Medicine and Religion

Chaplain to casualty

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The idea of appointing a chaplain to work exclusively in an accident and emergency unit has caused surprise among hospital staff and administrators alike. It is not that either group is unaware of the deep emotional and personal needs of many casualty patients, but rather that the connection is rarely made between these needs and a chaplain who has been specifically equipped to meet them. It is strange that, while a chaplain may work freely among patients with similarly acute needs on the wards, he is often brought into casualty only as a last resort—as a specialist to take over when the regular team can no longer cope. It is true that experience may enable the casualty team to cope with emergency-related emotional trauma more confidently than staff in other departments, yet accident and emergency staff frequently feel inadequate when they are required to come alongside a distressed patient or a grieving relative. I believe this is partly due to the lack of time available for this aspect of nursing care to be either taught or practised, but mainly because the need for emotional detachment inherent in their role prevents staff from empathising with patients and relatives on anything but a relatively superficial and ineffectual level. Many accident and emergency staff are prepared to move beyond their role in order to care more deeply, but this is often achieved at the cost of their own effectiveness once the crisis has passed. I believe that it is far more satisfactory for there to be a chaplain, based in casualty, who can work as an integral member of the accident and emergency team and relieve their burden of inadequacy by applying his own specific skills with the deeper emotional empathy inherent in his vocation.

Though not yet ordained I spent nine weeks last year working experimentally as a chaplain to the accident and emergency department at St James's University Hospital in Leeds. This unit handles nearly 90 000 patients each year (between 250 and 350 a day), of which over two-thirds are new cases. The sheer volume of patients gave me a fascinating insight into the many stress factors affecting staff, as well as an invaluable opportunity to work alongside them in a wide variety of situations. I learnt very quickly that team identity is extremely important in crises where speed and co-operation are essential for the preservation of life. My first week was thus spent learning to use the free access given me in a way which neither obstructed the team nor forced them to accept me. Unintentionally it was my willingness to get covered in blood, helping with one particularly nasty accident, which led to my full integration into the team. From then on, dressed as a doctor, with an explanatory name badge, I was able to move unobtrusively around the department observing, assessing needs, and helping where necessary.

Alleviating anxiety

The largest proportion of my time was spent with patients who suffered more from apprehension than their actual injuries. I noted that the surrender of independence which takes place when a person becomes a patient on entering the unit can often be a very disturbing experience. Convinced either that his injury is so severe that it demands immediate attention or that it is so minor that he needs only a quick reassuring glance at it from the doctor and a bus home, the patient is unable to do anything but wait. With every minute of waiting the frustration grows. Often this is aggravated when the patient is rendered completely passive by being locked in a trolley, perhaps in a supine position, where it is impossible to see anything but the myriads of dots on the ceiling tiles. This frustration often results in an ever deepening apprehension: "What is the matter with me?"; "What will they do?" which, for some, becomes so unbearable that, after hurling abuse at an already pressurised staff, they take their own discharge, limping defiantly to the door. For those who stay the apprehension may lower their pain threshold and render them unable to communicate clearly and concisely when they do see a doctor. Much can be done to alleviate apprehension before it causes problems, and I soon learnt to recognise patients who were finding the waiting hard. To avoid even more anxiety I would approach them indirectly, perhaps talking to patients adjacent to them first, and then simply give them a chance to share their feelings with one who had time to listen. Frequently the process of relating the precise details of their accident was therapeutic in itself, and they would visibly relax, secure in the knowledge that something was being done at last. Often I would try to distract their attention from pain by chatting about their families and pets, and where necessary would contact relatives. Once they had noticed my name badge, and recovered from their surprise at having been talking to a chaplain, I would offer to pray with them: only exceptionally was this offer refused. The few moments of anonymity I gained by not immediately identifying myself as a chaplain were important, in that I was able to reassure the patients before they could make the inevitable (though erroneous) connection between chaplains and last rites! Though my work was directed primarily at the patients it affected the staff, who were far more relaxed knowing that there was "someone out there" keeping an eye on things, particularly on a busy day when there could be more than 300 patients in the department within three hours.

Growth of trust

As trust between us grew the staff began to take the initiative in calling me when they felt I could offer specialised help. These occasions were many and varied, but gradually a pattern emerged. I would be called in automatically for patients who were in extreme pain or distress, when it was helpful for them

to have a hand to hold, or someone to listen; for the dangerously ill, with whom I'd talk and pray; for the parents of injured children, whose presence and distress inhibited some staff; for violent and mentally unstable patients, who tended to sit and talk to a chaplain in preference to other staff; and for patients who were afraid of treatment or tests (sutures, gastric washouts, and ECGs, etc). Because the staff themselves had asked me to be present they were quite happy to suture away at one end while I chatted away at the other. Indeed, so close was our working relationship that myopic consultants, unable to read my name badge, would assume that I was simply one of the unit's doctors and would baffle me with eager questions about a patient's PQRS complex.

