Whole-Time Anglican Chaplaincy Appointments (HCC, 1998: Appendix B)

Section A
QUALIFICATIONS
1. To be in Holy Orders within the Anglican Communion.
2. To have served a title and/or be eligible to be licensed to officiate by the Bishop.
3. To have served a minimum of 3 years and preferably 5 years in ministry. It is desirable that this be whole-time. If the experience of ministry is part-time (e.g. NSM) then the period should be 5 years.
4. To have some post-basic qualification pertinent to the job or role applied for.

Section B
EXPERIENCE AND PERSONAL GROWTH
1. Experience of health care whether part-time or whole-time.
2. Communication skills/Interpersonal skills.
3. Some evidence of personal growth or faith.

Section C
SKILLS AND KNOWLEDGE
1. Evidence of knowledge of such things as the Patient’s Charter and the Ethos of Health Care.
2. Able to express self clearly and communicate thoughts and ideas.

Section D
OTHER REQUIREMENTS FOR THE POST APPLIED FOR
1. Training
   Appropriate training courses required
2. Education
   This may be graded according to the level of job/role applied for. Certain hospitals may require more academic approach, i.e. a graduate as opposed to [General Ordination Examination].
3. This section to be more specific to the actual job profile – Acute/Psychiatric/Community/Teaching etc., and may include factors such as:

**Relevant Skills and Experience**
- Car driver
- Ability to teach and train others
- Management skills
- Ethical knowledge
- Multi-Faith experience/Ecumenical experience
- More specific counselling/therapy training
- Liturgical skills
- Knowledge of mental health issues

4. **Chaplaincy Standards Awareness**
   Links could be made in this section with the 5 key roles in the Chaplaincy Occupational Standards, and perhaps be expressed as an ability to:
   - Identify and assess needs for chaplaincy provision
   - Manage and develop a chaplaincy service
   - Provide opportunity for worship and religious expression
   - Provide pastoral care, counselling and therapy
   - Provide an informed resource on ethical, theological and pastoral matters

5. **Self Awareness**
   Degree of insight, identification of training needs to match the requirements of the post.
## Appendix D: The National Profile for Chaplain Entry Level
*(NHS Employers, 2013)*

<table>
<thead>
<tr>
<th>Job Title:</th>
<th>Chaplain Entry Level</th>
</tr>
</thead>
</table>
| Job Statement: | 1. Assists in the delivery and maintenance of a chaplaincy service  
2. Undergoes training in order to acquire the expertise to work as a healthcare chaplain |

<table>
<thead>
<tr>
<th>Factor</th>
<th>Relevant Job Information</th>
<th>JE Level</th>
</tr>
</thead>
</table>
| 1. Communication & Relationship Skills | Providing and receiving complex, sensitive information; barriers to understanding  
Pastoral, religious, spiritual support for patients/clients and the bereaved | 4(a) |
| 2. Knowledge, Training & Experience | Expertise within specialism underpinned by theory  
Knowledge of a range of religions and faiths plus hospital related chaplaincy procedures, acquired through degree or equivalent training | 5 |
| 3. Analytical & Judgemental Skills | Range of facts or situations, requiring a comparison of a range of options  
Comparison of a range of facts before advising staff, patients or carers on spiritual issues | 3 |
| 4. Planning & Organisational Skills | Plan and organise straightforward activities, some ongoing  
Plans religious services, own workload, surveys, audits | 2 |
| 5. Physical Skills | Physical skills obtained through practice  
Word processor, keyboard use, driving skills | 2 |
| 6. Responsibility for Patient/Client Care | Provide specialised advice in relation to care  
Provide spiritual and emotional support to patients and clients | 5(c) |
| 7. Responsibility for Policy/Service Development | Follows policies within own role, may be required to comment  
Follows Chaplaincy policies | 1 |
| 8. Responsibility for Financial & Physical Resources | Handles cash, valuables  
Handles collections, donations | 2(a) |
| 9. Responsibility for Human Resources | Demonstrates own activities to new or less experienced employees  
Demonstrate duties to new staffs | 1 |
| 10. Responsibility for Information Resources | Record personally generated information  
Updates client records | 1 |
| 11. Responsibility for Research & Development | Undertakes surveys or audits, as necessary to own work  
Participates in e.g. faith surveys | 1 |
| 12. Freedom to Act | Clearly defined occupational policies, work is managed, rather than supervised  
Works independently, decides when necessary to refer to manager | 3 |
| 13. Physical Effort | Combination of sitting, standing and walking  
Walking between work areas, some work in awkward positions | 1 |
| 14. Mental Effort | Frequent concentration predictable, work pattern predictable/unpredictable  
Concentration for pastoral support to patients, carers, daily devotions/unpredictable work pattern due to unexpected deaths or situations | 2(a)-3 (3) |
| 15. Emotional Effort | Frequent highly distressing or emotional circumstances  
Supporting patients, clients, relatives, staff in emotional circumstances e.g. bereavement, terminal illness, suicide | 4(b) |
| 16. Working Conditions | Occasional unpleasant working conditions  
Verbal aggression | 2(a) |

JE Score Band: JE Score: 333-398  
Band 5
Appendix E: The National Profile for Chaplain (NHS Employers, 2013)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Relevant Job Information</th>
<th>JE Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communication &amp; Relationship Skills</td>
<td>Provide and receive highly complex, sensitive or contentious information agreement or co-operation required. Pastoral, religious, spiritual support for distressed patients, clients and the bereaved.</td>
<td>8(a)</td>
</tr>
<tr>
<td>2. Knowledge, Training &amp; Experience</td>
<td>Specialist knowledge across range of procedures underpinned by theoretical knowledge. Knowledge of a range of religions and faiths plus hospital related chaplaincy procedures, acquired through degree or equivalent training and experience.</td>
<td>6</td>
</tr>
<tr>
<td>3. Analytical &amp; Judgemental Skills</td>
<td>Complex facts or situations requiring analysis, interpretation comparison of a range of options. Comparison of a range of complex facts before advising staff, patients or carers on spiritual issues, analysis of complex multi-cultural issues.</td>
<td>4</td>
</tr>
<tr>
<td>4. Planning &amp; Organisational Skills</td>
<td>Plans religious services, own workload, surveys and audits.</td>
<td>2</td>
</tr>
<tr>
<td>5. Physical Skills</td>
<td>Physical skills obtained through practice. Word processor, keyboard use, diving skills.</td>
<td>2</td>
</tr>
<tr>
<td>6. Responsibility for Patient/Client Care</td>
<td>Provide specialised advice relation to care. Provide spiritual and emotional support to patients and clients.</td>
<td>5(c)</td>
</tr>
<tr>
<td>7. Responsibility for Policy/Service Development</td>
<td>Implements policies and propose changes to practices, procedures for own area. Implements chaplaincy service policies and comments on the development of new policies.</td>
<td>2</td>
</tr>
<tr>
<td>8. Responsibility for Financial &amp; Physical Resources</td>
<td>Handle cash, maintain stock control, authorise signatory. Small payments. Handles collections and donations, maintain chaplaincy supplies, authorise small payments.</td>
<td>2(a) (c) (d)</td>
</tr>
<tr>
<td>9. Responsibility for Human Resources</td>
<td>Handle and maintain stock control, authorise signatory. Small payments. Handles collections and donations, maintain chaplaincy supplies, authorise small payments.</td>
<td>2(a) (c) (d)</td>
</tr>
<tr>
<td>10. Responsibility for Information Resources</td>
<td>Records personally generated information. Updates client records.</td>
<td>1</td>
</tr>
<tr>
<td>11. Responsibility for Research &amp; Development</td>
<td>Undertakes surveys or audits, as necessary to own work. Participates in e.g. faith surveys.</td>
<td>1</td>
</tr>
<tr>
<td>12. Freedom to Act</td>
<td>Clearly defined occupational policies, work is managed rather than supervised. Broad occupational policies. Chaplaincy work is managed rather than supervised/freedom to initiate action within chaplaincy procedures.</td>
<td>3-4</td>
</tr>
<tr>
<td>13. Physical Effort</td>
<td>Combination of sitting, standing and walking. Walking between work areas, some work in awkward positions.</td>
<td>1</td>
</tr>
<tr>
<td>14. Mental Effort</td>
<td>Frequent concentration; work pattern unpredictable. Concentration for pastoral support to patients, clients, carers, daily devotions, unpredictable work pattern due to unexpected deaths or situations.</td>
<td>3(a)</td>
</tr>
<tr>
<td>15. Emotional Effort</td>
<td>Frequent highly distressing or emotional circumstances. Supporting patients, clients, relatives, staff in emotional circumstances e.g. bereavement, terminal illness, suicide.</td>
<td>4(b)</td>
</tr>
<tr>
<td>16. Working Conditions</td>
<td>Occasional/frequent unpleasant working conditions. Verbal aggression.</td>
<td>2(a)-3(b)</td>
</tr>
<tr>
<td>JE Score/Band</td>
<td>JE Score: 409-441</td>
<td>Band 6</td>
</tr>
</tbody>
</table>
Appendix F: The National Profile for Chaplain Team Manager (NHS Employers, 2013)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Relevant Job Information</th>
<th>JE Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communication &amp; Relationship Skills</td>
<td>Provide and receive highly complex, sensitive or contentious information; agreement or co-operation required. Pastoral, religious, spiritual support for distressed patients, clients, carers and the bereaved.</td>
<td>5 (a)</td>
</tr>
<tr>
<td>2. Knowledge, Training &amp; Experience</td>
<td>Specialist knowledge across range of procedures underpinned by theory knowledge of a range of religions and faiths plus hospital-related chaplaincy procedures. Acquired through degree equivalent training and experience.</td>
<td>6</td>
</tr>
<tr>
<td>3. Analytical &amp; Judgemental Skills</td>
<td>Complex facts or situations requiring analysis, interpretation, comparison of a range of options. Companionship of a range of complex facts before advising staff, patients or carers on spiritual issues. Analysis of complex multi-cultural issues.</td>
<td>4</td>
</tr>
<tr>
<td>4. Planning &amp; Organisational Skills</td>
<td>Plan and organisation of complex activities or programmes, requiring formulation, adjustment. Plans the chaplaincy service, organise trust-wide seminars for local clergy/faith leaders, plans team activities</td>
<td>3</td>
</tr>
<tr>
<td>5. Physical Skills</td>
<td>Physical skills obtained through practice Word processor use driving skills</td>
<td>2</td>
</tr>
<tr>
<td>6. Responsibility for Patient/Client Care</td>
<td>Accountable for direct delivery of sub-division of a clinical, clinical technical or social care service. Delivers a trust-wide chaplaincy service (treated as equivalent to a sub-division of a service).</td>
<td>6 (d)</td>
</tr>
<tr>
<td>7. Responsibility for Policy/Service Development</td>
<td>Propose policy or service changes, impact on own area Develops policies with wider impact e.g. bereavement.</td>
<td>3</td>
</tr>
<tr>
<td>8. Responsibility for Financial &amp; Physical Resources</td>
<td>Authorised signatory; holds delegated budget Sign off travel expenses; holds delegated Chaplaincy budget</td>
<td>3 (a)/3 (d)</td>
</tr>
<tr>
<td>9. Responsibility for Human Resources</td>
<td>Day to day supervision, teach/deliver specialist training, line management for single function or department. Day to day management of chaplaincy staff; provides specialist teaching to other chaplaincy staff.</td>
<td>3(a)(c)-(4)</td>
</tr>
<tr>
<td>10. Responsibility for Information Resources</td>
<td>Record personally generated information Updates clients records</td>
<td>1</td>
</tr>
<tr>
<td>11. Responsibility for Research &amp; Development</td>
<td>Undertake surveys or audits, as necessary to own work Participates in e.g. faith surveys</td>
<td>1</td>
</tr>
<tr>
<td>12. Freedom to Act</td>
<td>Broad occupational policies Work independently, freedom to initiate action within organisational aims and objectives.</td>
<td>4</td>
</tr>
<tr>
<td>13. Physical Effort</td>
<td>Combination of sitting, standing and walking. Walking between work areas, some work in awkward positions</td>
<td>1</td>
</tr>
<tr>
<td>14. Mental Effort</td>
<td>Frequent concentration; work pattern unpredictable Concentration for pastoral support to patients, clients, carers, daily devotions, unpredictable working pattern due to unexpected deaths or when working in mental health units.</td>
<td>3 (a)</td>
</tr>
<tr>
<td>15. Emotional Effort</td>
<td>Frequent highly distressing or emotional circumstances Supporting relatives after a patient dies. After suicide or sudden death, dealing with relatives of patients.</td>
<td>4 (b)</td>
</tr>
<tr>
<td>16. Working Conditions</td>
<td>Occasional/frequent unpleasant working conditions Verbal aggression</td>
<td>2(a) /3 (a)</td>
</tr>
<tr>
<td>JE Score/Band</td>
<td>JE Score 475-491</td>
<td>Band 7</td>
</tr>
</tbody>
</table>

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Appendix G: A locally-agreed Job Description for a Chaplain Team Manager (source: Plymouth Hospitals NHS Trust)

<table>
<thead>
<tr>
<th>Job Group:</th>
<th>Chaplaincy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Job Title:</strong></td>
<td>Head of Department of Pastoral &amp; Spiritual Care</td>
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<tr>
<td><strong>Existing Grade:</strong></td>
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<tr>
<td>Directorate/Division:</td>
<td>Human Resources</td>
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<tr>
<td>Department:</td>
<td>Pastoral &amp; Spiritual Care</td>
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<tr>
<td>Location:</td>
<td>Derriford Hospital</td>
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<tr>
<td>Reports to:</td>
<td>Director of Human Resources</td>
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<tr>
<td>Accountable to:</td>
<td>Director of Human Resources</td>
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**Job Purpose**

To manage the Department of Pastoral & Spiritual care which provides for the pastoral, spiritual, ethical and religious needs of patients, staff, visitors and students within the Trust. To manage personnel within the Department of Pastoral & Spiritual care, incorporating the Team Chaplain (and Deputy Head of Department), Trust chaplains, bank chaplains, honorary chaplains, religious visitors, students and Department volunteers. To be the religious lead for one’s own faith community. To be the senior generic chaplain for the Trust.

**Key Dimension**

a. Discern and assess pastoral, spiritual and religious need of patients, relatives, and staff.

b. Arrange an appropriate response with available resources.

c. When appropriate, and in partnership with relevant agencies, provide continuing support in the community.

d. To be a pastoral, spiritual, religious and ethical resource to the Trust and wider community.
1. **Specialist knowledge and practice:** to provide specialist knowledge of one’s own faith tradition as well as that of other traditions, cultures and faith communities. To be a specialist adviser on ethical issues related to healthcare. With regard to birth rites, serious illness, and death and the dying, to provide specialist knowledge of one’s own faith community, its rites and rituals. To provide specialist spiritual assessments, and act as a resource for other healthcare professionals who make spiritual assessments as a component of care planning within the continuum of care.

2. **Rites and rituals:** to conduct services of public worship regularly in the hospital (and, when required, elsewhere), in accordance with one’s own faith tradition or ecumenically. To administer the rites and practices of one’s own faith tradition to in-patients and out-patients, and to provide for the religious and spiritual need of patients, relatives and staff who are unable to remain in contact with their faith community. To provide such services as required by the wider Hospital community, and to chaplain the organisation. To arrange and publicise times of worship in accordance with faith needs. To arrange and/or conduct contract funerals for both babies and adults as required. To arrange and/or conduct services of naming and blessing of babies who die during pregnancy. To arrange such Memorial Services and other corporate or public events and services as the Trust requires. To advise on all aspects of pastoral,
spiritual and religious bereavement (ante and post-death care) as well as funerals.

3. **On-call:** to offer twenty-four hour cover for pastoral, spiritual, and religious needs. In particular, three generic on-call sessions (outside normal working hours) each week, and such week-day and week-end work and extra on-call sessions (outside normal working hours) as necessary. To be the on-call team leader for major incidents and emergencies, and to arrange such team leader cover as required. To be the lead chaplain for particular areas of the Trust, and to provide emergency generic cover to any area of the Trust. To be able to respond to A&E, and to emergencies, as trauma chaplain.

4. **Staff:** working alongside the Department of Occupation Health, and the Trust Staff Counsellor, to provide staff counselling, support, supervision and mentoring. Working with the Human Resources Directorate, to provide staff mediation. To advise, plan, write and implement Trust policy on pastoral, religious and spiritual issues pertaining to all Trust staff, as part of the Trust’s *Improving Working Lives*. To maintain responsibility for the Trust’s *Religion at Work Guidance Note*.

5. **Line management responsibilities:** to manage the Department’s human resources, including the processing of staff leave (holiday, sickness, educational and retreat), appraisals, disciplinary matters, as well as health and safety assessment and risk analysis. To supervise the professional practice of the Spiritual Care Adviser, Plymouth Teaching Primary Care Trust. To be responsible for training within the Department, identifying training needs (in addition to those arising out of the appraisal process), and disseminating training and educational opportunities.

6. **Financial responsibility and accountability:** to exercise budgetary control. To be responsible and accountable for the Department budget; to be responsible and accountable for the Department charitable budget; to be an authorised signatory for cash and other financial payments; to be an authorised signatory for two funds (Department and charitable); to
monitor all throughputs of money and stock for the Department, as well as salary payments for all service staff. To be responsible for the maintenance and fabric of the Department offices on level 7, the Chapel on level 7, and the Sir Jules Thorne Viewing Suite on level 4.

7. **Training and education**: to be the Trust-lead for training in pastoral, spiritual and religious care and to be actively involved in promoting spiritual, religious and cultural care. To provide specific training in the area of bereavement, cultural and spiritual matters, as well as healthcare ethics. Consequently, to be responsible for the co-ordination of multidisciplinary training of staff and students (including students of the University of Plymouth and the Peninsular Medical School); to participate in the induction of all new members of the Trust with regard to pastoral, spiritual and religious care, as well as providing information about staff support and mentoring. To be responsible for training concerned with specialist spiritual (e.g. palliative care needs) and multi-faith issues; to represent the Trust and contribute to national training and educational forums on behalf of the Trust.

8. **Direct patient care**: as a highly-skilled communicator, to establish and maintain relationships, sometimes in pastorally challenging, as well as unpredictable, unpleasant and hostile environments. To negotiate, comparatively assess and work within highly complex and sensitive situations and to provide such pastoral, spiritual and religious advice and care as necessary. To practise in traumatic situations, e.g. grief counselling following a sudden death, the sensitive disposal of foetal remains, and counselling extremely disturbed psychiatric patients. To practise in situations where there is exposure to verbal and occasional physical aggression. To responsibly manage clinically-unsupervised patients during chapel services, as well as accepting responsibility for their movement to and from the services by bed and wheelchair. To make independent specialist judgements regarding pastoral spiritual and religious care, dependent upon situation. Showing a high degree of flexibility, to adapt to unpredictable and unpleasant working conditions
when required, and to respond to or co-ordinate a response for all emergencies notified to the Department.

9. **Multi-disciplinary practice:** to co-operate with clinical and management staff wherever possible in multi-disciplinary meetings and department meetings as and when attendance is appropriate. To play a full part in discussions where pastoral, spiritual and religious needs of patients might be a component of care-planning. To be a resource, for all healthcare colleagues, as lead chaplain in this specialist area of work.

10. **Community liaison and participation:** to liaise with and advise local religious leaders and faith community pastoral agencies (e.g. the CELL visiting scheme) about the pastoral, spiritual and religious care of patients, visitors and staff. To receive information from such leaders, within the confines of confidentiality. To be a resource for the Trust for such local and national multi-faith information. To actively implement and encourage patient and staff liaison about the work of the Department and the Trust’s response to spiritual and religious care issues. Working alongside the Trust Press Office, to liaise with the media and accept invitations to broadcast on issues of pastoral, spiritual and religious concern on radio (e.g. BBC Radio Devon) and television. To provide religious services for members of the public where there is a religious or spiritual need arising out of their healthcare experience (e.g. the twice yearly service of Remembering & Sharing for parents whose baby has died during pregnancy or around birth). To arrange the civil or religious marriages of patients with the Registrar of Births, Marriages and Deaths or the Archbishop’s Faculty Office. To meet, and discuss common issues with, the local Funeral Directors twice yearly.

11. **Standards:** to ensure the highest quality of service through nationally-agreed chaplaincy standards, and the Department of Health guidance contained in its publication *NHS Chaplaincy: Meeting the Religious and Spiritual needs of Patients and Staff*. In addition, this will take account of Trust and team objectives. To maintain patient referral records and to supervise chaplains, students and volunteers with regard to patient and
relative contact and recording. To be responsible for the implementation of religious and spiritual care policies e.g. the conduct of faith groups and the presence of unauthorised religious visitors to the hospitals. To co-ordinate and revise, from time to time, the Trust Spiritual Care Strategy set out in the document, *The Direction, Focus, & Structure of the Department of Pastoral & Spiritual Care (revised February 2004)* in conjunction with the Diversity committee and the Public-Patient Involvement Steering Group.

12. To have keyboard skills and office skills as required. To attend such training as required by the Trust and highlighted by individual performance appraisal.

13. To encourage and lead innovation and change within both the Department and the service it offers. To be proactive in audit, research and development and in responsive practices.

14. To participate in the process of individual performance appraisals, and to attend mandatory training and other training as agreed.

15. To lead on the development and implementation of the Department’s strategy plan and its commitment to the objectives of the Trust.

16. To respond to major and critical incidents on behalf of the Department. To be spiritual care lead chaplain on all aspects of emergency care.

17. To be responsible for one's own professional and spiritual development. To organise and attend team meetings, Department conferences and workshops, as well as other meetings and supervision as arranged. To undertake an annual retreat. To abide by the CHCC Code of Conduct.
Appendix H: A locally-agreed Person Specification for a Chaplain Team
Manager (source: Plymouth Hospitals NHS Trust)

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<tr>
<th>ATTRIBUTES</th>
<th>ESSENTIAL</th>
<th>DESIRABLE</th>
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<tbody>
<tr>
<td>Knowledge &amp; Experience</td>
<td>To have proven pastoral, spiritual and religious experience in highly complex, emotional and distressing situations, particularly in trauma situations and another speciality. Experience of working with other cultures and faiths. An understanding of medical ethics. To have highly developed specialist knowledge of spiritual care issues (with specialist knowledge of own tradition and others), multi-faith issues and cultural care. To be able to plan and implement development strategies, internally and for the Trust. To be able to develop specialist spiritual assessment and care, with integration into patient pathways, also resourcing staff and others. To manage department consisting of different and complex layers, staff, volunteers and community support. To have financial experience, working with money, budgets, and accounts. To have knowledge, skills and experience of counselling and pastoral techniques,</td>
<td>To have provided pastoral care for people experiencing an episode of mental illnesses. To have trained and managed volunteers. Creatively adaptable and sensitive within a liturgical and sacramental ministry. An ability to identify one’s own training needs in line with the requirements of one’s post.</td>
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and spiritual direction (the latter within own faith community).
To have experience of and taken a lead in institutional chaplaincy issues, such as staff training, support, ethical issues, policy & community involvement.
To have IT and communication experience.
To have 3 years experience of working within a hospital environment as a chaplain

| Qualifications | To be a graduate, and authorised by relevant faith community, with 6 years recognition as a religious leader.
To have 3 years experience of working within a hospital environment as a chaplain | To have Masters degree, or to be willing to engage in postgraduate work in relevant field.
Recognised Counselling Qualification
To be registered as a chaplain with the College of Health Care Chaplains. |

| Aptitude & Abilities | Ability to communicate with staff, patients and others in situations with highly sensitive information and/or in highly distressing circumstances.
Possess a deep personal spirituality.
Display empathy. | Demonstrate proven management abilities.
Ability to facilitate change within an organisation |
| Disposition, Attitude & Motivation | Demonstrates rapid adaptability.  
Demonstrate ability to work unsupervised.  
Able to recognise and assess limits to competencies of one’s self and others.  
Decisiveness.  
To be approachable and sympathetic.  
Ability to give and receive constructive criticism in an appropriate manner.  
Ability to assess and prioritise situations rapidly.  
Works in a calm and organised manner.  
Team player.  
Committed to working constructively and creatively with other Christian denominations.  
Committed to working constructively and creatively with other World Faith Groups.  
Able to demonstrate vision.  
Able to enthuse and motivate colleagues.  
Well presented and in good physical and mental health.  
Committed to self-learning and self-development.  
A person with humour.  
Able to demonstrate personal integrity and an ability to maintain confidentiality.  
Able to demonstrate an understanding of the dynamics of large organisations and the challenges of a ministry to healthcare institutional structures.  
Proven work record as a team leader. |
<table>
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<tr>
<th>Circumstances</th>
<th>Able to carry out regular on-call rota commitments.</th>
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<tbody>
<tr>
<td>Other factors</td>
<td>To engage in chaplaincy care audit/research.</td>
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Appendix I: A Postal Questionnaire about Ministerial Priesthood

The aim of the following questions is to elicit your understanding of Anglican priestly ministry.

Personal details
1. How old will you be on 1st September 2010?
2. What is your gender? Please enter M(ale) or F(emale)
3. What was the name of the college/ministerial training course you attended?
4. What was the date of your ordination to the priesthood?

Parish experience
5. How many years have you been in parish-based ministry?
6. How many years did you serve as an assistant curate or team vicar?
7. How many years have you been a full-time incumbent?
8. How many parishes have you served as a full-time incumbent?

Full-time sector or extra-parochial ministry
9. Since ordination have you worked full-time in non parish-based ministry? Y(es) or N(o)
If yes, please give details below. If no, please go to question 11.
10. employer e.g. Vountary Agency/Diocese/MOD:
    post title:
    how many years did you serve in this post:
    area of work e.g. RAF, consultancy, administrative:

    employer e.g. Vountary Agency/Diocese/MOD:
    post title:
    how many years did you serve in this post:
    area of work e.g. RAF, consultancy, administrative:
Church tradition

Church tradition is a disputed concept. Here it is used in preference to the non-inclusive term ‘churchmanship’. It refers to general groupings of members of the Church of England according to their understanding of church doctrine and liturgical practice. The three principal forms of Church tradition are Low Church, Broad Church and High Church. Although these categories hold less credence than they did during the twentieth century, they retain some meaning. Within each tradition there are sub-categories. Varieties of low Church tradition include charismatic evangelical, traditional evangelical, open evangelical and conservative evangelical; varieties of high Church tradition include traditional Anglo-Catholic, moderate Catholic, modern Catholic, liberal Catholic, prayerbook Catholic and Anglo-Papalist.

