

# Translating Theological Reflective Practice into Values Based Reflection: A Report from Scotland

Ewan Kelly

## *Summary*

*This article, based on work in the Scottish Health Care system describes a remarkable vision for mutual learning among health care professionals and chaplains through Values Based Reflection groups. Chaplains' facilitative and supervisory input has the potential to transform individuals and teams and, with time, organizational culture which in turn enhances the wellbeing of caregivers and the cared for.*

Healthcare chaplains are practitioners who routinely create safe, bounded spaces at a bedside, in waiting rooms, or hospital offices for individuals to tell their stories, explore issues of meaning and purpose, and reflect on their experience of life. The natural abilities and honed skills which chaplains utilise to enable others, in one to one relationships, to engage in such reflective activity are transferrable into group situations. It has been found that regular intentional theological reflective practice in facilitated groups with chaplaincy colleagues enriches their practice, enhances their relationships with fellow team members, and promotes personal well-being. As a result, chaplains are being trained to help other healthcare disciplines to engage in similar inter-disciplinary reflective practice. In this case, the focus for reflection is not theological but practitioners' values, attitudes, and behaviours to help inform future practice.

Such development and promotion of values based reflective practice (VBRP) amongst healthcare staff and managers by healthcare chaplains is currently being upscaled and embedded—across the National Health Service (NHS) in Scotland—with direct support and funding from the Scottish

---

Ewan Kelly, Programme Director for Healthcare Chaplaincy and Spiritual Care, NHS Education for Scotland (NES) and Senior Lecturer in Practical Theology, School of Divinity, University of Edinburgh, New College, Mound Place, Edinburgh EH1 2LX, Scotland (Email: E.R.Kelly@ed.ac.uk).

*Reflective Practice: Formation and Supervision in Ministry*

ISSN 2325-2855

© Copyright 2013 *Reflective Practice: Formation and Supervision in Ministry*

All rights reserved.

Government as a means of enhancing staff experience and resilience. This affords healthcare chaplains in Scotland an opportunity not only to influence cultural change in our national health service, but to fully integrate and promote specialist spiritual care provision at a time of financial austerity when chaplaincy services are under threat.

#### DEVELOPMENT OF INTENTIONAL THEOLOGICAL PRACTICE AMONGST HEALTHCARE CHAPLAINS

Faith communities have formed and influenced healthcare provision in Scotland since Christianity was brought to our shores in the first millennium. Chaplains offering religious services have been appointed within larger hospitals for centuries. However, the integration of generic healthcare chaplaincy offering spiritual care to all, whatever a person's worldview or beliefs, is still in its infancy within the health service in Scotland. Within the last fifteen years, the numbers of full-time chaplains has risen from the mid-teens to over sixty and the Scottish Executive (now Government) has produced national guidelines for local health services regarding spiritual care, including chaplaincy provision (2002 and updated in 2008).<sup>1</sup> At present, due to current financial restrictions, many such positions are under threat of being frozen or down-graded when vacancies occur. This has prompted more strategic thinking within the Scottish healthcare chaplaincy community to consider how chaplains collaboratively and innovatively can:

- maximize their impact on healthcare culture for the betterment of patient, staff, and organizational well-being,
- develop an evidence base to reveal the added value and value for money of chaplaincy services to healthcare,
- promote the unique role of chaplaincy in National Health Service (NHS) in Scotland at strategic not merely operational levels, and
- review healthcare chaplaincy training and education provisions in order to better equip practitioners to be fit for the purpose of working within an increasingly complex and ever-changing milieu.

Historically, there has been a lack of homogeneity in education and training amongst the Scottish healthcare chaplaincy community, unlike in North America where clinical pastoral education (CPE) has been the norm for many years as a formative learning experience for clergy and as an especially rigorous one for healthcare chaplains in order to become certified. In addition there has been very little intentional group reflective practice

amongst the Scottish healthcare chaplaincy community, certainly in a coherent and consistent manner, and individual supervision remains voluntary.

