

THE POTENTIAL FOR EFFICACY OF HEALTHCARE CHAPLAINCY AND SPIRITUAL CARE PROVISION IN THE NHS (UK)

A SCOPING REVIEW OF RECENT RESEARCH

JANUARY 2008



COMMISSIONED BY
NHS (UK)

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Acknowledgements

I would like to thank a number of people for their contribution to this work. The steering group helped guide the work and keep it focussed and the expert readers ploughed their way through the first draft and gave helpful and productive suggestions which made the final outcome much more readable and useful. Thanks to all.

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There is one other person who I would like to mention. My husband Donald who has tolerated the extreme sport of literature reviewing like a trooper. My love and thanks to him in particular.

Executive Summary

This is the report of the Review of recent research into the potential for Efficacy of Healthcare Chaplaincy in the NHS (the Efficacy Review). The Efficacy Review was commissioned in 2006 as part of the Caring for the Spirit NHS Project led by NHS Yorkshire and the Humber. The report comprises five sections with supporting annexes.

The NHS has laid down a requirement that health service treatment should be evidence based and this Review identifies and codifies this evidence. Against a background of evidence for the importance of spiritual care within health care, the evidence base for healthcare chaplaincy is limited for a number of reasons which are discussed throughout the report, and is focused on particular topics. There is thus a need for additional research and the areas on which this may concentrate are set out in later sections.

Section Two explains the context in which chaplaincy is provided in the NHS. The changes in the NHS matching changes in society are also matched in healthcare chaplaincy. In particular, the development of a multi-faith society has challenged chaplaincy to update its structure and to evidence its knowledge and skills. Whilst these changes have progressed, healthcare chaplaincy has moved from an assumption of presence to affirming a case for chaplaincy of which this Review is part.

The methods used to undertake this Review are set out in Section Three. The process followed was adapted from that used by the Joanna Briggs Institute for evidence-based practice which offers an opportunity to expand the scope for searching in fields where there is little research activity. The process used is an analysis of all the available literature (that is, evidence) using criteria for judgement of its usefulness and relevance to healthcare spiritual practice.

The results of the Review (Section Four) are categorised in the main topic areas of the articles reviewed. This categorisation sets out a map by which the developing interests and concerns of healthcare chaplains can be plotted. The research literature is listed in the review annexes and as it stands does not directly or substantially address the issue of efficacy in healthcare chaplaincy. For this reason, proposals for a research strategy are included in Section Five.

In Section Five, the Review considers the current profile of chaplaincy research against the patient's journey in healthcare settings. Associations are made between the patient's journey and chaplaincy-spiritual care and a model is offered which suggests research topics to sit alongside the patient pathway. The research strategy proposes that the gaps in the evidence base can be filled through a focus on research into patient outcomes.

Section 1

Introduction

1.1 Background

In November 2003 South Yorkshire NHS workforce development confederation published a strategy for the chaplaincy and spiritual healthcare workforce (Caring for the Spirit: 2003). Part of this strategy was to commission a review of literature to assess the state of the evidence base in UK healthcare chaplaincy prior to the formulation of guidance for chaplaincy research.

This report comprises that review.

The aim of this scoping review process is to produce a readable and rigorous overview of the research on the efficacy of healthcare chaplaincy and spiritual care in the UK. It is intended that the completed review will

- a) provide practitioners and others with evidence to inform practice
- b) add to the knowledge base of researchers and practitioners in the field of healthcare chaplaincy
- c) stimulate healthcare chaplaincy research

The review goals are:

- To systematically review existing evidence on the efficacy of chaplaincy-spiritual care in the UK NHS setting, with the aim of identifying implications for policy and practice
- To describe and evaluate critically the contribution of different research measures, techniques and designs used in this area
- To identify future priorities for research and provide outline proposals

1.2 Who should be reading this review

The review is aimed primarily at practicing healthcare chaplains and spiritual care givers. However it is hoped that it will be of interest to other healthcare professionals and NHS managers who have an interest in healthcare chaplaincy. It has relevance to all healthcare professions who are attempting to establish an evidence base. It is intended to contribute to the development of an awareness of the potential impact of chaplaincy amongst this body of people.

It does this in three ways.

Firstly it identifies the key topics of discussion (called categories) and research that are found in the published literature in the UK from 1990 up to June 2007. This gives the reader an idea of the preoccupations that currently exercise the published authors and researchers.

Secondly, having identified the key topics, it considers the substance of these topics and the nature of the research methods which have informed the discussion. This helps the reader consider useful and appropriate methods of enquiry in this field and contributes to the discussion about the nature of evidence, efficacy and method. A category map is developed to show the relationship between the categories and to stimulate discussion about future research.

Thirdly it highlights some of the key issues that emerge from the discussion that provide a suggested pathway for research into UK healthcare chaplaincy and spiritual care. In doing so it offers a visual representation of the healthcare journey, the current research categories and a set of hypotheses to stimulate research questions.

1.3 The authors of this report

This report has been researched and prepared by Dr H Mowat with the assistance of Angie Mutch, Mowat Research, Dr Pete Wimpenny, Joanna Briggs Institute, Robert Gordon University, Dr Iain Atherton, St Andrews University, Dr W. Eboh, Robert Gordon University, Patricia Atkinson, Mowat Research, Dr Suzanne Bunniss, NHS Education Scotland and Dr C Maclean, librarian Robert Gordon University, Aberdeen.

Part of the process of developing the report was to take expert advice from leaders in the field via telephone interviews and to ask expert reviewers internationally to review the first draft. This has helped the author incorporate the wisdom gained from these experts into the final report. The mistakes and gaps are the responsibility of Dr Mowat. A list of these expert readers is given in the Acknowledgements.

1.4 How to read the report

The research literature around healthcare chaplaincy in the UK NHS is relatively modest and the lions share of the literature reported here is in the form of high grade opinion, often based on available research, rather than specific research reporting per se.

The key focus of this report is the categories and themes that have emerged from the literature, the relationship between these and the “patient journey”, and the possible research agenda in the light of this.

Throughout the review we have referred to healthcare chaplaincy. It is intended that this study will be highly relevant to those who work within the chaplaincy centres within the NHS who are not only chaplains but spiritual care givers, part time pastoral visitors, volunteers and so on. We include in the term healthcare chaplaincy all those involved in the delivery of spiritual care under the umbrella of the NHS chaplains centre, office or department.

1.5 Glossary of Terms

NHS	National Health Service
RCT	Randomised Controlled Trial
JBI	Joanna Briggs Institute
LREC	Local research ethics committee
MREC	Multi centre research ethics committee
AUDIT	Monitoring of existing practices, information
RESEARCH	Discovery of new practices, information
WHO	World Health Organisation

1.6 The nature and structure of the review

The National Health Service (NHS) has laid down a requirement that health service treatment should be evidence based. The gold standard of evidence based medicine is the medical efficacy study. Clinical trials of therapeutic drugs are typically set up as randomised controlled trials and their science is the subject of analysis and debate.

A systematic review of efficacy would typically assume that there are studies that have been carried out that test a variety of interventions against a required outcome. These studies would then be analysed for the accuracy of their methods and would be subjected to a meta analysis from which a definitive understanding of the most appropriate intervention to maximise efficacy would derive. As Greenhalgh (2001) shows the systematic review is a counsel of perfection and most medical review articles are written in a journalistic style. The development of the National Institute for Clinical Excellence¹ has encouraged the tightening up of systematic reviews in order to provide a sensible evidence base for clinical medical practice. This systematic approach and its outcome of evidence based practice is now aspired to by most healthcare professions. The range of professional groups working in the National Health Service are at different stages and have different approaches to evidence based practice. Evidence based practice is now however the yardstick by which professional practice is measured and resourced. If a practice is not supported by evidence it is unlikely to be resourced.

We believed at the start of the literature review that we would find only a small amount of literature on the efficacy of chaplaincy which adopted the standard methods of intervention studies and randomised controlled trials.

It was not possible to produce a systematic meta analyses of intervention studies to comment on the efficacy of healthcare chaplaincy simply because so few exist.

Healthcare chaplaincy has a very limited evidence base for a number of reasons which are discussed throughout the report. However a lack of evidence of efficacy does not mean that the work of the hospital chaplain and spiritual care giver is not efficacious. Absence of evidence does not mean evidence of absence. This is consistent with the inherent assumption in qualitative enquiry that a theory of practice is derived from the data and can then be used as hypotheses for further research.

¹ www.nice.org.uk

The report is presented in sections.

Section Two will briefly consider the current “story” of chaplaincy by way of introduction to the topic and as a means of setting the scene. It is hoped that this will be of interest to both healthcare chaplains and to readers who have no real sense of the history or background of healthcare chaplaincy. It refers to current changes at both individual, group and societal level that are influencing the story.

Section Three gives a full account of the method used to conduct the literature review. It was decided to use a particular system developed by the Joanna Briggs Institute for evidence based practice. This system has real advantages because it incorporates opinion based work into its scope and allows for an evaluation of opinion as well as an evaluation of the practical value of the article to spiritual healthcare practice.

Section Four takes the reader through the review categories in some detail. This is the longest section and represents the substance of the report. The categories are derived from the current published literature which was judged to have relevance to the question of efficacy.

Section Five considers the relationship between the research categories that come out of the review and the current understanding of what we have called the “hospital journey”. This includes patients, staff, organization and families. The section finishes with suggestions for possible research topics.

The reference section contains a general bibliography which is for use in Sections One, Two, Three and Five and a specific Section Four reference list which comprises the review.

There are a number of annexes which are intended to act as helpful additional material. Those wishing to access the full database should request it from info@mowatresearch.co.uk. Those wishing to purchase a digitised hard copy of the report should also contact info@mowatresearch.co.uk.

Section 2

Context

2.0 Introduction

This section is intended to give a very modest overview of the context in which healthcare chaplaincy finds itself. The section here highlights some of the key issues that confront the 21st Century healthcare chaplain and that make an evidence based approach to practice so important.

2.1 The changing NHS

The original vision for the National Health Service (NHS) was based on the post war wish to defeat the five giants of oppression. This included the setting up of a welfare state in which healthcare was provided free at the point of delivery and provided cover from cradle to grave. Chaplaincy has been part of NHS provision since its inception in 1948.

The NHS is the biggest employer in the country. The NHS has undergone a series of major changes over the last 20 years. This has resulted in changes to the way in which professions are perceived, it has involved re-organisation of the management process, it has focussed attention on patient choice and patient centred medicine. The NHS is a public service aimed at providing basic healthcare for all as a result of taxes raised through national health insurance. The NHS is a major focus of political policy for all the main parties. The relationship between investment, resource allocation, professional practice, professional power, measurable outcomes and patient voice and votes is part of the picture of the NHS. The NHS is both subject to, and influencer of, the political winds and moods of the UK. Arguably it is a barometer for wider social and cultural relationships.

2.2 Multiculturalism, anti-discrimination and diversity

At the turn of the millennium one of the major foci for the NHS is to produce a patient-led service where individual needs are accommodated within a nationally fair system. The intention and mission is to address 6 groupings that can potentially be susceptible to discrimination. This is known as the diversity agenda. It is expressed slightly differently in England and Scotland but the principles remain largely the same.^{2 3}

² Promoting equality and human rights in the NHS - a guide for non-executive directors of NHS boards

21 July 2005 Electronic only Supersedes/replaces: Promoting equality and diversity in the NHS: a guide for board members Crown

³ Fair for All is the name given to the overall approach to promoting equality and diversity being used by NHS Scotland. Fair for All aims to develop a culturally competent health service that will eliminate discrimination and promote equality of opportunity for everyone.

In particular, equality of access to the health service is believed to be problematic for people from the following groups:

- *disabled people*
- *faith /religious/ groups*
- *minority ethnic communities [including gypsy travellers, refugees and asylum seekers]*
- *older people, children and young people*
- *the lesbian, gay, bisexual and transgender community*
- *women and men*

The current healthcare chaplains role is bound up with these anti discriminatory movements. In particular the chaplain is a lead in respecting the rights of those of declared faiths and those who declare no faith, to observe these preferences within their healthcare experience.

2.3 The original purpose of NHS healthcare chaplaincy

Historically NHS Healthcare chaplaincy was a mainly Christian based service funded by the NHS. The assumption behind chaplaincy is that there is a relationship between illness, suffering and religious faith and that this is connected to “recovery”. This association has survived despite the increasing distance between religion and science and religion and the state. As we have noted, the rise in interest in spirituality and the determined distinction between spirituality and religion reflected in the literature, has further “complexified” the situation (Swinton and Mowat: 2006). The position of the chaplain in the hospital is based on historical precedent and pre-dates the setting up of the NHS in 1948. Typically hospital chaplains have been Christian ministers and have either been employed to work full time for the hospital or take on some part time sessions as part of their parish ministry. Their management was shared between church and hospital and their role as representative of the church in the organisation went largely unquestioned. The way chaplaincy was configured in any one hospital tended to be a consequence of local circumstances.⁴

2.4 Changing healthcare chaplaincy – movement from an assumption of chaplaincy to a case for chaplaincy

Michael Wilson (1971) wrote extensively on the role of the hospital chaplain using survey research as part of his empirical work. Wilson was based in Birmingham and undertook a study of the role of the hospital chaplain following a request about provision of a chapel. It was thought important to understand the role of the chaplain before committing funds to redesigning or investing in new chapel facilities. This prompted an important and seminal text on the role of the chaplain.

In his study Wilson used a sociological eye to raise some crucial and abiding questions about hospital chaplaincy. He raised these in the context of questions about the role of the hospital in society. He noted that the obvious three key tasks of the hospital were to cure, care and teach healthcare professionals. He proposed an overriding task, a primary task based on the Tavistock understanding of primary task, which was linked to the idea of communities of health.

⁴ Georgina Nelson (1999) “Hospitals” chapter 8 in Giles Legood “Chaplaincy: the Church’s Sector Ministries” Cassell

“the primary task of the hospital is to enable patients, their families and staff to learn from the experience of illness and death how to build a healthy society”. (p6)

This powerful expression of the primary task of the hospital immediately locates the work of the hospital chaplain. It places the work of the hospital chaplain in the centre of the organization and the hospital community in the midst of suffering and change.

However as society changes and a division between religion and state organizations progresses, so the role of the chaplain qua religious becomes more delicate and complex. The chaplain can no longer assume a taken-for-granted place in the hospital. The cultural assumptions of chaplaincy are changing. Ann Ulanov (2007) has challenged chaplains with an even greater task. She writes of chaplains as working with fragments and remnants:

“You who see struggle and sorrow in your work as chaplains, who witness the fragility and strength of people reaching for new life in the midst of their old life crumbling around them, ...see remnants.” (p12)

She challenges chaplains to act as witnesses to the moment, to hold more than one story or version of events in order that others can learn to do the same and to make links and connections in order to encourage globalism and tolerance. She calls this remnant consciousness. Her view is that chaplains are called to work with this remnant consciousness in order to encourage global perspective which is the only way forward. The alternative is to have a rigid “one story” trying to fit as the whole story.