Given the limitations outlined above, please provide answers to the following questions using one of the categories outlined above.

11. How would you describe the church tradition of the parish where you worshipped when you experienced a calling to ordained ministry?

12. How would you describe your own sense of church tradition when you experienced a calling to ordained ministry?

13. How would you describe your own sense of church tradition when you were ordained?

14. How would you describe your own sense of church tradition today?
15. How would you describe the church tradition of the parish where you currently serve? *If you serve in a group of parishes, please list them below according to tradition.*

| Parish A: |
| Parish B: |
| Parish C: |
| Parish D: |
| Parish E: |
| Parish F: |
| Parish G: |
| Parish H: |
| Parish I: |
| Parish J: |

**Your understanding of priesthood**

*Please rank the following statements about Anglican priesthood by circling the appropriate number*

- Strongly disagree (1); moderately disagree (2); slightly disagree (3); slightly agree (4); moderately agree (5); strongly agree (6)

16. There is no fundamental difference between a priest and any baptized person of the Church.

1 2 3 4 5 6

17. The priest is fundamentally different to other baptized members of the Church.

1 2 3 4 5 6

18. Only the priest can fully represent the Church to God.

1 2 3 4 5 6

19. Only the priest can fully represent God to the Church.

1 2 3 4 5 6
20. All the tasks assigned to a priest could just as well be carried out by any Church lay member if only Church law allowed it.

21. At ordination, God endows the priest with a new identity.

22. There is no difference between ordained and non-ordained ministry.

23. A non-ordained baptized person should be allowed to preside at Holy Communion.

24. It is only the training of a priest that sets him/her apart from a non-ordained baptized person.

25. Once a priest, always a priest.

26. Only within the context of an ecclesial community does a priest retain a

27. The priest represents the person of Christ at Holy Communion.

28. The calling into Christ at baptism is no different from the calling into Christ at ordination to the priesthood.
29. Ordination to the priesthood is about what a person does, a set of functions, rather than a way of being in the life of the Church. (Cockworth and Brown).

30. Spiritually, priesthood adds a new dimension over and above what is given at baptism.

31. The priest is as Christ in the sacrament of Holy Communion.

32. The priest is set apart from non-ordained baptized people in that he/she is a sacrament who performs sacramental acts.

33. Ordination to the priesthood recognizes that a person has certain gifts which are to be encouraged and recognized.

34. Ordination to the priesthood affirms what is already gifted by God.

35. Ordination to the priesthood changes a person in a way which can never be revoked.

36. The priest is not only a person who performs certain actions but a person who is changed at ordination.

37. Priesthood is more about character than it is about function.

38. The priest is more about being than doing.
39. Ordination to the priesthood is not about identity but about a series of functions.

1  2  3  4  5  6

40. Is priesthood about who you are, a way of being in the life of the Church that was indelibly marked upon you at ordination?

1  2  3  4  5  6

41. If priesthood is about both what you do, i.e. a set of functions and about who you are, i.e. your 'being' marked by an indelible character, which has more relevance to your ministry?

1  2  3  4  5  6

**Function**

List the principle functions of your ministry. Please list these functions according to the amount of time you give to each function on average each week, e.g. management of colleagues, administration, sermon, sacramental worship, prayer, teaching, pastoral visiting, counselling and so on.
Appendix J: An Initial Stage in the Development of a Semi-Structured Interview

Aim
The development of a focused questionnaire exploring the self-perceived identity of the Anglican NHS healthcare chaplain as priest and healthcare chaplain.

Objectives
To elicit, from ordained Anglican priests in healthcare ministry, working in NHS hospitals in England, their conceptualization of identity in terms of Anglican priesthood and healthcare chaplaincy as well as the relationship of ‘being’ and ‘identity’ to ‘function’ and ‘role’.

Questions to clarify sample population
What is your current appointment?
What is your pay band?
In what year were you ordained an Anglican priest?
Were you previously in the ordained ministry of another denomination? Please give details i.e. denomination and number of years in ordained ministry.
How many years have you ministered as a healthcare chaplain?
How many years have you been in your current appointment?
Given the limitations of labels, which of the following might describe your church tradition: evangelical, broad-church or catholic?

Questions to explore self-understanding of ‘priestly identity’ and ‘healthcare chaplain identity’ prior to interview
1) Priestly identity:
What does the concept ‘priestly identity’ mean for you? (Why this question? to explore different understandings of ‘priestly identity’)
In what ways has this developed since you were first ordained an Anglican priest? (Why this question? to explore the development of the concept ‘priestly identity’)
What does the concept ‘priestly identity’ mean for you in your ministry as a healthcare chaplain? (Why this question? to explore the integration of the two
identities of priest and healthcare chaplain and the relevance each holds for the other)

What does the concept ‘priestly identity’ mean for those to whom you minister? (Why this question? to explore the perceived relevance of ‘priestly identity’ in the work setting and areas of perceived value and/or tension)

2) Healthcare chaplain identity:
In what ways would you speak of or view the identity of a healthcare chaplain? (Why this question? to explore different understandings of the identity of the healthcare chaplain)
In what ways might those to whom you minister speak of or view the identity of a healthcare chaplain? (Why this question? to explore perceived value given by others and impact on self-worth)
In what ways do you think that the identity of the healthcare chaplain has changed since 1948? (Why this question? to explore an individual’s awareness of developments within healthcare chaplaincy and its consequences for current delivery of healthcare chaplaincy)

3) Priesthood:
Is there one or more theological motifs that contribute to your understanding of priestly identity? (Why this question? to elicit understanding and interpretation of priesthood: examples might be God’s faithfulness, Christ’s sacrifice or covenant theology)
Is there one or more scriptural passages that contribute to your understanding of priestly identity? (Why this question? to elicit understanding and interpretation of priesthood: examples might be Matthew’s Great Commission, Mark 10:45; Luke 22:25-27, or Romans 15:16, 2 Cor.3:4-12, Hebrews 5:6)
What liturgical rite or ceremony is important to your understanding of priestly identity? (Why this question? to elicit understanding and interpretation of priesthood: example might be Ordination commission or Eucharist)
What do you perceive to be the relationship of the priest to the Church? (Why this question? to elicit understanding and interpretation of priesthood in the light of other non-ordained ministries)
What do you perceive to be the relationship between the priest and the Diocesan Bishop? (Why this question? to elicit understanding and interpretation of priesthood in terms of episcopacy)

What do you perceive to be the theological relationship of the two concepts: ordained priesthood and the ‘priesthood of all believers’? (Why this question? to elicit understanding and interpretation of the distinctive nature of priesthood)

4) Healthcare Chaplaincy:

Is there one or more theological motifs that contribute to your understanding of an identity of the healthcare chaplain? (Why this question? to elicit understanding and interpretation of healthcare chaplain: examples might be healing, reconciliation and wholeness)

Is there one or more scriptural passages that contribute to your understanding of an identity of the healthcare chaplain? (Why this question? to elicit understanding and interpretation of healthcare chaplain: an example might be Matthew 25)

What liturgical rite or ceremony is important to your understanding of an identity of the healthcare chaplain? (Why this question? to elicit understanding and interpretation of healthcare chaplain: example might be anointing of sick and baptism)

What do you perceive to be the relationship of the healthcare chaplain to the Church? (Why this question? to elicit understanding and interpretation of healthcare chaplain as an expression of Church)

What do you perceive to be the relationship between the healthcare chaplain and the Diocesan Bishop? (Why this question? to elicit understanding and interpretation of healthcare chaplain as an expression of Church)

What do you perceive to be the theological relationship of an ordained Anglican healthcare chaplain and the non-ordained healthcare chaplain? (Why this question? to elicit understanding and interpretation of the distinctive nature of the ordained Anglican healthcare chaplain)

What do you perceive to be the theological relationship of an ordained Anglican healthcare chaplain and Free Church healthcare chaplains? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)
What do you perceive to be the theological relationship of an ordained Anglican healthcare chaplain and Roman Catholic chaplains? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)

5) Ontology & Function:
In what ways, if any, do you consider that Anglican priesthood involves a distinctive character, a change in a person’s ‘being’ following ordination? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)

In what ways, if any, do you consider that baptism involves a distinctive character, a change in a person’s ‘being’ following the rite of baptism? (Why this question? to elicit understanding and interpretation of the ontological relationship of the baptized and the ordained)

In what ways, if any, do you consider that Anglican priesthood constitutes a role or series of functions? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)

What is the relationship between the character of Anglican priesthood, on the one hand, and its role or functions on the other? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)
Appendix K: A Semi-Structured Interview developed for the Pilot Study

**General Questions**

1.1 How did you come to be ordained as an Anglican Minister? *(the participant’s story)*

1.2 What do you think ordination confers? *(the participant’s narrative construct)*

1.3 How did you come to be a healthcare chaplain? *(the participant’s story)*

1.4 What do you think ordination brings to the post of healthcare chaplain? *(the participant’s narrative construct)*

1.5 In what ways does the concept ‘priesthood’ have meaning for you? *(the participant’s narrative construct)*

**Ministerial identity**

2.1 In what ways has your thinking developed since you were first ordained an Anglican minister? *(Why this question? to explore the development of the concept ‘ministerial identity’)*

2.2 What value, meaning or importance is it for you, as a healthcare chaplain, to be an ordained minister? *(Why this question? to explore the integration of the two identities of ordained minister and healthcare chaplain and the relevance each holds for the other)*

2.3 What does it mean, for those to whom you minister, that you are ordained? *(Why this question? to explore the perceived relevance of ‘ministerial identity’ in the work setting and areas of perceived value and/or tension)*

2.4 What drew you into healthcare chaplaincy? *(Why this question? to explore tensions and developments in thinking arising from previous parochial ministry experience)*

2.5 In what ways has your experience of healthcare chaplaincy led you to re-think or develop your understanding of ordained ministry? *(Why this question? to explore the development of ‘priestly identity’)*

**‘Healthcare chaplain identity’**

3.1 How would you describe what it means to be a healthcare chaplain? *(Why this question? to explore different understandings of the identity of the healthcare chaplain)*
3.2 As an ordained healthcare chaplain, which is more important: what you do or who you are? (*Why this question? to explore any perceived distinction between the role and identity of the healthcare chaplain*)

3.3 In what ways might those to whom you minister understand the nature of healthcare chaplaincy? (*Why this question? to explore perceived value given by others and impact on self-worth*)

3.4 In what ways do you think that the identity of the healthcare chaplain might have changed since 1948? (*Why this question? to explore an individual’s awareness of developments within healthcare chaplaincy and its consequences for current delivery of healthcare chaplaincy*)

**Ordained Ministry**

4.1 Are there one or more theological motifs that resonate with your understanding of ministerial identity? (*Why this question? to elicit understanding and interpretation of priesthood: examples might be Christological or pneumatological, God’s faithfulness, Christ’s sacrifice or covenant theology*)

4.2 Are there one or more scriptural passages that resonate with your understanding of ministerial identity? (*Why this question? to elicit understanding and interpretation of priesthood: examples might be Matthew’s Great Commission 28:19f, Mark 10:45; Luke 22:25-27, or Romans 15:16, 2 Corinthians 3:4-12, Hebrews 5:6*)

4.3 What liturgical rite or ceremony is central to your understanding of ordained Anglican ministry and why? (*Why this question? to elicit understanding and interpretation of priesthood: example might be Ordination commission or Eucharist*)

4.4 What do you perceive to be the relationship of the ordained minister to the Church? (*Why this question? to elicit understanding and interpretation of priesthood in the light of other non-ordained ministries*)

4.5 What do you perceive to be the relationship between the ordained minister and the Diocesan Bishop? (*Why this question? to elicit understanding and interpretation of priesthood in terms of episcopacy*)

4.6 In what ways do you understand the relationship between the two concepts: ordained ministry and the ‘priesthood of all believers’? (*Why this question? to elicit understanding and interpretation of the distinctive nature of priesthood*)
Healthcare Ministry

5.1 Are there one or more theological motifs that contribute to your understanding of the ordained healthcare chaplain? (Why this question? to elicit understanding and interpretation of healthcare chaplain: examples might be healing, reconciliation and wholeness)

5.2 Are there one or more scriptural passages that contribute to your understanding of the healthcare chaplain? (Why this question? to elicit understanding and interpretation of healthcare chaplain: an example might be Matthew 25)

5.3 Would you say that there is a liturgical rite or ceremony that embodies your understanding of the ordained Anglican healthcare chaplain? If yes, in what way? (Why this question? to elicit understanding and interpretation of healthcare chaplain: example might be anointing of sick and baptism)

5.4 What do you understand to be the relationship of the healthcare chaplain to the Church? (Why this question? to elicit understanding and interpretation of healthcare chaplain as an expression of Church)

5.5 What do you understand to be the relationship between the healthcare chaplain and the Diocesan Bishop? (Why this question? to elicit understanding and interpretation of healthcare chaplain as an expression of Church)

5.6 What do you understand to be the theological relationship of an ordained Anglican healthcare chaplain and the non-ordained healthcare chaplain? (Why this question? to elicit understanding and interpretation of the distinctive nature of the ordained Anglican healthcare chaplain)

5.7 What do you understand to be the theological relationship of an ordained Anglican healthcare chaplain and Free Church healthcare chaplains? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)

5.8 What do you understand to be the theological relationship of an ordained Anglican healthcare chaplain and Roman Catholic chaplains? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)

Ontology & Function

6.1 In what ways, if any, do you think that baptism involves what some call a ‘distinctive character’, some profound change in a person’s ‘spiritual identity’
following the rite of baptism? (Why this question? to elicit understanding and interpretation of the ontological relationship of the baptised and the ordained)

6.2 In what ways, if any, do you think that Anglican ordained ministry involves a distinctive character, some profound change in a person’s ‘spiritual identity’ following the rite of ordination? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)

6.3 In what ways, if any, do you consider that Anglican ordained ministry constitutes a role or series of functions? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priesthood)

6.4 What is the relationship between the ‘distinctive character’ of Anglican ordained ministry, on the one hand, and its role or functions on the other? (Why this question? to elicit understanding and interpretation of the distinctive nature of Anglican priest)
Appendix L: The Final Format of the Semi-Structured Interview

Thanks for agreeing to take part in this research which is looking at the interface of two identities: that of ordained minister and healthcare chaplain. A few things before we begin. First, when I refer to ordination, I mean Anglican ordination to the priesthood. Second, within the research you will not be identified by name so the contents of our conversation will be used anonymously. Finally, I would like to record our conversation. Is that OK? Do you have any questions at this stage.

The participant’s story
1.1 What led up to your seeking ordination as an Anglican priest or minister? (The participant’s story)
1.2 How did you come to be a healthcare chaplain? (To explore developments in thinking arising from previous parochial ministry experience)

The participant’s ‘priestly identity’
2.1 What do you think ordination to Anglican priesthood confers? (The participant’s construction and understanding of priesthood)
2.2 How do you understand the relationship between the two concepts ‘priesthood’ and ‘ministry’? (The participant’s construction and understanding of priesthood)
2.3 As an ordained Anglican priest, which is more important: what you do or who you are? (To explore any perceived distinction between the ontological and functional aspects of Anglican priesthood)
2.4 In what ways has your understanding of what it means to be an Anglican priest developed since you were first ordained? (To explore the process of formation and the developing construction and understanding of ‘priestly identity’)

The participant’s identity as healthcare chaplain
3.1 How would you describe what it means to be a healthcare chaplain? (To explore different understandings of the identity of the healthcare chaplain)
3.2 As a healthcare chaplain, which is more important: what you do or who you are? (To explore any perceived distinction between the ontological and functional aspects of the healthcare chaplain)

3.3 What added value does being an Anglican priest bring to the post of healthcare chaplain? (To explore the perceived value, construction and understanding of ‘priestly identity’)

3.4 From your experience, what do you think it might mean, for those to whom you minister, that you are an ordained Anglican priest? (To explore the perceived relevance of ‘priestly identity’ in the work setting and areas of perceived value and/or tension)

3.5 In what ways has your experience of healthcare chaplaincy led you to re-think or develop your understanding of ordained priesthood? (To explore the process of formation and the developing construction, understanding and relevance of ‘priestly identity’)

3.6 In what ways might those to whom you minister understand what healthcare chaplaincy is all about? (To explore the perceived value and relevance given by others and the impact on self-worth)

3.7 How do you think management within your Trust perceives healthcare chaplaincy? (To explore in what ways a person’s ‘priestly identity’ might have been shaped by the ethos of the employing organisation.)

**Ordained Ministry**

4.1 Are there any theological motifs or themes or doctrines that resonate with your understanding of priestly identity? (To elicit an understanding and interpretation of priesthood: examples might be Christological or pneumatological, God’s faithfulness, Christ’s sacrifice or covenant theology)

4.2 Are there any scriptural passages that resonate with your understanding of priestly identity? (To elicit an understanding and interpretation of priesthood: examples might be Matthew’s Great Commission 28:19f, Mark 10:45; Luke 22:25-27, or Romans 15:16, 2 Corinthians 3:4-12, Hebrews 5:6)

4.3 What liturgical rite or ceremony do you perceive as central for you as an Anglican priest and why? (To elicit an understanding and interpretation of priesthood: examples might be ordination commission or Eucharist)

4.4 How would you describe the theological relationship between the ordained Anglican priest and a lay person whose ministry is licensed by an Anglican
bishop? (To elicit an understanding and interpretation of priesthood in the light of other non-ordained licensed ministries)

4.5 How would you describe the theological relationship between the ordained priest and the Diocesan Bishop? (To elicit an understanding and interpretation of priesthood in terms of episcopacy)

4.6 What do you understand to be the theological relationship between the two concepts: ordained priesthood and the ‘priesthood of all believers’? (To elicit an understanding and interpretation of the distinctive nature of priesthood in terms of both ecclesial order and ecclesial community)

Healthcare Ministry

5.1 Are there any theological motifs or themes or doctrines that resonate with your understanding of the healthcare chaplain? (To elicit an understanding and interpretation of the healthcare chaplain: examples might be healing, reconciliation and wholeness)

5.2 Are there one or more scriptural passages that resonate with your understanding of the healthcare chaplain? (To elicit an understanding and interpretation of the healthcare chaplain: an example might be Matthew 25:31-46)

5.3 What liturgical rite or ceremony do you perceive as central for you as a healthcare chaplain? (To elicit an understanding and interpretation of the healthcare chaplain: example might be anointing of sick and baptism)

5.4 What do you understand to be the relationship between the healthcare chaplain and the mission of the Church? (To elicit an understanding and interpretation of the healthcare chaplain as an expression of Church)

5.5 What do you understand to be the relationship between the healthcare chaplain who is an Anglican priest and the Diocesan Bishop? (To elicit an understanding and interpretation of the healthcare chaplain as an expression of Church)

5.6 With the appointment of non-ordained NHS full-time healthcare chaplains in England what, theologically, does the healthcare chaplain who is an ordained Anglican priest have to offer which is distinctive? (To elicit an understanding and interpretation of the distinctive nature of the healthcare chaplain who is an ordained Anglican priest)
5.7 What do you understand to be the theological relationship between the healthcare chaplain who is an Anglican priest and the healthcare chaplain who is a Free Church minister? (To elicit an understanding and interpretation of the distinctive nature of Anglican priesthood)

5.8 What do you understand to be the theological relationship between the healthcare chaplain who is an Anglican priest and the healthcare chaplain who is a Roman Catholic priest? (To elicit an understanding and interpretation of the distinctive nature of Anglican priesthood)

**Ontology & Function**

6.1 In what ways, if any, do you think that baptism involves what some call a ‘distinctive character’, some profound or metaphysical change in a person’s ‘spiritual identity’ following the rite of baptism? (To elicit an understanding and interpretation of the ontological relationship of the baptised and the ordained)

6.2 In what ways, if any, do you think that ordination to Anglican priesthood involves a distinctive character, some profound or metaphysical change in a person’s ‘spiritual identity’ following the rite of ordination? (To elicit an understanding and interpretation of the distinctive nature of Anglican priesthood)

6.3 In what ways, if any, do you consider that ordination to Anglican priesthood constitutes a commission to undertake a series of tasks or a function for the Church? (To elicit an understanding and interpretation of the distinctive nature of Anglican priesthood)

6.4 What do you perceive to be the theological relationship, if any, between what some have conceptualized as the ‘distinctive character’ of the Anglican priest as against Anglican priesthood understood as a series of tasks or a function for the Church? (To elicit an understanding and interpretation of the distinctive nature of Anglican priesthood)
Appendix M: The Initial Letter Sent to Participants

The Department of Theology and Religion
Hammersmith Hospital
Du Cane Road
London W12 0HS
Telephone: 07929775228
email: tony.kyriakides-yeldham@imperial.nhs.uk

Dear

I am carrying out research at Exeter University into the nature of Anglican priesthood particularly with regard to healthcare chaplaincy.

What interests me is the variety of thinking around the concept of Anglican priesthood and, to enable me to tap into this breadth of thought, I would like to interview twelve healthcare chaplains among them yourself. The format would be a face-to-face semi-structured interview. Anonymity would be guaranteed.

If you agree, I would send you a two page outline of the research together with the questions which will form the basis of the interview. This will give you the opportunity to reflect on your understanding of priesthood before we meet. The interviews will last from 90 to 120 minutes and would be recorded for later transcription.

Having spent seventeen years in healthcare chaplaincy, most recently for ten years as chaplain to Plymouth Hospitals NHS Trust, I am aware of the number of research requests that land on the desks of healthcare chaplains. What are you likely to gain for your time?
In a pilot study, colleagues spoke of how they had gained much from the opportunity to reflect on their own priesthood.

Over the next fortnight, I hope you will not find it too great an intrusion if I phone you at work to find out whether you are willing to participate in this research.

Kind regards.

Yours sincerely,

Tony Kyriakides-Yeldham
Appendix N: Details of the Semi-Structured Interview Sent to Participants

Thanks for agreeing to take part in this research which is looking at the interface of two identities: that of ordained minister and healthcare chaplain. Two points of clarification. First, when I refer to ordination, I mean Anglican ordination to the priesthood. Second, when reporting the research, where specific reference is made to content in a transcript, this will be non-attributable to ensure that no participant can be identified in any way. Anonymity is guaranteed and will be rigorously enforced. Finally, when we meet I would like to audio record our conversation and I will ask your permission at the time.

Section one
1.1 What led up to your seeking ordination as an Anglican priest or minister?
1.2 How did you come to be a healthcare chaplain?

Section two
2.1 What do you think ordination to Anglican priesthood confers?
2.2 How do you understand the relationship between the two concepts ‘priesthood’ and ‘ministry’?
2.3 As an ordained Anglican priest, which is more important: what you do or who you are?
2.4 In what ways has your understanding of what it means to be an Anglican priest developed since you were first ordained?

Section three
3.1 How would you describe what it means to be a healthcare chaplain?
3.2 As a healthcare chaplain, which is more important: what you do or who you are?
3.3 What added value does being an Anglican priest bring to the post of healthcare chaplain?
3.4 From your experience, what do you think it might mean, for those to whom you minister, that you are an ordained Anglican priest?
3.5 In what ways has your experience of healthcare chaplaincy led you to re-think or develop your understanding of ordained priesthood?
3.6 In what ways might those to whom you minister understand what healthcare chaplaincy is all about?
3.7 How do you think management within your Trust perceives healthcare chaplaincy?

**Section four**
4.1 Are there any theological motifs or themes or doctrines that resonate with your understanding of priestly identity?
4.2 Are there any scriptural passages that resonate with your understanding of priestly identity?
4.3 What liturgical rite or ceremony do you perceive as central for you as an Anglican priest and why?
4.4 How would you describe the theological relationship between the ordained Anglican priest and a lay person whose ministry is licensed by an Anglican bishop?
4.5 How would you describe the theological relationship between the ordained priest and the Diocesan Bishop?
4.6 What do you understand to be the theological relationship between the two concepts: ordained priesthood and the ‘priesthood of all believers’?

**Section five**
5.1 Are there any theological motifs or themes or doctrines that resonate with your understanding of the healthcare chaplain?
5.2 Are there one or more scriptural passages that resonate with your understanding of the healthcare chaplain?
5.3 What liturgical rite or ceremony do you perceive as central for you as a healthcare chaplain?
5.4 What do you understand to be the relationship between the healthcare chaplain and the mission of the Church?
5.5 What do you understand to be the relationship between the healthcare chaplain who is an Anglican priest and the Diocesan Bishop?
5.6 With the appointment of non-ordained NHS full-time healthcare chaplains in England what, theologically, does the healthcare chaplain who is an ordained Anglican priest have to offer which is distinctive?
5.7 What do you understand to be the theological relationship between the healthcare chaplain who is an Anglican priest and the healthcare chaplain who is a Free Church minister?

5.8 What do you understand to be the theological relationship between the healthcare chaplain who is an Anglican priest and the healthcare chaplain who is a Roman Catholic priest?

**Section six**

6.1 In what ways, if any, do you think that baptism involves what some call a ‘distinctive character’, some profound or metaphysical change in a person’s ‘spiritual identity’ following the rite of baptism?

6.2 In what ways, if any, do you think that ordination to Anglican priesthood involves a distinctive character, some profound or metaphysical change in a person’s ‘spiritual identity’ following the rite of ordination?

6.3 In what ways, if any, do you consider that ordination to Anglican priesthood constitutes a commission to undertake a series of tasks or a function for the Church?

6.4 What do you perceive to be the theological relationship, if any, between what some have conceptualized as the ‘distinctive character’ of the Anglican priest as against Anglican priesthood understood as a series of tasks or a function for the Church?