Two years ago, motivated by the concerns outlined below the Chaplaincy Training and Development Unit of NHS Education for Scotland (NES) funded the training of a small cohort of chaplains from a range of geographical areas (health boards) to enable them to begin to facilitate intentional group theological reflective practice within the Scottish chaplaincy community. The objectives of group theological reflective practice were:

- To ensure that spiritual care is safe for all on the receiving end;
- To ensure that all encounters are person- rather than, pastor-centered;
- To make spiritual care more effective through widening the repertoire of pastoral responses chaplains employ;
- To enable the personal and professional growth of the chaplains by providing a regular space in which to reflect on the content and processes of their work;
- To support chaplains in carrying the projections and transferences of the role;
- To provide a space for chaplains to experience vocational regeneration and renewal; and
- To foster a resilient workforce and build stamina for the long haul.<sup>2</sup>

#### MOVING FROM *HABITUS* TO *PHRONESIS*:

#### THE EDUCATIONAL APPROACH INFORMING THEOLOGICAL REFLECTIVE PRACTICE

Such a movement in educational approach involves supporting and empowering learners to develop their practice in stages from novice, advanced beginner, competence, proficiency, expertise, and mastery to practical wisdom. *Habitus* is the acquisition of knowledge which enables a practitioner to apply and utilise that knowledge competently with ‘third-person-detachment’<sup>3</sup>—to enable consistent, safe, and effective practice. In Scotland, capabilities and competencies for healthcare chaplains have been developed as well as standards for chaplaincy teams<sup>4</sup> to promote and monitor such practice. This is in line with other healthcare professions where competency based education and training has been the pre-dominant approach to learning since the 1980’s. The limitation of a competence-based model is that, though it has contributed to a workforce that is technically competent, it encourages orientation towards tasks rather than persons and transactional relationships between practitioner and patient rather than therapeutic ones. In other words:

[A] competency-based model for healthcare education and training is rather reductionist in approach and sits more comfortably with the view

that healthcare provision is a technical science that applies acquired knowledge utilizing a relevant skill set to cure, alleviate, and care. As an educational methodology, it does not do justice to the art of healthcare where intuition, discernment, and creativity are significant to a practitioner's decision-making and performance in their role.<sup>5</sup>

Movement towards practicing with *phronesis*, or practical wisdom, involves applying knowledge in a certain context and time and in an appropriate manner relevant to the person(s) involved. It is concerned not only with what is embodied or performed and when, but how and why. *Phronesis* involves sound judgement or wisdom to utilise gathered reflection on previous experience to inform practice in the present. Promoting practical wisdom in practitioners involves building on their basic competency—cognitive engagement in the acquisition and application of new knowledge as well as the ongoing formation of character and virtue. Ongoing engagement in practice based peer group learning, exploring the values and meanings of therapeutic encounters, is one way of supporting practitioners to grow in their professional wisdom.

When I came to post as strategic lead for the development of healthcare chaplaincy and spiritual care in the NHS in Scotland in 2009, there was no organised or structured means by which chaplains could engage together with the theological questions posed by their spiritual care practice in the messy, sometimes traumatic, context of healthcare. Scottish pastoral theologian David Lyall, himself a former hospital chaplain, reminds us that theological reflection is not merely an intellectual exercise, but is rather an exercise in 'personal integration.' In the academy, theology is taught as a top-down exercise of absorbing others' concepts and beliefs. Theological reflection on practice with colleagues in the context of the workplace enables the ongoing exploration of the questions new experiences pose our beliefs, worldviews, and values. Lyall observed that:

[T]he actual working theologies which drive our actions are shaped not by creedal statements (certainly not by creedal statements alone) but by our experience of life. Within each of us there is a continuous internal dialogue taking place as we seek to relate present beliefs to fresh experience, allowing the emergence of a developing personal theology.<sup>6</sup>

#### AN APPROACH TO THEOLOGICAL REFLECTION IN GROUPS

A group of ten Scottish chaplains received interactive training for eight days over the course of a year. The method utilised to help participants facilitate group theological reflective practice in their localities is a verbatim approach.