So both Wilson and Ulanov, writing 4 decades apart are challenging chaplains with the same task, teaching people to work with suffering, but Wilson was writing from an assumption of healthcare chaplaincy. His writing is located in a context where healthcare chaplaincy is assumed to be a good and lasting thing. Ulanov is making a case for healthcare chaplains in the context of more fractured and less “religious” society.

This is at the heart of the current situation in which chaplains find themselves and explains why chaplains need to reinforce and extend their thinking and practice through development of a research base.

Advances and changes in our society in the UK reverberate within the NHS. The increasing multicultural nature of our society has required us to re think and extend our thinking about the relationship between health, well being, faith and religious practice. Attempts at non discriminatory behaviour, upheld by law, require us to be much more conscious of diversity and equality in treatment and practice. However the imperatives of limited resources mean that choices have to be made based on evidence of need. Provision of religious care for patients who practise a religion no longer meets the needs of a society that is declaring itself to be more interested in spirituality than religion. (Davie 1994, Hay 2006, Heelas and Woodhead 2005).

Hospital chaplaincy therefore is now increasingly concerned not only with serving and supporting those with specific religious beliefs and practices but also those with no religious beliefs and practices.

Changes to job descriptions and role specifications for chaplaincy now mean that chaplains can and do come from any of the major recognised faiths and full time chaplains are expected to minister to people of all faiths and none. Chaplains with a strong faith tradition inevitably find themselves working in a setting where the majority of their “flock” do not share the same background, beliefs or cultural assumptions.

2.5 The politics of healthcare chaplaincy

Hospital chaplaincy finds itself in a political setting. Ellmore (2006) shows that healthcare chaplains are now being asked to become involved in NHS policy and the change process therein⁵. Questions are asked about the need for and work of the hospital chaplain. These questions may well be asked for a variety of reasons other than service value. However value for money is part and parcel of how chaplains are judged. If, as Ulanov (2007) suggests, the 21st Century chaplains role is to first and foremost act as witness to suffering and to attest to multiple stories then the political understanding and to some extent engagement of the Chaplain is important.

2.6 Key thinkers and influences

There are some very important key documents that have been produced that interested readers should know about. These are listed under general references. These were identified by initial interviews with experts in the field. These frame the “turns” in healthcare chaplaincy and help further put into context the current situation. These turns show the movement from the contextual understanding of hospital chaplaincy as that of religion as a healing art to healthcare chaplaincy as a response to spiritual needs as they express themselves in ill health and suffering.

The box below suggests the movements that are taking place within healthcare chaplaincy and the daily choices that have to be made in order to practice healthcare chaplaincy.

From religious to generic spiritual caretaker
From responding to religious needs to responding to all spiritual needs
From theologically based definitions to personal definitions of spiritual need
From working with faith group to working with multi-faith, or no faith groups
From gifted amateur to healthcare professional
From outsider to insider
From intuitive based or theory based cleric to evidence based healthcare practitioner
From organisational needs to patient needs
From one story to multiple stories
From teacher to responder
From outsider to leader

2.7 Need for evidence based practice

These choices, as expressed in the box, show why healthcare chaplaincy currently needs to identify its core tasks and skills and its place within a modern healthcare system. One of the key factors that make healthcare practice distinctive is the reference to the evidence base. Healthcare chaplains, as yet, do not have a specific evidence base that both protects and extends their work. Although historically there was an assumption that healthcare chaplaincy, in the name of religion, had an obvious relationship with suffering and recovery, the change in understanding of religion and the distinction between religion and

⁵ Ellmore Peter (2006) On being a healthcare chaplain –prophetic , political and professional The Journal of Health Care Chaplaincy Vol 7 No 2

spirituality⁶ requires that healthcare chaplains are more robust in their approach to their evidence base. This is noted in the USA by Vandecreeke and others (see appendix 2) and in Australia by Lindsay Carey.⁷

2.8 Psychoneuroimmunology (PNI)

An area of research which has immediate relevance as a theoretical underpin for healthcare chaplaincy is the area of psychoneuroimmunology. PNI is a new discipline which combines the accumulating data on the relationship between psychosocial functioning, neuroendocrine function and the immune response.

Psychoneuroimmunology is demonstrating that what people believe, think, and feel (which is dependent upon beliefs, morals, previous social conditioning, present socio-economic conditions, social support structures, etc) has a direct effect on neuroendocrine and immune functions in our bodies.⁸

Harold Koenig and his colleagues' work in America, particularly at Duke University,⁹ and the evolving work of neuroscientists in the UK¹⁰ is beginning to demonstrate a robust connection between immune response and beliefs. The protective effects of social network, feelings of self esteem, sense of meaning are shown through the changes to the neocortex which in turn affects the biological systems of neuroendocrine and immunological function.

A brief review of the thinking in this discipline can be found in Geoffrey Lachlan's review (footnote 8).

2.9 American, European and Australian influences

Although the brief of this review is to concentrate on UK National Health Service Chaplaincy work, there is a growing body of knowledge from America, Australia and Europe.¹¹ This helps us understand better the UK Chaplaincy situation.

American chaplaincy has developed CPE (Clinical Pastoral Education) which is a post graduate qualification available as part of a clinical qualification. Chaplains are seen as part of the clinical team. The Australian Chaplaincy Utility Research Unit¹² produces research and commentary as does The Centre for Ageing and Pastoral Studies in Canberra¹³.

⁶ Hay D (2006) *Something There: the biology of the Human Spirit* Darton Longman and Todd

⁷ <http://www.caperesearch.com.au>

⁸ Geoff Lachlan. (2007) *Patients with religious and belief needs – guidance for NHS staff.* NHS Scotland

⁹ www.duke.edu

¹⁰ Psychobiology Group: Directed by Professor Andrew Steptoe, the Psychobiology Group is concerned with the pathways through which sociodemographic and psychosocial factors influence physical disease processes. A major aim of the group is to understand how factors such as socioeconomic status, social isolation, work stress and hostility 'get under the skin', and influence biological functions in health and disease. A second theme is the investigation of lifestyle and patterns of health behaviour, and how behavioural methods can be used to encourage health behaviour change. The Psychobiology Group was established in 1999, and is multidisciplinary in nature. Members of the group have backgrounds in health psychology, psychophysiology, social psychology, cardiology, molecular biology, psychoneuroimmunology and nursing. The group is currently funded by the British Heart Foundation, National Institute of Aging, the National Prevention Research Initiative, and the Economic and Social Research Council and the Medical Research Council. www.ucl.ac.uk

¹¹ European network of healthcare chaplains <http://www.eurochaplains.org/>

¹² <http://www.caperesearch.com.au>: Dr Lindsay Carey

¹³ www.centreforageing.org.au

In addition the American patient population is far more “religious” in the sense of practicing specific religion and this has made research into the relationship between religious practice and well being arguably easier to manage. This is because religious practice is used as a proxy measure for faith. In the UK our faith traditions and developments are different and whilst it is important to know about and learn from the American literature it is not directly transferable to the UK context.

This section has briefly summarised the current situation within healthcare chaplaincy and identified some of the common themes and strands.

Section Three will now go on to describe the methods used to conduct this review.

Section 3

Methods

3.1 Summary of methods section

This section explains the process of the literature review and takes the reader through each of the steps.

The detail of this section should be of particular relevance to those wishing to conduct a literature review. Conversations with chaplains and experience from specific courses over the years have indicated a timidity regarding the research task. This section helps the reader through the specifics and generality of an important aspect of the research method.

Evidence based practice is part of the common culture of the National Health Service. Growing in importance in the 1990's and led by medical practitioners, evidence based practice is now the main benchmark by which healthcare professionals measure and account for their clinical practice. The systematic review of current research is a mechanism by which best evidence can be identified and understood.

The nature of evidence and efficacy is a subject of constant scrutiny and debate as different health and social care professionals embrace evidence based practice models.

The systematic review of the research is now extended to include wider definitions of evidence rather than the narrow confines implied by the randomised controlled trial. The integrated review considers quantitative, qualitative and opinion based work. (Dixon Woods et al 2004).

The process followed in this report was adapted from the Joanna Briggs Institute for evidence based practice. Research based literature in the discipline of healthcare chaplaincy is limited in the UK. Consequently some adaptations were required.

There have been seven steps in this process.

1. General familiarization and interviews with key informants
2. Setting inclusion and exclusion criteria
3. Setting key words, identifying databases and performing searches
4. Initial rejection or acceptance, secondary sorting, primary and secondary reading, considered acceptance or rejection

5. Categorising themes in the articles, first draft and reviewers comments on first draft
6. Re-searching databases using categories as keywords
7. Final drafts, comments from panel.

Discussion of the limitations of the study complete this section.

3.2 Evidence based practice and the systematic review process

During the 1990's the concept of evidence based medicine and practice evolved. Guidelines for good practice based on systematic reviews of available evidence have been enshrined in the National Institute for Clinical Excellence and the Cochrane Library. Whilst the concept of evidence based medicine is not without its difficulties, as a method of trying to offer best possible clinical care, it is largely unparalleled and the approach is now one that is internationally pursued in health and social care settings.

Evidence based medicine was initially a reaction to ad hoc "expert or experience based" medical practice. This was not based on a systematic understanding of current evidence rather it tended to be based in the intuitions, knowledge and common practice of the clinician. Evidence based practice is a way of operationalising the best possible research and giving different systems of research particular values. The systematic review not only attempts to collate all the evidence available on a chosen topic but judges its value in terms of the rigour of the science that it applies.

There are three associated behaviours related to evidence based medicine which have shaped modern day healthcare practice and which are relevant to healthcare chaplaincy.

Research awareness: In order for the patient to receive the best possible treatment available the clinician is required to "know" the evidence. This implies an understanding of research methods in order to judge the evidence.

Systematic review of research: The best possible evidence is gained through a distillation of comparable scientific research that can be summarized and synthesized.

Continuing Professional Development: Medical training, research and practice should instill and develop the skills required to make the judgments and syntheses required as an ongoing process of continuing professional development.

Other health and social care disciplines and allied health professionals have now followed suit and are engaged in the work of evidencing their practice in a similar way. The philosophical bases for these professions allied to medicine are not necessarily similar to that of scientific medicine. This has meant that as the evidence based "movement" has expanded, a wider approach to the concept of research and evidence has been required. It is now acknowledged that there are different ways of collecting evidence and that evidence itself comes from a variety of sources, which have integrity and validity within themselves but which do not conform to the randomized controlled trial structure. Colin Robson (2002) has written extensively about the development and challenges of different types of social research method.

This is the arena in which healthcare chaplains are now required to work. Healthcare chaplains also require an evidence base to underpin their practice.

3.3 The nature of evidence, efficacy and effectiveness

If healthcare chaplains are to find evidence that their practice is effective, a definition of evidence is required.

Evidence is defined as grounds for belief or disbelief, data on which to base proof or to establish truth or falsehood.

There is, of course, extensive literature about the nature of evidence, particularly what is understood to be good evidence and the relative values of different methods of discovery. Swinton (2001) has written a very readable account of some of the complexities of trying to establish the nature of evidence. Using quantum physics as an example of real science, he shows that even “hard” and hardest science finds that intangible and un-measurable processes are at work affecting data collection.

When data is collected that is about social life and individuals’ behaviour and attitudes within it, then the complexities of establishing hard and fast outcomes increase. When data is sought about individuals and their inner lives, understood as their spiritual and religious lives, then the methods used must necessarily be approximate. The tendency to use qualitative methods is obvious. Qualitative methods should not be understood to be somehow less rigorous than the more quantitative methods. Each methodological tradition has its own background and logic and its own rigour attached to the process. (Swinton and Mowat: 2006).

Evidence is arguably not only what we can see and touch but also that which we feel. Evidence is therefore what people say about feelings as much as what changes take place in the body as a consequence of a new therapeutic drug.

The definition of “evidence” is complex. This is not new and dates back to the enlightenment when science struggled to distinguish itself from religious thought and teaching. A consequence of the complexities of the meaning of evidence is the need to find a method or set of methods that can capture the “intangible” to some extent and offer a useful basis for knowledge and practice.

There also needs to be a clear understanding of what effective practice means. *Effective* is commonly defined as productive of or capable of producing a result. Even effective may not be enough. Practice is also required to be efficacious. This is defined as capable of or successful in producing an intended result.

Healthcare chaplains are being asked to show that what they do results in desired outcomes for those they work for ie patients, families, staff, organisation, community. This requirement is linked to resource allocation. The question is how does healthcare chaplaincy expedite the healthcare journey for those who are recipients and providers of health care.

Healthcare chaplains are currently unlikely to be able to provide evidence based on the typical gold standard approach. Research that intends to show that an intervention or practice “works” has to produce some outcomes against which to measure the intervention or practice. If the work of the chaplain or spiritual care giver is to be shown to be useful it must show that some agreed and valued outcome is achieved. The problem for healthcare chaplaincy and spiritual care is that outcomes may not

- a) be visible
- b) be measurable
- c) be available in the timescale of the “typical” research project
- d) be agreed by all parties
- e) be static over time

This does not mean that healthcare chaplaincy practice is not valued or valuable but it does mean that it may be difficult to demonstrate immediate outcomes. A good outcome in a health service is, arguably, to either resolve the health problem which has presented or provide care for those whose health problem cannot be resolved. A good outcome contributes to wellbeing. At times the good outcome causes some distress and anxiety before it is achieved, for instance cessation of smoking or changes in diet and exercise.

The healthcare chaplains or spiritual carers understanding of a “good” outcome will be just as complex given the theological understanding of suffering and ill health. A good outcome for spiritual growth and comfort might be an act of forgiveness which in its process causes great distress and anxiety. In common with other healthcare professions, the outcomes for chaplaincy may not be immediately measurable and have a more long term ripple effect.

There is a complexity in establishing outcome measures for healthcare chaplaincy. This is reflected in corresponding lack of intervention research currently carried out. Currently studies tend to focus on the process of chaplaincy rather than the outcome.

3.4 A systematic literature review as part of an evidence based culture

The systematic literature review is a response to the 1990’s call for evidence based medicine, embodied in the work of Professor Archie Cochrane and Professor David Sackett (Cochrane, 1972). The Cochrane review is commonly understood to be a “gold standard” of the systematic review.

Typically a systematic literature review is an overview of original published and peer reviewed research in a particular and specified field which

- contains a statement of objectives, materials and methods
- has been conducted according to explicit and reproducible methodology (Greehalgh: 2001:120)

The intention is to summarise and critically assess all the available evidence for one intervention by use of meta analysis. The growth in availability of e-resources (published articles in peer reviewed journals online) has meant that the art and science of the systematic literature review has greatly evolved over the last few years. The searching systems and use of key words for these enormous data bases improve almost daily.