Thanks again for giving your time.
THE CHURCH OF ENGLAND PRIEST AS NATIONAL HEALTH SERVICE
CHAPLAIN: SINGING THE LORD’S SONG IN A STRANGE LAND?

THE AIM OF THIS RESEARCH

(1) to consider, theologically, the identity and integrity of the Church of England priest;
(2) to consider, theologically, the identity and integrity of the National Health Service Anglican priest-chaplain;
(3) to consider the compatibility and divergence of identity and integrity for the Church of England priest ministering as a full-time NHS chaplain in England;
(4) to consider the development and currency of models of Anglican priesthood based on ontology and function, and whether these might provide a theological rationale for health care chaplaincy.

BACKGROUND & NEED FOR RESEARCH

The pivotal research question signals two assumptions: that the role of the National Health Service (NHS) chaplain in England is changing, and that this is happening without sufficient and sustained theological reflection. A changing role suggests altered perceptions: what does the NHS chaplain represent to the employing organization and authorizing institution? To what extent is the 21st century NHS chaplain (already described by some NHS Trusts as a spiritual caregiver or provider) comparable or compatible with the character of priesthood within the Church of England, from which the majority of NHS chaplains continue to be appointed? If one is witnessing a paradigm shift in hospital chaplaincy, new assumptions (according to Kuhn\(^1\)) require the reconstruction of prior assumptions and the re-evaluation of prior facts.

Writing in 2000, and based on extensive research, Orchard perceived hospital chaplains to be a vulnerable group of health care professionals lacking a ‘grounded understanding’ of their role and function. She went on to suggest that chaplaincy was ‘a

profession ... still wrestling with issues of nature and purpose’ yet apparently ‘little explored by academics or practitioners themselves.’

Two years earlier, in 1998, Woodward wrote about the ambivalence of the chaplain: the extent to which the pull of the secular institution (its norms and expectations) was greater than the church authorising, as well as prescribing, the chaplain’s understanding of ministry and pastoral care. Significantly, Woodward found an all too ready acceptance of NHS language and management tools, and a dearth of theological reflection and conceptualisation.

The justification for this proposed research is that twelve years later the situation is little different. Health care is not an event but requires ‘a continuous process of reflection and re-evaluation from those who inhabit it.’ There is an even greater need to provide a theological critique of the identity and integrity of the role of the hospital chaplain. This cannot be divorced from the context within which hospital chaplaincy exists and is practiced.

At the same time, within the Anglican Church (and in some other Christian denominations) there is ‘little sense that the shape of being a priest is to be found as something held by the Church; little sense that there is some core of living the life of the priest to which all can and should approximate. Rather, there is a strong sense that each must mould themselves according to their gifts, convictions and situations.’

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4 Orchard, *Hospital Chaplaincy,* p. 12
5 Allan, P. (2002) ‘The Priest, Sex and Society’ in Guiver, G. (ed.) *Priest’s in a People’s Church.* London: SPCK, p. 102; Allan cites the work of the Roman Catholic philosopher Charles Taylor (*Sources of the Self: The Making of the Modern Identity,* Cambridge: CUP, 1989) who has taken up the notion of authenticity (and the linked notion of integrity) and adds: ‘We should certainly wish for priests of integrity: those who are priests wish to be so with integrity, to live an authentic priestly life... how are those to be realized? What is needed first is an acknowledgement of the way in which adherence to these goals is coloured and compromised by being inalienably of our generation. And in this generation authenticity too often means no more than, ‘It feels right to me.’ And when we say, ‘It belongs to my integrity to…’ we mean, ‘I am going to impose what I take to be my right...’"
Appendix P: An Instrument to Locate Churchmanship Orientation

HIGH CHURCH (y axis)

TRADITIONAL (X axis)      LIBERAL

LOW CHURCH
Appendix Q: Stage two – A Systematic Review

Introduction

1.1 Summary: what led to your seeking ordination as an Anglican priest?
1.2 Summary: how did you come to be a healthcare chaplain?
2.1 Summary: what do you think ordination to Anglican priesthood confers?
2.2 Summary: how do you understand the relationship between the two concepts ‘priesthood’ and ‘ministry’?
2.3 Summary: as an ordained Anglican priest which is more important, what you do or who you are?
2.4 Summary: in what ways has your understanding of what it means to be an Anglican priest developed since you were first ordained?
3.1 Summary: how would you describe what it means to be a healthcare chaplain?
3.2 Summary: as a healthcare chaplain, which is more important, what you do or who you are?
3.3 Summary: what added value does being an Anglican priest bring to the post of healthcare chaplain?
3.4 Summary: from your experience, what do you think it might mean, for those to whom you minister, that you are an ordained Anglican priest?
3.5 Summary: in what ways has your experience of healthcare chaplaincy led you to re-think or develop your understanding of ordained priesthood?
3.6 Summary: in what ways might those to whom you minister understand what healthcare chaplaincy is all about?
3.7 Summary: how do you think management within your Trust perceives healthcare chaplaincy?
4.1 Summary: are there any theological motifs or themes or doctrines that resonate with your understanding of priestly identity?
4.2 Summary: are there any scriptural passages that resonate with your understanding of priestly identity?
4.3 Summary: what liturgical rite or ceremony do you perceive as central for you as an Anglican priest and why?
4.4 Summary: how would you describe the theological relationship between the ordained Anglican priest and a lay person whose ministry is licensed by an Anglican bishop?

4.5 Summary: how would you describe the theological relationship between the ordained priest and the diocesan bishop?

4.6 Summary: what do you understand to be the theological relationship between the two concepts, ordained priesthood and the ‘priesthood of all believers’?

5.1 Summary: are there any theological motifs or themes or doctrines that resonate with your understanding of the healthcare chaplain?

5.2 Summary: are there one or more scriptural passages that resonate with your understanding of the healthcare chaplain?

5.3 Summary: what liturgical rite or ceremony do you perceive as central for you as a healthcare chaplain?

5.4 Summary: what do you understand to be the relationship between the healthcare chaplain and the mission of the Church?

5.5 Summary: what do you understand to be the relationship between the healthcare chaplain who is an Anglican priest and the diocesan bishop?

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5.7 Summary: what do you understand to be the theological relationship between the healthcare chaplain who is an Anglican priest and the healthcare chaplain who is a Free Church minister?

5.8 Summary: what do you understand to be the theological relationship between the healthcare chaplain who is an Anglican priest and the healthcare chaplain who is a Roman Catholic priest?

6.1 Summary: in what ways, if any, do you think that baptism involves what some call a ‘distinctive character’, some profound or metaphysical change in a person’s ‘spiritual identity’ following the rite of baptism?

6.2 Summary: in what ways, if any, do you think that ordination to Anglican priesthood involves a ‘distinctive character’, some profound or metaphysical change in a person’s ‘spiritual identity’ following the rite of ordination?
6.3 Summary: in what ways, if any, do you consider that ordination to Anglican priesthood constitutes a commission to undertake a series of tasks or a function for the Church?

6.4 Summary: what do you perceive to be the theological relationship, if any, between what some have conceptualized as the ‘distinctive character’ of the Anglican priest as against Anglican priesthood understood as a series of tasks or a function for the Church?
Introduction

As set out in chapter five (§5.4.5), having completed stage one of the data analysis, a concentrated engagement with the data which I describe as immersion, listening to and transcribing the recorded interviews, reading and re-reading the transcripts and returning time and again to the voices of the participants, I turned to the next stage, the systematic review, which is presented in this appendix. This was the moment when I systematically reviewed the interviews, gathering the participants’ responses under each question. This I describe as a vertical ordering of the data and enabled me to compare and contrast each of the participants’ responses question by question. The process involved going backwards and forwards between the different participant responses to a particular question looking for common themes, different perspectives, competing claims and fresh insights.
1.1 What led to your seeking ordination as an Anglican priest?

This question provided the opportunity for participants to reflect on the nature of their calling to priesthood.

For some, it was a long journey or a response to existential questions: ‘what’s the world about?’(‘Hugh’), or a seminal experience, working as a physiotherapy assistant and one day praying with the family of someone who was dying. ‘He died as we were praying, and when I came out... I went into the toilets and started to cry and say, ‘What are you doing Lord? You either want me to work in physiotherapy or full-time Christian ministry’. And that’s when I started to follow the call’ (‘Mary’). It might be ‘just knowing and meeting people who... inspired me’ (‘Hugh’) or a spiritual ‘awakening of a sense of God in my being and wanting to have an expression of that really; a vehicle within which that could be expressed’ (‘Nigel’). Attending Mass in a Brazilian shanty town ‘I used to feel this sense of what was happening there at the altar was the most beautiful thing in the world and was actually worth giving everything for. And that was... the beginning of my sense of vocation’ (‘Sarah’).

The majority were cradle Christians although not necessarily Anglican: one had been a Baptist (‘Andy’), another a Quaker (‘Sarah’) while a third described herself as coming from a Free Church tradition though not regular in attendance (‘Rita’). There was talk of resisting vocation (‘Nigel’; ‘Rita’) or ambivalence either to attending a selection conference (‘Hugh’) or to the Anglican Church itself (‘Claire’). Whereas ordination ‘seemed to find me’ (‘Mary’), another ‘found myself at theological college. I still wonder why’ (‘Phil’). One participant thought ordination was about ministry rather than priesthood (‘Vanessa’) while another recognized her vocation only when she became a healthcare chaplain: ‘going into ordination training... felt quite functional for me’ (‘Claire’).
1.2 How did you come to be a healthcare chaplain?

This question served a dual purpose, not only to gauge the development of priestly identity arising out of prior parochial ministry, but to learn whether a negative experience of parish life might have influenced a participant’s decision to become a healthcare chaplain. Such an experience could shape a person’s sense of priestly identity. In fact, four participants (‘John’; ‘Andy’; ‘Rita’; ‘Mary’) talked about their dissatisfaction with parish ministry: a team vicar’s job ‘turned out to be a complete nightmare’ (‘John’); twelve months as a vicar proved ‘a very difficult time’ and culminated not only in a resignation but the ‘thought, I wasn’t actually even going to be going back to ministry’ (‘Andy’); ‘I have absolutely no interest whatsoever in being a parish priest... it’s an alien environment’ (‘Rita’); and ‘a church that’s frustrated me to bits’ (‘Mary’). For two others, a major life event featured in their decision to move into healthcare ministry (‘Phil’; ‘Claire’).

Across the participant group, positive factors included work or placements that had been undertaken in a health or social care setting (‘John’; ‘Phil’; ‘Sarah’; ‘Vanessa’) and being the recipient of the ministry of healthcare chaplaincy as a patient’s relative (‘Vanessa’) or as a friend (‘Hugh’). For two people, healthcare chaplaincy was not a ministerial context they had initially considered because of their dislike of hospitals (‘Claire’; ‘Barbara’). One participant, working in the field of mental health, reported a prior interest: a college essay title, *Was Abraham a case for treatment?* provided an introduction to psychiatry and the anti-psychiatry movement and ‘that whole area of mental health, psychiatry, and... the interface of religious experience and psychotic experience’ (‘Nigel’).

More generally, it was the multi-faith and multi-cultural context which was particularly appealing (‘John’) or as another put it, ‘I wouldn’t want things to be too narrowly Christian’ (‘Sarah’). Also important were conversations in the ‘market place’ with people who were less likely to be found in church (‘Hugh’). For others, chaplaincy provided ‘a vocation within a vocation’ (‘Rita’), a pastoral opportunity, listening to people’s stories (‘Sarah’); and the admission that ‘if I really, really had a vocation to the ministry, it was to pastoral care rather than to priesthood’ (‘Andy’).
Some referred to a defining experience, an influential book e.g. Cecily Saunders’ autobiography (‘John’) or an inspirational person e.g. a sector ministry chaplain (‘Phil’). Only one person acknowledged that, once he had completed his curacy he had been open to parish ministry, but that the first job he was offered happened to be in healthcare chaplaincy (‘Brian’).
2.1 What do you think ordination to Anglican priesthood confers?

This question, delving into the participant’s narrative construct of priesthood, presented a theological or conceptual challenge to some: ‘I struggled on this one big time’ (‘Phil’); ‘I don’t know’ (‘Sarah’); ‘I find this a very difficult question’ (‘Claire’).

Priesthood as authority was understood in different ways: responsibility for a tradition and a share in the ‘negotiation of what the tradition... could become’ (‘John’); the ‘role of being a living symbol... of the potential for all people to have a connection with the divine. And the priest is the person who lives that symbol on behalf of the community’ (‘Nigel’); or authority ‘in a particular church community’ (‘Andy’), a ‘professional badge of office’ (‘Andy’), a non-hierarchical authority devolved by the Church (‘Mary’) which was simply ‘beyond words’ (‘Phil’).

One participant expressed priesthood as a charismatic presence with particular reference to three actions unique to priesthood, whereby the Holy Spirit is invoked on behalf of God’s people. It confers an authority to pray ‘particularly for the outpouring of God’s Holy Spirit in terms of reconciliation and forgiveness, in terms of the transformation of the gifts that we offer to God [making] him present [in the Eucharist]; [and] in terms of blessing the people’. There was a caveat to this in that while other people can invoke the Holy Spirit, and the Holy Spirit is present even when priests are not, ‘the priest is a sign of the presence of God’s Holy Spirit in the Church and in the whole of Creation... a condensed [sign of that presence]’ (‘Brian’). Another spoke about ‘the grace of the Holy Spirit to do the work of a priest... It puts you in a different relationship to the community that you’re given to serve. But I wouldn’t want to make it just something which is about a difference in how you are perceived in a particular community’ (‘Sarah’).

The notion of priesthood incorporating metaphysical change was firmly dismissed by one person (‘Andy’) while another was ‘suspicious of all this deification of the clergy’ (‘Sarah’). This did not exclude the possibility of psychological change (‘Hugh’) or a relational change with God, whereby ‘my
gifts are to be used by God in service to the Church and to the world’ (‘Vanessa’). While there were those who viewed ordination simply as a commissioning (‘Claire’), one spoke of power (‘Mary’) and a patient who felt that in talking with a chaplain ‘it is like talking to God’ (‘Sarah’). What was unexpected was the sense of loss associated with priesthood and the tears that accompanied this revelation (‘Mary’): ‘the burden of it’ (‘Rita’); ‘in a sense it cost me my marriage’ (‘Mary’) and ‘ordination takes quite a lot from you... I don’t think it’s all about being given stuff’ (‘Sarah’).
2.2 How do you understand the relationship between the two concepts ‘priesthood’ and ‘ministry’?

As in the previous question (2.1) this explored the participant’s narrative construct of priesthood.

What emerged was an honesty and vulnerability as participants grappled not only with a theology of ministry and priesthood, but its impact at a personal level. Some narrowly interpreted the question in terms of their own priesthood: ‘ministry [is] what we decide to do with that gift [of priesthood]’. In which case, ministry and priesthood are inseparable e.g. ministry as ‘doing’ and priesthood as ‘being’. Should a priest no longer practise their priestly calling ‘you are [still] a priest and that can’t be taken away from you’ (‘Rita’). One participant spoke of his dislike of the doing-nature of the word ‘ministry’: ‘priesthood is the opposite... it’s a being word. It’s an ontological thing for me...; ministry, as a concept, can actually be something which erodes the person and wears them out. [It] burns them out’ (‘Nigel’). Alternatively, the sacred or sacramental element of ministry, ‘living out of the sacraments you celebrate’, for some defined the distinctiveness of priestly ministry (‘Sarah’).

However, a broader view conceded that ‘all priests are ministers but not all ministers are priests’ (‘Andy’). In fact, one participant did not ‘see anything too special about [priesthood] other than you’ve been ordained by God to serve and you’ve been... authorized by the Church’ and ministry supersedes priesthood in that it is at ‘the heart of it all’ (‘Rita’). Another was more relational and inclusive in his understanding of priesthood. The Church is the priestly community within which is to be found God’s presence in creation. In which case, any individual expression of priesthood is inseparable from the priesthood of the whole Church, for otherwise the priest would be disconnected from God’s presence in creation (‘Brian’).

Again, brokenness and pain were apparent. One participant referred to the words of the ordination rite of the Roman Catholic Church: ‘may you become like the mystery that you celebrate, may you be taken, blessed, broken and shared’ (‘Sarah’). Another participant observed: ‘The use of those words forms
the Church and what the Church is meant to be’ (‘Brian’). As the interviewer, I was often aware of the emotional and psychological vulnerability some participants courageously shared: ‘confusion is more my real answer, and in recent years, as my theology [and] my whole spiritual journey has moved, I’ve even been at the point of thinking can I with integrity remain a priest in the Church of England’ (‘Claire’).
2.3 As an ordained Anglican priest, which is more important: what you do or who you are?

This question encouraged participants to explore the ontological and functional aspects of Anglican priesthood.

Again, one participant spoke of struggling with this question (‘Mary’), while another challenged ‘simplistic dualisms’ (‘Brian’) but, in the main, the interrelationship of priesthood as being and doing was recognized. ‘What you do flows out of who you are’ (‘Sarah’). ‘What I do needs to be done in a way that has integrity’ [i.e. is congruent with who I am] (‘Claire’). ‘It’s about being genuine and people seeing the genuine person in order to trust them’ (‘Mary’). The sense of integrity was framed as being able ‘to take me into the situation as opposed to [the Church] adapting me to the situation’ (‘Vanessa’).

The idea of priesthood as ‘being’ was variously interpreted as ‘presence’ (‘Phil’), a ‘part of my identity in a greater way than I would have imagined before I was ordained’ (‘Rita’), ‘the sacramental minister, the prophetic presence and the reconciler’ (‘Barbara’) and was contrasted with the superficiality of value systems based solely on doing. Referring to parables that Jesus directed towards religious hypocrisy, one participant warned about ‘religious people who come to too quick and easy conclusions about who they are in terms of their religious identity’, and how Jesus was intent on ‘pulling the rug out from under their feet by saying, ‘well actually you’re not that at all.’’ It was suggested that current discussions about the nature of priesthood and ministry had highlighted its counter-cultural credentials in a society which endorses a work-ethic interpreted as productivity and wealth (‘Brian’).

As the interviews progressed, what became apparent was the qualitative nature of the interviewee-participant relationship. In some instances it was perceptibly pastoral: in answering this particular question, one participant remarked that ‘[to a] lot of clergy I wouldn’t talk about any of this because [I] just think it’s so off the wall. I wouldn’t trust them’ (‘Barbara’).
2.4 In what ways has your understanding of what it means to be an Anglican priest developed since you were first ordained?

While this question addressed the development of ‘priestly identity’ for each participant, it played into the frustration, the bewilderment and the discomfort many felt towards the Church.

NHS chaplaincy, for some, represented not a semi-detachment from the Church but a welcomed detachment (‘Hugh’; ‘Nigel’; ‘Claire’). The point was made that the ministry of the Anglican NHS priest-as-chaplain embraces everyone making the label Anglican redundant in the workplace. ‘I barely feel that I’m part of the Church of England and I don’t actually miss the Church of England’ (‘Sarah’). Alternatively, the healthcare setting provided that place ‘where I felt I could hold together the fact that I was an Anglican priest with doing what I wanted to do, and having the freedom to be who I needed to be’ (‘Claire’) or, as another put it, the confidence to be ‘who I am as opposed to what I thought the Church expected of me. It’s a much more freeing thing; more liberating’ (‘Vanessa’).

One participant readily accepted a colleague’s description of him as a Christian Buddhist: ‘it makes sense and I can relate to that’ (‘Phil’). Another added, ‘[w]e don’t quite know where we are or what we are or what is the greater whole, of which we’re a part... I don’t understand what’s happened to that Church’ (‘Hugh’).

Recalling the process of priestly formation, one participant saw it as an introduction to the institutional side of religion with its rules, traditions and patriarchy, and the frustration that was evoked (‘Claire’). It was perceived as a process in which ‘you try and fit yourself into boxes rather than allowing yourself to be at home with who you might be in your own history’ (‘Brian’). A distinction, it was claimed, needs to be drawn between how people perceive the priest, because where it simply reflects ‘constructs within a particular cultural environment... you shouldn’t be sucked in by that or play up to people’s projections which are perhaps your own counter-projections on them’ (‘Brian’), and the priest’s own reordering or deconstruction (‘Nigel’), or a despairing of priestly identity. ‘I don’t even have a clear stance now on what priesthood is... that I’m just being a bit of a fraud’ (‘Claire’); and the acknowledgement that
there are ‘priests who have left chaplaincy and... their Anglican faith’
(‘Vanessa’).

Thus, for some, a priestly identity might be ‘less doctrinally anchored’ (‘John’) while for another it was crucial to be rooted in her context, ministry and priesthood because of the risk of being ‘seen [as] a loose cannon within both [the NHS and the Church]’ (‘Vanessa’). One participant admitted that the ‘mystical, metaphysical... sacerdotal element [of priesthood] has pretty much evaporated’ (‘Andy’) but, for another, there was an ‘exciting unfolding’ alongside what they understood to be a mature ability ‘to cope with more uncertainty’ (‘John’). This was echoed by another participant: ‘something about developing as you get older and having to learn to sit with some of the contradictory things that we all think and feel’ (‘Brian’).
3.1 How would you describe what it means to be a healthcare chaplain?

At first glance, this question may appear to have produced a broad spectrum of themes, but common threads can be detected.

First, the NHS priest-as-chaplain is on the edge of two institutions, the Church and the NHS: a place of vulnerability (‘Mary’) and uneasy tension (‘John’) as well as a place of exciting creativity (‘John’). In this hinterland, it can seem that neither institution understands the work of the NHS priest-as-chaplain (‘John’; ‘Nigel’). Yet, existence on the edge has its advantages for it can provide a buffer or protection from both institutions. In this respect, we discover ambivalence. On the one hand, ‘It suits me... to be a little remote from the Church’ (‘Andy’); ‘I would see myself less as... representing the Anglican Church’ (‘Sarah’); ‘I’m not sure I any longer feel the necessary sense of connection to the Church in the way that I used to’ (‘Sarah’), while on the other hand, ‘I think [patients are] comforted by the fact that they don’t think of me as part of the hospital Trust... people look to me as somebody who is... slightly to one side of the institution... it gives you the possibility to comment from the outside’ (‘Andy’). This same participant valued what he described as fence-sitting. Perhaps it was the lack of clear boundaries which suggested to one participant that the role of the NHS priest-as-chaplain had something in common with the medieval court jester who possessed both wisdom and the right of access to every member of the royal court (‘Phil’).

Second, the NHS priest-as-chaplain is the champion of spiritual care within the NHS: ‘celebrating the spiritual’ (‘Hugh’); ‘delivering training to staff right across the board in spiritual and religious care’ (‘Phil’); ‘it’s about trying to enable [the NHS]... the people that work there and the people who are receiving care to keep spirituality in mind’ (‘Claire’); ‘connecting people to their spiritual being’ (‘Barbara’). The nature of spirituality was addressed by two participants, one suggesting that ‘[i]f we can find our humanity we are finding our spiritual side’ (‘Phil’) and the other opting for a secular or consumerist approach in terms of ‘what helps you; what gives you meaning and purpose’ (‘Hugh’). Religious faith, for some, appeared to be secondary to this spiritual care agenda: to use religious language and rituals only ‘when appropriate’ (‘Hugh’) or include faith ‘if
that is how someone expresses their spirituality’ (‘Claire’), while another participant talked about how he had ‘reclaimed the word religion because [it] had been thrown out’ (‘Phil’). Describing her work as being at the ‘very edges of mission’ though ‘perhaps not seen by the Church as that’, one participant talked about how, in each encounter, ‘bidden or not bidden, God is present’ (‘Vanessa’).

Third, the NHS priest-as-chaplain is person-centred: ‘meeting a person where they are and letting them lead wherever they want to go’ (‘Vanessa’), ‘being there for everybody... whether they’re a person of faith or of a different faith from mine, or of no faith whatsoever’ (‘Rita’) and recognizing ‘the value of every encounter that you have’ (‘Vanessa’). Another described his work as enabling ‘people [to] identify what it is to be human in this very pressurised and incredibly stressful environment’ (‘Phil’). An interesting metaphor likened the role of the NHS priest-as-chaplain to the piano accompanist who ‘has to listen carefully to the singer while following the notation, but actually it’s about being attuned to the singer... supporting the voice rather than dominating [it]... and being able to move with that voice’ (‘Nigel’).

The vulnerability of the NHS priest-as-chaplain is never far from the surface: ‘I feel quite vulnerable myself, but being able to be there with some sense of hope, or even to be a sounding board against God, or to be a sign of hope because... there’s something else outside this trauma that they can cling to’ (‘Mary’).
3.2 As a healthcare chaplain, which is more important: what you do or who you are?

In this question, as I explored the perceived distinctions between ontological and functional aspects of the healthcare chaplain, workplace tensions were palpable.

A number of participants held the view that NHS employers were more concerned with measurable outcomes: ‘accountability and accounting for every single minute of your day and what you do’ (‘Brian’) or, as one participant cynically described it, the importance of ‘counting lamp posts’ (‘John’). What was also apparent was that some NHS priests-as-chaplain might collude with this: either ‘I get caught in the trap of doing’ (‘Hugh’) and ‘doing is important otherwise nobody takes any notice’ (‘Phil’) or there is the need to justify their employment, ‘a feeling that we’re watched so we ought to do...; there’s a thing about feeling we have to be relevant...; there’s also the feeling that someone could say... ‘why are we employing these people?’ (‘Hugh’). ‘What I do is important because the [NHS] institution needs to recognise what chaplaincy does’ (‘Phil’). For some participants, ‘who you are’ as an individual was inseparable from priesthood, ‘because I am a priest’ (‘Mary’), while others choose to draw a distinction, that ‘being’ means being visible... and that starts from who you are. I don’t think it starts from being... a priest’ (‘Andy’).