A verbatim is shared by a presenter in a small group context and the facilitator encourages participants to respond to what is presented in a manner which is non-judgemental and provisional. In so doing, respondents are encouraged to frame their contribution utilising three kinds of seeing or witnessing of an event, as reflected in three different Greek words used in the account of the discovery of the empty tomb in the Gospel of John (20:1–9a).

Firstly, Mary Magdalene and John *noticed* (Greek word, *blepo*) that the stone has been rolled away and the linen wrappings on the floor of the tomb are also noted. Secondly, Simon Peter's seeing the linen wrappings and the cloth used to wrap around Jesus' head is not the Greek *blepo*, but *theo* (from which we get the English word theory). In John's narrative, Simon Peter has not just noticed these cast aside objects, but has begun to construct tentative theories about what has happened and has informed their happening. Once something of possible significance has been noticed by group participants, it may prompt the presenter to *wonder* about what has been said, felt, performed, or meant in the actual encounter being reflected upon or in the present moment of intentional reflection.

Thirdly, there is a seeing in John's telling of the resurrection story, which conveys deeper *realization* or spiritual understanding '...the other disciple, who reached the tomb first, also went in, and he saw (*horaō*) and believed...' (John 20:9). For Leach and Paterson, such *realization* conveys something of the kingdom—a theological insight not merely a psychological one. In the context of group theological reflective practice, participants can offer their responses to the presenter's story of practice in order to stimulate reflection by noticing and wondering, but presenter and participants can only realise something about themselves and their practice—no one can realise anything about another's work.<sup>7</sup>

In preparation for group theological reflective practice, the presenter of the verbatim is asked to engage with the following questions which have been designed to promote the development of *phronesis* in participants' practice.

- a. What was this experience about—for the other(s), for me?
- b. Whose need was being met? And how?
- c. What were its implications for the other(s) and for me?
- d. What does it tell me about my pastoral ability?
- e. What questions does it raise about God, my values, beliefs, worldview/frame of reference?

During the group session the presenter shares her responses to these questions and her colleagues are invited to respond in the manner above to promote further reflection. Reflective practice is ended by each participant stating how what they have realised from the shared learning will inform their future practice.

#### EVALUATION OF REGULAR INVOLVEMENT IN GROUP THEOLOGICAL REFLECTIVE PRACTICE BY SCOTTISH HEALTHCARE CHAPLAINS

After participating in regular group theological reflective practice every four to eight weeks for over a year, 70 chaplains who were currently employed for more than half their working week in healthcare were asked to evaluate the impact of their involvement in this approach to formational learning. Thirty-seven chaplains returned a questionnaire which sought information about the impact of participation in regular group reflective practice on:

- spiritual care practice
- relationships within chaplaincy teams
- chaplains well-being and motivation at work.

#### *Impact on Spiritual Care Practice*

Ninety-five percent of the chaplains who responded to the evaluation indicated that participation in reflective practice over recent months had impacted positively on their practice. Comments on how such intentional shared engagement had influenced practice included:

From our first engagement with reflective practice it was clear that it had the potential to enhance person-centred care in two complementary ways:

- first, it encouraged a habit of continual reflection on my practice, even if it is simply mulling things over between encounters or at the end of the day;
- secondly it encouraged me to reflect on what the encounter revealed about myself, not only as a practitioner but as a person alert to my own developing spiritual nature.

After all, both the words 'spiritual' and 'care' are key to our practice. It has become not only a practice, a thing to be done, a way of doing the job, but a way of being:

It has enhanced my spiritual life as it gave me the skill for reflecting on my faith and spiritual self and its impact on my work and relationship with the patients I serve. This has helped me filter the content of what *to* share with patients.

### *Impact on our Chaplaincy Team Relationships*

Eighty-five percent of respondents felt that reflecting theologically together had a positive effect on relationships within their chaplaincy team. Narrative feedback on this aspect of influence included:

It has increased the level of trust within the team, given us insight into each other's work and encouraged confidence in each other. Uncertainties have been explored and shared. Consequently, it has increased everyone's sense of integration within the team along with a sense of solidarity with colleagues.