There are now different types of systematic literature review and different Centres, virtual or otherwise, that support the systematic review.

The systematic literature review is no longer confined to reviewing the randomised controlled trial studies. Previously the assumption was that this scientific methodology was the only one that could yield evidence of efficacy. Systematic reviews now include qualitative methods and types of opinion that in themselves contribute to knowledge.

3.5 Joanna Briggs Institute (JBI) systematic review process

The Joanna Briggs Institute for Evidence Based Practice offers an opportunity to expand the scope for searching in fields where there is little research activity. As has been indicated, this is very much the case for UK healthcare chaplaincy.

The Joanna Briggs Institute¹⁴ is an international Research and Development Unit of Royal Adelaide Hospital, and an Affiliated Institute of the University of Adelaide. With headquarters located in Adelaide, the capital City of the State of South Australia, and international Collaborating Centres in Europe, Africa, Asia, the Americas, and Australia and the Pacific, the Institute was established in 1995 and became fully operational in late 1996. The formation of the Institute arose from the recognition of a need for a collaborative approach to the evaluation of evidence derived from a diverse range of sources, including experience, expertise and all forms of rigorous research and the translation, transfer and utilisation of the "best available" evidence into healthcare practice.

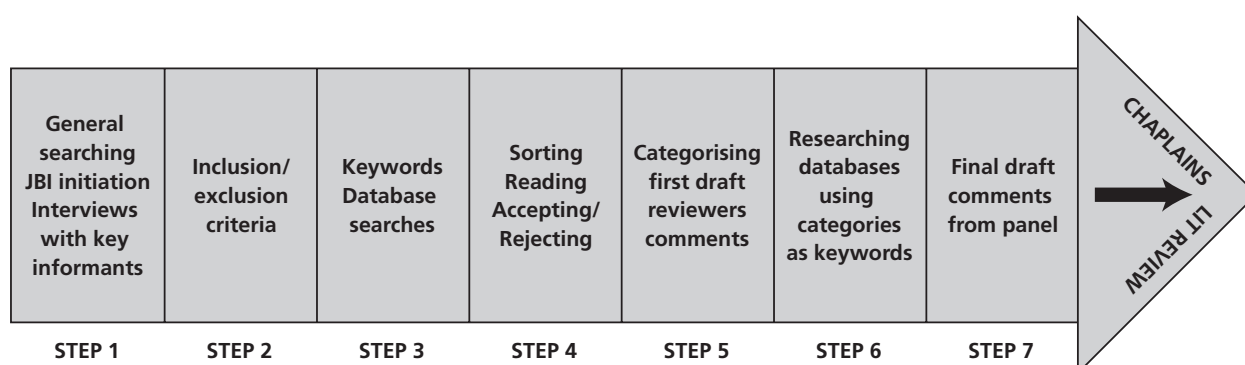
JBI defines a systematic review as a process.

“The systematic review process is essentially an analysis of all the available literature (that is, evidence) and a judgment on the validity and reliability (or otherwise) of a practice.” (JBI,2007).

JBI follows the process developed by the Cochrane Collaboration and incorporates the dissemination approach developed by the NHS Centre for Reviews and Dissemination at the University of York. Each JBI review is undertaken by a consultant who reports to a review panel and the review process is confined to a period of six months. Updates of reviews are undertaken when required, as identified at annual strategic planning meetings. All reviews are assessed for update every 5 years.

There is a satellite Centre at the Robert Gordon University, Aberdeen directed by Dr Pete Wimpenny and Dr S. Wilcox.

3.6 A summary of the process of the healthcare chaplains' research review



¹⁴ www.joannabriggs.edu.au

3.7 The 7 steps of the review process

Step 1: General familiarisation and key informant interviews

This first step involved a general familiarization with the electronic data bases and interviews with key informants who were “experts” in the healthcare chaplaincy field. The key informants were asked to comment on:

- *The scope of the review*
- *Recommended references and sources*
- *Final product expectations*
- *Key research questions for healthcare chaplaincy*
- *Useful contacts*
- *General comments*
- *Miscellaneous*

These interviews yielded suggestions about key search terms, inclusion and exclusion criteria, suggestions for data bases and general background information which helped locate the review in a wider context.

Step 2: Setting the inclusion/exclusion criteria

Criteria were as follows:

Date from:	Articles on or after 1990 – the 1990 community care changes in Britain affected the development of NHS service delivery. There is also an exponential rise in articles about spirituality and health care after 1990.
Country:	Studies focusing on United Kingdom healthcare chaplaincy. The steering group agreed that the understanding of spiritual and religious care between Britain and the US were too different for them to be comparatively analysed.
Proxies:	The limited field prompted a use of some “proxy” studies. Some non UK studies have been included in the review because of their generic interest in terms of methods or replicability in UK settings or because of their international reputation in this field. These are identified specifically when they occur.
Published Articles only:	Noel Brown (Orere Source editor: www.sach.org.uk) takes the view that books tend to be extensions of articles already published and that articles give a better sense of the current scope and thinking. Typically a review will only consider peer reviewed published articles. We have adopted this view. It was decided to concentrate the review section on only published articles rather than books. However because we know that databases do not always pick up all relevant material we have included some unpublished theses and reports which are well known and important milestones in the development of healthcare chaplaincy. The early informant interview and later draft comments helped with this.

Published Articles only (cont):	We have referred to key materials and books that are important to the context and background of healthcare chaplaincy throughout the text. We have also included a list of relevant books that we recommend to the reader interested in extending their knowledge of spirituality and health care in a broader sense than our review has allowed.
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Step 3: Key words and databases

A list of search words, phrases and their derivatives was produced:

- *Chaplain, chaplaincy*
- *Religion, religious practices, religious care*
- *Spiritual, spiritual practices, spiritual care*
- *Clergy*
- *Multi-faith, multicultural*
- *Efficacy of chaplains, effectiveness*
- *Healthcare, hospital, hospice*
- *Pastoral, pastoral care, pastor*
- *Intervention and chaplain*
- *Christian, Christianity, ministers, vicars*

In each case Chaplain* was combined with a specific key word. Using the * means that any derivative of chaplain is captured.

Databases

Initial Searching was applied to

- *Medline*
- *CINAHL*
- *Web of Knowledge*
- *ASSIA*
- *AMED*
- *Scopus*
- *Emerald*
- *The Cochrane Library*
- *ASLIB*
- *Psychlit*

The initial search produced 77 articles. These 77 articles were sorted for their precise relevance based on the inclusion criteria and the number reduced slightly.

At this point a trawl was also made of the grey literature and related websites (See Annex 1).

The commissioning team, suggested extensions to the search terms at the December 2006 meeting, to include

'gerontology', AND Chaplain* AND Spiritual *AND Intervention
'palliative care AND Chaplain* AND Spiritual* AND Intervention

hospice' AND Chaplain* AND Intervention
'pediatrics' AND Chaplain* AND Intervention
'mental health chaplaincy AND efficacy'. AND Intervention

We increased our search to include

Google Scholar

Further research terms were added

Research and chaplain*
Evidence based practice and chaplain*

Research and chaplains yielded 42 responses in Cinhal of which 9 had some relevance. 5 of these are American authors. (4 VandeCreek and Norwood.) Medline yielded 13 of which 3 were relevant and they were repeats of the 9 in Cinhal. Assia yielded no hits with these key words.

Cochrane yielded no further hits. Google Scholar yielded 5 hits already retrieved. Evidence based practice and chaplain* delivered no hits.

Hand searches

Electronic database searching is not a perfect process. There will be gaps in the information in the databases. This may be because particular journals are not indexed by the databases and in the case of healthcare chaplaincy two journals were searched by hand to make sure that they were included. These journals were

- *Scottish Journal of Health Care Chaplaincy* which is now available on line but not linked into the databases
- *Contact. The Practical Theology Journal* which has an online directory but does not come up in all the databases.
- *The Journal of the College of Health Care Chaplains*. This publication is not available on line or as an archive.

This resulted in 142 hits in total. In reality this meant an additional nine new and accepted references. Most of the additional hits were related to nursing.

It is fair to say that most of the references which we excluded were of interest to chaplains and had a relevance by implication. We have listed some of these for the readers' interest in Annex 2.

Step 4: Sorting process

a) Abstract and title acceptance or rejection

Articles were sorted at title and abstract stage into accepted and rejected on the basis of the degree to which the article suggested any relevance and reference at all to efficacy in UK healthcare chaplaincy. Every key word search included chaplain*. One of the limitations of this process was the fact that all articles related to spirituality and health care should be of interest, by implication, to healthcare chaplains and may well have contained implications for practice but this necessarily excluded many of these more general articles on spirituality and health care. Our inclusion in the initial sorting was broad.

b) Initial acceptance into review

Once articles had been accepted for review we applied various sorting mechanisms to try and ensure appropriate inclusion or exclusion.

The articles were initially sorted into research or opinion.

Articles were then photocopied and distributed across the team of readers. Readers were asked to decide on the relevance and acceptability of the articles by using one of three tools depending on the broad nature of the article as qualitative, quantitative or opinion. Qualitative articles were logged and analysed using the JBI tool QARI, ‘Qualitative Appraisal and Review Instrument’, whilst text and opinion articles (which made up the bulk of the literature found) were logged and analysed using the JBI tool, ‘NOTARI’: ‘Narrative, Opinion and Text Assessment Review Instrument’.¹⁵ Quantitative articles used an appraisal tool from ‘CASP’: ‘Critical Appraisal Skills Programme’, a web-based tool with Learning Development at the Public Health Resource Unit¹⁶. We found this latter a better evaluation tool for the type of quantitative studies we were reviewing. On the whole the reviewing tools were adequate although it was very quickly obvious that there were many types and standards within each category. HM acted as primary reader and the other readers as secondary readers.

c) Level of evidence

It was agreed to use any level of evidence from JBI level 1 “unequivocal” to “not supported”, level 4. This allowed us to include a wide range of articles and to be able to see the scope of the literature available. The importance of covering opinion based articles in the light of little research based materials is obvious.

d) Type of evidence

The broad scope of the review encouraged by the JBI process meant that there was a need to categorise the type of evidence to be included. JBI have developed criteria for type of evidence based on the feasibility, appropriateness, meaningfulness and effectiveness of the work under consideration. This allows greater scope for inclusion of articles that are opinion based. We have included one additional criteria, relevance to healthcare chaplaincy. This FRAME process is recorded in the database.

Any article to be included had to cover at least one of these characteristics.

Feasible and practical: could the material reported in the article be used at a practical level, as a basis for practice, by healthcare chaplains?

Relevant: is the material relevant to healthcare chaplaincy in so far as there are implications that could have a direct impact on healthcare chaplaincy practice?

Appropriate: Is what is being recommended or discussed in the article appropriate to healthcare chaplaincy in an NHS setting?

¹⁵ JBI website gives more information about these processes

¹⁶ www.phru.nhs.uk/casp

Meaningful: Does the article have some resonance with the work of healthcare chaplains? Will the material mean something to the healthcare chaplains?

Efficacy: Does the article report positive intended outcomes that are shown to be linked to healthcare chaplaincy practice?

e) Type of opinion based articles

It was decided to categorise the opinion based articles into four different types.

Hypothesis formulating opinion: Articles that could be used as a starting point for a research project

Current commentary opinion: articles that comment on the current situation in healthcare chaplaincy and events that impact upon this

Specialist commentary opinion: articles that focus on a particular aspect of healthcare chaplaincy

Personal and political commentary based on experience: pieces that are distinct from the case study, but which report opinion based on personal practice.

Step 5: Categorisation and first draft out to reviewers

These articles were then allocated an overall subject category by HM. Most of the articles covered more than one category. These categories were discussed at the interim steering group meeting as were the draft ideas of an emerging model of efficacy. Feedback from this meeting and subsequent discussions with knowledgeable people in the field helped confirm and refine them.

The first draft was completed and sent out to reviewers for comment in March 2007. (See Acknowledgements.)

Reviewers were asked to comment on

- *Gaps in the review based on their knowledge of the field*
- *The readability of the report*
- *The theory of efficacy*
- *The emergent research agenda*
- *The key points in the “story” of chaplaincy*
- *Some editorial and style related questions*

Step 6: Re-searching and redrafting

Key words relating to each category were used to search through the data bases as a final checking system.

The final number of references included in the review was 89 of which 57 were UK based. This process finished in June 2007.

Step 7: Final drafts

Two further drafts were completed with the review signed off by the panel in October 2007.

The write up of the review has held two aspects firmly in the forefront.

Firstly, this review, as agreed with the commissioning group, is intended for relatively inexperienced chaplain researchers and others in healthcare who are interested in healthcare chaplaincy and spiritual care giving. The authors have this type of reader in mind throughout the review. It is intended to be readable and interesting and above all encouraging to those wishing to embark directly or indirectly on research in this field.

Secondly, this review cannot be exhaustive. Even in the less research active world of healthcare chaplaincy the expectation is that this review is a beginning of a dynamic process of maintaining a literature base that allows researchers in this field to embark on their researches.

A literature review is therefore best seen as a dynamic and ongoing process rather than a definitive statement. This is a view shared by the Cochrane Group who update their systematic reviews on a regular basis.

A version of this review will be held on the database for Joanna Briggs Institute. It is hoped that it will be updated on an annual basis.

The JBI system is set up so that Chaplains and researchers across the world can contribute to the updating by leaving messages on the protocol.

3.8 Limitations of the study

The main limitations of this piece of work are:

a) The inclusion and exclusion criteria have determined that books are not part of the review. This means that some work and particularly some unpublished reports are not included in the actual review. Some members of the reviewing panel felt that this was a serious limitation given the nature of theological research and writing. The argument is usually advanced that published articles represent the most recent and up to date state of play of a subject. This is certainly the case in other healthcare disciplines. The relative “youth” of the healthcare chaplaincy research discipline may mean that this argument is less relevant to this particular discipline. As a consequence of this we have included relevant books in the general bibliography in the Reference Section. Some of these contain research findings which will be of interest to the chaplain researcher. However this omission remains a concern. It is worth noting that if healthcare chaplaincy is to take its place as a healthcare profession, publication in peer reviewed journals will be seen as a benchmark of professional development.

The discussion of study limitations regarding books is important. It also reflects the need for a change in emphasis in chaplaincy. At the moment it is an interface between theology and health. Practitioners (ie chaplains) lean heavily on theological training and reflection due to their initial training and experience. Engaging with peer reviewed journals means entering an evidence based world where rigor evidenced by peers outweighs opinion expressed by an individual in a single book.

b) The inclusion of some international work as part of the text inevitably means that other works of similar value have been excluded. Those cited have been based on the judgment of the author as adding something helpful to the discussion around the categories. The international references have been used as examples and ways of pursuing an argument. This has been welcomed by some of the reviewers and criticized by others.

c) The process of a systematic review for a subject that has very little “scientific” research currently has meant that some of the most interesting sources for material are not on the electronic databases. This is a discipline in its infancy and as the evidence base progresses and research matures so the relationship to the databases should improve. This is a matter for the healthcare chaplaincy research community both nationally and internationally.

d) Research work carried out by healthcare chaplains, for instance in the context of higher degrees, is rarely published and this has presented some challenges. The healthcare chaplains’ community “know” of local work but in order for it to be useful to the wider community it must get into publishable form. This is again a challenge for the healthcare chaplaincy research community.