As a matter of procedure I always joined the standby team at the ambulance doors when there was a resuscitation call. Then while the patient was whisked away I could take care of the relatives, taking them from the ambulance to the visitors' room. Although generalisations can be dangerous, the feelings of the relatives I cared for were a mixture of several different emotions: they were frightened, excited, numb, and frustrated all at once. Physically they were ready for action, stimulated by the suddenness of events and fear of the outcome, while mentally they were disorientated and unable to perceive the reality of what was taking place. Although longing to "do something," they were unable to focus their minds sufficiently to make any positive response to this urge, and thus sat passive but frustrated, behind closed doors, acutely aware of every footfall and clatter of equipment outside. The nursing staff are acutely aware that someone ought to be with the relatives, but they are restricted in two ways. Firstly, there is often simply no time for a nurse to sit and talk to relatives when her colleagues are under additional pressure because of the redirection of staff to the resuscitation room. In most cases a five-minute chat and a cup of tea are woefully inadequate, anyway, and serve only to frustrate the nurse, who wishes she had more time, and further unsettle the relatives, who need the minimum of interruption if they are to remain in control of their emotions. Secondly, and more subtly, there is the thorny problem of emotional involvement.

While the medical staff must remain emotionally detached from their patients (if their diagnosis and treatment are to be sufficiently objective) nursing staff do need some degree of empathy with a patient in order to act with his co-operation. It is one thing to achieve this controlled empathy with a sick patient, but quite another to maintain the same degree of control with a distressed relative. Here we are dealing with emotions and reactions common to all of us, and it takes little imagination for a nurse to see herself in the relatives' position or be reminded of bereavements from her own life. Perhaps it is significant that the few occasions I have seen casualty staff in tears have all been connected with bereavement. Death stirs up feelings in all of us, and observing grief in others can be profoundly disturbing to ourselves. I believe it is unrealistic to expect nurses to help relatives adequately while, at the same time, preserving their own protective distance. The two are practically incompatible.

Sharing the hurts of others

In contrast, as a chaplain based in casualty, I had both the time and the resources necessary to care for relatives in a more satisfactory way. Because my time could be spent with those in greatest need, wherever they were, I was perfectly free to spend several hours sitting, talking, and praying with relatives, or simply listening while they put their racing thoughts into words. Then, because in this time they had come to know and trust me, they were freer to express their grief when the death was announced. So many staff deprive relatives of this freedom to react; never intentionally, but with remarks such as "Don't cry—you'll only upset yourself" when really they mean "Don't cry—you'll upset me." Relatives who are free to sob uncontrollably or kick the wall in the presence of someone who nevertheless accepts them are relatives who can begin to realise the authen-

ticity of their situation—and begin to accept it. I always offered to pray with relatives, both before and after the death, for, as a Christian, I believe that God does not stand aloof from human suffering: rather he took on himself all the pain and failure of sinful humanity, put it to death on the cross, and broke its power for eternity. When Jesus rose from the dead God showed that men might have a new and living relationship with him, and that this would continue beyond death. Though few relatives professed anything other than a basic theism, many found tremendous comfort as I showed how God could transform their own lives: it was as if the death of their relative gave them a glimpse of a long forgotten eternity to which they themselves could one day belong. Death, like birth, is a situation in which man often perceives the reality of God.

If a chaplain based in casualty has adequate time to care effectively for bereaved relatives he also has resources uniquely equal to the task. One such resource is the freedom with which he is permitted to care for the spiritual dimension of human life. In a Health Service founded largely on humanist philosophy a chaplain's freedom to care for the neglected spiritual dimension of man's being is a privilege to be used. While Christian nursing and medical staff are not encouraged to share their faith a chaplain is at least permitted to do so, and in this way make his own contribution to meeting the total needs of the patient. Yet the staff, too, have their needs, and it was only as I worked with them that they felt I could understand enough for them to share their frustrations and fears. I, too, became acutely aware of their reactions and was undoubtedly able to sense things an outsider could never perceive. I remember the momentary look of pain in the eyes of a student nurse when a patient arrested on her and died within hours of her first day in casualty; and the edge of frustration in the voice of the doctor who, having fought for the life of a patient, is overruled by a consultant with an air of nonchalance characteristic of outsiders in accident and emergency. All these hurts are the small tips of a large iceberg made up of past failures and pain, from home as well as work, that many staff attempt to submerge further as they care for the hurts of others. It takes the warmth of God's love to melt the ice when it breaks the surface: and while that love can flow through any Christian not every Christian has the time to channel it where it is most immediately needed.

The chaplain himself is not immune from pain. I vividly remember the nightmare that followed the death of a 14-year-old boy during my first week; and the agony of comforting a young man who, arguing with his fiancée, caused a car accident from which he emerged unscathed only to watch helplessly as she bled to death. Such experiences cause pain, yet it is paradoxically this very ability to share the hurts of others that makes a chaplain's role so unique in an accident and emergency department. Perhaps a chaplain's greatest resource of all is the power of God, through the Holy Spirit, which alone, more than personality or training, is able to sustain him in pain from day to day.

My experiment in Leeds ended in December. The staff and I are convinced of its success. The next move is in the hands of the staff in other large accident and emergency departments, who alone can show their own need of a chaplain in casualty.

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Does atmospheric pressure affect blood pressure?

Low atmospheric pressure as experienced in an ascent to an altitude of 5000 m (16 400 ft) has no consistent effect on arterial pressure. An increase of atmospheric pressure as experienced in a dive to a depth of 150 ft (45 m) in water also has no effect. If the oxygen content of the inspired gas mixture is increased, however, then there may be a small increase in blood pressure (about 5 mm Hg).—PETER F SEMPLE, consultant physician, Glasgow.