It is a good means of encouraging and developing skills and abilities in each other to build up strong and collective confidence in teamwork. It is also a good method of debriefing, allowing freedom to share personal experience without judgment in order to develop peer support and encouragement through mutual learning. To know that your experience has been acknowledged and understood through sharing is very liberating. It helps team members feel affirmed and valued. As a result of our group reflective practice sessions I have become more trusting of colleagues and there is less fear attached to sharing about perceived struggles/failures/challenges. There has been a marked sense of belonging to a team who are all aiming to improve their practice as it will benefit the patient and colleagues.

### *Impact on Chaplains' Personal Well-being and Motivation at Work*

Eighty-three percent of chaplains who responded felt that such regular intentional group reflective practice enhanced their resilience and vocational fulfilment. The chaplains conveyed a profound sense of finding a renewed sense of meaning and purpose in their spiritual care practice and the realisation that engaging in such shared reflectivity activity was a means of staying well in a demanding and draining role.

It has been a safe and supportive space leading to diffusion of cumulative stress. Because it has reinvigorated my work and my relationships with colleagues it has increased my sense of wellbeing and increased my sense of motivation.

Theological reflection and recognition of authenticity—and other core values—in encounters grounds me and enables me to keep in touch with my understanding of ministry. These insights are for me often buried (paradoxically) in initial analysis where I have deemed the encounter to have been too shallow/not good enough/having not met the expectation of the other. It is important to underline that this is a rigorous process not simply a way of affirming one another's practice with no expectation of becoming better practitioners. For me it is important to state that the importance of looking after myself is not an end in itself but in the impact

that has on my practice and therefore on those who come into contact with me as a practitioner.

There are times, I think, when we struggle to know if we are doing a job which is worthwhile and valued by others. The affirmation which comes from engaging in reflective practice, particularly when the encounter we bring to the table may be one which has troubled us or been full of questions, has had a very positive effect on my sense of doing something worthwhile—and well.

Such findings help to endorse the fact that group theological reflective practice is a transformational educational activity that can change and reinvigorate individuals and inform their future practice.

#### TRANSLATION INTO VALUES BASED REFLECTIVE PRACTICE

The healthcare system in the United Kingdom is under considerable pressure. Widespread understaffing in a range of disciplines due to financial constraints is a significant contributor to organisational stress. At the same time, managers and practitioners are expected to meet politically driven targets and waiting times, for example, in emergency rooms, for surgery, and for cancer interventions. In 2010, the Scottish Government launched the Quality Strategy for NHSScotland<sup>8</sup> which laid out the priorities for healthcare to be safe, effective, and person-centred. At present, the main political focus for the Scottish health service is the third of these points. This is due (at least in part) to:

- service users informing the government through national feedback surveys that what they seek from healthcare practitioners is compassionate as well technically competent care (Scottish Government 2010).<sup>9</sup>
- several high profile media examples substandard ethical practice within the health service—bullying cultures in certain localities, a lack of transparency around patient waiting times, low morale and dehumanisation amongst healthcare staff leading to poor standards of care.<sup>10</sup>

In order to illustrate the above in the reality of significant issues facing the health service in the United Kingdom, the following vignette is offered—cited by Francis. A patient admitted into Accident and Emergency (Emergency Room) was reprimanded by members of staff for calling his wife:

When I was told I was to be admitted, I was left in a small cubicle for several hours on a trolley, no pillows, no blankets, and when I rang to tell my wife, I was admonished quite sharply by someone who told me to ‘get a life’ and not use the phone in hospital. Eventually I got a pillow and then an hour later, a blanket arrived which I refused because it was covered in someone else’s blood.<sup>11</sup>



Such feedback and bad publicity forces politicians, healthcare strategists, and leaders concerned with the aim of improving care to consider key questions about workforce and organisational spirituality and wellbeing:

- How do we help keep our health service workforce healthy and human?
- How do we create and maintain cultures where practitioners feel of worth and are able to find meaning and fulfilment in their roles by embodying their core values in their daily work?