Section 4

Findings – The Review Pathway

4.1 Summary of the review pathway

The intention of the review is to summarise and comment upon the current research base for the efficacy of healthcare chaplaincy.

We have already noted that the research literature as it currently stands does not directly or substantially address the issue of efficacy in healthcare chaplaincy. What we have been able to do is categorise the literature that has been found in terms of its implications and relevance to efficacy. This categorization gives the reader a map with which to plot the developing interests and concerns of healthcare chaplaincy. We are assuming that the published literature reflects common current concerns. At the end of this section we illustrate the map of categories and in Section Five we consider the development of a research agenda in relation to the patient journey.

The categories discussed in this section reflect the main topics that we found in the articles that we reviewed. These represent the published focus of concern in the field of UK healthcare chaplaincy.

This section goes through the categories and discusses the articles related to these categories. At the beginning of each category is a comment on the relevance and implications to efficacy. A list of the authors referred to in each of the categories can be found in Annex Four. Many of the articles cover more than one category. A wider reading section points the interested reader to material not included in the review but which contributes to the topic. At the end of each category there is a short discussion called “pause for thought” and some suggested research questions, which are summarised in Section Five.

4.2 Categories found in the review of literature

1. *Definitions of spirituality and religion*
2. *The link between spirituality and wellbeing*
3. *Defining evidence and efficacy in healthcare chaplaincy*
4. *Current situation in healthcare chaplaincy*
 - a. *Professionalisation and specialisation*
 - b. *Future and potential of chaplaincy*
 - c. *Education and training of healthcare chaplains*
5. *Territory – who should do spiritual care*
6. *Assessment of spiritual need*
7. *Patient perspectives*
8. *Multi-faith issues*

4.2.1

Definitions of spirituality, religious and spiritual need

Relevance to efficacy: although articles considering definitions of spirituality and religion do not immediately address questions of efficacy, they do give an understanding of the current concerns and offer building blocks in the research agenda.

There is generally an increasing interest in spirituality reflected in the growing literature. This interest encompasses the definitions of and distinctions between spirituality and religion. In particular the nursing research literature has developed a robust debate about the importance of definitions of spirituality and religion and the associated concern about whose territory spirituality is, in the healthcare setting.

There is, by contrast, limited research based work carried out by chaplains on the meaning and distinctions of religion and spirituality.

Wider Reading Suggestions

- McSherry W (2006) *Making Sense of Spirituality in Nursing and Health Care Practice* Jessica Kingsley Publishers
- Hay David (2006) *Something there: the biology of the human spirit* Darton Longman and Dodd Ltd.
- Orchard H (2001) *Spirituality in Health Care Contexts* Jessica Kingsley Publishers
- White G (2006) *Talking about spirituality in healthcare practice: a resource for the multi professional healthcare team* Jessica Kingsley Publishers, London and Philadelphia

Summary of themes

- *Spirituality is part of holistic care*
- *The rise in interest in spirituality is a critique of rationalism and religion*
- *The search for definitions of spirituality is rarely found in non christian work. Other faiths see spirituality and faith as intertwined.*
- *There is an overlap between emotional and spiritual needs*
- *Spirituality is best seen as a cluster concept using existing psychological constructs*

- *There is and should be a clear distinction between religion and spirituality*
- *The concepts of self, others and God are the key concepts from which spiritual actions are derived, such as hope, meaning, connectedness, beliefs, searching, journey*
- *The concept of spirituality is dynamic and exploratory*
- *Nurses should concern themselves with spirituality*
- *Nurses should not concern themselves with spirituality*
- *Religion not spirituality should be the province of the chaplain*
- *There is no need for a definition of spirituality*
- *Spirituality can be defined through use of assessment tools*
- *Assessment tools lead to better definitions and respond to the dynamic nature of spirituality*
- *Definition of spirituality must remain inconclusive because in that way it avoids reductionism*
- *Spirituality is an overarching dimension of human life and is related to all other aspects of human life.*
- *Spirituality is wider than religion*
- *Religion has a rich spirituality within it*

Walter's two articles (1997 and 2002) are a useful place to start. We classified these as highest quality opinion articles. Walter is a sociologist. His articles are typical of high level opinion which has implications for chaplains. This type of article contributes to a discussion about chaplaincy and its future and offers new knowledge for chaplains to work with. The articles are not specifically about chaplaincy. The particular value of Walter's article to the discussion about definitions of religion and spirituality for chaplains is that it challenges chaplains to identify their own core role in the holistic enterprise of caring for the dying. This is of course the same challenge that chaplains in acute, mental health and other sectors face.

In the first of the two papers reviewed (Walter 1997) he traces the evolution of three main definitions of spiritual care and the practical consequences of these definitions. He concentrates in particular on the most "popular" definition which distinguishes religious and spiritual. He focuses his attention on the hospice. He notes that historically spiritual care with the dying was about passage to the next life and confession and forgiveness as part of that process. Christian religious communities provided spiritual care to the dying with reference to the after life. This is changing. As spiritual care becomes more "popular" different ways of delivering it grow up and have implications for those charged with that delivery. One option is that as religious and spiritual care are seen as separate, chaplains only focus on religious care. This flies in the face of holism and equal access to spiritual care. Thus the preferable option of joint responsibility for delivery of spiritual care gives opportunities to all those interested in spiritual care.

As spiritual care becomes routinised, Walter argues, definitions of spirituality in particular become more sympathetic to familiar concepts which are located in the psycho social context. This means that the third type of definition of spirituality as a joint responsibility assumes that all have spiritual needs and all are searching for meaning. In terms of understanding the heart of spiritual care he suggests that the distinguishing features of spiritual care as distinct from psychological care are

- *Discernment*
- *Vulnerability*
- *Love*

These, he suggests, are what might make chaplaincy/spiritual care different to other types of psychological care.

Walter's (2002) second article pursues these arguments. Here he identifies the fact that British nurses tend to encourage a distinction between religion and spirituality. He asks the question, again focusing on palliative care, as to whether all staff can provide spiritual care. He notes that the definitions of spirituality are now becoming so broad as to be unmanageable.

He wonders, as a sociologist, why there is such a focus on defining spirituality. He offers three explanations. Firstly spirituality and the work of defining it represents a critique of scientific reductionism and church establishment. Spirituality is a concept that cannot be reduced to that which is easily measurable. Whilst this is a problem, as we have discussed, for evidence based practice, it is also a statement that some aspects of human suffering and experience are immeasurable. As a society, he suggests, we have to decide whether the immeasurable is also the unimportant. Secondly he advances the view that the attempt to separate religion from spirituality is an attempt to challenge religion and established church institutions. This reflects a societal mistrust of institutions. Thirdly he suggests that competing personal convictions amongst practitioners and authors in the healthcare setting have prompted an increasing interest in spirituality.

Spirituality he argues is a discourse that is used by the English speaking world to distance itself from religion. He notes that people have to be taught the difference between religion and spirituality which implies no easy definition is available.

He suggests that healthcare workers push the distinction between spirituality and religion.

“What we do know is that a) it is a discourse used, indeed vigorously promoted, by many of those moving beyond or from religion, b) these people are not representative of the entire population, but c) are likely to constitute a disproportionate number of healthcare workers, especially nurses and chaplains.” (p136)

Gillian White (2000) a research dietician conducted a small scale qualitative research project that provided an opportunity for members of a multi professional team to explore the concept of spirituality together. She developed a co-operative inquiry process which is related to grounded theory and action research. This was part of her doctoral research into spirituality and adult learning. In this process healthcare professions, including chaplains, met 15 times over the course of one year

“to explore our own spirituality with a view to how that informs our work”. (p480)

The group were given academic articles about the nature of spirituality and spiritual care to stimulate discussion. These are not identified in the write up. The exploration of spirituality dominated the first four months of the inquiry.

The co-operative inquiry came up with an agreement that spirituality is a unique potential in every human being, distinctive yet not separated from the physical and psychological. The group referred to the journey of life and that

“something stays with you, that is the essence of you. Although it might change, you can't lose it”. (p481)

The enquiry group wanted to broaden the understanding of spirituality away from an association with religion.

“Viewing spiritual needs as primarily the concern of the professional chaplain limits the provision offered, emphasising “religious” needs rather than spiritual needs, and leaving little for those without a defined religious belief system.” (p481)

Concepts and metaphors such as journey, search for meaning, connection and wholeness were identified. White (2000) noted that the group benefited from the research process. They identified a new confidence in being able to discuss these matters and clarified that being with clients was as important as doing things for them. The group remained unconvinced about a formal spiritual assessment tool fearing that spirituality would be seen as another task by use of a formal tool, rather than as part of holistic care. This is a view shared by others (Kelly: 2002) and is discussed later.

Michael Wright (2002), a UK chaplain, conducted a phenomenological study on the essence of spiritual care. Again in the setting of palliative care he carried out 16 interviews with spiritual care stakeholders from different religious traditions or no religious faith. His sample was purposive, meaning that he chose respondents specifically as data emerged and as he wanted to clarify and check out themes. He also used a snowballing technique to identify people with the required characteristics. Each participant was asked open ended questions including “ what do you understand by the word “spirituality”. He then tabulated significant statements into different sections. He identifies the transcendent understanding of spirituality by his respondents, reaching beyond and within the self and the capacity to search for meaning by addressing the big questions of life and death.

His conclusions are of some relevance to chaplains.

He notes that spirituality incorporates intangible and immeasurable features that contrast with the “high-tech” physical care which dominates hospital life. He also notes the increasing lack of confidence on the part of health professionals to enter the spiritual domain of patients,

“seeking instead what are deemed to be a safe pair of hands. Chaplains are generally seen in this light, but low staffing levels, underfunding and the demands of spiritual care giving are sources of tensions. Within this scenario spiritual care frequently becomes substituted by religious care.” (p7)

He concludes by noting that the lived experience of those interviewed is founded on the belief that all humans are spiritual beings. He expresses the hope that more research can be carried out perhaps using the opportunity of the investment in new information systems on patient spirituality and religious affiliation.

Dyson et al (1997) carried out a literature review on the meaning of spirituality. This review identifies a working framework for the exploration of spirituality. The authors identify the complexity of distinguishing between religion and spirituality and suggest that in empirical fact most people do not make a hard distinction and therefore to separate religion and spirituality entirely would be unrealistic. This framework is made up of three constructs: self, others and “God” (authors parentheses) and the relationship between them. Subsumed within this “framework” are “psychological activities” (my parentheses) which pursue the self, others and God, using psychological constructs such as hope, connectedness, beliefs, and meaning making which they call expressions of spirituality.

This article proposes that “God” should be defined as whatever the individual takes to be of highest value in his/her life. This has obvious implications for the work of healthcare chaplains and begs the question as to whether a concept so loose and individualistic can in fact be a basis for healthcare service. The paper finishes by calling for interventions and assessment systems.

Johnson (2001) in his opinion based article about assessment tools, begins by reviewing the literature on the meaning of spirituality and its distinction from religion. He agrees with Walter that the concept is almost impossible to define and the usefulness of the, largely nursing, work on this subject is

“overshadowed by the ambiguous, subjective and often intangible nature of spirituality” (p179)

Wright M (2004) starts his article by noting that spirituality is regarded as an essential feature of hospice care across Europe, although a generally accepted definition is still unclear. He provides an inclusive model of the spiritual domain which includes the self, others and the cosmos. This is very similar to Dyson et al (1997). He however acknowledges that spirituality for many people lies at the heart of religion. He identifies spiritual models by which we can understand spirituality and its distinction and association with religion. Whilst acknowledging an increasing number of people who believe without belonging (Davie 1994) he identifies the activity of becoming at the heart of spirituality. He offers the reader four models

1. *Developmental models* founded on the premise that there are stages in spiritual growth. These are linked to the psychological models of growth.
2. *Needs based models* which suggest that human beings have a need for meaning
3. *Values based models* associated with what have been called ultimate values of love, truth, forgiveness and reconciliation.
4. *Personhood models* associated with spirituality as a form of human relationship and emotions.

In his own model he suggests three key questions that we all ask ourselves; who am I, who are we and why are we here. He then circumnavigates those questions with spiritual activities of becoming, finding meaning, transcending and connecting. Often this journey around these questions using the spiritual activities is prompted by awareness of death. He likens spirituality to a diamond

“with its multiple facets revealed or concealed, depending on the viewer’s angle of observation. At best, inclusive models of spirituality resonate with hospice concepts of holism and the values of acceptance and non judgemental compassion.” (p77)

The relevance of this article for hospital chaplains lies in the palliative care assumption of the inclusion and centrality of the spiritual which currently resides with the hospital chaplain.

Hollins (2005) offers a robust opinion based article on spirituality and religion. As a chaplain she is the only writer in our review to tackle the current marginalisation of religion as part of the search for a definition of spirituality. She confirms that religion is spiritual and the rich symbols associated provide needed routines and rituals. She reviews Swinton’s attributes of spirituality although there is no reference for these, and adds to them, creating attributes of religion. She argues that the similarity which exists between them emphasises the connectedness between spirituality and religion. These are reproduced below.

Box 1 Attributes of Spirituality (Swinton)	Box 2 Attributes of Religion (Hollins)
<p>Meaning The ontological significance of life: making sense of life situations, deriving purpose in existence</p> <p>Value Beliefs and standards that are cherished, concerning truth beauty, and worth of a thought, object or behaviour, often discussed as ultimate values</p> <p>Transcendence Experience and appreciation of a dimension beyond the self, expanding self boundaries</p> <p>Connecting Relationship with self, others, God or a higher power and the environment</p> <p>Becoming An unfolding of life that demands reflection and experience, includes a sense of who one is and how one knows</p>	<p>Meaning Divine and ontological purpose, and significance of life; developing purpose, sometimes through suffering</p> <p>Belief Framework for one's life that can be challenged and is challenging, sustaining, informing and guiding in relation to life's crises; the sanctity of life</p> <p>Belonging The family of the faith, a sense of history and of future</p> <p>Nurturing , sustaining Prayers, worship, symbolic language and ritual</p> <p>Transcendence Seeking for and being found by God or the divine; going beyond self, having a relationship with God or the divine; life beyond death</p> <p>Becoming Growing in relationship to God or the divine, a sense of divine call or invitation, sensing a response</p> <p>Principles Ethical and moral standards, a framework for thought and behaviour related to truth, love, justice and compassion</p> <p>Connectedness Relationship with others, the local community and environment, service to others in the name of God or the divine</p> <p>Forgiveness, hope love, joy and compassion Divine attributes that are sought for one's life, which are to be exercised in relation to others and self</p>

She argues that the implications of the enduring relationship between religion and spirituality is, at the very least, that serious attention should be given to the “religious question” posed at patient admission and that staff education and training in spiritual health is required. This is an obvious research area for the healthcare chaplain and spiritual care giver.