Interestingly, the comment was made that ‘being’ in an NHS context is ‘doing’, that ‘I have to show that I’m around and people see me’ (‘Hugh’) but, generally, there was an acceptance that what you do and who you are equally important and co-dependent: ‘what I do flows from who I am’ (‘Nigel’); ‘[i]nitially it’s who I am, in order to do what I do’ (‘Mary’). Moreover, ‘the quality of one’s being determines the quality of one’s presence’ which not only means ‘attending to one’s being’ (‘Nigel’) or, as another described it, ‘my mindfulness approach personally and professionally’ (‘Claire’), but an awareness of personal baggage, ‘issues that are unresolved in your own heart and soul’ (‘Sarah’).
3.3 What added value does being an Anglican priest bring to the post of healthcare chaplain?

The intention here was to assess the perceived importance of priestly identity by way of a question about the additional value Anglican priesthood might bring to the role of the NHS priest-as-chaplain. Two participants, however, interpreted this as an invitation to consider the contribution of Anglicanism rather than Anglican priesthood (‘Hugh’; ‘Barbara’). A third acknowledged the potential ambiguity in the question and addressed both aspects (‘Brian’).

In terms of Anglicanism, some acknowledged the benefits of ‘connectedness’, belonging to the Church of England given its national status and authority as the established Church in England: ‘a cultural, community recognition’ (‘John’); ‘a national identity’ and its premise that ‘God... is already present in the whole of our national life’ (‘Brian’); ‘we’re not an off-the-wall organisation. There is some kind of authenticity’ (‘Barbara’). Alongside this was an appreciation of the broad nature of the national Church not only because it has ‘a sense of being there for everybody’ (‘Hugh’) but because ‘certainly the tradition of the ecclesiology which I’m wrestling with [means that the Church of England is not] just being Church and making Christians, it’s about something much broader... which is kingdom-focused’ (‘Brian’); ‘rooted in a tradition which is about valuing people and valuing communities’ (‘Sarah’). While there were relational advantages of being part of an external institution, such as access to a bishop when there were ‘problems’ or ‘concerns’ (‘Hugh’), one participant reported that when she was ‘in an identity crisis with regard to my role as an Anglican priest’, her bishop left her with ‘no support whatsoever’ (‘Mary’).

The added value of Anglican priesthood was attributed, in part, to the rigour of formation: ‘in residential training... you do the two-in-the-morning tough conversations’ (‘Nigel’); ‘quite a bit of you [is] stripped away’ (‘Nigel’); ‘the curacy... which gives you a range of experience’ (‘Nigel’); ‘a massive part... of what has made me who I am today’ (‘Claire’). Furthermore, one participant suggested that ordination, as a marker in a process of training, enables NHS priests-as-chaplains to be accommodated within an NHS professional career structure like other healthcare professionals (‘Brian’). Another drew a
comparison with different models of healthcare practice found in disciplines such as nursing or occupational therapy and suggested that what he brought to healthcare chaplaincy was ‘a model of spiritual care and we call it Anglican priesthood’ (‘John’). Others reckoned that priesthood bestowed an authority as one who represents the Church of England, ensuring integrity of ‘what we do, where we are and what we can’t share’: so a person who could be trusted as a confidant and had authority to administer the sacraments (‘Vanessa’).

A more contentious note was sounded by a number of participants who argued that Anglican priesthood per se was not important. What was important was wearing a dog collar as a visible sign of ordained ministry; being ‘an ordained minister of some Church or another... The vast majority of people are not fussed about which Church’ (‘Andy’). Even then, as one participant put it, ‘there is a... real question to be asked about whether there is any added value an ordained person can bring into this context’. In a later question (3.6), this same participant refers to his pastoral care of a patient and argues that ‘priesthood is nothing to do with it’, but then says ‘you see, that’s nonsense as well because on the other hand I am a ministerial priest and who I am at present is to do with all of that formation and actually me feeling that, yes, I have been given this gift of priesthood and living it. So although I say that it has nothing to do with it, it was me who was with her, so I brought something of that personal story of which ministerial priesthood as a gift is a part. So that is the difficulty there’ (‘Brian’).

In another conversation, the importance of sacramental ministry and its intrinsic link to priesthood was broached. Over the course of ten years chaplaincy, this person’s sacramental role had been reduced. Her Trust had raised the possibility of curtailing her Eucharistic ministry even more. If this was to happen, she envisaged her integrity as a priest would be called into question and, in consequence, her continuing role as a chaplain (‘Mary’).
3.4 From your experience, what do you think it might mean, for those to whom you minister, that you are an ordained Anglican priest?

This question delved into the perceived relevance of ‘priestly identity’ in the workplace: its perceived upside and downside.

While some reported that the fact of being an Anglican priest was unimportant for all but a ‘tiny minority’ (‘John’), there was some indication that, generally, a visit from the chaplain was viewed as a positive experience (‘Hugh’). Whether this had more to do with wearing a dog collar, that symbol of ordained or authorized Christian ministry irrespective of denomination, remains an open question: as one participant put it, ‘is it they want to have a priest or is it... they want to see the dog collar?’ (‘Brian’). Perhaps both, given the experience of another participant who reported that on going to see a patient without a dog collar she was told, ‘I need you to wear your dog collar because then I can relate to you as a priest and believe that’ (‘Sarah’). Where it was positive, some attributed this to a ‘kind of cultural residual’ (‘John’), a ‘spiritual authority’ (‘Nigel’) and the opportunity to discuss spiritual concerns in a way not possible with other healthcare professionals, ‘and that it will be understood’ (‘Claire’). ‘I’m meeting people where they’re at, with questions about God, life, death, the whole mortality-spiritual aspect of things, where they would never darken the doors of the Church to come and ask those questions’ (‘Mary’).

Another factor was the quality of the relationship: one which brought comfort, ‘they felt like they’d had a warm blanket put around them’ (‘Claire’), and enabled a sense of connection ‘with something outside... their immediate physical surroundings’ (‘Phil’), ‘representative of the Church and the community, the parishes and everything’ (‘Mary’), perhaps ‘the trans-personal’ (‘Claire’), in a ‘safe place’ (‘Vanessa’) with a ‘proper professional person; that you know what you’re doing. But I don’t think they’re too fussed about you being a priest’ (‘Andy’) who is there ‘to listen and help in any way we can’ (‘Phil’); ‘something about acceptance, something about compassion’ (‘Claire’). This, of course, is not the exclusive territory of NHS chaplains who happen to be Anglican priests but, for some priesthood was crucial, providing access to a sacramental ministry (‘Brian’; ‘Rita’) or what might be perceived as bona fide prayer (‘Sarah’).
Nonetheless, as one participant pointed out, what needed to be addressed was less his ‘own perception of priesthood [but] how we relate to other people’s perceptions of priesthood and what they are expecting’ (‘Brian’). Again, in common with other Christian chaplains, the NHS priest-as-chaplain might be the object of negative projections, such as the ‘religious bigotry’ of staff (‘Nigel’), misconceptions, ‘they think I’m just there to give last rites (‘Mary’), or previous unhelpful or damaging encounters with the Church of England (‘Vanessa’). In which case, there remains the possibility of presenting the Church in a different light, with the chaplain working to an inclusive, multi-faith agenda, rather than ‘narrow and bigoted and self-referential’ (‘Sarah’) and so emphasizing that the ministry of the Church of England is open to all (‘Sarah’; ‘Rita’). Admittedly, as one participant pointed out, the implications of her being an Anglican priest ‘rarely comes up... in actual conversations’ (‘Claire’), but for this research it is the tacit impressions of the NHS priest-as-chaplain which are important.
3.5 In what ways has your experience of healthcare chaplaincy led you to re-think or develop your understanding of ordained priesthood?

This question encouraged the NHS priest-as-chaplain to reflect on the influence of healthcare chaplaincy for, as one participant, acknowledged, it ‘has led me to think a lot about my understanding of ordained priesthood’ (‘Claire’).

One prominent theme involved buildings and sacred space. Plans for a multi-faith centre in a new hospital prompted one participant ‘to re-think or develop [my] understanding of priesthood [around] the theme of hospitality as a... core metaphor for who we are and what we do, both in priesthood and in chaplaincy’ (‘John’). There was a sense of relief. No longer did church buildings restrict or intrude upon ministry: not having ‘to worry about the church that’s seven, eight hundred thousand years old where the lead’s being stolen every week’ (‘Hugh’) or ‘the mission in a grade one listed building... to keep the church building going’ (‘Vanessa’) or ‘having to think to raise £20k for a new toilet in... a listed building’ (‘Vanessa’), but the satisfaction that ‘Church is not about a building for me’ (‘Nigel’). Even in the healthcare setting, there were reservations about creating sacred space: ‘we’ve been having new prayer rooms organised, and I felt a little bit awkward about that because I’m not sure that I necessarily want one...; having a space of any sort becomes a liability and if I have to take patients ‘out’ to be religious I worry about that’ (‘Hugh’).

Perhaps the notion of buildings here is, in itself, a metaphor for the Church as a ‘self-perpetuating institution’ (‘Sarah’), ‘caught up... in doing stuff and ticking boxes and Church growth and numbers’ (‘Brian’), whereas healthcare chaplaincy is a ‘different sort of missionary work but not with the intention of getting... bums on pews’ (‘Vanessa’); ‘seeing ministry and mission out[side] the Church as opposed to having the Church structures as the boundaries’ (‘Vanessa’). As one person remarked, ‘I would say that now I would definitely be more Kingdom-centred than Church-centred’ (‘Sarah’). For others, a re-evaluation of priestly identity brought to mind the young curate: ‘I liked being called ‘father’ and did have some grandiose ideas about myself’ (‘Andy’). As a healthcare chaplain, there is a ‘simplicity and openness’ (‘Hugh’) about priesthood, an ‘incredibly liberating [expression] of ministry’ (‘Vanessa’), in
creative partnership with others: ‘lay people... are seen to do ministry in a way that... in a parish [would be] referred up to the priest’ (‘Brian’), ‘network[ing] with the deanery and chapters... because I don’t want to be a long distance lone runner’ (‘Mary’) and where ‘God is present outside the Church... in the multi-faith context’ (‘Brian’) and where the expression of priesthood is ‘much less of a particular faith-based role’ (‘Claire’). The call of priesthood is ‘about entering other people’s worlds... we don’t crowd the people into ours’ (‘Hugh’) but there remains a sense of frustration with the Church because it does not make use of the insights healthcare chaplaincy could offer: ‘I think we’re often pioneers... at the cutting edge of how we respond to society’s sense of the sacred’ (‘Hugh’) but there is no mechanism for healthcare chaplaincy to enter into a dialogue with the Church. Predictably, the focus of priesthood is ‘on the person in front of me and what’s helpful to them and anything to do with... the Church would come way second to that’ (‘Sarah’). It is ‘about being at that place where people have experienced damage... where the damage is, however that damage has occurred [or] is occurring’ (‘Nigel’).

Once again, the focus and direction of priesthood for the NHS priest-as-chaplain fuels discontent: ‘although I feel quite separate from the Church, it’s that sacramental side of things that keeps me connected to it’ (‘Sarah’). ‘I’m worried about my role as an Anglican priest within healthcare chaplaincy’ (‘Mary’). As one participant describes it in answer to the next question (3:6): ‘the healthcare chaplain... has a sort of semi-detached relationship with the Church’ (‘Brian’).
3.6 In what ways might those to whom you minister understand what healthcare chaplaincy is all about?

As one participant conceded, this question was not going to produce a 'stock answer' ('Brian'), for given the 'whole spectrum of stakeholders in the NHS... it's a phenomenal range of understandings' leaving the chaplain as one who 'juggles with... [a] huge range of expectations and understanding and projections' ('John'). What I wanted to assess was the impact this might have on a chaplain’s sense of self-esteem and self-worth in the workplace.

Unhelpful stereotypes are apparent when staff and patients think they understand the role of the chaplain: the 'angel of death' ('Mary'), the benign vicar 'just patting people on the back' ('Nigel'), the evangelist ('Rita'), the exorcist ('Nigel') or simply a personal and 'negative experience [of Church]' ('Phil'). A 'narrow view' of religion among colleagues can lead to 'masses of baggage which people feel free to project out there, but [which for the chaplain] becomes a straight-jacket' ('Nigel').

Alternatively, there are patients who have 'got an idea but they can't always convey what it is' ('Phil'), who appreciate that the chaplain is someone 'able to listen and accompany and go into some of the dark places that they don't feel they can share' ('Hugh'). Another participant, working in mental health, suggested that on admission every one of his patients faced 'a crisis of meaning on a soul level'. In order for that meaning 'to re-emerge through the uttering of the words of their story' they needed a 'listening accompanist... where their soul can be attended to'. Then, '[patients] know exactly what they have to do' ('Nigel').

In similar vein, another participant maintained that patients instinctively knew what pastoral care was and 'would quite often accept care from the... chaplain, but... might well refuse something that they perceive as being more professional'. He went on to add, 'I'm not suggesting that what we offer is not professional, but I think in their perception it's not professional in the way that... psychological support would be' ('Andy').
An ambiguity surrounding professionalism emerges in a further interview where a participant described a long-term pastoral relationship as a ‘semi-professionalized friendship’. When invited to say more, he compared chaplaincy and psychological support in terms of the limits and differences between the two. In one case, a psychologist had declined to treat a patient and it was left to the chaplain to sit ‘with [the patient] every day for at least half an hour, and just feel her depressiveness, and come out thinking ‘that was a fucking awful meeting and I feel really awful... And what I was hearing from the psychologist was... we’re not going to sit and do that because there is... nothing we can do for her... She’s not going to do her CBT\(^1\) homework and therefore she can’t get better. There’s nothing we can do’. The chaplain added, ‘there was nothing I could do for her really except sit with her, and I suppose that is interesting when you think about what prayer is about... It’s not about doing very much. ...It’s about presence’ (‘Brian’).

Elsewhere, in their support of staff, chaplains can be seen less as ‘a priest or the vicar... but as a...critical friend, as a voice or a presence outside... their particular environment’ (‘Phil’). Despite this, from a managerial perspective\(^2\) one participant was convinced that chaplaincy was only tolerated: ‘my experience here... [is] that we are seen as a need that they perhaps could do without, but they’ve got to have it...; a box that somewhere says we must provide this care’ (‘Phil’). Even when an NHS ‘decision maker’ is a member of a church congregation no assumptions can be made about the extent to which chaplaincy will be supported: one such person ‘appears to have absolutely no idea of what we do and doesn’t want to know as long as we’re there and keeping quiet’ (‘Phil’). Conversely, patients with a Church background might welcome the presence of the chaplain, ‘whilst I am here you’re... my priest. You can give me Communion’ (‘Phil’). Nonetheless, the feeling persists that neither the Church nor its clergy ‘really understand how healthcare chaplaincy works’ (‘Brian’).

How this affects the NHS priest-as-chaplain is variable. Where chaplaincy is valued, such as in a hospice setting, it can be ‘comfortable in a kind of way’ (‘Rita’). Inter-

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\(^1\) Cognitive Behavioural Therapy.
\(^2\) This anticipates the next question (3.7).
cultural encounters can be ‘exciting and fascinating’ (‘John’). At the same time, it can be time-consuming ‘trying to get people to understand what it is we're about’ (‘Nigel’). The relationship with the Church may feel ‘semi-detached’ (‘Brian’), yet patient expectations can be extraordinarily high: ‘we need you... to be holy girl. We can’t have a rich girl coming in here. We need a poor priest serving God in rags; serving God on bread and cheese. We need a priest to come in here and serve God in rags for nothing’ (‘Sarah’). Or then again, there can be the suspicion that on visiting a patient, ‘it’s probably just as much a mystery to them when I leave... as when I arrive’ (‘Vanessa’).
3.7 How do you think management within your Trust perceives healthcare chaplaincy?

In framing this question about how NHS Trust management perceives healthcare chaplaincy, I was also interested in how a person’s identity might be shaped by the ethos of his or her employing organisation.

Among some participants there were signs of frustration and uncertainty: ‘I don’t think [management] have the faintest clue and that’s okay if they leave me alone and keep giving me a job’ (‘Sarah’); ‘inasmuch as they think about us at all...’ (‘Andy’); I really don’t think they know what we are about’ (‘Phil’). Discussions in a policy-making group left one participant seething, ‘God that lot! Still caught up in the old view where chaplains are religious functionaries’ (‘John’). There was ambivalence, ‘I think there is an understanding that chaplains aren’t quite of the NHS; that we bring something different and we have a certain freedom to act’ (‘Hugh’); irritation, ‘we’re seen to be some sort of lesser professionals by some in management and by other professionals’ (‘Brian’); political manoeuvring, ‘the whole palliative care culture and environment is... obviously very conscious of the need for spiritual/religious care but... consultants don’t want to give up their patients to palliative care... [in which case] is there an over-identification of chaplaincy with palliative care?’ (‘Brian’); and a victim of pragmatism, ‘that’s exactly what senior management want... they [only] want those emergency things covered’ (‘Brian’).

Even the history of chaplaincy can be disabling: ‘[senior people] still caught in the mindset that we are here... [for] a few religious patients and occasionally a religious member of staff...’ (‘John’); again, ‘how chaplaincy is perceived [by] this Trust and managers is quite out-dated...’ (‘Brian’); and finally ‘[one line manager] founded the chaplaincy here in 1992 or 1993 and, in her own mind, we’re [still] the parish church’ (‘Phil’).

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3 Conversely, ‘Andy’ held that management had ‘a reasonable understanding of what we’re about.’
4 The discussion took place during a meeting of an Equality and Diversity Steering Group. As the participant put it: the ‘one part of the organization that I would hope to be more sympathetic than most in an official sense – not what people really think but kind of officially’.
Unsurprisingly, financial stringency was also a factor: ‘when there’s money...’ (‘Hugh’); ‘management don’t want to hear that because that’s got the potential of costing them a bit’ (‘Phil’); and again ‘the screws have tightened with the money’ (‘Hugh’).

This was far from the whole story though. Some reported ‘that [the management view] is quite positive’ (‘Nigel’), ‘we are valued and appreciated and even respected’ (‘Andy’), and, as a team, thought of ‘very highly’ (‘Barbara’). The work of the chaplain may be ‘a mystery [but]... we have the complete trust of the hospital management’ (‘Vanessa’). Unsurprisingly, the standing of chaplaincy may owe something to the personality of the chaplain: ‘they absolutely love us... because of the people we are’ (‘Mary’). Occasionally other roles that the senior chaplain undertakes can provide additional credibility or a vehicle for promoting the work of chaplaincy. For example, in heading up a Trust’s Equality and Diversity portfolio, one participant acknowledged that the Trust valued chaplaincy because it linked into ‘faith and cultural communities’. It was seen as ‘an important part of what this Trust is trying to do and what this Trust stands for and its values... living out what the Trust is trying to do with diverse teams’ (‘Claire’). Another participant thought her team was viewed positively ‘because our Chief Exec and a number of people on the Board are practicing people of faith’ (‘Rita’). In a different Trust, the support of the professor of palliative care, a practising Christian, was instrumental in making a chaplaincy-led spiritual assessment mandatory when a patient was placed on the ‘end of life care pathway’.\(^5\) Not only did this raise the team’s profile but resulted in its nomination for an award recognizing ‘dedication to quality and improvement’ which, subsequently, it won (‘Mary’).

\(^5\) This was, in effect, the Liverpool Care Pathway which was withdrawn after a national review. It has been replaced by the five priorities outlines in the paper, *One Chance to Get it Right*, which will be dependent on locally developed plans, systems and tools.
In section 4, the questions focus on how each participant, *as a priest*, perceives the nature and development of Anglican priesthood and priestly identity. It is in section 5 where the questions focus on how each participant, *as a healthcare chaplain*, perceives the nature and development of Anglican priesthood and priestly identity. The separation of priesthood and healthcare chaplaincy was deliberate as I explored the extent to which each participant had internalized priestly identity while ministering in a healthcare context. In practice, many of the participants found it difficult to separate and conceptualize priestly identity as distinct from their role as a healthcare chaplain.
4.1 Are there any theological motifs or themes or doctrines that resonate with your understanding of priestly identity?

In asking participants to select theological motifs, themes or doctrines which resonated with their sense of priestly identity, my aim was to discover more about how each participant interpreted priestly identity.

Two comments are striking because they imply that the Church can become extraneous in the context of the NHS: ‘I actually couldn’t think of any, which is awful isn’t it. I genuinely couldn’t think of any, and then I thought that’s daft. I’ve been an ordained priest for sixteen years and I suddenly realise I can’t think what they are... This has made me think... ‘Why am I a priest in this role?’ and actually I don’t have to be. It may be that I happen to be a priest but... it doesn’t mean I have to be a priest to do it’ (‘Phil’); and, for another participant, ‘those college days when we looked at various doctrines and things seem a long time ago and it’s not something perhaps my mind readily engages with’ (‘Rita’).

Other participants considered the NHS itself unreceptive to certain interpretations of priesthood. For example, ministerial presence or ‘learning how to be and how to be available’ might not ‘go down at all well in NHS-talk or NHS circles... [because NHS management] want functional definitions’ (‘John’).

In the course of the interviews, incarnational presence or incarnational models of chaplaincy were frequently alluded to: ‘God’s presence... made known through human beings’ (‘Nigel’); ‘God come among us as one of us to share our pain and every aspect of our lives’ (‘Andy’) or seeing Christ in other people, ‘looking for it and reflecting it and wanting to witness [to] that’ (‘Hugh’). In fact, ‘without an incarnational model we’d be lost’ (‘Hugh’). A variant on this theme of deification or Christification⁶: ‘God’s presence and the love of Christ actually growing and evolving in the world. We’re all participators in that. We have our

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⁶ In Orthodox Theology, Christification refers to the ontological union of God and those who are baptised who ‘become participants in the divine nature’ (2 Peter 1:4). The use of the word ‘ontological’ does not imply that the humanity of the baptised person is compromised. Rather, it describes a union of the substance of God with the substance of the baptised person whereby the two interpenetrate one another while each retains their essence (cf. Cooper, 2014).
part to play... right here, right within us, right now’ (‘Nigel’). What was also apparent was a view that, compared with a parish church context, the NHS provided greater opportunities to witness to, or be a witness of, God's incarnational presence: ‘chaplaincy’s even more about presence than is, say, parish priesthood’ (‘John’) and ‘way beyond the boundary of any church’ (‘Nigel’); witnessing to ‘God’s presence in others who may not be proclaiming it in words... may not even necessarily know [that God is present]. ‘The act of compassion [is] a movement of God’s love through humanity [and] a sign of God’s incarnation’ (‘Nigel’).

One participant made the point that incarnation ‘speaks at both ends. Bethlehem and the crib are at one end and then Gethsemane and the cross at the other end [...] with] the hope of resurrection beyond. It’s a very powerful motif if used with caution’. He then added, ‘It’s where priesthood comes from, isn’t it? It’s where all mystery comes from, in the sense of ministering’ (‘Andy’). Even when used with caution, the proposition that Christ’s suffering might be a vehicle offering spiritual insight is questioned: ‘the idea of the solidarity of Christ with those who are suffering is problematic to me now, although I believe in it. People don’t necessarily want somebody else to be in the shit with them, they want somebody who can get them out of it’ (‘Sarah’).

For some participants, the passion narrative and resurrection account are seen to directly address those issues which centrally occupy the ministry of the NHS priest-as-chaplain. In describing herself as an ‘Easter Saturday’ (sic) person, one participant juxtaposed hope and uncertainty: ‘Easter Saturday (sic) is, I guess, the pits because obviously Good Friday is horrendous and there is death; but I think waking up the morning after and the kind of nothingness and not [having] reached Easter Sunday, that is often what life is about... We don’t know what tomorrow holds so it’s hope in that sense’ (‘Claire’). The priest serves as ‘a symbol of hope’ and is the means of ‘finding hope in the struggle [and] in the uncertainty’ (‘Claire’). In the same vein, another participant described her priesthood as accompanying people when they are wrestling with the cruelty and injustice of tragic loss. While facing the reality of Good Friday, loving Jesus even as he is being crucified and railing against abandonment, she

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7 This participant meant Holy Saturday, the day before Easter day.
remains one of the ‘resurrection people’ who have no answers but offer hope ‘that God’s there’: ‘that’s what my priestly, costly ministry, is all about. Just trying to be alongside them’ [i.e. ‘people who have just suffered the worst ever thing that could happen’], ‘not making sense of it’ (‘Mary’). This was a sentiment echoed by another person: ‘I think it’s very much the being in-amongst, on-the-ground, trying to live out love and compassion and hope’ (‘Claire’) for as was acknowledged ‘life is a gift but sometimes it’s a pretty crap gift really and I don’t think that gets recognised a lot in churcchy stuff or theological stuff’ (‘Sarah’).
4.2 Are there any scriptural passages that resonate with your understanding of priestly identity?

Continuing the theme of resonance and priestly identity, in this question I explore what scriptural passages may reveal about a person’s perception of priesthood.

The comment of one participant seems to confirm an attitude found in previous interviews: that priesthood is peripheral for some NHS priests-as-chaplain. ‘I’m clear on scriptural passages about healthcare chaplaincy, for me that rings true. But in terms of priestly identity, it isn’t something I’ve reflected on or thought about for a long time’ (‘Claire’).

Nonetheless, for this participant the story of the disciples on the Emmaus Road\(^8\) does have common ground with priestly ministry as it ‘fits with the kind of priesthood I can cope with, which is [about] being alongside somebody in the presence of God, and talking and exploring and moving onwards to a point at which things are revealed’ (‘Claire’). This same episode prompts another participant to liken her role to one who accompanies people as Jesus did: ‘to be there to walk the journey [and] to perhaps explain things, to encourage, to share a meal... that might lead on to something sacramental; it might not, but if it doesn’t... the journey has been the important bit of it’ (‘Rita’).