Healthcare chaplains in Scotland have been able to offer the government—as well as educationalists, local health service leaders, and practitioners—one possible educational response to such important issues, which may enable personal transformation of practitioners as well as contributing in the long term to cultural change and enhancement of person-centred care. It is the translation of group theological reflective practice into a more inclusive inter-disciplinary values based reflective facilitated by chaplains.

#### *Values Based Reflective Practice*

With the drive to develop (or rediscover) person-centred care within health and social care in Scotland, there is increasingly a move from a primarily competency based educational approach which promotes task orientated practice and transactional relationships between professional and patient—focussing on delivering safe, consistent, and measurable practice—to learning which encourages the nurture of practical wisdom or *phronesis*. At the heart of reflection, which informs the development of such artful practice, is the need to explore a person's individual motives, commitment, and action. VBRP is a resource which potentially may help to facilitate such a transition and enable practitioners to (re)connect with the vocational motivation that brought them into healthcare in the first instance. Moreover, it may help staff to develop the kind of self-awareness that prevents the acting out of behaviours and attitudes that degrades both patient and practitioner. As Hawkins and Shoheit put it, "Knowing ourselves, our motives and our needs, makes us more likely to be of real help. In that way we do not thoughtlessly use others for our own ends, or make them carry the bits of ourselves that we cannot face."<sup>12</sup>

The evidence gained from Scottish healthcare chaplains engaging in regular intentional theological reflective practice suggests that enabling and encouraging healthcare staff from a variety of disciplines to do likewise would offer a means to sustain and (re)motivate those practitioners, as well as helping them to explore what values and beliefs inform their own practice.

### *Method*

This approach to reflection of practitioners on their practice is the same as described for group theological reflection amongst chaplains—a facilitator encouraging participants to notice and wonder about what each presenter shares. However, during VBRP, a written case study of 200–400 words, read aloud, is the format of choice by which a practitioner’s experience is shared in the group (not a verbatim). This deliberate use of case studies is a pragmatic one—to try to encourage involvement of a range of disciplines and individuals (many of whom may never have previously engaged in reflective practice in such a structured format), and to enable meaningful VBRP to take place in 30–35 minutes with a skilled facilitator to maintain focus.<sup>13</sup> A degree of reflective rigour on the part of those who prepare and present case studies is ensured by written guidance given to inform their form and content. This includes commenting on:

- themselves prior to the encounter to be explored—for example, their feelings, anticipated role, and aims,
- their prior knowledge of the situation,
- the practitioner’s initial impressions—body language, tone of voice, atmosphere, gut feelings,
- the encounter itself—what is unspoken as well as what is verbalised and acted out, the silences, and strength of feelings experienced within oneself and expressed by the other(s),
- insights, feelings, and thoughts as the practitioner reviews and re-examines the encounter.

What makes this approach different is the intentional focus on the following with particular attention to examining values (instead of a specific focus on theological reflection):

1. Whose *need(s)* were met during the encounter?
2. What does this experience tell me about my caring *ability*?
3. What does it tell me about *me*?
4. What questions does it raise about my *values* (that inform my attitudes and behaviours)?
  - *With whom did the power lie in the case study?*
  - *Whose voice(s) dominated or had most value?*
  - *Whose voice(s) were not heard or undervalued?*

At the end of each session every participant is asked to name:

What future action will you take in relation to this encounter:

- *For the wellbeing of the patient/carer/member of staff or others involved?*
- *For your own future practice?*
- *For your own wellbeing?*

*Piloting, then Embedding, VBRP into the National Health Service of Scotland*

Healthcare chaplains have developed pilot VBRP groups in a variety of contexts across Scotland—in intensive care units and mental health management teams, with midwives, and among family physicians. Plans are being made to integrate the model into a new leadership course for medical consultants and to inform research into trainee family doctor resilience. The model has been showcased at local person-centred care educational events and a variety of single discipline conferences (for example, occupational health practitioners) and multi-disciplinary conferences. The Scottish Government has requested VBRP to be demonstrated at a national learning event as part of the Scottish *National Person-centred Health and Care Delivery Programme* so it may be utilized as part of their national strategic drive to improve staff experience.<sup>14</sup>

The next step within the Scottish healthcare chaplaincy community is to develop the capacity to roll out and embed the model throughout the health service by training chaplains to train and supervise clinical educators from other healthcare disciplines to do the facilitation of local contextual VBRP. Furthermore, the approach is beginning to shape Scottish Government person-centred policies and guidelines, for example, there are plans to integrate a VBRP-influenced approach to inform the next revision of the Palliative Care Directed Enhanced Service in primary health care in Scotland.