The final article to be reviewed in this section is perhaps the most relevant given the remit of the review to consider efficacy. This is a research article written by managers of health services in America (Clark et al 2003). The authors report a comprehensive systematic literature review and original research to ascertain whether patients' emotional and spiritual needs are important, whether hospitals are effective in addressing these needs and what strategies should guide improvement. We have included this article as a proxy. It offers real possibilities for interventions using patient led listening and support incorporating the idea of story telling. In the context of definitions it shows the link between the spiritual

and psychological needs and also between spiritual/psychological needs and recovery. The literature review was conducted using a *Pub Med* search and produced no systematic literature reviews on the topic of addressing patients' emotional spiritual and psychosocial needs as of August 18th 2002. There is no information about the key words used and limited information about data bases searched. However, there is a substantial reference list.

They conclude that definitions of spirituality consistently include the psychological concept of a search for meaning and hope. Emotions and spiritual needs also interrelate on a clinical level. This is discussed in category 6. What they raise at the beginning of the article is the issue of overlap between psychological and spiritual, the relationship between affect and spirituality.

They go on to show a strong relationship between the degree to which staff addressed emotional /spiritual needs and overall patient satisfaction. Three measures most highly correlated with this were that staff

1. *understood the inconvenience of ill health*
2. *responded to complaints*
3. *included patients in treatment decisions*

Clark et al argue for a strong relationship between overall patient satisfaction and emotional and spiritual needs confirmed by previous studies. They also cite studies that demonstrate that meeting emotional and spiritual needs promote

- *Shorter stay in hospital*
- *Better prognosis*
- *Less depression*
- *Quicker recovery*

This research is American and we have discussed the research issues of translating findings into the UK setting. However it shows perhaps that linking emotional and spiritual needs together offers an opportunity. By acknowledging the overlap between emotional and spiritual needs chaplaincy interventions can be developed that can improve patient satisfaction and contribute to outcomes valued by the hospital.

Pause for thought on definitions

The definitions of spirituality and religion and the distancing of spirituality from religion are evident. Chaplains have not obviously engaged in the debate over definitions as witnessed by the number of articles found in the search and the low number of articles found in general under the search terms "definitions and spirituality".

Defining spirituality and distinguishing it from religion may turn out to be a room with no doors. Perhaps as a dynamic concept which is "understood" in the same way that love is understood, but understood differently by all who experience it, the focus for chaplaincy research should be to acknowledge that most of us don't like being ill and that being ill brings with it changes and challenges that make us question and worry about the future. Some of those worries and questions will be profoundly searching and may require some help. Chaplains, of any faith, have a theological and philosophical framework to respond to these questions which they can offer as a way of thinking. The individuals concerned can choose to use

that framework or not. This is in just the same way that individuals can choose whether or not to take the advice of doctors, nurses, occupational therapists or physiotherapists.

Possible research questions – definitions of spirituality, religion and spiritual need

Is it important to distinguish religion from spirituality?

Is spirituality a particularly Western construct?

Are spiritual needs and psychological needs similar?

What do patients report as spiritual/religious needs?

In what circumstances do individuals respond to chaplaincy and spiritual care and do they feel better as a result?

Having considered the debates around the definitions of religion and spirituality we now move on to the relationship between spiritual care, religious practice and wellbeing.

4.2.2

Links: relationship of spiritual care/religious care to well being

Relevance to efficacy of healthcare chaplains: whilst there may be complications in defining religious and spiritual need in order to establish an agreed baseline, there is nevertheless a growing body of knowledge that shows a generally positive link between spiritual and religious practices and well being. This is an important link with obvious consequences for healthcare chaplaincy. If there is an efficacious relationship between spiritual or religious practice and health, and chaplains are seen as the conduits of spiritual and religious practice, the role of the chaplain as part of an efficacious process can be asserted.

These articles help the reader marshal the arguments needed to discuss the evidence base for the relationship between well being and spiritual or religious beliefs and practices.

The relevance to healthcare chaplaincy is in how the growing evidence base can help chaplaincy formulate interventions that help patients feel better.

Wider Reading Suggestions

Koenig H., McCullough M., and Larson, D. (2001) *Handbook of Religion and Health Oxford*: Oxford University Press
 Larson D.B., Sawyers J.P., and McCullough M (1997) *Scientific Research on Spirituality and Health: A consensus Report*, Rockville MD National Institute for Healthcare Research

Summary of themes

The themes that have come out of the articles reviewed here which are predominately from the USA are

- *It is a duty of spiritual care providers/chaplains/managers to be informed about the current research related to wellbeing and spiritual care.*
- *Evidence has to be shown about relationship between spirituality and health to convince healthcare staff.*
- *The positive correlation between religion and well being is not surprising.*
- *The most well known studies are the USA prayer studies. The prayer studies are complicated and should be approached with caution.*
- *There are no chaplaincy based studies.*
- *Spirituality is not measurable.*
- *There is a protective affect of religious involvement.*
- *Attendance at religious worship does not necessarily signify faith.*
- *Opportunities exist for chaplains to work with others on research projects.*
- *Qualitative research is more appropriate for researching chaplaincy effects.*
- *The intangibles are still important. The research agenda should not restrict itself to what is measurable.*
- *It is probably most fruitful to choose interventions related to patient satisfaction.*

Speck (2005) looks at the evidence base for spiritual care. He asks if there is evidence to support the provision of spiritual care in health service settings. He notes that spiritual care givers will be required to have an understanding of the evidence base. He considers definitions of spirituality as we have seen and then poses the question “is spiritual care beneficial?”. He identifies the fact that most of the early attempts to discover whether spiritual care is beneficial for patients were undertaken in the United States and so are influenced by a different social and healthcare culture to that of the UK. Moreover the US material tends to use the terms religion and spirituality interchangeably while claims of efficacy of religious faith were inflated. He lists a number of British outcome studies between 1980 and 2000.

Swinton and Pattison (2001) also summarise the link between spirituality , religion and well being. They note the potential for harm of religious or spiritual beliefs when they are

- *judgemental*
- *guilt inducing*
- *replace mainstream medical care*
- *become associated with a negative God image and deferring coping styles*
- *used to justify prejudice and hatred*

There are some methodological and conceptual problems with some of the studies which should be noted. The main question is whether or not quantitative methods of the experimental type can be used to establish efficacy of a spiritual or religious intervention. The second problem is whether or not it is possible to distinguish the type of intervention. In most of the American studies there is little attention paid to the distinction between spirituality and religion. This means that the associations between well being and the intervention are difficult to unpack and understand. For instance if a study concludes that religion is good for you because people who go to church live longer, we have to ask what we are measuring by the term religion. Is it the physical activity involved in getting to the place of worship, kneeling down and so on. Is it the social network maintenance involved in the coffee or fellowship, clubs or activities surrounding the worship? Or is it a faithful inner life that makes the difference to length of life?

The conceptual rather than methodological criticism is very well put by Gleason (2004). He is quite clear that spirituality is not measurable and that religious affiliation and clinical outcomes research do not capture the whole picture. Gleason's USA based article has been included because of the breadth of discussion it offers a "young" research field such as healthcare chaplaincy. He focuses on pastoral research both past, present and future.

For now in the context of the evidence base he notes an increasing "burgeoning" interest in pastoral research as well as increasing hazards. He notes two stimuli to this interest. Firstly the increasing imperative of outcomes as a matter of professional responsibility manifest in the iconic Cochrane review, which we have already noted. Secondly the increase in interest in religion and health heralded by the Age of Aquarius and the accompanying focus on holism, new age spirituality and patient centred care. He then lists a number of studies that specifically focus on pastoral care, spirituality and healing and which have been conducted by religious researchers from many disciplines rather than clinical clergy pastoral researchers. He sends out a clear warning that

"the continuing reticence of clinical chaplains overall to engage the head in their heart work has left a void in the very essence of chaplaincy into which other disciplines have moved." (Gleason: p301)

He quotes Margot Hover, a chaplain writing in the Journal of Pastoral Care and Counseling (2002) as wishing that

"social scientists and researchers, particularly those with a definite religious/spiritual viewpoint would find a different word for their focus than prayer. Prayer studies assume that the prayer, or pray-er controls the outcome, much the same way that an aspirin related to a fever ...if prayer is viewed functionally rather than in terms of a relationship with God...that is...a Being who is beyond our control, a relapsed cancer patient could very likely wonder if she or he "prayed right"." (in Gleason: p302)

The extension to this is that if prayer becomes a commodity with an evidence based positive effect, then any negative outcomes may be the cause for complaint and pursuit by the prayed for against the pray-er!

This criticism of prayer studies is interesting in the light of Benson's study (2005). This is an example, again American, of a big randomised controlled study, funded by the John Templeton foundation. This foundation is dedicated to funding research that promotes a relationship between science, medicine and religion¹⁷. This study considered the therapeutic effects of intercessory prayer in cardiac bypass patients. It concluded that intercessory prayer itself had no effect on complication free recovery from CABG but certainty of receiving prayer was associated with a higher incidence of complications.

An alternative way of considering the link between spiritual and religious care and health and wellbeing is to report a narrative case example. This is a kind of action research or unstructured intervention where the process is recorded and its outcomes considered in retrospect. This is very typical of medical reporting where a case study is used as the data. Carosella (2002) again an American author, offers an interesting example of this by looking at the role of spirituality in dialysis care. She notes that research in 1982 carried out by Mary O'Brien and reported in the Journal of Religion Health suggested that 74% of 126 chronic dialysis patients believed that their religious beliefs affected their ability to cope with their disease and treatment regime and that prayer was a major vehicle of support. It is unclear what Carosella's role is in the dialysis unit, it was probably as medical social worker. She tells the "story" of

¹⁷ www.templeton.com

the dialysis unit where

“dialysis staff seldom probed very deeply into that often intangible realm of spirituality, nor did we invite our pastoral care colleagues to be regular members of our team to assist us in this process”
(Carosella p149)

A difficult situation with an elderly woman from a strong Catholic background where she was very distressed by her treatment and in danger of dying was helped by the social worker praying with the older woman. This caused the social worker and the whole team some discomfort. They were however

“Deeply moved by the level of comfort those moments of prayer immediately provided to the patient”
(p149)

The Director of Pastoral care then appointed a new chaplain and determined that his routine assignments would include the dialysis unit and he would be available on a daily basis to meet with staff and patients. The chaplain was incorporated into the multidisciplinary team over the next few months. Staff met with him daily. There was a two way educational process and he worked closely with the social worker. Themes that emerged as important for staff and patients were loss and thanksgiving. They arranged an ecumenical service as a service of remembrance and celebration.

The conclusion was

“The addition of a dialysis chaplain to the interdisciplinary team “enhanced” both team collaboration and the delivery of care to patients. Spirituality and organized religion were discussed more openly with patients by all team members and timely referrals were made to the chaplain, who could address more in- depth spiritual concern.” (p151)

This is an example of a piece of work that offers an intervention, describes a method and comes up with some proposed outcomes and enables others to repeat the intervention. However, it is difficult to call this a piece of research. Arguably the missing component is the more detailed collection of data about the outcomes, and/or the presence of a control which would show a difference between the intervention, the introduction of the new chaplain, and the group who received “standard” dialysis unit care.

This type of case study reporting is a good start though. It is typical of a number of the articles about work based in the UK. Seeing research as a continuum is helpful here. In fact we classified this article as opinion but it is still an example of evolving good practice based on emerging evidence. It is also worth noting the medical practice is built up on case by case experience and reporting and that in General Practice there has been good arguments for N=1 research, meaning that individual case study reporting can be as helpful and as much part of evidence as the large population studies.

If the randomised control trial is at one end and the descriptive case report at the other end, then in the middle are the intervention studies, secondary data analysis and interview led “perspective” studies. All these types of study can look at the relationship between spiritual and religious observance and well being but chaplains’ research needs to use that information as the basis for chaplains based practice and research. Much of the research found has relevance to chaplains by implication rather than a direct account of chaplains work. For instance, Alexander Clark’s work (2003) discussed earlier, is a study that makes a case for meeting emotional and spiritual needs in order that patients experience greater satisfaction with their hospital stay. This study identifies three practices that can meet these needs.

- *The practice of recognising the inconvenience of ill health in the patient*
- *The practice of responding to complaints*
- *The practice of including patient in treatment decisions*

These three components demonstrated a link with desired hospital outcomes of shorter stay, better prognosis, less depression in patients and quicker recovery (therefore less costly time in hospital). Again, by implication, these practices could be a targeted and central role for chaplains as part of their service. What is required is specific research to see whether the application of this into chaplaincy does produce the hypothesised effects.

The third proxy American study discussed here is Baker (2000). This is specifically about a pastoral care intervention with older adults. The purpose of this pilot study was to determine the efficacy of pastoral care both as a means of buffering the negative effects of depression in older adults and as a prophylactic to deter the potential negative impact of life circumstances in older adults at risk of depression. He recruited 120 subjects from a church related continuing care retirement community of 700 in Pennsylvania. Three groups were identified. Those with a diagnosis of depression who were taking psychotropic medication, those who were at risk of depression evaluated by the multidisciplinary team to having at least one preterm criteria including loss of the ability to engage in usual functional patterns because of concurrent physical illness, loss of spouse, shift in family dynamics, family history of depression, loss of supportive social network and those considered normal healthy individuals. All participants were screened and consented. Excluding criteria included cognitive impairment, less than 65 years old, untreated hypertension, English as second language and uncorrected sensory loss. Each group was matched according to age, gender and level of care and then assigned to the treatment or control group. Pre test base line data was gathered designed to quantify variables of religiosity, religious practice, spiritual well being, self transcendence, depression, social participation and history of depression. Validated measures were used for spiritual well being, self transcendence and depression. Other variables were measured through Likert like scales.

The intervention was described as “pastoral visitation” by healthcare chaplains. The treatment group received an intensive regimen of weekly pastoral care visits by ordained ministers in good standing with their respective church bodies. The treatment and control groups were then compared by comparing pre and post test scores and group comparisons. Post test scores for depression decreased for the treatment group while the control group scores increased. The paper presents tables showing the variable and the pre test control and treatment scores and post test control and treatment scores. The treatment group displayed a reduction in religious, existential and spiritual well being at the follow up. We do not know when this was but the explanation given by the author is that the visitation intervention was withdrawn and thus the participants became more depressed. This raises moral and ethical issues for the research process.

