The specialist nurse as MSE

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As a specialist nurse practitioner (neonatal) I am currently exploring the development of my role as a spiritual care provider within this clinical environment. I am also to shortly commence ordination training within the Church of England, as a minister in secular employment (MSE). In this article I discuss how I see my role developing as an ordained minister/specialist nurse practitioner within the workplace, what it means to be an MSE, and how it will effect the clinical environment, staff, patients, family and chaplaincy team.

Developing the role of a MSE in this way necessitates addressing clinical practice in relation to the specialist practitioner outcome 17: 'initiate and lead practice developments to enhance the nursing contribution and quality of care' (UKCC, 1998). As I am actually in the process developing practice, I experience at first hand the difficulties involved with change, the conflict and resistance that can arise. As part of developing as an MSE, I reflect on those experiences, frustrations and how to deal with some of the negative attitudes encountered.

Reflection has the potential to be a valuable tool in improving patient care and for changing nursing practice. It is the process of turning thoughtful practice into a potential learning situation and aims to change behaviours, perspectives or practices (Mackintosh, 1998). As the role of the MSE is not widely understood I have struggled to find relevant literature within the field of nursing and have therefore had to draw on literature from other sources, and also on the knowledge of various people who specialise within this form of ministry.

The 'Specialist Nurse Practitioner' (S.P.) according to the UKCC (1994) is required to exercise higher levels of judgement and discretion in clinical care. As such they are expected to undertake more complex decision-making than some other professional practitioners and to improve standards of care through supervision of practice, clinical nursing audit, developing and leading practice, contributing to research, teaching and supporting professional colleagues. In order to achieve this level of practice the individual is required to concentrate on a particular field and undergo appropriate education, which must be attained at degree level, (UKCC, 1998).

So how does being a Minister in Secular Employment relate to this? Fundamentally, an MSE has the opportunities to bridge the gap between the church and the secular world, by integrating faith with their working life. An MSE will make themself available pastorally and confidentially, to stand alongside those people that need support, and help to ease burdens, enabling others to realise joys. This form of ministry complements the ministry of all Christians at work, the work of the stipendiary minister or visiting chaplains in industry, hospitals, colleges and other spheres, (CHRISM, 2003).

What does the term spirituality mean? Reed (1992) suggests that spirituality is concerned with an individual's past, present and future, especially when facing illness or the prospect of death. It demonstrates how all aspects of life, physical, psychological and social, are interrelated and interconnected.

The spiritual aspect of nursing care is often neglected by nurses today. McSherry (2000) suggests that the preoccupation with the technological and material elements of care have replaced the notion of holistic and individualised care, at the centre, which rests spirituality. In addition, Ellis (1980) suggested that as nursing has become so biologically orientated, spiritual matters are a source of discomfort and embarrassment for the nurses. This is my experience within the field of neonatal intensive care. The biological needs of the baby come first and foremost, but by the time a child reaches intensive care their condition may have deteriorated so much that the baby may be dying. It is often only then that staff will consider broaching, as symbol of the spiritual, asking the parents if they want their baby baptised.

Birth and death represent two of the most significant events in human experience and these two poignant happenings converge in the Neonatal Intensive Care Unit (NICU) in a unique way. With the

advances in knowledge and expertise more infants are surviving but the deaths of the sickest and smallest babies have assumed different proportions now that so much is possible. This has meant an increased exposure to the world of ethics and moral decision-making, involving fragile human beings, often at the edge of viability, (Boxwell, 2000, McHaffie and Fowlie, 1996).

Granstrom (1985) proposed that fear may be a reason for a nurse's reluctance to incorporate spiritual care into nursing practice: fear of getting into a situation they cannot handle, fear of intruding on a person's privacy and fear of being converted or confused in their own belief system. McHaffie and Fowlie (1996) discovered in their work on the decision to discontinue treatment that it was rare for nurses to spontaneously mention the chaplain or minister at this point even though, when questioned they thought the role of the minister was very important. However, my experience is that there may be a reluctance to involve the chaplaincy team as medical staff are unfamiliar with the chaplains. This was an important point raised by a colleague of mine during a recent conversation.

Considering the neglect of the spiritual in the clinical environment, I have considered a number of issues to help develop the role of the MSE / nurse. Good communication - regular information through meetings (informal as well as formal) and newsletters, and an atmosphere of trust - is essential if smooth and anxiety-free changes are to be made. Change is also likely to be implemented most successfully when people improve their own knowledge and when they feel part of the changes taking place; this will hopefully prevent any resistance to change (Parrish, 1996). As MSE is a concept that is not widely understood within the Churches, resistance, in my experience, has been more marked amongst Chaplaincy staff than fellow nursing staff.

On a personal level I feel that becoming an ordained minister within the workplace will enable me to develop my own spiritual ministry, which will enhance my role as a nurse. By developing as an MSE, this will open up a new aspect of care within the clinical environment. Ordination will affirm and, in the eye's of the Church, authorise this ministry, and would provide me with an authority to perform the sacramental elements of spiritual care, e.g. baptism/blessing's and funerals, (Francis, 2001). This would assure the parents that if I were to baptise their baby it would be performed 'properly' by an ordained minister. In addition, although the NHS Trust has an excellent chaplaincy team, the families are often unfamiliar with them. This 'gap' could be bridged by having a specialist nurse who, as a minister, is able to perform the sacramental elements, is already familiar and who knows their baby. An important issue to mention at this point is that I aim to work alongside the chaplaincy team, which will continue to be as integral to the daily life of the NICU as to any other aspect of the hospital's life. Furthermore, my role remains that of a nurse and I would only be able to provide such formal ministerial functions as my workload and workplace allowed.