This sense of representing the person of Jesus is apparent in words another participant paraphrases from Galatians: ‘I have been crucified with Christ; it is not I but Christ who lives within me’.\(^9\) What is evident, however, is that accompanying others as Christ can be a costly affair for everyone involved. Once again, paraphrasing a verse found in all three synoptic gospels, ‘he who tries to save his life loses it and he who loses his life for my sake, saves it’\(^10\), this participant reflects that ‘[p]eople... come because they’re in a situation of loss very often. What does the priest have to lose to journey with them? I think that’s an interesting question. What might we go on losing as we journey with

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\(^9\) Galatians 2:19-21.  
\(^10\) Matthew 16:25; Luke 9:24; and Mark 8:35.
them, when we live with their hopes? What does it feel like to go through losses as we accompany somebody? Patients’ losses become your losses. What happens there? What’s happening in the light of your losing your life [that] it might be in some strange way saving it? What am I carrying, with the mystery of God’s being, in a journey of loss?’ (‘Nigel’). Clearly this is priesthood in a healthcare context.

The idea of ministering on behalf of Jesus leads another participant to recall a post-resurrection scene: Jesus interrogating Peter on the beach by the Sea of Tiberius\(^1\). The key phrases, ‘I love you; tend my sheep; feed my lambs’, are interpreted in terms of lay, diaconal and priestly or episcopal ministry: ‘[t]he initial resonance was, ‘you minister on my behalf because you love me.’ So [Jesus] is checking ‘do you love me?’ [That’s] the root of going out and being priest or chaplain or Christian in the world, having fostered and checked out that love for God. That’s like the root... And then ‘tend’ suggests... like diaconal. Feed perhaps could be more like priestly teaching or episcopate’ (‘John’).

Similarly, Paul’s metaphors about clothing and being clothed in Christ\(^2\) suggest for one participant the priest ministering as Christ: ‘ministerial priests wear these funny clothes all of the time. There’s the clerical collar. We dress up in cassocks and surplices and cassock-albs and wear stoles and chasubles and things... [but] for me [it’s] saying: this is what we are all called to... I am wearing the chasuble. This is the yoke of Christ. This is not me simply dressing up. It’s about what we are all called to’. As a metaphor ‘it is central to how we should see the relationship between ministerial priesthood and the theology of priesthood and baptism’ (‘Brian’). For another participant, this identification with the person of Christ resonates with the passage from ‘Philippians and the call to imitate the self-emptying of Christ\(^3\) in that the priest as pastor needs to be empty, ‘com[ing] completely fresh and open to each pastoral situation... You are a skilled pastor if you realise that... you are empty’ (‘Andy’).

\(^1\) John 21:15-19.
\(^3\) Philippians 2:5-11.
There are stories of healing. For one participant working in the field of mental health, the episode of Jesus arriving in the country of the Gerasenes and actively searching out the man possessed with an unclean spirit\(^\text{14}\) ‘is a part of what [priests] do’ (‘Hugh’).\(^\text{15}\) For another, the healing of Peter’s mother-in-law\(^\text{16}\) is a reminder that we are all broken people, but that the priest, in being healed, becomes ‘a channel of Christ’s love and grace’, and is made ‘strong enough’ to go out and minister, feeding others with Christ’s presence (‘Rita’). This sense of brokenness brings to mind for another participant John’s account of the feeding of the five thousand and the gathering up of the broken pieces (‘Sarah’).\(^\text{17}\)

The passion and resurrection account, by mirroring ‘raw human life as I experience it’ also provides an ‘identity that [for one participant] works’ (‘Phil’), although, for another participant, what is important is the removal of the body from the cross, its entombing\(^\text{18}\) and an imagined conversation between Nicodemus and Joseph of Arimathea: ‘We’ve got to do something with this and we’ve got to do what we can. This terrible thing’s happened’. For the priest, ministering among people ‘to whom terrible things have happened’, the resurrection lies ahead, perhaps some considerable way ahead, and while ‘we can claw our way towards [it]... I’m working on that sort of space in-between, which [has]... a sort of grimness to it, but with a sense of hope’ (‘Hugh’); or, as another participant described it, ‘being a priest [is] about supporting people in recovering as much of the fullness of life as they’re able to, within whatever constraints are placed upon them by their illness’. Recalling words from ‘John’s’ prologue, ‘in him was life, and the life was the light of all people. The light shines in the darkness, and the darkness did not overcome it’,\(^\text{19}\) this participant draws on Johannine theology ‘to see priesthood not as being about one little

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\(^\text{15}\) In fact, the proposition that Jesus proactively searches out the man is a gloss on the original text. Nonetheless, even if this has been recalled incorrectly, imagined or invented, it remains indicative of how this participant perceives priesthood.
\(^\text{17}\) John 6:5-15. What is distinctive about John’s account is the command Jesus gives: ‘Gather up the fragments left over, so that nothing may be lost’ (John 6:12). Although the participant did not make specific reference to this verse, absent from the synoptic gospels (cf. Matthew 14:13-21; Mark 6:31-44; and Luke 9:10-17), it is this which distinguishes John’s account and leads me to wonder whether the participant had this verse in mind. In other words, priesthood entails a responsibility to ensure that no one is lost.
\(^\text{18}\) Matthew 27:57-61.
\(^\text{19}\) John 1:4.
section of life, but giving me a wider vision of stuff than that, so that all of life is sacred, not just a little religious subsection of it’ (‘Sarah’).

Servanthood, as it is set out in Matthew 25:31-46, draws together many of these themes. As a couple of participants expressed it: ‘That’s very much what I base my ministry on simply because that’s what people have done for me. During my time of pain and loss, people have carried me and walked alongside me and prayed for me when I can’t pray’ (‘Mary’); and ‘that thing of service, of washing... people’s feet’ (‘Barbara’).

However, for one participant, who had served as an evangelist in the Church Army before ordination, what was prominent in her priestly ministry were the sacraments. This led her to choose the Corinthians’ account of the Last Supper20 and the story of ‘Phil’ip baptizing the Ethiopian Eunuch21 (‘Barbara’).

4.3 What liturgical rite or ceremony do you perceive as central for you as an Anglican priest and why?

In this question, the theme of resonance with priestly identity focuses on each participant’s choice of liturgical rite or ceremony and what this might reveal about priesthood.

Predictably, nine of the twelve participants select the Eucharist as central to Anglican priesthood but offer different reasons. For one, it provides ‘the sign par excellence which we have been given, to show that God has come among us and that we feed on him and know his healing in every aspect of our lives’ (‘Andy’). For another, the importance of the Eucharist resides not in ‘the magic bits as I call it... [but in] the deep spiritual symbolism [of being together in community]’ (‘Phil’), what is described by yet another participant as ‘a simple symbol... an interactive thing that people do together’ (‘Hugh’). In answer to an earlier question (4.1), one participant spoke about the Eucharist not only as a liturgical event but as the transformative power of God signalling the ‘in-breaking and the fullness of God’s reign’. However, he now provides a different emphasis, referring to those times ‘when I was finding it difficult to find where God was, even in my own life, never mind anybody else’s life or the life of the world [and] that putting on a chasuble and being at the altar was where God found me’ (‘Brian’). Another participant portrays this as ‘God coming to us in simplicity and brokenness and offering us life and healing and peace out of that simplicity and brokenness... That’s how God comes to us in our lives and that is how we should come to one another in life as well’ (‘Sarah’).

The centrality of the Eucharist, however, is not an inevitable consequence of ordination. One participant saw ordination as a commissioning into some expression of ministry, ‘but more and more, my own journey has [shown me] the centrality of the sacrament, being that person who presides at the Eucharist... [and] sharing in that mystery and the powerfullness of it’ (‘Vanessa’). Again, as another participant reports: ‘It’s where we are fed and where as priests we feed others or Christ feeds others through us’ (‘Rita’).

Aside from the Eucharist, there are other thought-provoking responses.
When asked to choose a liturgical rite or ceremony central to her priesthood, one participant immediately responded with one word, ‘none’, then adding that the ‘ceremonial side of priesthood is what I’ve moved away from... how that’s interpreted within the Anglican Church’. She goes on to explain that this is not a rejection of all ceremonies and rituals but her need for creative, spontaneous, original and authentic liturgy. This she has experienced within the worship of the Iona Community and also in a Roman Catholic retreat centre where, once a week, the priest ‘facilitates Holy Communion with people from all sorts of backgrounds and faiths and denominations, and... ironically it’s probably there I’ve experienced the most inclusive Holy Communion: in a Catholic retreat house with a Catholic priest!’ (‘Claire’).

For another participant, it is contemplation: ‘probably not liturgical... very mindfully sitting on [my prayer cushion] and very mindfully being present to God as a daily practice; and, in that act, surrendering to God’s presence. That’s my communion’. It touches on the Eucharist in that it incorporates thanksgiving or ‘gratitude... as the fundamental attitude’ (‘Nigel’).

Also touching on the Eucharist, as well as baptism, is the role of reconciler. As one participant put it: ‘with people that are dying, when they’re conscious they tell you stuff that they’ve never told anybody before and I think that is a very special place to be’ (‘Barbara’).

Yet again, for another participant it was the memory of being chosen to be the deacon of the oil for the anointing of the sick and dying, at the Maundy Thursday Chrism Eucharist, and the words prayed over the oil: ‘Blessed are you, sovereign God, gentle and merciful, creator of heaven and earth. Your Word brought light out of darkness, and daily your Spirit renews the face of the earth. Your anointed Son brought healing to those in weakness and distress. He broke the power of evil and set us free from sin and death that we might praise your name for ever. By the power of your Spirit may your blessing rest on those who are anointed with this oil in your name; may they be made whole in body, mind and spirit, restored in your image, renewed in your love, and serve you as sons and daughters in your kingdom’. For her, it is a prayer that encapsulates what it means to be a priest’ (‘Mary’).
Finally, one participant suggested the importance of the daily offices as characterizing ‘the traditional role of being a priest’ and providing a ‘rhythm and pattern and root’. Unfortunately, he admits, it is ‘never going to happen in healthcare chaplaincy... a world... where we’re having to play along, or games (most of which I like). I like exploring the stuff we’re having to look at now, like recording data... [and] going to management meetings... It does mean there might be a meeting on, when you might [prefer] to say mid-day prayer. You can’t you know. I should do mid-day prayer a bit early or a bit later so that I can go to that meeting, but then of course something else comes up or I need to be seen to be visiting ‘x’ number of people; all those silly pressures’ (‘John’).

22 In the Book of Common Prayer (1962), under the heading ‘Concerning the Service of the Church’, it states that ‘all Priests and Deacons are to say daily the Morning and Evening Prayer either privately or openly, not being let by sickness, or some other urgent cause’.
4.4 How would you describe the theological relationship between the ordained Anglican priest and a lay person whose ministry is licensed by an Anglican bishop?

By contrasting Anglican priesthood with licensed non-ordained ministry, I wanted to learn more about what participants might consider to be the essence of priesthood.

The phrase ‘theological relationship’, i.e. how *theologically* ‘x’ stands in relationship to ‘y’, is used in a number of subsequent questions and caused some uncertainty among participants: ‘I’m not quite sure what you mean by theological relationship’ (‘Andy’) and ‘it’s a term that I’ve not really come across before’ (‘Rita’).

With respect to this question, two participants spoke about struggling to find an answer (‘Phil’; ‘Mary’). As one put it, ‘I don’t think there’s [as] much difference as some people want... or perceive there to be’ (‘Phil’). This was supported by other comments: ‘It’s a minefield... I wouldn’t want to say there is a difference in quality between one and the other’ (‘Hugh’) or, as another participant admitted, there was (and perhaps continues to be) the assumption that ‘to be a real person in ministry [you needed] to be ordained’ (‘Barbara’).

The question one participant asked of me, ‘Is it that some clergy think that priests are separate?’ (‘Sarah’) was particularly interesting given that the person who asked this question had been trained for ordination at a theological college which stands in the catholic tradition of the Church of England. It was rhetorical and suggested how far this person had journeyed, theologically, from her days as an ordinand. As she went on to explain, she did not believe in ‘lay separation’ (‘Sarah’).

This was not the view of another participant who spoke about ‘that ontological thing’: ‘priesthood is something [about] changing you, changing your relationship [with God]... You have to change as a person’, a change in which she considered the priest to be, paradoxically, both a passive recipient and an active player: ‘do you change or are you changed? ...It’s both isn’t it?’
Two other participants referred to a theology of ontological change. One dismissed the idea ('Andy') and the other reinterpreted it: ‘what I would call the ontology of priesthood... is there [at] the core of my being, this relationship with God. And I believe that to be universal. I believe that everybody has [the potential for] that’. He went on to say that while there is ‘probably’ no difference between the priest and any other baptized person, the priest is a symbol ‘of the possibility of that relationship of [the] soul to God... [which] every culture needs’. Moreover, he held out the ‘hope that other people [would] grow into it without having to go through the ridiculous route of ordination in the Church’ ('Nigel').

Where a difference between ordained and non-ordained licensed ministry was acknowledged, various reasons were put forward.

It could be seen as a difference of function revolving around responsibilities, authority and leadership. Citing St Paul’s description of the body of Christ\(^{23}\), one participant pointed out that ‘there are many different functions within the body but actually we’re all needed, we’re all necessary, because we all make up the whole’ ('Rita'). Another described this as ‘complementary’ ministries ('John'). From personal experience of licensed non-ordained ministry, ('this is my baggage. I own up to that'), one participant remembered her erstwhile clergy colleagues (although they never introduced her to others as a ‘colleague’) as at times absorbed by ‘their own self-importance’ ('Barbara'). Another participant agreed: ‘I think priesthood is very dangerous. I think that it can add vanity [and] all sorts of trappings which one has to be very wary of’ ('Nigel'). Others talked about being ‘totally turned off by a notion of hierarchy in the ministry’ and that no ministry was more importance than any other ('Andy'). Rather it was ‘just different roles and tasks’ ('Barbara') or, as another suggested, not only a matter of function but about ‘self-identity’ ('Hugh').

Self-identity, itself, was understood in a number of ways. One participant spoke about the ‘proper professionalism’ of priesthood by which he meant being ‘highly trained for a particular post’. When it was pointed out that this implied a licensed lay minister was not professional, the participant admitted, ‘I wouldn’t

\(^{23}\) cf. 1 Corinthians 12:1-11; Romans 12:3-8.
quite say that'; rather that the process of ‘formation’ was different for ordained and non-ordained ministry (‘Andy’).

Self-identity was also bound up with ‘sacramental authority’, in particular Eucharistic presidency which, in the context of healthcare chaplaincy, raised questions about what constituted a worshipping community. ‘Presidency of the Eucharist within some ecclesiological frameworks is about the community which is gathered around Christ, and of course you’re in a different position in a hospital’ (‘Brian’); or as another participant acknowledged ‘[t]he key action is celebrating the Eucharist, which would, in any other context, make me, some Sundays at least, president of the community... But in this context I don’t think that quite works except when there is a service to be taken, if you see what I mean’. He then added, crucially, ‘I’m not absolutely sure that my priesthood does mean very much in this context’ (‘Andy’).

Finally, self-identity might depend on the nature of a person’s vocation: ‘[t]heological relationship? I don’t know. It’s something about vocation again. Why isn’t that person [trained as a reader and licensed by the Anglican bishop] ordained? It’s a different vocation, isn’t it? It’s a different calling. It’s a different vocation’ (‘Mary’).

Then again, ‘[t]here’s a mystery thing [to priesthood]... that probably [I’ll] at some time unpack. It will probably be in retirement. [I’ll] just go along with it now’ (‘Vanessa’).
4.5 How would you describe the theological relationship between the ordained priest and the Diocesan Bishop?

In putting this question, I wanted to learn more about what participants understood to be the nature of priesthood by asking them to consider the theological relationship that exists between the ordained priest and the diocesan bishop.

Again, this was unfamiliar theological territory for many of the participants: ‘I’ve never really thought about it, would you believe?’ (‘Phil’) and ‘I’m dubious about the whole role of a bishop in my work as [a] healthcare chaplain. I suppose it’s not something I have to think about that much’ (‘Claire’). But this did not deter engagement: ‘I really thought about it because we tend to think that relationship with bishops is not theological it’s more organizational’ (‘Phil’).

The bishop was perceived as the priest who, in collegial relationship with other priests, is the first among equals. ‘I look at the relationship of Jesus and his disciples. In one sense, there’s equality amongst them, and in another sense, one of them, in Jesus, has particular gifts or a particular understanding or a particular vision that they hadn’t got, and they learn from him. That’s how I look to a bishop’ (‘Phil’): for leadership, authority and insight but as ‘different expressions of the same ministry’ (‘Barbara’). However, it is an uncertain authority that the bishop holds: ‘I am still questioning the [bishop’s] authority... because, in my role here, I’m actually employed by a Healthcare Trust, which is a secular organisation. So I have two bosses. But the Healthcare Trust is the one who pays my wages, who sets out my job description, who has certain expectations of what I will do and how I will fulfil my role and there could be, at times, contradictions in what they want and what the diocesan bishop might expect me to do or say. So that’s why I’m being a bit ambivalent about it because I recognise that I have to have authority from the bishop. I have to have the bishop’s license in order to do my job’ (‘Rita’).

There was recognition of the pastoral relationship between the bishop and the priest: ‘in his ordination to the episcopate [there] is an extra responsibility of pastoral care to the priests who he’s in collegial relationship with’ (‘Nigel’); ‘I
would look to my bishop for pastoral care of myself’ (‘Andy’); ‘the pastor of the pastors’ (‘Vanessa’) ensuring that priests are ‘keeping their spiritual journey alive’ (‘Nigel’). Shepherding was mentioned a number of times in terms of leadership, oversight and pastoral support, yet the fact that episcopal sees are tied to geographical areas was itself problematic. ‘It’s a strange relationship, theologically or otherwise really, because I live in wwww diocese but I work in xxxx diocese [in which there is the] bulk of my work. But we also cover yyyyy as well...; all these boundaries... don’t really work... But my diocesan bishop is the bishop of zzzzz and it’s a large diocese so it’s got other bishops as well. There’s no way he can get to know everybody...; and this diocese is very parish-oriented’ (‘Claire’).

Spiritual and ministerial dislocation was mentioned in various guises: So, for example, one participant bemoaned the fact that she only saw the diocesan bishop at the annual chrism mass (‘Barbara’). For another, ‘we sit so loosely... outside the structures of the diocese that there just isn’t much there really, theologically or otherwise’ (‘Claire’). In fact, it is a relationship ‘so caught up with the current structures of the Church of England, which I don’t like and I don’t agree with, it’s hard to even say, because I think to have a positive good relationship, the structures of the Church need changing. So I struggle with that really’ (‘Claire’). While feeling ignored by her bishop, another participant was adamant that ‘I want to stay under the care of my diocesan bishop, and I want him to always be aware of what is going on in my priestly ministry as chaplain... [H]e will see me at all the diocesan events, even if it’s just to jog his memory’ (‘Mary’). Again, when senior Church management does get it right, such as tailoring the paperwork of Ministerial Development Review24 to address the

24 (1) Ministerial Development Review (MDR) facilitates a guided discussion framed around an office holder’s ministry. The purpose of the review is to look back and reflect on what has happened over the last year or two of ministry and, informed by that, to look forward to plan, anticipate and develop a clearer vision for what lies ahead. In looking back there is an opportunity to acknowledge all there is to be thankful for and anything that is a matter for lament, and in looking forward to anticipate the changing demands of the role, identify future objectives and areas for potential development.

(2) MDR is founded in the assumption that all office holders are responsible to God for the ministry entrusted to them and that they are accountable to the Church and to one another for the way in which it is exercised. Ministry is a gift and a trust for which each individual holds account. Accountability includes a preparedness to grow and develop on the basis of experience and the learning gained from it. It is about affirmation and encouragement as well as challenge. (Church of England, 2010).
specific context of a sector minister, it feels as if ‘it’s only a scratch on the surface’ (‘Mary’).

A further perspective was offered with the suggestion that episcopacy was ‘God’s gift to the Church which says you’re called beyond simply the local and that you have to hold together in a greater unity’ (‘Brian’), what another participant called ‘part of a greater whole’ (‘Hugh’). This catholic construal of Church underpinned by the threefold ministry, within which the bishop is a sign of unity and the Church of England priest is ordained into the Church rather than the Church of England, brought to the surface concern about the ecclesiological divisions within the Church of England: it ‘becomes more complicated as we get into all the stuff about flying bishops... How did we get into that mess? I don’t understand it. I don’t understand the theology. There doesn’t seem to be a theology...’ (‘Hugh’); and the [bishop] as ‘the focus of unity or disunity within the diocese’ (‘Brian’).

There were inherent difficulties in answering this question given the complex nature of the relationship between the priest and the bishop: ‘at its worst, which is not a theological relationship, it’s worse than useless’ (‘Andy’) and ‘I think I’ve been treated quite badly’ (‘Claire’). What was acknowledged, theologically, was an attachment: ‘I’m an extension of what [the bishop] does’ (‘Phil’), that priests ‘have a role to exercise the episcopate’ (‘John’), that ‘my ministry is the bishop’s ministry’ (‘Brian’) and both are ‘different expressions of the same ministry’ (‘Barbara’). In this, bishop and priest share leadership, oversight, authority and pastoral care: a relationship which in some respects is ‘functional’ (‘Claire’).
4.6 What do you understand to be the theological relationship between the two concepts: ordained priesthood and the ‘priesthood of all believers’?

In asking participants to consider the related concepts, ordained priesthood and priesthood of all believers, my objective was to gain further insight into each person’s understanding of ministerial priesthood.

Once again, some participants found themselves theologically floundering although only one admitted that ‘I just don’t know what it means... it’s a term that I tend to hear from the quite evangelical friends of mine’ (‘Phil’). 25 Another remarked: ‘I think it’s... a question that’s worth asking’ (‘Andy’) while yet another confided ‘I’ve never talked in this sort of speak since I was at college’ (‘Mary’).

Others recognized that all baptised people have a responsibility to proclaim the gospel: ‘[t]hat’s how their the priesthood is exercised, through their being a Christian in the work place, a Christian in the home, a Christian in the neighbourhood, a Christian in their hobbies or whatever’ (‘John’); ‘living out that spiritual journey’ (‘Claire’) where ‘God equips us all to have ministries of various sorts’ (‘Vanessa’). However, ministerial priesthood was perceived to be one of leadership: ‘the lead vocation for empowering and enabling Christian discipleship or the Christian community’ (‘John’).

While some talked in terms of the ‘functionality of [ministerial priesthood]’ (‘Claire’), ‘we do more overt things and there are tasks which are laid out... for good order’ (‘Hugh’), others emphasized its sacramental value: ‘[t]he ordained priest is or might be a sign, an outward and visible sign, of the priesthood that we all share’ (‘Andy’), ‘the symbol of what is possible for all... [which] helps [the] priesthood [of the non-ordained person] to emerge’ (‘Nigel’). For one person, while any Christian may at times be a sign of Christ’s presence and God’s love, the ordained priest is always that sign. Unwilling to concede an ontological or metaphysical interpretation of priesthood, he went on to suggest a relational

25 The doctrine known as the priesthood of all believers, universal priesthood or common priesthood is based on 1 Peter 2:9. First proposed by Luther in 1520, its interpretation varies among Christian denominations.
explanation for a permanent change in the person of the ordained priest, comparing the priest to the teacher, bank manager and doctor who have clear professional roles, ‘where people come into a particular kind of relationship with you by virtue of being in that role’ (‘Andy’). Another made the same point: ‘[i]f you do [any job], and you do it with love and respect, it changes you’ (‘Hugh’). It is a two-way relationship in that ‘the ordained priest... demonstrate[s] what priesthood looks like’ while ‘the priesthood of all believers [is] there to remind ordained priests... what priesthood is about’ (‘Sarah’), ‘each of us in our vocation and ministry’ (‘Barbara’).

One further comment was itself quite revealing: ‘I think it must be very clear to you, I’ve definitely moved into a place of thinking in terms of ministry rather than priesthood, particularly in this context’ (‘Andy’).
5.1 Are there any theological motifs or themes or doctrines that resonate with your understanding of the healthcare chaplain?

In asking participants to consider theological motifs or themes or doctrines that they would associate with the work of the healthcare chaplain, I wanted to learn more about how each interpreted the role.

Answering this question, five participants (‘Andy’; ‘Sarah’; ‘Barbara’; ‘Rita’; ‘Mary’) referenced scriptural passages (the focus of the next question, 5.2). These I summarize at question 5.2. Nonetheless, what the participants did share was informative. So, for example, as a preamble, one participant referred to his decision not to attend meetings of the local deanery chapter and deanery synod. These, he considered ‘a waste of time’ because of an agenda ‘dominated by parish matters’ as well as a belief that ‘they... don’t understand us’ (‘John’). Another participant happened to mention her difficulty with the word ‘theological’ ‘because a lot of my inspiration nowadays comes from Buddhist traditions. I wouldn’t call myself a Buddhist at all but that’s where a lot of my inspiration comes from’ (‘Claire’).

Spirituality, as a theme, was selected by two participants. One recalled a definition of spirituality as ‘that which gives life and animation’ (‘John’).26 For the religiously-minded, this might involve prayer, liturgy or scriptural texts whereas for a non-religious person, it might be family, hobbies, music or food. In meeting spiritual needs, the chaplain needed to be alert to both. For the other participant, it was Celtic spirituality which informed his work as a chaplain. The ministry of the Celtic saints, Aidan and Cuthbert, was not one intent on imposing the Christian faith but rather, through listening and understanding local beliefs, customs, values, issues and struggles, might enable people to become aware of God in their lives: ‘that’s what chaplaincy is about for me... What [it is] that might give them some strength or some insight or some hope’ (‘Phil’). Another participant referred to a group he and a drama therapist had brought together. The aim was to perform a series of mystery plays which were associated with a nearby city. Within these stories, ranging from ‘creation’ to the

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26 McGrath, in his book Christian Spirituality (1999), refers to the Hebrew word, ruach, which has a wide range of meanings including ‘spirit’, ‘breath’, ‘wind’ and ‘that which gives life and animation to something’. From this, McGrath proposes that a working definition of spirituality is ‘that which animates a person’s life of faith’ and ‘that which moves a person’s faith to greater depths and perfection’.
'end of the world', 'there is a truth and a sort of kernel of experience which is meditative and... resonate with people’. This was not evangelism but recognition that ‘a play is liturgy or at least the telling of a myth, a story with profound truth. ... [and that] encountering it, and working with it, we discover something of our own truth [and] we can work with our own experience by seeing it and encountering it in those great stories’. So chaplains are ‘tellers of stories and bringers of stories to which people can respond and find their own tales’ (‘Hugh’). 