Data was also collected concerning the specific pastoral care interventions and which were most efficacious for treatment of depression. Prayer, counselling for issues raised, grief work, the provision of blessings, active listening, life review were found to be significantly associated with a reduction depression scores. The author concludes that

“With an ever increasing older population before us and the likelihood that there will be a great number of elderly depressed persons, the results of this study would suggest that it is prudent to incorporate pastoral care as a cost effective complement to pharmacological intervention in the treatment of depression.” (p83)

This study is a good example of an attempt to quantify the work of the chaplain.

From the other end of the spectrum studies looking at the spiritual needs of patients offer a, by implication, relevance to the role of the healthcare professional and in particular the chaplain. These studies give chaplains a remit for practice and a basis for research. One such study based in Australia (McGrath: 2003) is a good example of such a genre. She notes that

“there is scant literature on the interface of religion and spirituality or the impact of serious illness on spiritual beliefs from the patients perspective using empirical research” (p881)

The study was funded by the Queensland Cancer Fund for two years and had five strands. McGrath reports the hospice patients arm which looks at spirituality in relation to hospice patients. She recruited 14 participants who had less than six months to live. The method was qualitative research interview using a phenomenological approach. This means that the researcher is committed to displaying the participants point of view with the researcher acting as co-participant and narrative/story teller. Her key “trigger” starting question was

“Can you tell me of your experience, in your own words and in your own way, from the time you became aware that you were ill? How has that changed how you see the world and what you believe is important?” (p885)

Using this method data is gathered through interview, recorded and analysed using codes and themes. She does not say whether or not she returned the data to the participants for further discussion and validation. Feedback loops are now fairly standard in qualitative research techniques. This is sometimes known as member checking (Denzin and Lincoln 2000).

She found three reactions to the challenge of terminal illness:

- *Patients did not turn to religion – religion not seen as important*
- *Patients actively turned away from religion*
- *Patients illness strengthened religiosity*

She discusses the spiritual views of the participants and concludes that the hospice findings affirm the significance of the focus on the here and now and connection with significant others rather than just meaning making as important dimensions of spirituality.

Finally Larson and Larson (2003) give an overview, called a literature review, of quantitative research in the USA of the relationship between spirituality and health. Echoing Speck’s concerns, we find in this paper that spirituality and religion are conflated.

Pause for thought

We have considered the way in which spirituality and religion are defined in the literature and some of the difficulties and challenges of conflation of these two concepts. We have also considered what is known about the relationship between health wellbeing and spiritual and religious practices and how different methods can be employed to empirically investigate these matters.

Both these have relevance to the efficacy of chaplaincy but neither is directly attending to this. By implication the evidence of positive relationships between spirituality, religion and well being should impact on the research agenda of chaplains.

If chaplains are the vehicles through which individuals can express their own religious or spiritual needs then chaplains need to be aware of the relationship between spiritual, religious needs and well being and how they can act as conduits for positive effects.

Possible research questions – links between spirituality, religion and wellbeing

How does the healthcare chaplain act as a conduit for a positive link between spiritual development and health?

4.2.3

Evidence and efficacy in healthcare chaplaincy

Relevance to efficacy: there are a number of articles that specifically consider the issues of definitions of evidence and efficacy. These are the beginnings of a discussion about the nature of evidence as it applies to the practice and discipline of healthcare chaplaincy. These could be seen as the building blocks for further discussion and research.

Wider Reading Suggestions

Greenhalgh T (2001) *How to read a paper: the basics of evidence based medicine* BMJ Books

Robson C (2002) *Real World Research* Sage Publications

Speck P.W. Cobb M and Fraser D (2005) *A standard for Research in Health Care Chaplaincy. Caring for the Spirit*. NHS

Swinton J (2001) *Spirituality and Mental Health: Rediscovering a “forgotten Dimension”*. London: Jessica Kingsley

Swinton J and Mowat H (2006) *Practical Theology and Qualitative Research Methods* SCM Press

Vandecreeke L Bender H and Jordan M (1994) *Research in Pastoral Care and Counseling: Quantitative and Qualitative Approaches* (Paperback)

Stanworth R (2004) *Recognising spiritual needs in People who are dying* Oxford University Press

Key themes from the UK literature

- *Narrative/story telling as method and practice*
- *Imperative of healthcare chaplains having an evidence base*
- *Dominance of evidence based practice*
- *Customer/patient/staff perspective and need should drive research and practice*

Hundley (1999) writing from a nursing perspective tackles the question of what is evidence. This is a helpful article.

She suggests that knowledge is acquired from a variety of sources:

- *Tradition*
- *Authority/policy*
- *Education or training*

- *Personal experience*
- *Trial and error*
- *Role modeling*
- *Intuition*
- *Research*

She then examines each of these sources for its reliability. Sources of knowledge that are seen as reliable, she notes, are often referred to as evidence and this is what is used in evidence based decision making or evidence based practice. She notes that the simplest classification for evidence to be used in clinical guidelines is probably also the most helpful. In this classification scheme there are three levels of evidence.

1. *Randomised controlled trials*
2. *Other robust experimental or observational studies*
3. *More limited evidence but advice based on expert opinion and endorsement of respect authorities.*

She shows that evidence based practice is far more than just using the evidence and involves a judgment by the clinician and taking into account specific context and circumstances.

She makes a very articulate and helpful case for evidence based practice and, using examples, shows the degree to which evidence must be multi faceted and take into account both qualitative and quantitative approaches.

In an opinion piece, Swinton (2002) focuses on the role of the healthcare chaplain and evidence for the same. Swinton starts from a position that suggests there is more to evidence than the “scientific” approach. In his view a narrow definition of science relies on knowledge only being correct if it is tangible, scientifically verifiable, generalisable and reproducible.

He highlights the value of narrative /story telling as a means of evidencing the lived experience of illness. He notes that there has been a significant movement towards the therapeutic significance of narrative for understandings of health and illness

“not simply as illustration to confirm or disconfirm diagnostic assumptions, but as a unique media which reveal new or “forgotten” dimensions of health and illness” (p8)

Swinton challenges chaplains to find methods of data collection that can capture this “evidence”. He advances the argument that chaplains have a unique and vital contribution to make to the practice of healthcare. This involves grasping the uniqueness of their own discipline and rather than becoming scientific in a narrow positivistic way, they should pursue methods that help individuals and groups understand and transform illness. He gives an example of a small study of the experience of women with depression. This type of research bears witness to suffering and is consistent with other authors’ views of the fundamental role of the chaplain as witness.

Speck (2004) reviews the idea of effective spiritual care. Spiritual carers should be a resource in the individual’s search for meaning and purpose. He suggests that one way of doing this work is to mutually construct meaning through narrative. His definition of effectiveness is rooted in the assumption of a relationship between chaplain and patient.

“It is difficult to envisage an effective chaplaincy, or spiritual care, service that does not strive to be truly interactive with the recipients of that care.” (p21)

McManus (2006) presents an argument for education and training of chaplains, the content of which is discussed later. In relation to definitions of evidence he writes

“The evidence base for chaplaincy’s impact on health and well being is still being developed, thus adding a further strand of weakness in regards to policy. This is in part due to the fact that the nature of chaplaincy interventions may be very complex, along with the state of development of research within chaplaincy itself.” (p666)

He notes that the National Institute of Health and Clinical Excellence (NICE) mentioned earlier as the embodiment of evidence based practice in the UK has recommended that people with cancer should have access to a range of supportive care, including spiritual care, despite its own review of evidence for spiritual care identifying that the evidence base needed further development. This suggests that there is a softening of the idea of “evidence” from policy making quarters.

Ahmed et al (2004) reviewed the evidence from randomised controlled trials of gastrointestinal cancer treatments which included supportive care for patients. They conclude that supportive care, including spiritual care, combined with chemotherapy can help patients by optimising the comfort of patients and their ability to function, as well as minimising the side effects of anti cancer treatments. They note that there is still a need to clarify the definitions of supportive care.

This study, published by the Cochrane Review Centre and therefore seen as appropriately “scientific”, offers opportunities to healthcare chaplaincy to develop a working definition of supportive care.

A good example of an attempt by healthcare chaplains to measure the effectiveness of chaplaincy is presented by Duffy and Munro (2005). Using a systematic approach to clinical governance based on quality management principles, a systems pattern, already in use in other departments in the Health Board, was applied to the Department of Spiritual Care.

This has 9 components

1. *Find out customers (sic) needs wants*
2. *Methods/practices needed to respond to needs*
3. *Resources needed to meet needs*
4. *Make sure clients/customers can access services*
5. *Bringing the right service and the right client together*
6. *Deliver the service*
7. *Find out if clients/customers are satisfied with service through..*
8. *Measurement of outcomes*
9. *Improve service delivery*

These components give the framework for what should be measured.

They then list the measurables as they see it.

- *Customers needs and wants*
- *Skills and knowledge bases required to deliver support materials required for staff*
- *Information requested by staff or patients on spiritual matters*
- *Reasons for failed visits*
- *Success in meeting clients needs*
- *Relationship between plan and outcomes*
- *The results of problem solving*

Duffy and Munro have given a helpful framework without suggesting how these measurements should be taken. They note the danger of degeneration into counting where quantity becomes quality. In spiritual care it is easy to see that number of clients visited (relatively easy to count and collect) becomes the measure of the quality of the visit (relatively complicated to record and analyse).

Johnson (2003) writing as a chaplaincy manager begins his article with the problems of establishing efficacy. In a similar way to Duffy and Munro he approaches hospital chaplaincy as a process which needs to be audited and validated. He notes that everyone in the hospital is a potential customer. He argues for customer surveys (both staff and patients). He says that there are very few examples of chaplains discovering what their staff customers think of their service and using the results to make changes. He refers to two unpublished surveys by way of example and wonders whether the results from the surveys were acted upon.

Surveys can of course consider both patient satisfaction – “did you get what you expected” – or patient expectation, – “What do you expect”. These are different questions. Johnson does not comment on the detail and difficulties of conducting valid surveys but certainly raises the importance of understanding patient needs and by definition operating a patient focussed service.

Fraser (2004) associates the development of a more confident and assertive healthcare chaplaincy identity with the development of an evidence base which can demonstrate effectiveness. He refers to Helen Orchard’s report (2002) in which she recommends that

“serious effort is expended on demonstrating to other healthcare professionals what chaplains are bringing to the bedside that is therapeutically effective rather than simply edifying” (p27)

Fraser (2004) endorses this recommendation adding that self definition and articulation validates what “we are about”. He highlights the importance of communication with other healthcare professionals. He argues that healthcare professionals need to know what the chaplains do and how they do it so that they can be embraced as part of the healthcare team. This implies that healthcare chaplains know what they are doing and how they do it.

He identifies four major benefits of healthcare chaplaincy which can be, should and indeed must be evidenced.

Institutional – advocacy for the psycho-socio-spiritual agenda

Operational – encouraging the staff and patient and family expression of feelings and exploration of the meaning of their experiences

Community – the chaplain as involvement agent

Cost effectiveness – for instance chaplains work reduces length of hospital stay, pain medications, staff stress

Pause for thought

Evidence is a broad concept. The authors reviewed here are suggesting that healthcare chaplains must engage in the debate about the nature of evidence and method as they develop strategies to examine efficacy. Without the healthcare chaplains input the narrow definitions of evidence that are currently dominant in the healthcare setting will prevail, chaplains will find it difficult to engage with these definitions and will tend to withdraw from the research process.

Possible Research Question – evidence and efficacy in healthcare chaplaincy

What counts as evidence in the spiritual encounter and work of healthcare chaplains?

4.2.4

Current chaplaincy – the role of the healthcare chaplain

- *professionalisation and specialisation*
- *future and potential*
- *education and training*

Relevance to efficacy: healthcare chaplaincy like other healthcare professions, has to make a case for itself. This has prompted articles that consider the nature of healthcare chaplaincy from descriptive studies to personal accounts.

Wider Reading Suggestions

Orchard H (2000) *Hospital Chaplaincy: Modern, Dependable?* A research report of the Lincoln Theological Institute, University of Sheffield The Kings Fund, London. This report focuses on chaplaincy within a sample of hospitals in London.

Mowat H and Swinton J (2007) *What do Chaplains do? The role of the Chaplain in meeting the spiritual needs of patients* Report No CSHD/MR001 Edition 2 Available from Mowat Research Ltd.

Key themes in this section

- *Chaplaincy is a process rather than an outcome*
- *“How” questions dominate the research agenda*
- *Chaplaincy has a marginal and ambivalent relationship with the NHS organisation*
- *There is an art, science and theology of being available*
- *Chaplaincy is a witness to suffering*
- *Finding methods to witness is a key challenge*
- *Professionalisation of healthcare chaplaincy brings with it educational and training responsibilities and research requirements*
- *Professionalisation will encourage specialisation*
- *The secure future and positive potential for chaplaincy is linked to creating a better knowledge base about practice*

Woodward (2000) helps to make Wilson’s work, as discussed earlier, relevant for today. Wilson (1977) defined chaplaincy within the context of the role of the hospital. Hospitals are schools for society in which attitudes to illness and health, ageing and death are taught. He also defines the task of the Church to

express in its common life the truth that sets men free to be fully human. Both these definitions are dynamic and involve process rather than outcome. The success of the healthcare chaplain depends more upon his individual personal qualities than the listable tasks and procedures of his job description. It is how the chaplain works rather than what precisely he does that gives chaplaincy its power and character. The role of the chaplain, according to Wilson, is “work of prayer and communication in thought, word and deed”. Wilson recommends the idea of the hospital chaplain as theological educator. Woodward’s conclusions are that, notwithstanding some limitations to Wilson’s work, there are three questions that we can take with us into the 21st Century.

- *What is the relationship between the chaplain as fundamentally a religious person and the desire to develop the chaplain as a religious professional? What is the knowledge base for chaplaincy?*
- *Where do chaplains find their security within the hospital culture? What skills are necessary for the chaplain in today’s hospital?*
- *How can Chaplains work ecumenically and in a multi-cultural society with a declining interest in faith?*

Mowat and Swinton (2005: see Appendix Six book list) carried out a qualitative research study in Scotland covering all full time healthcare chaplains at the time of study (n=44). This two stage interview and observation study examined what chaplains do. This study reinforced the different levels of work chaplains undertook both at individual, group and organisational level. What was particularly interesting was the difficulty chaplains had in articulating their core tasks. The idea of chaplaincy as a process was central to the discussion. Central also was the paradox and tension for the chaplain of remaining both inside and outside the organisation in order to minister to the organisation as well as the individuals within it. Norwood’s (2006) ethnography of chaplains is an American study but highly relevant to the understanding of the chaplain as marginal and ambivalent within the hospital.

