Written Submission from the

Muslim Spiritual Care Provision in the NHS

A project of the Muslim Council of Britain in partnership with the Department of Health

To All-Party Parliamentary Enquiry

into the current and future role of chaplaincy and spiritual care (including specifically religious care) within NHS associated healthcare settings

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In the Name of the God, most Gracious, most Merciful

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1. Introduction

1.1 We should like the Select Committee to take due account of the incontrovertible evidence that chaplaincy today is much neglected and regarded almost like a non-essential auxiliary part within the NHS. It is important that in view of the NHS's repeated commitments chaplaincy and spiritual care is formally adopted as an integral and mandatory part of health care.

1.2 We should also like the Select Committee to note that our project **The Muslim Spiritual Care Provision in the NHS,** hosted by the MCB in partnership with the DH, is a valuable resource and making noteworthy contribution in recruiting, training and empowering Muslim Chaplains for the health service. Working closely with the Multi Faith Group for Healthcare Chaplaincy (MFGHC) it is contributing in setting up authorisation process for Muslim chaplains and occupational standards for chaplaincy. The project is also drafting a guidelines document for the professional conduct of Muslim chaplains. Its work supports the healthcare professionals with appropriate awareness to provide effective but culturally sensitive treatment to their Muslim patients.

2. Spiritual care is the stepping -stone of Health care

2.1 The history of Hospitals shows that healthcare originates from spiritual care. Hospitals cared for the soul as much as the body. Faith can be a powerful comfort where suffering is constant and death close at hand.

2.2 The word ‘Hospital’ emanates from hospitality. The Lead-Chaplain in the Barts and the Royal London Hospital is still called “Hospitaler”.

2.3 Matthew chapter 25 tells us to feed the hungry, clothe the naked and take in the stranger. Medieval European hospitals aimed to implement this fully. Modern hospital provides medical care for both rich and poor, but medieval hospitals established by religious institutions simply cared for the poor. They provided a home for those too handicapped or elderly to work, people who might otherwise have to beg in the streets if their families could not care for them. Other hospitals took in the stranger. They were hostels for pilgrims and other wayfarers. The leperhouses had their own rationale - segregation of the leper.

2.4 Medieval hospitals in Europe were religious communities, with care provided by monks and nuns. (An old French term for hospital is *hôtel-Dieu*, "hostel of God.") Some were attached to monasteries; others were independent and had their own endowments, usually of property, which provided income for their support. Some hospitals were multi-function while others were founded for specific purposes such as leper hospitals, or as refuges for the poor or for pilgrims: not all cared for the sick. Not until later where most hospitals multi-functional, though the first Spanish hospital, founded by the Catholic Visigoth bishop Masona in 580 at Mérida, was a *xenodochium* designed as an inn for travellers (mostly pilgrims to the shrine of Eulalia of Mérida) as well as a hospital for citizens and local farmers. The hospital's endowment consisted of farms to feed its patients and guests.

3. Islamic world

3.1 The earliest recorded hospitals in the medieval Islamic world refer to the hopital of al-Walid ibn 'Abdul Malik (ruled 705-715 CE) which he built in 86 AH (706-707 CE). It somewhat resembled the Byzantine nosocomia, but was more general as it extended its services to the lepers and the invalid and destitute people. All treatment and care was free of charge and there was more than one physician employed in this hospital.

3.2 In the medieval Islamic world, 'Darus Shifa'/ 'Mustashfa' / 'Bimaristan' was established which can be called a hospital in the modern sense, an establishment where the ill were welcomed and cared for by qualified staff. Muslims were the first to make a distinction between a hospital and other forms of healing temples, sleep temples, hospices, assylums, lazarets and leper-houses, all of which in ancient times were more concerned with isolating the sick and the mad from society "rather than to offer them any way to a true cure." Some thus consider the medieval Muslim hospitals as "the first hospitals" in the modern sense of the word. The first public hospitals, psychiatric hospitals and medical universities were also introduced by medieval Muslims.

4. Whole -person care

4.1 In today's multi-cultural society all health care professionals will, at some point in their career, come into contact with people from a variety of cultural and religious backgrounds. For Muslims, like all other faith groups, religion plays a role, perhaps even a central role, in understanding health, disease as well as cure. An appreciation of this will help professionals to provide a culturally sensitive care.

4.2 All patients expect to be treated with dignity and respect appropriate to their need while in the care of the health service. *Core Standard (C13a) of the Healthcare Commission*, NHS's regulatory body also requires, **"Healthcare organisations have systems in place to ensure that the staff treat patients, their relatives and carers with dignity and respect".** [1] In order to meet such requirements and expectations health care professionals need support of the professional chaplains. Good clinical practice and best quality care invariably demand care for the whole person, both body and spirit.