For another participant, his ministry was framed within the doctrine of the imago Dei: human beings created in the image of God. What was striking was his separation of the ‘image of God’ from the ‘likeness’ of God. This allowed him to claim that ‘because God’s image dwells within us... it is seeking to manifest itself more and more into the likeness [of God]’. The chaplain is someone who accompanies and gives witness to the yearning, deep in the soul, that desires to grow more and more into that likeness (‘Nigel’). 

The use of the word 'compassion' featured in the response of two participants but the contexts were quite different. One participant spoke about her profound anger with God as she observed the suffering and torture which were commonplace in people’s lives. She felt hypocritical 'seeming to represent an institution which was basically there to defend God when I felt that some of God’s actions were indefensible'. What sustained her was a belief that undergirding the universe was gentleness and compassion, both of which were imperative to her ministry as a chaplain and as a Christian (‘Sarah’). The other participant who referred to compassion did so as part of a list of attributes or attitudes which included presence, listening, attention, attentiveness, mindfulness and incarnation. By way of illustrating these, she touched upon the story of St Martin of Tours and the beggar: ‘he doesn’t just take off his whole cloak and shift the problem, [be]cause then he’d be naked, or whatever, but he shares so they both have warmth; and that kind of sharing and supporting and warmth is ideal for trying to explain what chaplaincy is’ (‘Claire’).

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27 According to Wehemeier (1971), medieval theologians distinguished the 'image of God' from the 'likeness of God'. 'Image' referred to each person's innate resemblance to God while 'likeness' denoted the divine moral attributes that human beings lost in the fall. Modern exegesis has largely abandoned such a distinction (Collins, 2006, 62).
The implicit presence of eschatology shaped the thoughts of another participant who had worked in palliative care, ‘an environment in which all of those metaphors about the end things are there’. His was a ministry ‘lived in an Advent season [in which] it’s always about expectation... about people living in particular periods in which they are hoping for something and maybe [their] hopes being a wee bit dashed’ (‘Brian’).

The motif of the parish model of ministry still had relevance for another participant despite her NHS context: ‘we have three thousand staff here and we have five hundred [patients]... so we have a responsibility for them in that way of the parish’. However, hers was a model of parish ministry ‘beyond our denomination, beyond our faith, beyond whatever’, one in which ‘we’re still on that missio Dei’. ‘We’re finding God in the world and we’re meeting the people where they are and who they are and how they are, as opposed to waiting for them to come... searching us out’ (‘Vanessa’).
5.2 Are there one or more scriptural passages that resonate with your understanding of the healthcare chaplain?

In asking this question, I wanted to gain further insights into each participant’s understanding and interpretation of healthcare chaplaincy.

Two participants referred back to question 4.2, (i.e. scriptural passages that resonated with their understanding of priestly identity). The first did not think that anything ‘stood out... other than the one I gave earlier [in answer to question 4.2]’ (‘John’) while the second believed that as far as her priestly identity was concerned ‘I live out my life as a priest in this healthcare setting’ (‘Rita’).

However, she did offer a further scriptural passage, the Good Samaritan\(^\text{28}\) : those to whom she ministered ‘can be in the gutter... bruised and a bit battered and wondering what’s going to happen’. The Good Samaritan ‘turned to somebody who wasn’t of his cultural background or faith community’ which speaks to both the multi-faith context of chaplaincy and the fact that chaplains ‘are there for all people’ (‘Rita’). This episode was recalled by another participant who posed the question, ‘Are hospital chaplains more generally Lucan Christians in the sense that Luke... has so much about social justice and care? And the way in which I would understand hospital chaplaincy isn’t simply about what I do with an individual, but is actually a social justice ministry’ (‘Brian’).

The post-resurrection account of Jesus and the two disciples on the Emmaus Road\(^\text{29}\) was mentioned by two participants. For one, it was a source of hope, accompanying a person when the journey is a rollercoaster and the chaplain has ‘no idea of really what’s going on’ (‘Barbara’). The other, having mentioned storytelling before (see 5.1 summary), returned to this theme with Jesus on the Emmaus Road as the storyteller: ‘that through the telling of the story you come to a sense of who you are, and of resurrection, within your own story’. To this,

he added an interesting postscript: an awareness of storytellers ‘who struggled with their own suffering’ (‘Hugh’).

The presence of suffering evoked further scriptural passages. The Passion narrative brought to mind both passivity (‘suffering in the same way as Christ’s passion narrative suggests that Christ just took it. Not resisting’) and ‘a narrative of loss’. As the chaplain accompanies those experiencing loss, it is ‘like being a midwife, waiting for the emergence of this new being through the loss of what’s being held in the womb. The womb has to lose the child in order for the child to be born’. Unlike other healthcare professionals who diagnose in order to treat, cure and ‘fix’, the chaplain ‘is one who accompanies [in order] to discover where that journey is going... being with... experiencing with’, and waiting on what will emerge (‘Nigel’).

Suffering was implied in other biblical passages. One participant called to mind words in John’s account of the feeding of the five thousand, ‘gather up the broken pieces’, and, from the Prologue to John’s gospel, ‘light shining in darkness and darkness not overcoming it’. What was hinted at, though not voiced, was a sense of purposeful hope in the face of a profound anger with God for the suffering and torture with which people live (‘Sarah’).

A personal experience of suffering, though the word ‘suffering’ was never used, prompted one participant to choose the episode of the Gerasene demoniac. Having been diagnosed with ‘reactive depression’, he found that on his return to work some months later, the gospel reading for his first Sunday was the healing of the Gerasene demoniac. Preaching ‘very personally’ on this text, he ‘could relate to [how the demoniac felt]’. What he said ‘hit a nerve’ because some members of the congregation ‘actually got up and walked out part way through the sermon’ while others revealed he had given them permission to admit to ‘something we could never talk about’. The story of the Gerasene demoniac, a person ostracised, chained, held down physically and emotionally and sent ‘to a

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31 A paraphrase of John 6:12.

32 A paraphrase of John 1:5.
dark place’, was itself a ‘whole model of chaplaincy’. As Jesus steps of the boat the ‘first thing he says is ‘Who are you?’ His first contact is human. It’s ‘Who are you?’ Not ‘What are you?’ ‘Why are you here?’ or ‘What are you saying?’ or ‘Don’t do that to me’. But ‘Who are you?’ [Jesus] wants to know [the demoniac] (‘Phil’).

Suffering, as lamentation, brought to the mind of another participant the relevance of exilic literature. This, he argued, is echoed in manuscripts of Mark’s gospel where there is no resurrection account. ‘You’re still in exile and you haven’t come back to the Promised Land – an experience which resonates with patients, resonates with me when I’m ill [and] resonates with my whole experience of my father’s illness’. Again, in the Book of Revelation, its dreams, visions, aspirations, nightmares and ‘psychedelic quality’ that can also conjure up what it is ‘like to be ill sometimes’ (‘Brian’).

Other references included the story of blind Bartimaeus and the ‘person-centred’ question Jesus asks, ‘What can I do for you?’ As chaplains ‘we hear what the needs are and we actually stop and make ourselves available and then ask ‘What it is we can do?’ (‘Claire’); Jesus washing the feet of his disciples and giving them a new commandment, that imperative to love (‘Andy’), which another participant associated with Romans 8:39 (‘Nigel’); Jesus sending out the disciples, a model for chaplains going where they are needed and ‘making that ground holy and seeing the holiness of every person... created by God, loved by God though... perhaps not recognising God’ but deserving of respect and dignity (‘Vanessa’); the importance of healthcare chaplains being ‘able to somehow engage with the upside-downness of the Beatitudes’ (‘Nigel’) and, finally, Jesus walking on water, an episode which demonstrates that ‘Chaplaincy is not simply a professional skill. It is being present, as Christ, to those in need’ wherein the chaplain should never ‘lose sight of what you are called to be and indeed what people want you to be’ (‘Mary’).

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33 Jeremiah 39-43; 2 Kings 22-23; the opening chapters of Ezra; Daniel 1-6; Susanna; Bel and the Dragon; 1 Esdras 3:1-5:6; Tobit; and Judith.
35 John 13:34.
5.3 What liturgical rite or ceremony do you perceive as central for you as a healthcare chaplain?

Once again, this question was directed towards eliciting further insights into each participant’s understanding and interpretation of healthcare chaplaincy.

Although one participant (‘Sarah’) decided that she had nothing further to add to her earlier answer to question 4.3 (what liturgical rite or ceremony do you perceive as central for you as an Anglican priest?), the focus of this question, directed at the role of the healthcare chaplain, did reveal differences among the other participants.

Nine participants considered the Eucharist to be central to the ministry of a healthcare chaplain (‘Hugh’; ‘Phil’; ‘Brian’; ‘Sarah’; ‘Claire’; ‘Vanessa’; ‘Barbara’; ‘Rita’; ‘Mary’). While three acknowledged that they presided at an ‘open table’39, a practice that does not necessarily contravene the canons of the Church of England40, the attitude conveyed suggested they considered themselves exempt or autonomous in the matter of national Church governance: ‘anybody can take Communion; it really doesn’t matter because that’s about the grace of God in my view. And I haven’t got the church saying you can’t do that. Yes of course they can’ (‘Phil’); ‘[at] our Sunday services we ask no questions about the Eucharist as to who receives’ (‘Vanessa’) and, again, the Eucharist is a ‘flexible [yet] profound structure’ within which a Muslim is able to receive communion: ‘I don’t quite know about the theology of that... [but] I’m hoping that, at some point, he’ll bring a passage from the Koran that he can read’ (‘Hugh’).

The Eucharist was also described as countercultural to the ethos of the hospital, a place where a medical team will go to extraordinary lengths to give ‘people that extra week of life, no matter what expense it might mean to them physically

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39 In the Church of England, an ‘open table’ is the practice that allows a person who is not an Anglican to receive Holy Communion as long as they are baptized (see the following footnote). An ‘open table’, however, may also refer to the practice of allowing a person who is not baptized to receive the Holy Communion, a practice the Church of England does not authorize.
40 Canon B15A (Church of England, 2015) stipulates four categories of persons who may be admitted to the Holy Communion; in each category, it is a requirement that the person is baptized.
as an individual, or to their families or to their emotional life’. In the face of ‘a
culture that is very denying of death’, the Eucharistic focus on the death of one
man, Jesus, and ‘breaking somebody’s body symbolically... is nonsense, but it’s
wonderful nonsense’. ‘The Christian tradition and faith... raises real questions
about the value of human beings and what we do to human beings, because at
the heart of that Christian story is [the belief] that death is not an annihilation,
but that death is in the end something which gives in to life itself’ (‘Brian’). As
someone else put it, the Eucharist is ‘about God coming to us in simplicity and
brokenness and offering us life and healing and peace out of that simplicity and
brokenness’ (‘Sarah’).

Aside from the Eucharist, two participants acknowledged the importance of the
blessing. For one, it was the blessing of ‘things and people and situations’
although he frankly admitted he could ‘never work out what the word [blessing]
really means. I need to read up more on the Jewish origins’ (‘John’). The other
person talked hesitantly about ‘inwardly blessing’, unsure that this was an
appropriate phrase. What he wanted to convey was an absence of any tangible
symbol, ‘making signs of the cross and swinging incense and stuff’, and instead
transforming what would be a liturgical act into a pastoral encounter (‘Nigel’).

Prayers of healing and the laying-on of hands with anointing were mentioned
twice (‘Andy’; ‘Mary’) and, by one participant, compared with the washing of feet
commonly associated with the liturgy of Maundy Thursday. When asked to say
more, he implied that instead of the feet washing on Maundy Thursday he laid-
on hands and anointed, a practice ‘I’ve taken to offering rather more to people,
if it seems appropriate, over the last two or three years’. The value he place on
this sacramental ministry (‘the incredibly powerful sense of needing it’) was
clearly evident in that he, and a fellow chaplain, would also anoint one another
(‘Andy’).

Though, strictly, not a liturgical rite or ceremony, two participants referred to a
ministry of prayer: ‘even if they don’t want you to visit, they want you to pray
[and] to be people of prayer’ (‘Vanessa’). One participant admitted, ‘I am
praying sometimes... praying things or praying through music - things that,
theologically, are very distant from where I’m up to. But in this whole ‘person-
led’ ministry, I will do what is needed... either how I might understand prayer, which might be sharing silence together, or being mindful, or doing loving-kindness meditation... through to the traditional form of the Lord’s Prayer’. This prompted me to ask whether she had come across Austin Farrer’s description of the priest as a ‘walking sacrament’. This proved to be an image with which she was uncomfortable because it called attention to the person of the priest. Nonetheless, she liked the words ‘sacrament’, ‘sacramental’ and ‘sacred’: ‘a lot of my theology is around the earth and our connectedness with the earth and that being sacred’. I wondered aloud: ‘Celtic?’ She replied ‘Pagan’ (‘Claire’).
5.4 What do you understand to be the relationship between the healthcare chaplain and the mission of the Church?

In asking this question, I sought to explore the extent to which healthcare chaplains considered themselves allied to the mission of the Church of England. Mission itself has fuelled considerable debate and controversy in the Church of England since the 2004 report, *Mission-shaped Church: Church planting and fresh expressions of church in a changing context* and the later 2007 report, *The Mission and Ministry of the Whole Church: Biblical Theological and Contemporary Perspectives*, published by the Faith & Order Advisory Group of the Church of England General Synod. In responding to this question, participants referred to mission as a ‘hot subject’ (‘Nigel’), a cause of tension (‘Phil’) and an issue which raised many questions (‘Hugh’). Concern was expressed for the welfare of clergy charged with the task of mission: ‘I meet an awful lot of tired and stressed out clergy... who are facing an awful lot of changes and don’t know where the resources are coming from’. The suggestion followed that mental healthcare chaplains might be used to support parish clergy (‘Hugh’).

What also emerged was uncertainty and friction in the relationship between some NHS priests-as-chaplain and the institution of the Church of England. A number of participants claimed that a too-narrow approach to its ecclesiology left the Church of England focusing on the parochial system whereas the ministry of healthcare chaplains paved the way for a far more radical expression of ecclesiology: ‘non-Christians, ex-Christians, fringe Christians [and] lapsed Christians’ let alone ‘Muslims of all sorts of shades and Hindu and Sikh and Rastafarian... the odd Buddhist [and] people who claim to be Pagan and Wiccan’. The opportunity this presents is ‘barely recognized’ by the Church (‘John’); an opportunity for ‘cutting-edge’ mission (‘Nigel’). Healthcare chaplaincy is ‘a missionary frontier of the Church’ (‘John’) but mission which is about ‘people catching something of the presence of God in their being... and allowing that to capture them and to lead them... whether it’s in Church or out of Church’ (‘Nigel’); or, as another participant put it, ‘helping people to identify whatever it is that gives them hope and meaning and understanding in the greater scheme of life’ (‘Phil’). As such, this might have little to do with growing a
Christian community or even a faith community, but rather enabling a person to discover ‘a sense of identity, being, meaning, understanding [and] belonging in whatever their community [might be]’ (‘Phil’). Yet ‘the mission of the church is often drawn away from that and becomes much more about trying to be viable... getting bums on pews and the whole evangelisation side of things’ (‘Claire’). In the opinion of two participants mission takes place ‘through one’s being and the action that emerges from one’s being’ (‘Nigel’) and ‘being there; it’s being alongside people’ (‘Rita’), while for another participant, healthcare chaplaincy was ‘one expression of what the Church is and a way of being Church’ (‘Claire’).

This seems to reflect an alternative set of values and priorities: ‘that healthcare chaplaincy is not only a countercultural sign within the medical context [but]... increasingly a countercultural sign within the ecclesial context, because the Church is forgetting that it’s there to care for people who are economically useless and who can’t do anything either or who are ill’ (‘Brian’). The competing reasons for mission within the Church, which for participants ranged from the need to increase congregational numbers (‘Phil’; ‘Claire’) to a fear of Islamification (‘Brian’), raised for one person a question about whether, in the future, a bishop would regard healthcare chaplaincy as irrelevant to the Church’s missionary endeavours (‘Brian’).

Yet, as some participants pointed out, healthcare chaplains not only provide an important Christian discourse within their workplace, a discourse which needs to be heard alongside the many others (‘John’), they also work in close co-operation with the Church, visiting and caring for patients on behalf of parish clergy (‘John’), networking with local churches (‘Mary’), officiating at parish services (‘Mary’), training those preparing for licensed ministry (‘Mary’) and taking seriously their own accountability under licence to the bishop (‘Mary’). In these and other respects, healthcare chaplaincy is ‘a different expression of Church but [one which is] very valid’ (‘Claire’).
5.5 What do you understand to be the relationship between the healthcare chaplain who is an Anglican priest and the Diocesan Bishop?

This question focused on the relationship of the diocesan bishop and the NHS priest-as-chaplain. This is a pivotal ecclesial relationship in that the diocesan bishop enshrines the unity of those congregations within his or her diocese, and promotes the development of the Church’s common life and mission within the surrounding community.41 Exploring this relationship would reveal the extent to which participants might consider themselves fully integrated into the life of the Church.42

While some acknowledged the ‘impossible’ job a bishop has (‘John’), in an institution ‘fighting for survival in a very difficult world’ (‘Phil’), participants spoke about bishops being ‘far more managerial’ (‘Phil’) and the absence of any ‘meaningful relationship’ (‘Nigel’). ‘We’re on the very edge of their consciousness and ownership and understanding’ (‘John’); ‘you’re off the radar and one learns not to have any expectations’ (‘Nigel’); ‘the diocesan bishop doesn’t impinge on my life at all’ (‘Sarah’), ‘I’ve tried to do something about this relationship... and nothing’s really happened’ (‘Claire’); ‘I sometimes do feel we’re not that connected’ (‘Barbara’), ‘we have to initiate [meetings with our diocesan bishop]’ (‘Rita’), and ‘it hurts when the diocesan bishop went round to visit all his [parish] clergy [but] has not done one-to-one visits on his [extra-parochial] chaplains... because he hasn’t got the time’ (‘Vanessa’).

A number conceded that the relationship was dependent on various factors: ‘different characters, different personalities [and] different priorities’ (‘Mary’). Factors might be the extent to which the bishop is interested or knowledgeable about healthcare chaplaincy e.g. ‘in this episcopal area, we have a bishop who has a conception of mission which is completely contrary to the one I’ve

41 Croft, 1999: 154
42 It is a requirement of employment that the NHS priest-as-chaplain is licensed by the diocesan bishop within whose jurisdiction the chaplain ministers. ‘The position of chaplain to a person or institution is not recognised in law as an ecclesiastical office. Unlike parochial ministry, the duties and parameters of a chaplaincy are not defined in statute or in the Canons, but are governed primarily by the requirements of the person or body that the chaplain serves and/or the person or body that appointed him or her, if different... Their contracts of employment, written or oral, sit alongside the licence from the bishop which authorises their ministry under Canon C8’ (Church of England Legal Office, 2011).
expressed as the mission of the Church’ (‘Brian’) and ‘he doesn’t have a clue [about] what I do and doesn’t really want to’ (‘Phil’); the extent to which the bishop is accessible: ‘the diocesan bishop is remote from people outside [his] particular episcopal area’ (‘Brian’); and the extent to which the bishop is perceived to be a focus of discipline\textsuperscript{43}: ‘...if I was in a relationship with a bloke and not be married and got pregnant, then the diocesan bishop would probably sack me...’ (‘Sarah’) and ‘the most relationship I had [with the bishop] in recent years was when I was off on maternity leave and I’d let the diocese know... and I actually got a phone call from the bishop’s secretary saying... ‘Would you care to tell us what date you got married on?’ [as if to say] ‘Just to make sure there’d been a marriage before the baby’” (‘Claire’).

This is not to deny that the relationship with the diocesan bishop can be ‘very positive’ (‘Hugh’), ‘supportive’ (‘Andy’) and important to maintain (‘Vanessa’). Indeed, while the bishop may not employ the NHS priest-as-chaplain, for one participant it is a relationship ‘that’s more part of who I am and how I work as a priest’ (‘Rita’).

\textsuperscript{43} Under the Clergy Discipline Measure 2003 as amended by the Clergy Discipline (Amendment) Measure 2013, the diocesan bishop, by virtue of his office and consecration, is required to administer discipline on any minister licensed in his diocese (see s.8(2) of the Measure).
5.6 With the appointment of non-ordained NHS full-time healthcare chaplains in England what, theologically, does the healthcare chaplain who is an ordained Anglican priest have to offer which is distinctive?

With this question, I wanted participants to reflect, theologically, on what might distinguish the healthcare chaplain who is an ordained Anglican priest from one who is not ordained. Although I did not define what I meant by ‘non-ordained NHS chaplain’, I did prompt participants to consider the case of an Anglican lay person who is the full-time manager of an NHS Trust chaplaincy team.

Comparing himself to a full-time NHS chaplain who is not Christian, one participant spoke of his own Anglicanism, schooled in Anglican spirituality and spiritual care, as a distinguishing feature (‘John’). More generally, there were signs of insularity, ‘I didn’t even know that there were non-ordained chaplains... but actually thinking about it I know one... a friend of mine who is a Muslim who’s clearly not ordained and she’s a chaplain’ (‘Sarah’); uncertainty, ‘It’s... one of those I-wouldn’t-start-from-here kind of questions’ (‘Andy’); or pre-conceptions, ‘I think it would be very odd to have a senior chaplain who wasn’t an ordained Christian minister of some kind, because you’re looking for that kind of professionalism... and that kind of relevant experience’ (‘Andy’). The absence, in other world faiths, of an overarching body to validate or endorse a person’s status, as an authentic and recognized representative of a particular faith group, presented difficulties of ‘authority and identity’ (‘Barbara’). One participant spoke about his uneasiness, as a member of an interviewing panel appointing a non-religious spiritual care provider: ‘I have mixed feelings about it. I can see the logic of it because there’s an argument to say... look at the people that come. Most of them have not been to a church at all, and out of the ones who say they’re spiritual... half of them will be Pagans and half will be Buddhists’ (‘Hugh’).

When the issue of non-ordained Christian chaplains was raised, some participants took a practical or functional stance. Embarking on the recruitment of an ecumenical Christian chaplain to his team, one participant spoke about being ‘open [and] fully prepared to consider candidates who were not ordained except for the fact that he needed ‘someone who was ordained to do the
ordained bits’ (‘John’). The ordained ‘bits’ were in part liturgical which precluded one potential applicant for a chaplaincy post: ‘she decided that wasn’t the role for her because she would have had to take services as part of her job’ (‘Hugh’). More significant was the need to provide a sacramental ministry, especially the presidency of the Eucharist. In addition, ordination was seen to impart a confidence, ‘to just push the boundaries a bit for pastoral and indeed for missionary ends’ (‘John’), and an authority and identity (‘Barbara’) as well as accountability and recognisability (‘Hugh’). An interesting variant, on the issue of authority, was suggested by one participant in that ‘If the Church in the future does not invest in chaplaincy within public institutions then the Church will lose the ability to actually talk at any level within national life with any authority’ (‘Brian’). Regarding recognisability, one participant considered that, for an NHS employer, it was salient that another body, the Church had deemed it appropriate to confer leadership on someone by way of ordination (‘Vanessa’). Ordination itself was seen to provide a training (‘Sarah’), formation (‘Nigel’; ‘Claire’) and professionalism (‘Andy’) as well as ‘a particular relationship with the Church or with the bishop... in theological terms even if it’s not always worked out in practice’, underlyng which was the assumption that this would not be the case for someone who was an Anglican authorised lay minister (‘Rita’). Nonetheless, the non-ordained chaplain was seen as someone who would not only contribute different ideas and gifts but demonstrate that ‘you don’t have to be marked out as being something special’ (‘Hugh’).

Significantly, a number of participants downplayed the importance of ordination. That although ‘there should be a priest accessible for Christian patients who wish to receive sacramental ministry’, what was more important was ‘what the person was actually like... the depth of their compassion... their sense of being integrated around their own experiences of suffering... [and] their capacity to love and value people for who they are and not for who the person wants them to be’ (‘Sarah’).

Yet, as one participant put it, ‘is it the person [or] is it the Anglicanism?’ (‘Claire’). This was a question which highlighted ambivalence. Commonsense might hold that ‘all manner of people becoming chaplains’ would be a reasonable development for an NHS department offering spiritual care (‘Claire’).
With regard to the chaplain who manages such a department, ‘I can’t see any problem... if you’re going to be sat in an office delegating tasks. I don’t think there’s really much need for someone to be ordained. But out there doing the business, yes, I do think people should be ordained’. When I asked ‘Why?’ she merely acknowledged her ‘mass of inconsistencies’ (‘Sarah’).
5.7 What do you understand to be the theological relationship between the healthcare chaplain who is an Anglican priest and the healthcare chaplain who is a Free Church minister?

In this question, I was interested to discover what participants considered to be the distinctive nature of Anglican priesthood. However, in general, participants were hesitant to articulate any theology of Anglican priesthood which might enable a distinction to be drawn between the Anglican and Free Church ministerial order. Whether this was because, as one person put it, ‘I don’t feel superior to others’ (‘John’) or a belief that there was ‘no difference, same focus’ (‘Claire’) remains a moot point: ‘We like to see the differences instead of the uniqueness that complements each other’ (‘Barbara’) and ‘I think there might be a slight difference of order [but] not a difference of theology, and not anything I would lose sleep over’ (‘Andy’). Again, ‘in the broader context I think we’re all working along the same path’ (‘Rita’) or as another participant summarized it, ‘all part of the Kingdom of God, isn’t it?’ (‘Hugh’).