A feature of the road towards MSE has been situations where I have become frustrated at not being able to promote aspects of spiritual care because as a nurse it is not seen as relevant to express your own beliefs. Recently, for example, I was involved with the care of a baby about to undergo surgery. Although the parents enquired about having their baby baptised, they decided not to. Their reason was, 'We don't want to tempt fate!' As a Christian I felt this was a situation that could have been discussed further, however, as a nurse this was not possible, (NMC, 2002). As an ordained MSE, I anticipate having more opportunity to influence an individual's thinking on the spiritual aspects of care. Spiritual care ought to be a positive aspect of care, not seen as a negative element - which is often the case. In this case, that by having their baby baptised/blessed is about asking for God's protection and guidance on the situation and it is not 'tempting fate.' I realise that this would have to be developed in a way that is not imposing, and ways need to be developed of making parents aware of the presence of an MSE in the unit and how they might use this.

McHaffie and Fowlie (1996) ascertained that where a baby does die, if staff introduce parents to the hospital chaplain, who is familiar with the life in the NICU and who has seen their baby, this enables them to approach their baby's funeral more confidently and the ceremony becomes more personal. I realise that for a parish priest to conduct a baby's funeral must be one of the hardest services they will have to undertake, especially when they do not know the family. The presence in the hospital of an MSE / nurse again potentially acts as a bridge, helping provide a more personal service during a time of emotional stress.

Unusually in my situation it is external factors that are influencing the development of practice. Shortly after I started exploring the path towards ordained MSE, I approached the senior hospital chaplain. I felt it was important to involve him at this stage in the process, to minimise resistance to change, to ensure that he felt part of what was being developed and to enable him to contribute to the process. (Bennis, 1998, Marquis, Huston, 2000, Parrish, 1996). Despite involving him at this early stage, encouraging him to be part of this development in clinical practice, and completing a 6-month placement with the chaplaincy team to develop a mutual trust and gain some experience of the role of the chaplain, I continue to meet with resistance, (Marquis, Huston, 2000).

McHaffie and Fowlie (1996) suggest that it is the role of the chaplain to offer spiritual support, as they are in a position to answer deep questions on life, offer a moral view, and give hope in difficult situations. An ordained minister gives an authentic air to proceedings in the NICU which can be reassuring to staff and parents. McHaffie and Fowlie (1996) found that parents need something to cling on to at traumatic points of their lives, even those who are not at all religious. Upon reflection I feel that this may be why there has been some resistance by the senior chaplain; he perhaps feels that I would encroach upon the chaplain's role. However, I feel that I will be promoting the spiritual aspect of care and therefore complement the service of the chaplaincy team. This has been frustrating and disheartening. However, despite this resistance I continue to keep him informed. On reflection I feel the resistance to this type of ministry is due to the lack of understanding which in turn has led to the chaplain feeling threatened by a nurse wanting to become ordained, (Francis, 2001).

Although I have had frustrations with trying to develop practice, I have found my nursing colleagues far more supportive towards this aspect of specialist nursing being introduced into the clinical environment. I have the support of the lead nurse and several members of the nursing team, with whom she I confide. The lead nurse has expressed her support and has stated she will assist with the various aspects needed to set up this service. For example: approaching management, contracts, and liasing with the senior chaplain and the church.

A specialist nurse as an ordained minister would benefit the staff by providing a confidential, familiar and friendly support network. In a church congregation the minister is a confidant, someone to trust, to share problems with but who is also a vital friend. When things become tense and hard questions are being asked, ministers can act as confidants whose discretion can be relied upon, (McHaffie and Fowlie, 1996). I recognise that I already provide this to some extent, as some of the staff have sought me out to ask advice and to discuss problems confidentially. Ordination would enable the staff to recognise a formal authority to minister as well as one of 'being there'. I could also use this role to develop clinical supervision on the unit. This is a process that promotes personal and professional development within a supportive relationship. It aims to promote high clinical standards and develop expertise by supporting staff, helping to prevent problems in busy, stressful practice settings, (Faugier and Butterworth, 1994).

However, the matter of confidentiality may become an issue, if a member of staff came to speak to me as a minister and not as a nurse. As a nurse I am bound by the 'The Code of Professional conduct' on issues such as confidentiality, (NMC, 2002). The Church of England has recently issued guidelines for conduct of clergy, which on confidentiality correspond closely to the professional code. Furthermore, there has always been an understanding that conversations between the priest and those to whom they minister are confidential. However, as far as sacramental confession is concerned there is absolute confidentiality. This would be an area needing careful consideration if a person wished to talk in confidence. Perhaps certain rules would need to be discussed before a confidential conversation took place, for example by stating that if the conversation was to break the nursing professional code of conduct then as a nurse I would have no choice but to break confidentiality.

The assignment on which this article is based has enabled me to reflect upon my current situation in developing clinical practice. The three years of ordination training, alongside continuing to work as a

specialist nurse practitioner, will take this further. It has been an interesting journey so far, with many loose ends still to tie up, but worth it.

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This article is developed from part of an assignment undertaken as part of Bsc (Hons) Clinical Nursing Studies with Specialist Practitioner award at the University of Central England.