#### CONCLUDING THOUGHT

In the current political and financial climates there are opportunities for healthcare chaplains to utilize their natural abilities, competencies, and practical wisdom to contribute significantly and, indeed, lead the way in helping staff to find meaning and purpose at work through the innovative use of new values based educational approaches. Chaplains' facilitative and supervisory input has the potential to transform individuals and teams and, with time, organizational culture—thus, enhancing the wellbeing of caregivers and those they care for. However, chaplains can only perform such roles effectively when attending first to our own formational and theological development in an ongoing and intentional manner.

## NOTES

1. Both found in the publication, Scottish Government Department of Health and Wellbeing, *Spiritual Care and Chaplaincy* (Edinburgh: Scottish Government, 2009).
2. Michael Paterson and Ewan Kelly, "Reflective Practice: a Method Developed for Healthcare Chaplains in Scotland," *Practical Theology* 6, no. 1 (2013), in press.
3. Joseph Dunne, "'Professional Wisdom' in 'Practice'" in *Towards Professional Wisdom: Practical Deliberations in the People Professions*, Liz Bondi, David Carr, Chris Clark and Cecelia Clegg, eds. (Farnham, UK: Ashgate, 2011), 16.
4. Chaplaincy Academic and Accreditation Board, Association of Hospice and Palliative Care Chaplains, College of Health Care Chaplains, Scottish Association of Chaplains in Healthcare, NHS Education for Scotland Healthcare Chaplaincy Training and Development Unit and NES–NHS Education for Scotland, *Spiritual and Religious Care Capabilities and Competencies for Healthcare Chaplains* (Edinburgh: NHS Education for Scotland, 2007).
5. Ewan Kelly, "Developing Competencies in Spiritual Care Provision," in *Spirituality in Healthcare*, Mark R. Cobb, Christina M. Puchalski, and Bruce Rumbold, eds. (Oxford, UK: Oxford University Press, 2012), 435–441.
6. David Lyall, *Integrity of Pastoral Care* (London: SPCK, 2001), 37.
7. Jane Leach and Michael Paterson, *Pastoral Supervision: A Handbook* (London: SCM Press, 2010).
8. The Scottish Government, *The Healthcare Quality Strategy for NHSScotland* (Edinburgh, Scotland: The Scottish Government, 2010), accessed March 8, 2013, <http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf>.
9. Ibid.
10. Jane Murkin, Alastair Pringle, J. Smart, J. Davies, and S. Maher, *NHSScotland 2012: People at the Centre of Health and Care: National Person-Centred Health and Care Programme Charter* (Glasgow, Scotland: NHS Education for Scotland, 2012).
11. Robert Francis, *The Mid Staffordshire Foundation Trust Public Inquiry: Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009: Vol. 1* (London: The Mid Staffordshire Foundation Trust, 2010), 154, accessed February 20, 2013, [http://www.midstaffsinquiry.com/assets/docs/Inquiry\\_Report-Vol1.pdf](http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf).
12. Peter Hawkins and Robin Shohet, *Supervision in the Helping Professions: Individual, Group and Organizational Approach*, Third ed. (Maidenhead, UK: Open University Press, 2006), 14.
13. It is a significant challenge in a Scottish healthcare context for staff to be freed from clinical contexts for even 30–35 minutes at a time to participate in Values Based Reflective Practice (VBRP). From experience of utilising verbatims in group reflective practice—this is insufficient time to do justice to the material prepared. It has been important to have buy-in regarding VBRP from healthcare leaders and managers in local contexts to enable their staff to have protected time in which to be involved.
14. Scottish Government, *The Healthcare Quality Strategy for NHSScotland*, accessed March 8, 2013, <http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf>.