Where a theological distinction was drawn, this was more apparent in the relationship with the Free Church minister than the Roman Catholic priest: ‘Obviously I would have to read their ordinal... but I think it would certainly be the case that the ordination prayers, if such a thing exists for Baptist ministers or URC ministers or whatever, would be a very different kind of thing from the Anglican or the Catholic ordinal... The intention is not the same’ (‘Andy’).

Two factors may have influenced the theological thinking of participants. One was the healthcare setting itself: ‘at an earlier point in my ministry, I would have been very sceptical about [the] inter-changeability of ministries and I would have found some difficulties with that. Increasingly a bit of me doesn’t really think that that’s important... in a hospital context those things do break down quite significantly’ (‘Brian’); ‘Is that like asking whether I think Free Church ministers are real priests...? At one time, to my shame, I would have said ‘No’ but I don’t think that now’ (‘Sarah’); and ‘probably, in the last six months, I’ve kind of taken leave of a lot of [theological] stuff and I’ve probably still got plenty more to take leave of yet’ (‘Sarah’). In a reference to two non-Anglican colleagues, a participant suggested that the experience of working in a hospital situation had
led them to be patient-led rather than influenced by what their Church would have required (‘Vanessa’). The second, and possibly related factor, was the influence of close working relationships in the ecumenical setting of healthcare: with ‘my colleagues from other denominations, who I respect and trust and value deeply, there is a friendship’. However, this friendship in the common cause and the common aim did not extend to a ‘common way of being’. As this participant went on to explain, ‘I don’t know why I’m using the word friendship and not collegiality... It’s not so much collegiality [that] you have with a group of perhaps Anglicans. It’s more... a collegial friendship because there are distinct difference[s]’ (‘Nigel’).

For other participants, the sole difference lay in sacramental ministry ‘beyond [which] I don’t see any difference at all to be honest’ (‘Phil’). Principal among the sacraments is the Eucharist but, in a hospital setting, the service of Holy Communion may be taken by a Free Church chaplain with patients unaware of the denomination of the officiant. Bread and wine from such a service may be reserved and given to patients unable to attend the service itself. When a participant mentioned an actual instance of this happening, I asked whether there was any difference between herself and the Pentecostal pastor ‘breaking bread’ to which she answered ‘No, I wouldn’t say so... patients don’t know the difference. They just know they’re getting Communion, and there’s somebody leading that who has authority within the church, or has been anointed or blessed or, you know, sanctioned to do that’. As for the Pentecostal pastor, would she see him as a lay person or part of the collegiality of priests? ‘He’s very much part of the college of priests’ (‘Mary’). However, another participant did admit that ‘If I thought I was getting the reserve sacrament consecrated by an Anglican priest, and actually it had been done by a Baptist priest (sic), I wouldn’t be happy. But it’s about integrity and honesty’ (‘Sarah’) and, presumably, not about sacramental theology.
5.8 What do you understand to be the theological relationship between the healthcare chaplain who is an Anglican priest and the healthcare chaplain who is a Roman Catholic priest?

Again, this question was directed at discovering what participants considered to be the distinctive nature of Anglican priesthood. However, as in the answers to question 5.7, there was little theological depth in the responses given by the participants.

What did emerge was evidence of a strained professional relationship between Anglican and Roman Catholic healthcare chaplains: rejection ‘by certain kinds of Catholicism’ (‘John’); ‘there’s a much greater tension there than there is between myself and the Free Church’ (‘Phil’); and difficulties ‘because of the Roman Catholic expectations and boundaries and limitations’ (‘Mary’). When, mistakenly, a Roman Catholic patient received Communion from a hospital volunteer, who was an Anglican priest, the Anglican chaplain received ‘an irate email from the Roman Catholic priest to say that this woman had received Communion and she had been traumatised by the fact that she had stepped outside the disciplines of her own Church’. As a result, even though some Roman Catholic laity are ‘open to receiving Communion’ from an Anglican, the participant does not allow it. In fact, perhaps predictably, Roman Catholic clergy appeared more concerned about sacramental boundaries than their laity (‘Brian’).

In terms of the theological relationship, one participant thought that the collegial friendship with Free Church colleagues, ‘in the common cause’, did not extend to Roman Catholic chaplains (‘Nigel’). While some participants voiced the view that there was no theological difference between Anglican and Roman Catholic priestly orders (‘Andy’; ‘Vanessa’), they conceded that the Roman Catholic Church did not offer reciprocal recognition. It was suggested, by one participant, that this was at the root of difficulties in the working relationship: ‘the Roman Catholic priest doesn’t recognise my priesthood, but he’s working for [i.e. managed by] an Anglican who happens to call himself a priest. But he doesn’t recognise that. And that, I think, creates a great deal of tension both ways’ (‘Phil’).
Conversely, two participants recounted personal stories of generosity and recognition: an ex-forces sessional Roman Catholic chaplain presiding at Mass inviting the Anglican healthcare chaplain to receive Communion ('Phil'), and a Roman Catholic parish priest, also working as a sessional chaplain, presenting a female Anglican chaplain with a stole he had purchased in Rome and which had been blessed by the Pope ('Mary').
6.1 In what ways, if any, do you think that baptism involves what some call a ‘distinctive character’, some profound or metaphysical change in a person’s ‘spiritual identity’ following the rite of baptism?

In asking this question I sought to establish and explore the nature of any theological correspondence between baptism and ordination which might be revealed in the participants’ interpretation of these two rites.

Although the question was phrased in a way which emphasized a particular theology of baptism, i.e. a distinctive character imprinted on a person’s spiritual identity, participants demonstrated theological independence and originality.

One participant framed baptism within a theology of immanence; that the ‘God dimension’ is already present in our world but inaccessible until it is ‘revealed or uncovered’ by faith. The Christian (or person of faith) experiences ‘exactly the same world’ as everybody else but sees it differently. Thus, ‘for baptism then or ordination, it’s more like seeing what’s already in there... [It’s] almost like an uncovering of hidden identity’ (‘John’) or, as another participant put it, ‘shining a spotlight on what’s already there and saying ‘did you know it was there?’” (‘Nigel’). Another spoke of ‘the profundity of what it is to be human’. That, with the insights of Freudian psychology, it is apparent that ‘children go through a sense of loss and death’ and, for parents, there are ‘the fears and hopes for a child’. Baptism is the Church’s recognition of this and the opportunity to mark ‘the dignity and the journey’ of each child (‘Hugh’).

The idea of journeying emerged in another response where it was claimed that, while baptism denotes something metaphysical, a person becoming ‘part of that mystical Body of Christ’, it does not necessarily mean that a person is changed. Baptism represents the sowing of the ‘seed of Christ’s love’ and change is dependent on what happens subsequent to baptism (‘Vanessa’).

In fact, a number of participants doubted the notion of metaphysical change occurring within baptism, one arguing that the sacrament was a ritual act that ‘only has meaning’ within the context of those who come together to celebrate it (‘Andy’); another, that it was an act of welcome and incorporation into God’s
people (‘Mary’); and again, in the context of a seriously ill neo-natal baby, that it was an act acknowledging a baby’s uniqueness and acceptance (‘Barbara’). Acceptance by who was not made clear: whether by the parents, by the community or by God. The idea of ‘washing away original sin’ was dismissed as ‘pernicious nonsense’ perhaps because nothing ‘can separate an un-baptized child from the life of Christ... or a Muslim or a Jewish person from the love of God’. While in baptism, a ‘person was being outwardly recognized as having an inner identity as a child of God’ there was no denying ‘that they are a child of God before their baptism’ (‘Sarah’).

Nonetheless, the concept of metaphysical change did lead one participant to juxtapose the patristic theology of transubstantiation and baptism. He argued that ‘in the Orthodox tradition and in the tradition of the Western Church up until the mediaeval period, [the Eucharistic epiclesis on both the elements of bread and wine and on the people] were kept together so that actually what you are doing is you’re not calling for God to just transform these things, you’re actually calling for God to transform the whole of the assembly’. Similarly, ‘baptism isn’t about the individual’ but a sign to the world that God is calling people into God’s work of transforming ‘the whole of creation, and how that transformation of the whole of creation is related to our vocation, as individuals, to take part in that transformative process’ (‘Brian’).
6.2 In what ways, if any, do you think that ordination to Anglican priesthood involves a distinctive character, some profound or metaphysical change in a person’s ‘spiritual identity’ following the rite of ordination?

Building on what I had learned from the responses to question 6.1, the focus both here and in the final questions was specifically on each participant’s understanding and interpretation of the distinctive nature of Anglican priesthood.

Presenting interviewees with what seemed an ‘almost impossible question to answer’ (‘Nigel’), one participant admitted that life was often a case of living with the questions: ‘you may have a feeling towards one [answer] but can’t always explain it or make it always logical’ (‘Rita’). Another experienced ‘a sense of being a priest’, but found it difficult to express this other than in functional terms. He recalled verses in Luke’s gospel spoken by Jesus on his return to Nazareth, verses that embodied the participant’s sense of calling and priestly ministry.44 ‘I find that I do that an awful lot... sight to the blind and freedom to the oppressed and all the rest of it’, but it was not without its frustration and struggle as he witnessed himself fall short of his own aspirations. What he did express was a priestly identity in the making, not fully realized (‘Hugh’).

Some approached this question hesitantly, conscious of ‘spiritual arrogance’ (‘Nigel’) or egotism. ‘Am I still the person I was before ordination? I’m not the one to judge that’ (‘Phil’) or perhaps when ‘drawing close to death there may be an opportunity to glance back and see distinctive moments [with] naked clarity’ (‘Nigel’). Although many admitted that ordination had brought change to their lives, as one person expressed it ‘the moment of ordination was something very different and very deep and very profound and awesome... [but] whether the essence of me is any different I’m not sure’ (‘Vanessa’). Another spoke of ordination as having ‘a bit of paper that says, technically I’m now a priest but actually it’s the ministering as a priest and the carrying of that priestly ministry that sort of embeds it in a sense’. The question ‘[w]hether that confers a ‘metaphysical change’?’ she left hanging in the air (‘Rita’). For others, the answer was straightforward: ‘ordination is more about symbolism... [and] not

that it creates this different kind of person’ (‘Claire’); ‘there’s no [metaphysical change]. I’m still losing my hair. I still get stressed, get quite angry and frustrated’ (‘Phil’).

However, some were prepared to acknowledge that what may have ‘felt [like] a kind of metaphysical change’ (‘Nigel’) could have been psychological or relational: ‘inwardly it felt like completeness’ (‘Barbara’); ‘experiences in life change us... they make us into the person that we are, for good or bad’ (‘Rita’); ordination brought about ‘a huge change in me [from being] someone who was very introverted to [that person who has] the quiet confidence I probably have now’ (‘Vanessa’). Another recalled that following her ordination ‘I became, and continue to be, more vulnerable in my encounters with others, but felt very much more accepted by the community [and] by the Church’. Again, in relational terms ‘I was seen as somebody of credibility by the people that possibly wouldn’t see [that in] other people, who are in the licensed [lay ministry]’ (‘Barbara’).

Tangentially, one participant was sceptical about the language of calling: ‘when people say God has called me to do this, that or the other... I was always a bit unsure about myself, but now I am tough with myself. I don't think I really believe in a calling in that way’. Rather, ‘the process of discernment is looking at ourselves, in a rigorous way, and thinking ‘where do my gifts lie? What are my gifts? How might it be appropriate for me to serve God given the nature of the gifts that I have?’’. With appropriate gifts, e.g. in pastoral care or preaching, ‘it might lead me to think that it might be a good idea to be an Anglican priest [but not that] God is calling me to be a priest’. For this participant, ‘calling is a Western luxury’ which begs the challenging question ‘how are you called if you are in one of those refugee camps in Somalia? What’s your calling?’ (‘Andy’).

The question this participant raised about the proper use of God’s gifts was coincidentally addressed in the response of another participant who believed that, at ordination, ‘the bishop is simply doing exactly the same as you’re being asked to do at the Eucharist. The bishop is calling for the Holy Spirit to come upon you. The bishop is calling for the gifts that God has already given to you to be used. And that's why ordination is a process... a process of being’ (‘Brian’).
This was just one instance when priesthood was interpreted within a Eucharistic framework, a 'spiritual life... centred around Mass... the shaping influence on my spirituality and I hope on my practice' (‘Sarah’), and yet a priesthood which, despite this Eucharistic focus, concerns ‘not just the Church. It’s to do with creation’ (‘Brian’).
6.3 In what ways, if any, do you consider that ordination to Anglican priesthood constitutes a commission to undertake a series of tasks or a function for the Church?

Continuing to explore each participant’s understanding of Anglican priesthood, this question focused on ordination as a commission to undertake tasks or functions for the Church.

The questions, in this final section, provided participants with an opportunity to expand on their understanding of concepts central to this thesis which had been the subject of earlier questions. Consequently, some answers were brief: ‘Back to that thing right at the beginning; that it’s both/and not either/or’ (‘John’); ‘That is what ordination to the Anglican priesthood is. That’s exactly what it is’ (‘Andy’); ‘commissioned to be, back to that being’ (‘Barbara’); 'It’s more than that, but I do think it means that as well’ (‘Sarah’); and, from one participant an even more succinct answer, ‘No’ (‘Brian’).

One participant suggested that while ordination uncovers priestly identity, the priest accepts those tasks which accompany the duty and responsibility of priesthood: the priest as person distinguished from ministerial priesthood (‘John’). This was echoed in other interviews: ‘some [priests] will be a vicar or a rector and some will be a chaplain... that’s more the role and priest is more the being’ (‘Claire’); and, again, ‘[p]erhaps the licence is the task bit... The rite [of] ordination is much more: ...to do with one’s being in God and affirming something about where one is on that journey and how that journey might manifest [itself] to do tasks in a church’ (‘Nigel’). One criticism, arising out of this, was that the Church too narrowly conceives ministry as a parochial system in which the ministerial priest is charged with the ‘cure of souls’. Such an all-encompassing provision of pastoral and spiritual care might be attractive for some, ‘daunting, but... quite lovely’ (‘Phil’), but runs the risk of excluding ministry beyond the Church. ‘I don’t think the Church... has a sense of what healthcare chaplains, mental health chaplains, can do. I think we’ve been a very under-used resource’ (‘Hugh’); a priesthood serving the needs of the Church ‘rather than the NHS or anywhere else’ (‘Claire’).
Although one participant interpreted ordination as a commission to *be* (‘Barbara’), another referred to the task oriented language of the Ordinal: ‘[t]here’s nothing about just being... [but rather] a whole list of activities that you’re commissioned to be engaged in’ (‘Rita’).
6.4 What do you perceive to be the theological relationship, if any, between what some have conceptualized as the ‘distinctive character’ of the Anglican priest as against Anglican priesthood understood as a series of tasks or a function for the Church?

This final question juxtaposed two key interpretations concerning the nature of priesthood, one ontological and the other functional, and asked participants to reflect on the theological relationship between the two if they considered a relationship did exist.

Having ‘come full circle’ (‘John’) some participants reiterated earlier comments while others provided further insights and images. Recalling the story of the Garden of Eden\(^\text{45}\), it was suggested that this was an account which shed light on an implicit tension: ‘[t]he original picture is that we’re supposed to wander beautifully around the garden, but actually we’re sent out to go and labour and work and do. And part of us wants to go back and wonder in the garden and be’. With an identity ‘determined’ by the work a person undertakes, there is an inherent tension between ‘being’ and ‘doing’. While ‘doing’ may provide ‘a sense of who I am’, the two remain uncomfortable bedfellows (‘Hugh’).

One participant made an oblique reference to Merton’s work on contemplation in which Merton distinguishes pure contemplation (infused with God’s being) and active contemplation (employing the resources of theology and philosophy, art and music): ‘the ‘being’ [of priesthood] will enable the tasks [of priesthood] to be ‘infused’ to use one of Thomas Merton’s terms’ (‘Nigel’)\(^\text{46}\). Another referred to Matthew Fox’s critique of the dualism of ‘either/or thinking’ as against the dialectic of ‘both/and thinking’ preferring to conceptualize the being and doing of priesthood as an example of ‘both/and thinking’ (‘John’).\(^\text{47}\) While there was general agreement about the primacy of being over doing, ‘something about a ‘presence’, ‘being’; out of [which] comes the ‘doing’ for me’ (‘Phil’), there was a difference of opinion about how this might be received in the healthcare context: for one person, it created conflict because ‘everything is so driven by target and

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\(^{45}\) Genesis 2:4-3:24.

\(^{46}\) Merton, 2003: passim.

\(^{47}\) Fox, 2000: 28.
time’ (‘Phil’) but for another a freedom because ‘I haven’t got to prove myself in
the tasks and the function and the managerial setup that seems to be coming
more and more into the diocesan/parish structure’ (‘Vanessa’).

However, a more radical appraisal was offered by one participant who
perceived church leadership models as making an idol of the Church itself:
‘Jesus doesn’t want us to be Christians and God doesn’t want us to be
Christians. God wants us to be Christ-like... priesthood always has to be kept
within that much wider horizon... [a] temporary, ironic and paradoxical thing that
is only necessary because we are so stupid and... [and] we mess it up anyway’
(‘Brian’).

Finally, a participant drew on the analogy of a glove: ‘you’re the glove and it’s
God’s hand inside you that enables you to carry out whatever it is he’s called
you to be’, what she described as an ‘incarnational indwelling’. In accepting
‘what God mystically and mysteriously has called you to be and do’, it was an
act of obedience rather than choice. Without God, ‘the gloves [are] just lifeless’,
‘I would be quite an unhappy and unfulfilled person’: ‘that, I think, is how I
perceive what I do and who I am’ (‘Mary’).
Appendix R: Stage three – Reflection

1. Evidence which suggests a dislocation of the two identities

Notably, while the interviews do catalogue the challenges and frustrations NHS priests-as-chaplain experience in their day-to-day work, the chaplain’s role itself emerges relatively unscathed. In contrast, there is clear evidence of the uneasiness and uncertainty which surrounds priesthood. It was devoid of meaning (‘Claire’); the label ‘Anglican priest’ inhibited ‘one’s sense of freedom in God’ (‘Nigel’); the Church of England seemed remote (‘Sarah’); sacerdotal priesthood was not being part of the calling (‘Andy’); and priesthood reflected a vacillating, indecisive Church of England, not knowing ‘where we are and what we are’ (‘Hugh’). In fact, priesthood could be ‘very dangerous’, feeding people’s vanity (‘Nigel’) and contributing to a false sense of hierarchy (‘Andy’).

What is not necessarily clear is whether these doubts about priestly identity predate a chaplaincy appointment or first emerged in the context of the NHS. One person spoke about resigning from his first brief incumbency with no intention of continuing in ministerial priesthood. After receiving counselling, and later joining a counselling team, he realized that his vocation was to ‘pastoral care rather than priesthood’ (‘Andy’). Perhaps priesthood ‘less doctrinally anchored’ (‘John’) is easier to exercise as a chaplain: a role in which priesthood can be given greater personal expression (‘Claire’) conforming less to what the Church might expect (‘Vanessa’) or as another participant put it, not simply reflecting ‘constructs within a particular cultural environment’ (‘Brian’). Even so, as a manager delegating work in a chaplaincy department, one person considered ordination unnecessary unless one was ‘out there doing the business’. Yet, as another participant observed, ‘out there’ healthcare colleagues may want the chaplain to be a critical friend rather than the priest; a person who, at one remove, is able to provide an objective voice or presence (‘Phil’).

Despite these expressions of ambivalence, what one person seemed to imply when he referred to a ‘mature’ ability ‘to cope with more uncertainty’ (‘John’), there were others for whom priesthood was embedded in their sense of
selfhood. For one participant, this was evident in her theology of the priest as president of the Eucharistic community. Over time, she had seen her Eucharistic ministry curtailed by her NHS Trust and was now concerned that it would insist Eucharistic services were discontinued altogether. This would threaten both her integrity as a priest and her continuing role as an NHS priest-as-chaplain (‘Mary’). Another person, fearing that she might be judged a ‘loose cannon’ within both the NHS and the Church, was left the more determined to be rooted in her context, ministry and priesthood (‘Vanessa’). These different scenarios illustrate the difficulties participants face in holding the two identities in harness. The one (‘Mary’) fears that a managerial and cost-cutting decision will divest her of her priestly identity, while the other (‘Vanessa’) believes that her survival, as an assumed maverick in both the NHS and the Church, is dependent on her being able to cement the two identities of priest and chaplain.

One way of avoiding the threat of dislocation is by constructing a model of priesthood that more readily accommodates the work of the chaplain. For example, one participant in critiquing Church leadership models claimed that priesthood makes an idol of the Church itself, and that the priest needs to be understood in broader terms as temporary, ironic and paradoxical. ‘You’re not going to be leaders in a church; you are actually called to be faithful to something which is beyond the church and beyond that in which you’re a leader’: faithful, he went on to argue, to a ministry of ‘social justice’ which characterizes healthcare chaplaincy (‘Brian’). A more conventional view of Church leadership was offered in other interviews and closely associated with the role of the priest (‘Claire’; ‘Vanessa’; ‘Rita’): a leadership ‘empowering and enabling Christian discipleship or the Christian community’ (‘John’) or, paraphrasing the Church of England Ordinal, to ‘lead God’s people in offering of praise and proclamation of the gospel’ (‘Mary’). As noted in the last paragraph, even the limited opportunities for exercising such a ministry are becoming more restricted, so reducing the role of the priest as the leader of the worshipping community and the enabler of Christian discipleship.

1 Another participant, who held a similar theology of priesthood associated with presidency of the Eucharist community, came to a different conclusion. In the absence of what he considered to be an authentic Eucharistic community, ‘I’m not absolutely sure that my priesthood does mean very much in this context’ (‘Andy’).
What did become evident was that while most participants were confidently able to articulate the role of the NHS chaplain, they were less able to offer a theology of Anglican priesthood. One expressed a disinterest in any formulaic theology of priesthood (‘John’). For others, priesthood was ‘integral [but] I don’t quite know what that means’ (‘Hugh’); or ‘beyond words’ (‘Phil’). The frank admission of one person was, perhaps, more representative of the participant group: ‘[t]here’s a mystery thing [to priesthood]... that probably [I’ll] at some time unpack. It will probably be in retirement. [I’ll] just go along with it now’ (‘Vanessa’). The need to negotiate a marriage of the two identities and so develop a coherent expression of self identity seemed to pass unnoticed. While some spoke about living out the life of the priest in the context of healthcare (‘Rita’), or made reference to the ‘proper professionalism’ of priesthood rooted in the rigour of formation (‘Andy’), or couched it in terms of an integrity bound up with priesthood as ‘what we do, where we are and what we can’t share’ (‘Vanessa’), others were more circumspect. One person argued, at least initially, that lay or ordained status was unimportant in the context of pastoral care. Then he admitted that it was a ‘nonsense... because... I am a ministerial priest and who I am at present is to do with all of that formation, and actually me feeling that, yes, I have been given this gift of priesthood and living it’ (‘Brian’). Particular striking were three other comments. The first was the claim that what was crucial in healthcare was not priesthood but a chaplain’s depth of compassion, the integration of personal suffering and a capacity to love and value people for who they are, rather than what a chaplain would like them to be (‘Sarah’). The second rejected the concept of vocation as God’s call to any form of work, including priesthood. Rather, discernment was about exploring the nature of one’s gifts and then asking how these might be used in God’s service. Any other notion of calling was a ‘Western luxury’ which made little sense for someone living in a Somali refugee camp (‘Andy’). The third was more a cautionary note for, in parables directed at religious hypocrisy, Jesus takes to task ‘religious people who come to too quick and easy conclusions about who they are in terms of their religious identity’. ‘Actually’, Jesus says, ‘you’re not that at all’ (‘Brian’).
2. Evidence which suggests why a dislocation of the two identities may have occurred

Irrespective of whether a reappraisal of priesthood began in the parish or in the hospital, or in the crisis of a major life event, there is evidence to suggest that the contrasting ethos, values and culture of the Church and NHS may be a catalyst for friction between the two identities of priest and chaplain. Further, that this may be compounded by the inadequate recognition the chaplain receives in either institution.

As an ecclesia, the Church of England’s rules, traditions and patriarchy can be frustrating, as one person testified (‘Claire’). Others talked of the Church as narrow, bigoted and self-referential (‘Sarah’), burdened by its buildings (‘Hugh’; ‘Nigel’; ‘Vanessa’), a ‘self-perpetuating institution’ (‘Sarah’) reduced to box-ticking, pre-occupied with growth (‘Vanessa’) and flawed by ecclesiological divisions (‘Hugh’). Critical of what she perceived to be an inward-looking Church, one chaplain maintained she had a continuing responsibility for missio Dei: ‘beyond our denomination, beyond our faith, beyond whatever’ (‘Vanessa’) while, for another, Kingdom-centred ministry trumped Church-centred ministry (‘Sarah’). Clerical caricatures, such as the benign (‘Nigel’) and ‘bumbling’ (‘Phil’) vicar, the evangelist (‘Rita’), the exorcist (‘Nigel’) and the ‘angel of death’ (‘Mary’), as well as personal and negative experiences of the Church (‘Phil’) was seen to promote a ‘narrow view’ of religion among some healthcare colleagues: ‘masses of baggage which people feel free to project out there, but [which for the chaplain] becomes a strait-jacket’ (‘Nigel’).