In a phenomenological study by a hospital chaplain looking at the essence of spiritual care (Wright 2002), one of the common themes to emerge in his analysis of the hopes for the future expressed by the 16 patients he interviewed was

“While acknowledging that many people give spiritual care, recognition of the chaplain’s central, often co-ordinating role, is thought to be important.” (p7)

The chaplains role, the giving of spiritual and religious care, is shared by others. This places healthcare chaplaincy in a precarious position. If others can do this what makes healthcare chaplaincy distinctive and valuable in the organisation? Wright provides us with some kind of an answer in the recognition of the co-ordinating role. The healthcare chaplain can discern the nature of the spiritual or religious need and delegate accordingly. This is linked to the ability to assess spiritual and religious need and is discussed later.

Michael Wright (2001) conducted a survey of chaplaincy in hospice and hospital as part of his doctoral thesis. There is not much detail of the method of the survey but the author uses the space to deliver the findings and make some general points to encourage wider debate. He refers to three “roles” for the chaplain which are sourced from earlier authors.

1. *The chaplain as priest, being there rather than doing. (Autton 1968)*
2. *The chaplain as circus clown – appearance of amateur, but highly skilled requiring experience and skill (Faber 1971)*
3. *The chaplain as wilderness (Moody in Legood 1999)*

He notes in his introduction that in the pioneering days in the 60's and 70's the hospices teams were

“Made up of disparate, but like minded people. Fired by a sense of vocation they responded locally to the needs of the dying. Within this context the chaplain represented one group among many that delivered spiritual care.” (p229)

He notes the change in climate as religious observance drops and multicultural contemporary society progresses. However his comment about the chaplain being one of a number of people who delivered spiritual care holds true today.

Wright's survey shows that spiritual care requirements of patients were both religious and non religious. The non religious requirements were around presence; someone to listen and someone to be there. In both hospice and hospital this was seen as a frequent recruitment. Opportunities to discuss questions of why me, pain, meaning of life, value of one's own life, suffering, forgiveness, transcendence, the nature of God, concern for relatives, death and dying and the afterlife were also perceived as present. The concern for relatives in both hospice and hospital patients was perceived as the most pressing discussion topic. Religious requirements of patients such as prayer, texts, worship, special rituals, baptism, confession, communion, anointing, and last rites were interestingly lower in the hospice than the hospital; both communion and prayer being more frequently asked for in the hospitals. They also reported “other responsibilities” of the chaplain, identified as managing and liaising with others. This was related to bereavement, liaison with religious leaders and spiritual care education. This was a survey which reported the perceived understandings of chaplains rather than patients.

The McGrath (2003) study mentioned earlier, emphasises the need for patients to be connected to family in the here and now, over and above the need for religious or spiritual support about death. This links back to the role of the hospital in preparing and teaching families and individuals how to be ill and well.

Wright discusses the role ambiguity inherent within chaplaincy. He wonders if managerial responsibilities offer a welcoming cluster of quantifiable outcomes against the backdrop of a more amorphous chaplaincy role. This echoes the same questions that Woodward poses about the secure knowledge base for chaplaincy.

Wright concludes his survey by calling for further research in a healthcare environment where patterns of delivery and spiritual care need are changing. Mitchell and Sneddon (1999) conducted a survey of chaplaincy in Scotland. This was Mitchell's postgraduate thesis. He conducted a descriptive survey to find out how chaplains in Scotland understand and practice spiritual care. He interviewed 10 chaplains from psychiatric hospitals, hospices and general hospitals. Data were collected using a self completion questionnaire diary and a semi structured interview. He piloted his study with three chaplains. He found that the diary did not work because the time scale was too short. Interestingly a study in America by the Catholic Health Initiatives (2002) also found that diary keeping was a difficult and fairly unreliable way of collecting data about activities.

Mitchell and Sneddon found that chaplains were relatively unaware of the wider debate surrounding spiritual care in the literature. The religious elements of the chaplains work did not by any means represent the majority of their work. The main elements of the chaplains work included spending time with individuals, families and staff and “being available” and providing informal spiritual support. It was very person centred work. They saw themselves as a resource for others both in practical terms and in terms of teaching others about spiritual care. Confidentiality, authenticity and trust were important

component parts of being available. The influence of palliative care on the chaplain's role as member of the team was noted. Work with staff was a large component of the chaplains focus and this reinforces what is already known; that Chaplains spend nearly 40% of their time with staff even though there may be little formal acknowledgement of this.

The idea of the chaplains role as symbolic is taken up by Murray (2002). In an opinion based article she considers the mental health chaplain and makes a clear distinction between spiritual help and psychological help. She offers the Trinitarian relationship as a model for chaplaincy practice. She suggests that this is helpful in helping those in need to recognise the presence of God in the chaplain. She points out the importance of interdependence between chaplain and patient and recognises that interdependence is a spiritual position which reflects the chaplains relationship with God.

Foskett (1993) in his opinion article about the implications of community care argues that the chaplains work is hidden. That chaplains are witnesses and pastors in but not of, the healthcare system. He also refers to the chaplain as a clown, as staff support and as witness to injustice. Ainsworth Smith (1998) identifies three foci for the work of the chaplain; Individuals, patients and their relatives; staff and trainees; the organisation. He emphasises that the needs of the organisation should be part of chaplaincy work. This is a form of witness.

“Being able to think in terms of an organisation and to realise how necessary it is to think in those terms may be less obvious, but of crucial importance.” (p384)

Williams et al (2004) look at the levels of stress in hospice chaplains. Managing stress and training to support is now part of the package of training offered to healthcare professionals either in house or by their professional bodies. Role confusion and working with suffering and loss may lead to stress. Referring to Wright's survey of hospice and hospital chaplaincy (2002) they noted that the role of the chaplain was expanding to include responsibilities such as education and the management of bereavement care. They also noted that the confidence of health professionals to enter the spiritual domain was waning and that the change in approach to religious and spiritual care with the emphasis on personal spirituality created a setting where lack of clarity about role and purpose amongst chaplains is evidenced.

They set up a questionnaire survey with open ended and closed questions. They distributed 201 questionnaires to hospice chaplains in the UK and had a response of 115 (57%). They included the 12 question General Health Questionnaire and Likert like self rating on stress. Their findings confirmed that the role of the hospice chaplain is varied and ranges from one to one support of patients to conducting of rituals and ceremonies. The lack of role definition and provision of bereavement support were significant determinants for perceived stress. One very interesting finding was the perceived lack of recognition of the chaplain's role by other members of staff. This is linked to the Catholic Health Initiative study (Shook et al: 2004) where one of the main motivators for the study and findings from it was the problem of lack of clarity of role. This meant that chaplains were unable to explain their role to others and this lack of “marketing” skill acted to the detriment of the perceived professionalism and value of the chaplain.

Professionalisation and specialisation

The changing nature of healthcare provision by the National Health Service in the United Kingdom requires changes in its healthcare staff. Agenda for Change¹⁸ is a good example of this process. All healthcare professions have been required to provide a more robust evidence base for their practice. In a resource hungry service there is increasingly less room for work that does not produce outcomes which are aligned with efficiency and effectiveness, both in terms of time and costs. Under the general heading of current issues in chaplaincy, the professionalisation of chaplaincy is an important theme. Again, this tells us little about the efficacy of chaplaincy but the discussion will require an understanding of a research base for the “profession”.

Swift (2004) advises caution about rushing headlong into professionalisation and adopting the evidence-based target approach dominant in the healthcare service. His argument is that healthcare chaplaincy must establish its “archive” (knowledge base) and that this should not necessarily be in the healthcare service arena dictated by the enlightened “scientific” community perspective but in the practical theology arena; chaplaincy has a chance to challenge and develop as a post modern profession. The use of the idea of friendship as a central position and activity would offer one way of developing new structures for both management and theological reflection on task.

He starts by confirming that chaplaincy is one of the most ancient of professions working in the caring services. He gives a very interesting history of the growing “corporate” awareness of chaplains as a distinct group. The debate about whether chaplaincy should be seen as a distinct ministry is recorded in the Tunbridge Report of 1973, funded by the Hospital Chaplaincies Council. This report recommended that chaplains remain in the mainstream of the Church’s work. The shift towards NHS Trusts “owning” their own chaplains is relatively recent and represents a change in the formal conception of chaplaincy. He refers to the current debate about professionalisation of chaplaincy with the wider sociology of professions and their knowledge base. He suggests the central concept of friendship is often seen as antithetical to professionalism. Whilst he acknowledges that friendship is fraught with difficulties, a reflective and critical model of friendship has much to say to the disenchantment of professional roles. He proposes the way forward for chaplains lies in a much more critical and reflective approach to their work in the NHS.

Cobb (2004) sees professionalisation in terms of identity and the characteristics that bind the chaplains together. He suggests that there are three communities in which the hospital chaplain resides and from who they take their identity. The first is the healthcare community and this requires an understanding and acknowledgment of power and authority and public office. The second is the disciplinary community. The professional bodies such as the Association of Hospice and Palliative Care Chaplains, the Scottish Association of Chaplains in Healthcare and the College of HealthCare Chaplains exist because of the need to maintain and develop specialist knowledge and skills. These professional associations typically have entry criteria, closed systems of knowledge gathering and common training. The third community is the faith community. Typically a chaplain will be in good standing with his or her faith community. The theological skill of practical theology gives the opportunity to engage and relate between theory and practice. The chaplain is a lived expression of belief and faith.

¹⁸ Agenda for change is part of the NHS modernisation programme. Information can be found on the UK Department of Health Website.

Kofinas (2006) writing on chaplaincy in Europe, says that despite the fact that chaplaincy is organised in various ways in Europe depending on its history, and politics, there are two major difficulties currently facing chaplaincy. First the professional status of the chaplain within the healthcare community and secondly preserving the patients rights for spiritual care. The European Network of Health Care Chaplaincy is engaged in both these issues.¹⁹

In America the professionalisation of healthcare chaplains has partly manifested itself in the development of clinical pastoral education. Craddock (2002) argues that Clinical Pastoral Education (CPE), a training model for the provision of spiritual care in medical centers, represents the emergence of a secularized professional practice from a more religiously based theological practice of chaplaincy. Gleason (2004) also gives a helpful account of the development of CPE in America and its pioneers. Whilst acknowledging the differences, there are some generalisable features of the process that are useful to the UK HealthCare Chaplain. It is apparent the same challenges face chaplaincy in America. In 2001 Larry Vandecreek and Laurel Burton prepared a joint statement on the role and significance of spiritual care on behalf of the five largest healthcare chaplaincy organisations in North America (see pdf appendix for list of reports). They note that the word spirituality is inclusive of religion and spiritual care includes pastoral care. This consensus paper identifies 10 specific roles which characterise professional healthcare chaplains in USA.

1. *providing a reminder of healing and power of religious faith*
2. *do not proselytize but reach across faith groups and protect patients from unwelcome spiritual intrusion*
3. *provide supportive spiritual care through empathic listening, demonstrating an understanding of person in distress*
4. *serve as member of patient care teams*
5. *design and lead religious ceremonies of worship and ritual*
6. *lead or participate in healthcare ethics programs*
7. *educate healthcare team and the community about spiritual matters*
8. *mediate and reconcile within organisation*
9. *act as contact persons to arrange assessment for complementary therapies*
10. *support research activities to assess the effectiveness of providing spiritual care*

Training is part of professionalisation and Ewan Kelly (2002) identifies the need for chaplains to develop skills in active listening or counselling. This is linked to the role of assessment in healthcare chaplaincy. We have considered this as a separate and important component of this literature review. Assessment implies entry into the professional skills gateway of chaplaincy. Kelly makes a case for de-emphasising formal assessment saying that spiritual needs change and assessment must be on going and can only be well carried out by healthcare professionals who have insight into possible needs. It is this that requires training rather than static assessment tools.

Gibbons and Miller (1989) is a good example of a case study of the chaplains work. The article generates a list of 11 aspects of contemporary hospital chaplaincy by using a case study of baby Sarah and the way in which the chaplains role unfolded in that particular case. From this the 11 features are listed. The very interesting feature of this case study report is the fact that the original staff led "referral" was in fact to tell the chaplain specifically how worried they were about the mother and her baby and pointing out that "Mom is going crazy, but she doesn't want to see anyone".

¹⁹ www.enhcc.org

The distinguishing features they draw out of their case study are:

- *The chaplain is part of the treatment team and environment*
- *The chaplain is not an independent agent but accountable member of staff*
- *The chaplain is a full member of the team who can call others into action*
- *The chaplain is part of the treatment program developed by the team*
- *The chaplain is a skilled person not just a well meaning warm body*
- *The contemporary chaplain is trained to recognize and address ethical issues at the bedside*
- *The chaplains role is not to displace the pastor but to fulfil a special requirement of ministry in the medical environment*
- *The chaplain can shape ritual to the situation*
- *The chaplain can provide a faithful and frequent presence in the midst of crisis beyond the means of parish clergy in both time and skills*
- *The chaplain may be intensely available to patients and families during crisis events but is not available long term*
- *Chaplain offers care to other caregivers.*

Future and potential of chaplaincy

Mitchell (2006) sees the future for healthcare chaplaincy in Scotland as being one of registration of chaplaincy as a healthcare profession over the next 10 years. The professional organisations will have established continuing professional development clinical supervision and accredited educations for chaplains which will be a requirement for newly appointed chaplains there will also be a clear and defined career structure.

Owens (2001) writes about the future of Roman Catholic healthcare chaplaincy. He encourages a promotion of the training of laity and clergy to encourage specialisation healthcare chaplaincy. He writes that Ignatian spirituality which is characterised by supportive and reflective accompaniment has been valued increasingly in a number of professions. He also calls for pastoral supervision which can provide a safe environment to challenge professional practice.

One of the particular aspects of professionalisation is the ability and practice of working in teams. The hospice chaplains are particularly well placed because of the approach to hospice work and its link with holism and spirituality. Rattray (2002) gives a short and useful account of the significance of the chaplain within the mental healthcare team. This is a personal opinion piece. She notes that the chaplain has a presence in both the worlds of pastoral care and mental health. The chaplain can teach and learn from the healthcare team. The team is the place where training can be given and received.

Education and Training of Healthcare Chaplains

Developing research and opinion about hospital chaplaincy education and training is part of a process of clarification of role for chaplains. Other healthcare professionals have research streams specifically about professional education needs and activities. This research helps to develop more confidence to explain and explore the efficacy of healthcare chaplaincy.

Williams et al (2006) conducted a questionnaire survey of clergy working in the diocese of Sheffield, to assess what skills and knowledge they believed they had in the area of spiritual care of those with terminal illness or experiencing bereavement. Although not directly about hospital chaplains it has some implications for chaplaincy training and notes the importance of training for clergy in the care of dying

patients and bereavement support. This self report questionnaire (n=125 actual respondents) demonstrated a desire amongst the respondents for more training in care of the dying and the bereaved. A survey of training colleges showed that the mean number of hours devoted to pastoral care of the dying and bereaved appears quite low, suggesting the training colleges are not meeting the training needs of clergy. The authors suggest that pastoral care of the dying and bereaved is a core activity for all parish clergy and should therefore be part of the core curriculum.