[1] This standard is further explained in details in Element 1 where by The commission advises 'All organisations' to show that they have '**systems to ensure that care planning takes into account issues regarding an individual patient's dignity'. Also 'ensure that dignity and respect is maintained for patients, carers and their relatives in relation to their end of life care and death, such as that their wishes are appropriately considered in care planning**.'

4.3 The importance of being culturally aware of people's diverse lifestyles is now recognised as being an integral part of delivering quality patient care. The NHS accepts spiritual and religious care as important factors in the provision of health care (NHS Chaplaincy Guidelines 2003, SYWDC- Caring for the Spirit 2003). Today no one disputes that effective healing happens when care is provided for the 'whole person', for both physical and material aspects as well as meta-physical and spiritual aspects of a person. Because, 'spirituality helps people maintain health and cope with illness, loss, trauma and life's transitions by integrating body, mind and spirit'. (A.Sheikh, AR Gatrad, U.Sheikh et al, Diversity in Health and Social Care, Radcliffe Publishing 2004, P 94)

5. Policy context

It is wrong to treat chaplaincy as something external to the healthcare provision, because most major Acts and policies of the NHS gives chaplaincy service legal status. These are:

- 1946 - Chaplaincy included in the NHS Act following intervention by the then Archbishop of Canterbury.

6. Policies/Guidance:

- Until the Agenda for Change introduced in 2005, Chaplains were governed by their own Whitley Council with regard to their NHS employment. The Chaplaincy Whitley Council sat within the "Scientific & Professional" group of staff. Whitley 'Councils in the NHS date back to 1948.
- Whole-time chaplains become part of NHS pension scheme 1976
- Pay and conditions for chaplains set out in DHSS letter PM(86)15 1986
- Multi-Faith Consultation between faith Communities 1997
- Secretary of State establishes multi-faith working party 1998
- Multi-Faith Group for Healthcare Chaplaincy formed 2002
- Patients' Charter 1991
- HSG (92) 2.

- Barts and the London NHS Trust: the pioneer of NHS Muslim Chaplaincy, 1992
- 2001 – South Yorkshire WDC agrees to lead on NHS chaplaincy-spiritual care project
- Caring for the Spirit strategy 2003

6.1 DH Guidance **2003 guidance** replaced HSG (92)2 and supported the provision of spiritual and religious care that has been part of the NHS since 1948. It stated that, "all NHS Trusts provide spiritual support for patients, staff and relatives through chaplains and faith community representatives. This document sets out arrangements to ensure sufficient steps are taken to meet the religious and cultural needs of the healthcare community, whilst also acknowledging that chaplains spiritual care givers are concerned with those who do not profess any particular faith".

- National workforce strategy (Caring for the Spirit) and new National policy guidance launched together 2003
- Caring for the Spirit 2003
- Agenda for Change 2005
  - Agenda for Change National Job Profiles for chaplains 2005
  - Agenda for Change agreement - with specific provisions for chaplains – 2005
  - 2007/08 – NHS Yorkshire and Humber issues reports on:
    - Efficacy of chaplaincy and an outline research strategy
    - Draft proposals for chaplaincy to be commissioned locally

- The Scottish DH published **mandatory** advice on the delivery of chaplaincy/spiritual care in 2002
- The Welsh Assembly (government) is to issue **mandatory** policy on chaplaincy/spiritual care for NHS Wales. This policy will be very similar to that of Scotland.
- NHS Northern Ireland has similar structures to Scotland and Wales in that policy is expected to be implemented and the DH supports that process.

7. Conclusion

In conclusion we submit that according to the evidence and arguments presented here it is clear that chaplaincy is not only inter-twined with healthcare service but even can reasonably claim to be its foster parent. If anything the evidence above only demonstrates that even in official policies and guidelines chaplaincy still occupies a distinct place. Spiritual care is integral to whole person care that NHS aims to provide and most certainly enhances the chances of cure. Therefore, chaplaincy/spiritual care deserves to be valued and resourced as it rightly deserves.

We also submit that the Muslim Spiritual Care Provision in the NHS project should be sustained and supported further to enable it to continue with its valuable services.

8. Recommendations

Muslim community submits that the 'All Party Parliamentary Enquiry into the Provision of Healthcare Chaplaincy' to take due account of the evidence presented here and to consider most carefully in order to give due weight to the following recommendations for future local and national policy and strategy.

8.1 Official recognition to be accorded to Chaplains as 'healthcare staff' and not auxiliaries. Many chaplains raised concerns that despite occasional pious pronouncements they still feel excluded and their services are not valued.

8.2 Once accepted as healthcare staff they should have access to basic patient information to enable them to discharge their duties without let or hindrance.

8.3 Reasonable resources and funds to be allocated to chaplaincy departments.

8.4 Religious affiliation data to be maintained and monitored to ensure appropriate spiritual care provision.

8.5 Muslim chaplains to be recruited where patient and staff numbers require them.

8.6 Funding for the Muslim Spiritual Care Provision in the NHS should be increased substantially.