Insecurity seemed to characterize the relationship between the NHS priest-as-chaplain and the licensing bishop. Theologically, there was a measure of agreement among interviewees that the priest participates in and furthers the bishop’s ministry (‘John’; ‘Phil’; ‘Brian’; ‘Claire’; ‘Barbara’). Yet in an institution which was ‘fighting for survival in a very difficult world’ (‘Phil’), the ‘managerial’ (‘Phil’) and ‘parish-oriented’ (‘Claire’) bishops of the Church of England were reckoned to disregard and discount the value, contribution or relevance of those priests who are healthcare chaplains (‘John’; ‘Nigel’; ‘Sarah’; ‘Claire’; ‘Vanessa’; ‘Barbara’; ‘Rita’); a relationship which ‘at its worst... [is] worse than useless’
(‘Andy’) and which may cause participants to harbour resentment. To some, the bishop was more concerned with ensuring that a chaplain’s behaviour did not bring the Church into disrepute (‘Sarah’; ‘Claire’). The fact that episcopal sees are tied to geographical dioceses, which do not correspond to NHS catchment areas, can mean that the NHS priest-as-chaplain comes under the jurisdiction of a number of bishops. In consequence, a person may feel denied the supportive oversight a parish priest can forge with one clearly identified locality bishop. Ecclesiastical structures would need to change in order to foster more positive relationships (‘Claire’), but for one participant, the bishop ‘will see me at all the diocesan events, even if it’s just to jog his memory’ (‘Mary’) and, for others, it is a relationship potentially ‘very positive’ (‘Hugh’), ‘supportive’ (‘Andy’) and important to maintain (‘Vanessa’). Indeed, one participant considered it a relationship ‘that’s more part of who I am and how I work as a priest’ (‘Rita’). Nonetheless, the general tenor was one of begrudging acquiescence. Even when senior Church management strives to get it right, e.g. tailoring the Ministerial Development Review to address the specific circumstances of a sector minister, scepticism remains. ‘[I]t’s only a scratch on the surface’ (‘Mary’).

For these and other reasons, chaplains may seek to distance themselves from the Church, avoiding chapter and deanery synod meetings because with an agenda ‘dominated by parish matters’, as well as a belief that ‘they... don’t understand us’, it can feel like ‘a waste of time’ (‘John’). Neither the Church nor its clergy ‘really understand how healthcare chaplaincy works’ (‘Brian’). This does not necessarily imply an unwillingness to co-operate with the Church: visiting and caring for patients on behalf of parish clergy (‘John’), networking with local churches, officiating at parish services, training those preparing for licensed ministry and taking seriously their own accountability under licence to the bishop (‘Mary’). Yet, some chaplains choose to assert their autonomy e.g. in matters of Eucharistic discipline (‘Hugh’; ‘Phil’; ‘Vanessa’) while others argue that healthcare chaplaincy needs to be accepted as ‘a different expression of Church but [one which is] very valid’ (‘Claire’).

However, any ‘expression of Church’ needs to be qualified in the context of the NHS. Reference has already been made to one model of priesthood as lead vocation for ‘empowering and enabling Christian discipleship or the Christian
community’ (‘John’). While such a model may meet the needs of a parish, it would be conflict-ridden in the secular world of the NHS where there exists a broad-based notion of consumerist spirituality (‘Hugh’; ‘Phil’; ‘Claire’), requiring the NHS priest-as-chaplain to work with people of all faiths and none. Possibly, it is a necessary compromise given that ‘at least two thirds of [patients] are not even claiming to be nominal Christian, let alone practising Christian’ (‘John’).

Religious language and rituals are used only ‘when appropriate’ (‘Hugh’), or faith enters a conversation ‘if that is how someone expresses their spirituality’ (‘Claire’). One person held that he had ‘reclaimed the word religion because [it] had been thrown out’ by the NHS (‘Phil’) while yet another believed her work to be at the ‘very edges of mission’, though ‘perhaps not seen by the Church as that’. In each encounter, ‘bidden or not bidden, God is present’ (‘Vanessa’).

As a result, traditional expressions of Anglican priesthood can become peripheral. A visit from the chaplain might be received positively (‘Hugh’), but the suspicion remains that this has more to do with the symbolism of the dog collar irrespective of Christian denomination (‘Andy’; ‘Brian’; ‘Sarah’). Only a ‘tiny minority’ specifically request an Anglican priest (‘John’), someone who provides a ‘spiritual authority’ (‘Nigel’) derived from a yesteryear culture (‘John’).

Generic chaplaincy, dispensing with denominational boundaries, is common in ecumenical departments where close working relationships can exist and mutual trust and respect can flourish. Such collegial friendships (‘Nigel’) are more readily achieved in a patient-centred NHS chaplaincy rather than one bound by Church rules (‘Hugh’; ‘Vanessa’). What is more important is that spiritual concerns can be discussed with a chaplain, irrespective of denomination, in a way not possible with other healthcare professionals (‘Andy’; ‘Claire’). Among some participants, denominational boundaries meant little: ‘no difference, same focus’ (‘Claire’), ‘negligible’ (‘Andy’), ‘[denominational] uniqueness that complements’ (‘Barbara’), something to be ignored (‘John’; ‘Hugh’; ‘Rita’): ‘a slight difference of order [but] not a difference of theology, and not anything I would lose sleep over’ (‘Andy’). Arguably, with attitudes such as these, the distinctive identity of the Anglican priest evaporates.

More remarkable were the comments of one person that, for her, ordained priesthood had little to do with a faith-based role, and that her sacramental theology stemmed from ‘our connectedness with the earth [as] sacred’ (‘Claire’).
When asked if this reflected Celtic theology, she replied it was Pagan, while adding that she had problems with the word ‘theology’. Although not a Buddhist, it was a tradition that informed her thinking and, within Buddhism, the concept of theology and, for that matter, prayer made little sense (‘Claire’). This ‘pick and mix’ approach to faith was not representative of the participant group as a whole, even though there was another participant who found it acceptable to be described, by a colleague, as a Christian Buddhist (‘Phil’). Nonetheless, it would suggest that some NHS priests-as-chaplain have distanced themselves from an identity which is congruent with Anglican priesthood, an identity which, according to the evidence, has not benefited from consistent and rigorous theological reflection by the participants (‘Phil’; ‘Claire’; ‘Vanessa’; ‘Rita’; ‘Mary’). In fact, it would seem that theological discourse and reflection left a number of participants struggling or discomforted (‘John’; ‘Phil’; ‘Sarah’; ‘Claire’; ‘Mary’). One notable exception was a participant who tutors on a theological education training scheme (‘Brian’).

Arguably, the secular context of the NHS has made theological engagement an extraneous pastime. According to a number of participants, NHS employers are more concerned with measurable outcomes (‘John’; ‘Hugh’; ‘Brian’) and quality assurance, ‘a box that somewhere says we must provide this care’ (‘Phil’; ‘Brian’). It can be a narrative of accountability and policy compliance with which chaplains may feel they need to collude (‘Hugh’; ‘Phil’). It is a context within which power resides with the professions and makes professionalization, rather than theology, a more persuasive agenda, even though it can lend itself to mixed attitudes or muddled thinking (‘Andy’; ‘Brian’). However, participants seemed to possess a sufficiently formed identity, as NHS priests-as-chaplain, that some were aggrieved when neither the NHS management (‘Andy’; ‘Phil’; ‘Sarah’) nor the Church (‘John’; ‘Brian’) seemed to understand their role, particularly NHS managers whose understanding of chaplaincy was limited to one of meeting religious need (‘John’).

The belief that, one day, an NHS manager could ask ‘why are we employing these people?’ (‘Hugh’) perhaps compounds an underlying vulnerability. One participant expressed this vulnerability, in a personal way, as her need to approach people with an openness that enabled trust to be established.
Reflecting on our interview, she admitted ‘I wouldn’t talk about any of this kind of stuff [with other clergy] because you just think it’s so off the wall. I wouldn’t trust them’ (‘Barbara’). Such an open attitude may expose participants to the intensity of the ‘suffering’ and ‘tortures’ commonplace in people’s lives. As one person put it, ‘probably when I first stopped wearing my dog-collar actually was when I was really angry with God for all that stuff and I didn’t want to... I felt like a hypocrite... seeming to represent an institution which was basically there to defend God when I felt that some of God’s actions were indefensible (‘Sarah’). ‘Patients’ losses become your losses’ (‘Nigel’). The cost of priesthood itself can be considerable (‘Sarah’; ‘Rita’; ‘Mary’) including the loss of a marriage (‘Claire’; ‘Mary’). This lays emphasis on healthcare chaplaincy as a single issue interest group focusing on illness, distress, suffering, disability, chronic illness and loss, and which distinguishes it from parish ministry.

It is a ministry which is shared with non-ordained volunteers, sometimes referred to as ‘lay chaplains’, who can undertake duties similar in many respects to those of the ordained chaplain, ministry which in a parish would be the domain of the priest (‘Brian’). Again, this appeared to diminish the distinctiveness of priesthood with participants acknowledging that there was little difference between the ordained and lay person (‘Hugh’; ‘Phil’; ‘Sarah’), or as one person described it, ‘lay separation’ (‘Sarah’). Another referred to the priest as a symbol of what the soul’s relationship with God, which others might grow into ‘without having to go through the ridiculous route of ordination’ (‘Nigel’).
3. Evidence which suggests the nature of any perceived dislocation

First, the evidence suggests that the chaplain is in a hinterland, struggling on two fronts. Although the NHS priest-as-chaplain is nominally licensed by the C of E bishop, the chaplain is employed by the NHS, paid by the NHS and works exclusively within the NHS, receiving appraisal, training, line management and eventually a pension from the NHS. The remit of the chaplain is spiritual, rather than faith-specific care. As champion of spiritual care (‘Hugh’), the chaplain is directly responsible and accountable for its delivery within the NHS; a spirituality which is notionally secular, subjective (‘John’; ‘Hugh’; ‘Phil’; ‘Barbara’) and egalitarian, and in contrast to a doctrinaire and hierarchical Church (‘Andy’; ‘Sarah’; ‘Claire’) deemed to be at odds with NHS core values such as inclusiveness, equality and diversity (‘Claire’). In terms of values and priorities, chaplaincy for some ‘is a countercultural sign within the ecclesial context, because the Church is forgetting that it’s there to care for people who are economically useless and who can’t do anything either, or who are ill’ (‘Brian’).

Second, the evidence suggests that the focus of the Church of England is believed to be directed, primarily, at parish and pioneer ministries to the exclusion of healthcare chaplaincy. The NHS priest-as-chaplain can lack confidence in the Church given the tenuous nature of ecclesial relationships (‘Hugh’; ‘Rita’) so often channelled through a bishop’s adviser for healthcare chaplaincy who, in turn, may be an NHS priest-as-chaplain (‘Mary’). Sacramental ministry, considered by some to be the defining action of priesthood, can be difficult to exercise, or is theologically undermined, in the absence of a stable worshipping community led by the NHS priest-as-chaplain (‘Andy’; ‘Brian’). This is compounded by the fact that the chaplain practises in a context which can underplay denominational and faith boundaries, attending to the needs of ‘non-Christians, ex-Christians, fringe Christians, lapsed Christians... and then Muslims of all sorts of shades and Hindu and Sikh and Rastafarian... the odd Buddhist... [and] people who claim to be Pagan and Wiccan (‘John’).

Third, the evidence suggests that some NHS priests-as-chaplain have remodelled, refashioned or reframed their identity as priest-chaplain in order to
more fully reflect their evolving discernment of what priesthood means (‘Nigel’; ‘Brian’) or to gain and ensure the recognition and understanding of the healthcare community (‘Hugh’; ‘Phil’). So, for example, the chaplain does not work independently but alongside colleagues of other disciplines, perhaps as part of a multi-disciplinary team. Occasions arise when a pastoral or sacramental response to patient need requires prior discussion with colleagues who have a clinical responsibility. A patient experiencing episodes of psychosis may request the sacrament of reconciliation, but the psychiatric team might advise against this, advice which the chaplain cannot ignore (‘Sarah’).

Fourth, the evidence suggests that unlike the mission and purpose of parish-focused ministry, chaplaincy is essentially pastoral, a person-centred ministry addressing individual spiritual need (‘Phil’; ‘Vanessa’; ‘Rita’); ‘a missionary frontier of the Church’ (‘John’) but one in which mission is about ‘people catching something of the presence of God in their being... and to lead them... whether it’s in Church or out of Church’ (‘Nigel’) or, as another participant put it, ‘helping people to identify whatever it is that gives them hope and meaning and understanding in the greater scheme of life’ (‘Phil’). There is no engagement with, or critique of the five marks of mission as adopted by the General Synod of the Church of England in 1996. Rather, the 

raison d’être

of chaplaincy is enabling a person to discover ‘a sense of identity, being, meaning, understanding [and] belonging in whatever their community [might be]’ (‘Phil’). Participants likened this to the piano accompanist who supports rather than dominates the vocalist (‘Nigel’) and, from the Bible, episodes such as Jesus asking blind Bartimaeus the ‘person-centred’ question, ‘What can I do for you?’; Jesus sending out the disciples, to go where they are needed, ‘seeing the holiness of every person... created by God, loved by God though... perhaps not recognising God’ but deserving respect and dignity (‘Vanessa’); Jesus walking on water, demonstrating the importance of ‘being present, as Christ, to those in need’, never to ‘lose sight of what you are called to be and indeed what

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2 To proclaim the Good News of the Kingdom; to teach, baptise and nurture new believers; to respond to human need by loving service; to seek to transform unjust structures of society and to challenge violence of every kind and to pursue peace and reconciliation; to strive to safeguard the integrity of creation and sustain and renew the life of the earth’ (Church of England, 2014).

3 Mark 10:46-52.


people want you to be’ (‘Mary’); and Jesus, encountering the Gerasene
demoniac as he steps from a boat, asks ‘Who are you?’ ‘His first contact is
human. It’s ‘Who are you?’ not ‘What are you?’ ‘Why are you here?’ or ‘What
are you saying?’ or ‘Don’t do that to me’. But ‘Who are you?’ [Jesus] wants to
know [the demoniac]’ (‘Phil’). One participant admitted, ‘I am praying
sometimes... things that, theologically, are very distant from where I’m up to.
But in this whole ‘person-led’ ministry, I will do what is needed’ (‘Claire’). The
focus of priesthood is ‘on the person in front of me and what’s helpful to them,
and anything to do with... the Church would come way second to that’ (‘Sarah’).
It is ‘about being at that place where people have experienced damage... where
the damage is, however that damage has occurred [or] is occurring’ (‘Nigel’). It
is an expression of incarnational presence beyond what is found in the parish
(‘John’), ‘beyond the boundary of any church’ (‘Nigel’). The story of St Martin of
Tours and the beggar becomes a parable for chaplaincy: ‘[St Martin] doesn’t
just take off his whole cloak and shift the problem, [be]cause then he’d be
naked, but he shares so they both have warmth’ (‘Claire’). Accompanying those
experiencing loss is likened to the work of a midwife ‘waiting for the emergence
of this new being through the loss of what’s being held in the womb. The womb
has to lose the child in order for the child to be born’. Unlike other healthcare
professionals who diagnose in order to treat, cure and ‘fix’, the chaplain ‘is one
who accompanies [in order] to discover where that journey is going... being
with... experiencing with’ and waiting on what will emerge (‘Nigel’).
Appendix S: Themes and Sub-Themes

In this appendix I present the results of the fourth stage of the analysis, abstraction, in which I focused on the main themes or constructs that I detected in the data (§5.4.7). Initially I searched for sub-themes which I then grouped into main themes or constructs. These I revisited and revised many times. Following this, I organized the participants’ responses under each main theme or construct. This was a precursor to the fifth stage, one of synthesis in which I correlated the main themes and established what I discerned to be a series of narratives. This I describe and develop in chapter six.

Vocation:
- chaplaincy as a distinct vocation
- the concept of vocation as illusionary
- vocation as a call to priesthood
- vocation as a call to ministry
- vocation to priesthood having the same standing as any other vocation

Church of England:
- the chaplain detached from the C of E
  - Church plays no part in chaplain’s work
  - chaplain not an apologist for Church
  - chaplain’s identity is not part of Anglican structures
  - C of E’s focus is on money, buildings, income and growth
- the C of E perceived as uncaring
  - not valuing chaplains
  - not using chaplains
  - as a self-perpetuating institution
  - as self-consumed
  - as having cultural residue
- participants struggle to maintain a relationship with the C of E
  - ambivalent towards the C of E
  - assist in parishes and dioceses
- chaplaincy viewed as a place for ‘failed’ or ‘problem’ clergy
Spirituality
- chaplain is responsible for spiritual and religious care
  - responds to society’s sense of the sacred
  - is a spiritual broker

Pastoral care
- person-centred
- person-led

Religion
- religious language needs to be used sensitively
- in the NHS, the chaplain reclaims religion
  - enables people to find God
  - re-interprets the meaning of God in people’s lives

Clothing
- clerical collar
- eucharistic robes

Professionalism
- body of knowledge
- registration
- patient consent
- semi-professional
- reflective practice

Ecumenical Relationships
- unconcerned about denominational differences
- recognition that differences are present in ecclesial order
- equivalent ministries
- personal friendships within the chaplaincy team
- affirming relationships
- strained theological and personal relationship with RC
Ordination
- minimally important
- the chaplain needs to be an ordained person
- part of a participant’s personal journey
- personality and aptitude more important than the fact of ordination

Priesthood
- theology of priesthood abstruse and challenging
  - subject to revision
  - inaccessible
- the personal cost of priesthood
  - burdensome
  - self-sacrifice
- characterized by parish ministry
- the importance of retaining a priestly identity
- of questionable relevance and peripheral importance
- elitist
- sacramental focus
  - cannot be compromised
- characterized as hospitality
  - as presence
  - as availability
  - as lifestyle
  - as a spiritual state
  - as self-giving
  - alter Christus
  - infusing a person’s identity
  - an enduring psychological or relational attribute
  - a model of spiritual care
- priestly authority
  - as a guardian of the faith
  - sacramental authority
  - delegated by the Church
  - authority within relationships
  - limited to a church context
– carries weight with some in NHS management
– conferred by patients
– creates discomfort for some participants
– induces hierarchy

**Eucharist**
– the importance and centrality of the Eucharist
  – spiritually nourishing
  – symbolic of a restored relationship
  – a sign of God’s reign
  – the priest who is lost, is found by God
  – a wonderful nonsense recalling death in a death-denying healthcare context
  – the challenge of priesthood without a Eucharistic community
– not centrally important

**NHS**
– NHS as a challenging environment
– the chaplain’s role misunderstood
  – caricatured
  – underestimated
  – overlooked
– a chaplain’s uncertain future
  – management’s outdated notion of chaplaincy
  – management’s begrudging acceptance of chaplaincy
– specialist units affirm the contribution of the chaplain
– assimilation by adopting language and communication style
– chaplaincy is an integral part of the NHS
  – produces NHS policies on spirituality
  – shapes its ministry for the NHS
  – promote itself within the NHS
  – prioritizes the NHS
  – represents the Church within the NHS
  – an outpost and arm of mission
  – provides a voice for social justice
Values
- conflict between the C of E and the NHS
  - inclusiveness
  - respect for spiritual autonomy
  - diversity

Dysfunctional relationships
- the chaplain’s relationship with the bishop
  - theologically the chaplain as priest is an extension of the bishop’s ministry
  - theologically a focus of unity yet also disunity
  - the bishop is a pastoral carer of priests
    - attends to the inner life of clergy
    - a positive relationship
    - remote
- the bishop’s focus is on parish ministry
  - problem with divergent diocesan/health catchment areas
  - the chaplain is not a stipendiary priest: a contrived relationship
  - lacks familiarity/understanding of chaplaincy
  - responsible for disciplining clergy but C of E and NHS may disagree about what constitutes professional misconduct
  - can be supportive, helpful and well-meaning
  - the chaplain has to take responsibility for maintaining a relationship with the bishop
- Deanery Chapter
  - an unhelpful parish focus

Mission
- Church does not regard chaplaincy as part of mission
- the participants were cynical about the Church’s mission intent
- a missed opportunity to formulate a new ecclesiology
- a response to Islamification
– inward looking i.e. to grow congregations
– participants interpreted mission as encouraging community beyond the Church
  – promoting presence of God in people’s lives and in their suffering rather than Church
  – conceiving mission as the in-breaking of God’s reign
  – revealing the sacred
  – enabling people to be more Christ-like

**Parish ministry**
– participants’ painful experience as parish priests
– a parish model of priesthood undermines the priesthood of the chaplain
– participants expressed ambivalence about parish issues of maintenance, security, listed building status, financial pressures and the need to grow congregations
– cause of ill-health

**Multi-faith**
– dialogue
– co-operation
– creative engagement
**Appendix T: Summary results of the instrument to locate churchmanship orientation**

The instrument to locate churchmanship orientation consisted of two axes. The $x$-axis enabled participants to self-assess their position on a scale of Traditional to Liberal ($-5$ to $5$). The $y$-axis enabled participants to self-assess their outlook on a scale of Low Church to High Church ($-5$ to $5$).

Thus there were four quadrants: Liberal/High Church (I); Traditional/High Church (II); Traditional/Low Church (III); and Liberal/Low Church (IV).

None of the participants placed themselves in the two quadrants Traditional/Low Church (III) and Liberal/Low Church (IV) (see figure 1. A scatter graph of participants’ churchmanship orientation.

One participant (P12) declined any label and plotted herself on the origin (0, 0). This participant explained she felt uncomfortable with labels.

One participant (P8) plotted herself 4.5, 0. This participant did not explain her decision. However, it may be salient that during the course of her interview this participant spoke about thinking ‘can I with integrity remain a priest in the Church of England?’

One participant (P9) plotted herself -1, 2. This placed her in the Traditional/High Church quadrant (II).

Nine participants placed themselves at different points in the Liberal/High Church quadrant (I): P1 (5, 1); P2 (3.5, 1); P3 (5, 1); P4 (3.5, 3.5); P5 (2, 2); P6 (3, 3); P7 (4.5, 4.5); P10 (1.5, 2); and P11 (4.5, 4). Thus it can be seen that their responses on the $x$-axis (Traditional/Liberal) ranged from 1.5 to 5 and on the $y$-axis (Low Church/High Church) from 1 to 4.5;

For the twelve participants, the mean was 3, 2 and the median was 3.5, 2.
Consequently, 75% of the participant group reflect a Liberal/High Church trend, while 83.3% of the participant group reflected a Liberal trend.

Figure T.1 Summary results of participants’ churchmanship orientation
Proposal and Consent Form for Research Projects

Title of Research Project: THE CHURCH OF ENGLAND PRIEST AS NATIONAL HEALTH SERVICE CHAPLAIN: SINGING THE LORD’S SONG IN A STRANGE LAND?

Name and title of Researcher: Prebendary Tony Kyriakides-Yeldham, post-graduate research student, department of Theology & Religion.

Details of Project:
The scheduled date for completion of this doctoral research is 2015. The researcher has been awarded a grant, towards university fees, from St Luke’s College Foundation. This amounts to £200 each year for a period of three years.

The research study has four aims:
(1) to consider, theologically, the identity and integrity of the Church of England priest;
(2) to consider, theologically, the identity and integrity of the National Health Service Anglican priest-chaplain;
(3) to consider the compatibility and divergence of identity and integrity for the Church of England priest ministering as a full-time NHS chaplain in England;
(4) to consider the development and currency of models of Anglican priesthood, and whether these might provide a theological rationale for health care chaplaincy.

You, the research participant, will be asked about your understanding of Anglican priesthood and healthcare chaplaincy.

The intention is to complete this phase of the research, involving twelve research participants, by the end of 2012.

The research participants: Participants will be Anglican priests who are currently working in the NHS in England as healthcare chaplains.

Data or information to be collected, and the use that will be made of it: You, the research participant, will be interviewed once and the interview will be semi-structured using a series of questions. In addition, you will be asked to mark on a graph where you perceive yourself to be in terms of the two constructs ‘liberal-traditional’ and ‘low church-high church’. It is anticipated that each interview will last between 90 minutes and 120 minutes. The transcripts of the semi-structured interview will be subject to a ‘content analysis’. When reporting the research, where specific reference is made to content in a transcript, this will be non-attributable to ensure that no participant can be identified in any way. Anonymity is guaranteed and will be rigorously enforced.
The research findings will be published as a doctoral thesis according to the statutes and regulations of the University of Exeter. It may be that, at a later date, the thesis will be edited into a book which might be published to the general public. Again, anonymity is guaranteed and will be rigorously enforced.

**How will the information supplied by participants be stored?**
All data will be securely stored and research participants identified by number which will be securely stored separately from the interview data.

**Contact for further questions:**
*Researcher:* Prebendary Tony Kyriakides-Yeldham  
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**Contact in the case of complaint or unsatisfactory response from the above named:**  
Dr Zoë Boughton  
Ethics Officer, College of Humanities  
University of Exeter  
Department of Modern Languages  
The Queen’s Building  
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*email:* Z.C.Boughton@exeter.ac.uk

**Consent:**  
I voluntarily agree to participate, and agree to the use of my data for the purposes specified above. I can withdraw consent at any time by contacting the interviewer.

*Note:* Your contact details are kept separately from your interview data.

**Printed name of participant:** .................................................................

**Signature of participant:** .................................................................

**Preferred contact - email or telephone:** ...........................................

**Signature of researcher:** .................................................................

*One signed copy to be retained by the researcher, and one by the participant.*
CERTIFICATE OF ETHICAL APPROVAL

Academic Discipline: Theology

Title of Project: THE CHURCH OF ENGLAND PRIEST AS NATIONAL HEALTH SERVICE CHAPLAIN: SINGING THE LORD’S SONG IN A STRANGE LAND?

Name(s)/Title(s) of Project Research Team Member(s): Prebendary Tony Kyriakides-Yeldham

Project Researcher’s Contact Details (email and telephone no.):

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e-mail: aprk201@exeter.ac.uk

Brief Description of Project:

The research study has four aims:
(5) to consider, theologically, the identity and integrity of the Church of England priest;
(6) to consider, theologically, the identity and integrity of the National Health Service Anglican priest-chaplain;
(7) to consider the compatibility and divergence of identity and integrity for the Church of England priest ministering as a full-time NHS chaplain in England;
(8) to consider the development and currency of models of Anglican priesthood, and whether these might provide a theological rationale for health care chaplaincy.

This project has been approved for the period
from: March 2012
to: December 2012

Signature [Signature]
Date: 13 March 2012

(College Ethics Officer)

Name/Title of Officer (BLOCK CAPITALS): DR ZOE C. BOUGHTON
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