The implied interest of this study to healthcare chaplaincy is two fold. Given that a common career pathway for healthcare chaplains is to move to chaplaincy from parish ministry, how well trained are hospital chaplains in these areas? Secondly what is the potential role for healthcare chaplains as tutors for clergy. A previous study by the same authors (Williams et al 2004) identified an association between hospice chaplains stress levels, key role in bereavement support and provision of spiritual care in secular environments. Again this self report questionnaire suggests, perhaps more through the free text responses than the numbers, that training can help reduce and limit stress.

Standards and competencies for healthcare chaplaincy are of growing interest as the professionalisation of chaplaincy and its incorporation into a formal healthcare context grows. Mitchell and Hibberd (2004) undertook a comparative assessment of ten Marie Curie Hospices using the Association of Hospice and Palliative Care Chaplains' standards for Hospice and Palliative Care. They report a self assessment procedure submitted in December 2003. These can be found in full on the AHPCC website (www.ahpcc.org.uk). They were asked to assess 7 standards using the self assessment tool also to be found on the website.

1. *Access to chaplaincy service*
2. *Spiritual and religious care*
3. *Multidisciplinary teamworking*
4. *Staff Support*
5. *Education and training*
6. *Resources*
7. *Chaplaincy to the Unit*

There was very little evidence to support the assessment that the standards were being met.

As already noted, McManus (2006) gives a recent and helpful account of the variety of standards that are developing concurrently. He is writing for an American audience about the UK situation. His key points are

- *Healthcare chaplains require a multi dimensional education and training across a range of domains*
- *These include theological interpersonal and healthcare domains*
- *As yet in the UK, no model exists that is truly akin to US style CPE.*

The importance of linking the core task of healthcare chaplaincy with the emerging competencies and standards for chaplaincy underscores the need for research based work on the role and potential for healthcare chaplaincy. Both these activities define and to some extent restrain healthcare chaplaincy.

Lehair (2005) conducted a small study on the healthcare professionals views of spiritual care. She was interested in staff reflections and opinions on the need for training in spiritual care. This was a well conducted piece of research. 110 questionnaires were distributed to healthcare professionals. 69 responded of whom 48 were nurses. The questionnaire had four sections of which the final question was

around training needs. This has implications for the role of the chaplain as teacher and educator. 63 of the respondents (out of 69) said that they would welcome training in the following areas:

- *Spiritual issues faced by seriously ill*
- *Religious and spiritual needs*
- *Issues around death and dying*
- *Cultural needs*
- *Indicators of spiritual needs*
- *Forgiveness*
- *Ethical issues*

Lehair is very modest about her work, calling it an audit and declaring her inexperience and nervousness about the research process. The result is a very helpful snap shot of the priorities in spiritual care as seen by a variety of healthcare staff. This gives a steer to a training and education agenda and to an educational research stream. In particular an interesting progression is to consider the way in which joint learning and education can promote multidisciplinary teamwork and a greater understanding of the role of the healthcare chaplain.

Gordon and Mitchell (2004) take up this point. Using a competence based model, they pilot reflective practice seminars as a method of education and training around spiritual care. Staff were invited to reflect upon their own competence in different domains and identify training and development needs.

Pause for thought

In this section we have focussed on opinion and research that looks at the current role and potential futures for healthcare chaplaincy. We have considered in particular the complexities of trying to establish the role via empirical research and the way in which the professionalisation of healthcare chaplains drives the research agenda.

As part of the Caring for the Spirit NHS project, Speck, Cobb and Fraser (2004) developed a Standard for Research in Chaplaincy as part of the completion of an update of the chaplaincy occupational standards. This research standard indicates ways in which chaplains can move from an awareness of evidence to active involvement in research activity. The skills required for this also represent a training need to be addressed by the professional bodies and/or NHS Trusts. This Standard was subsequently approved by the College of Health Care Chaplains (CHCC) and the Multi-Faith Group (MFGHC).

A general consensus seems to be that chaplaincy is a process which operates at different levels in the organisation and operationalises a number of key interpersonal skills backed up by a theological understanding of the relationship between health, illness and the spirit.

From the research here we can conclude that occasionally it includes religious practice but on the whole the focus is on expressed need to try and understand dis-ease felt by individuals, groups or organisations.

It has been suggested in these articles that the chaplain is a symbol of and witness to suffering. What is also clear from the articles reviewed is that chaplaincy is going through times of change and this involves engagement with the nature of professions.

Possible research questions – current chaplaincy role

Is it possible to audit the work of the hospital chaplain and benchmark common practice?

How can chaplains market and sell their “product”?

Does professionalisation lead to specialisation?

4.2.5

Territory – who should do spiritual care?

Relevance to efficacy: we know that there is a general upsurge of interest in spiritual care and spirituality generally. In the healthcare literature there is a debate about the proper role and place of different healthcare professions, in particular nursing, in the “delivery” of spiritual care. This has translated itself into two dominant views. One is that all healthcare professionals should have spiritual care as their remit as part of the holistic approach to caring and the other is that this should be the remit of specialists. Currently those specialists are generally assumed to be healthcare chaplains. However the growing interest in generic or inter-denominational and all faith chaplaincy is challenging this. The separation of religion from spirituality as two distinct phenomenon as discussed earlier also contributes to this debate.

Given the issues for the professionalisation of chaplains which have been raised in the literature and the discussions about spiritual care giving and spiritual need that imply a universal interest, the obvious next question is who should “do” spiritual care and who is doing it.

Wider Reading Suggestions

Speck P (1988) *Being There: Pastoral care in time of illness*. SPCK: London chapter 3

NICE (2004) *Supportive Care and Palliative Care*

Themes in this category

- *spiritual care is a generic skill required by healthcare professionals particularly nurses and occupational therapists*
- *spiritual care is a specific skill displayed by specially trained healthcare professionals, ie healthcare chaplains and spiritual care givers*
- *chaplains and spiritual care givers can provide generic/interdenominational care*
- *healthcare chaplaincy and “all faiths and none” approach required by a multicultural society*
- *Those giving spiritual care must understand their own spirituality*

Walter (2002) offers one view. In his paper on spirituality in palliative care he raises the question of who can help whom. In the context of his argument that spirituality should not be predefined but understandings sought as part of the process of identifying needs he considers the idea of accompanying dying people on their journey. He questions how far the companion can go with the person and he notes the radical differences between those who believe in an after life and those who do not and those who subscribe to a formal belief system and those who do not. He concludes that

“We might therefore be well advised to drop the assumption that any healthcare professional can offer spiritual care to any patients and to attend more carefully to the differences between and among patients and staff.” (p138)

He concludes by confirming the palliative care value that every patient is different and care should involve the whole team.

Whilst this question of who should do spiritual care is implicit and explicit in many of the articles in the review, very few are empirically based.

El Nimr et al (2004) conducted a survey on the view of mental health professionals and general practitioners regarding spiritual care and the effect of personal and cultural background on their views. This was an anonymous questionnaire posted to hospital nursing and medical staff in Warrington, UK and the GPs in the same catchment areas. They received 98 completed questionnaires out of the 148 distributed. Of those 98 61% were GPs, 8% were from psychiatric medical officers and 31% were from nursing staff.

The questions included

- *Attitudes to spirituality*
- *Whether mental health patients had different spiritual needs from others*
- *When the health professionals see themselves as giving spiritual care*
- *Whether they advocate involvement of the Clergy*
- *Whether they see spiritual care as important*
- *Whether they would like more training or have had any training.*

In terms of territory, most of the doctors felt that this was not a role appropriate to them. 50% of the respondents felt that mental health professionals were not the best people to assess and provide spiritual care. Doctors in particular felt they were not the best people. 20% of the nurses felt that nurses were the appropriate people to give spiritual care. This is quite a subtle study and the findings are worth considering carefully because they suggest further research questions. The authors acknowledge that some of their findings are crude.

- *Older respondents tended to be more interested in this subject*
- *Nurses are more likely than doctors to feel spiritual care to be of equal importance to other forms of care*
- *Psychiatrists felt that they were the best people to assess spiritual needs*
- *Non UK respondents were more likely to see the spirit as part of the body*
- *Non UK respondents were less keen on the concept of spiritual care*
- *Non UK respondents are more likely to see people with mental health problems as requiring different spiritual needs*
- *Very few of the respondents had had any training in this area*

Oates (2004) writing in an Australian context refers to both Wright (2002) and Walter (2002) as offering alternative views to the question of who should provide spiritual care. Writing in the context of chronic heart failure and the spiritual and psychological aspects of living with this condition, Oates discusses the ways in which ongoing spiritual care can be offered. He particularly focuses on life review and reminiscence as ‘meaning makers’. He finishes his article by considering who provides spiritual care. His conclusion is that if nurses are

“To be active in offering spiritual care to patients, some consider it to be important that they first come to terms with their own personal interpretations of spirituality.” (p489)

Babler’s research (1997) is included because it alerts healthcare chaplains to the growing debate and research into who should provide spiritual care. Babler is a Professor of social work in the USA. This research based article examined the differences between hospice social workers, nurses and spiritual care professionals in their provision of spiritual care to hospice patients and families in the USA. The findings are not surprising in that spiritual care givers are found to score highest on the spiritual care survey. This meant they provided the most spiritual care.

Reese and Brown’s (1997) USA quantitative survey of the different topics addressed to 37 dying patients by nurses, social workers and clergy shows that spirituality and death anxiety were the most commonly raised topics, neither of which were seen as medical matters.

This is a cross-sectional survey. The study reviews the notes of 37 hospice patients to examine the input of these professionals.

Methodologically, this was a small scale survey which would have been better presented as a pilot due to its small sample size. Cross sectional surveys are good for gaining a snapshot of a phenomenon at a given point of time. The data collected should have been analysed using descriptive statistics, at best frequencies, cross tabulation and chi square.

The study findings were not particularly surprising as the outcome of the role match of the different professionals is congruent with common sense expectations. Nurses within hospices do have specialist knowledge and are more able to deal with what some would term medical interventions especially relating to pain management. Again, social workers and clergy have different roles which as the findings suggest matched role expectation. This would support the current philosophy of interdisciplinary working especially in such settings as hospices which is heavily dependent on expertise of diverse professionals aiming to provide a high quality of care for patients going through very difficult periods in their lives.

This study was undertaken in 1997 approximately 10 years ago. The realisation of the importance of psychosocial and spiritual input for care of patients not only within hospices but other healthcare settings is well recognised as a must to ensure holistic care needs are being met.

Strang and Strang (2006) conducted a national survey of 172 Swedish hospital chaplains. This was a combined qualitative and quantitative study which generated categories via a content analysis of the responses. They found that the two dominant core activities identified by chaplains were:

- *deeper soul care of a therapeutic nature*
- *handling of religious and symbolic issues including blessings and sacraments*

The chaplains gave priority to general psychosocial problems. The authors concluded that healthcare chaplaincy is self-evidently central to the multidisciplinary team but that other hospital staff should have the capability to handle basic spiritual welfare.

Pause for thought

The research agenda requires healthcare chaplains to provide at the least an account of their practice and further an evaluation of it in terms of its efficacy. There is a need to mount a case for healthcare chaplains and an evidence based reason for the case.

This is what a sociologist might call contested territory and healthcare chaplains are required to engage in the debate.

A similar debate is evident in the collaboration literature where boundaries and roles are identified as crucially important to good collaboration. The more unclear the boundaries the more complex the collaboration. A number of authors in this review make the point that marketing and promoting chaplaincy is part of the process of understanding chaplaincy better both for non chaplains and chaplains alike.

Possible research questions – territory

Which aspects of the hospital chaplains role is properly understood to be specific to healthcare chaplains?

What training and educational issues arise from the discussion around territory?

What are the realities and possibilities of multidisciplinary working?

4.2.6

Assessment of spiritual needs as a core task

Relevance to efficacy: assessment of spiritual need is variously understood. This ranges from admission questions about religious affiliation to use of validated assessment tools to ascertain the spiritual lives and needs of patients.

Assessment of spiritual need is increasingly discussed in the literature. It has the potential to give the chaplains their healthcare credentials but is also seen as something that other professional groups, particularly nurses and OT's can do as part of their own professional practice. Assessment implies outcome measures. Assessment of need and response to it is the standard way by which evidence based services can understand and evaluate and resource their service input. A patient is assessed as needing a bed bath. The patient receives a bed bath and thus an audit trail is created and completed with process measures built in.

Wider Reading Suggestions

Stanworth R (2004) *Recognising spiritual needs in people who are dying* Oxford University Press

Narayansamy A (2004) *The puzzle of spirituality for nursing: a guide to practical assessment* British Journal of Nursing Vol 13 Iss.9 pp 1140-1144

In the case of spiritual assessment it becomes more complicated. What exactly is it that is being assessed? This is a point that Wright (2001) makes. It seems that there are a number of different types of assessment involved here.

In his survey Wright (2001) found that 71% (n=88/145) of the hospital trusts and 88% (n=71/116) of hospices indicated that an assessment was made of the patient's spiritual and religious and cultural requirements. He notes that 59% of the hospital assessment took place on admission whilst the hospice assessment took place during the patients stay.

Typical categories of assessment were:

- *Recording religious affiliation if any*
- *Spiritual need*
- *Spiritual distress*
- *Religious practice requirements*
- *Spiritual practice requirements*
- *Spiritual behaviours*
- *Religious behaviours*

Assessment implies action and leads to measurement of outcomes and efficacy. Assessment therefore has political and organisational implications and meanings.

As the link between spirituality, religion and well being has become more well known and better researched so the need for spiritual assessment has increased.

Pierce (2004), based in Canada, conducted a two stage survey with an intervention between surveys. The intervention was the introduction and implementation of the HOPE assessment tool. In his introduction he noted that in a survey conducted by O'Conner et al (2003) of 325 Canadian chaplains only half of those who replied had never heard of the spiritual assessment tools listed in the survey. 30% of those who had replied had developed their own spiritual assessment tool.

He surveyed 18 members of the multidisciplinary team in a palliative care unit. The first survey assessed how spiritual and religious needs were understood and addressed by staff. 18 members of interdisciplinary team were interviewed. Nearly half these respondents admitted to feeling uncomfortable about speaking about spiritual needs with patients but one quarter of the respondents thought these matters were raised weekly. Staff tended to use the chaplains notes in the nursing chart or discuss matters with the chaplain rather than the denomination chaplains or the pastoral visitors.

The intervention was based on the HOPE assessment. This assessment is sometimes viewed more about discernment than assessment. It goes through

- *Sources of hope meaning comfort, strength, peace, love and connection for the patient*
- *Organised religion and the patients experience of and views about spirituality*
- *Personal spirituality and practices*
- *Effects on medical care and end of life issues*

The tool is devised by Anandarajah and Hight with medical students and physicians in mind.²⁰

The intervention involved chaplains who firstly explained the concept of spiritual assessment and the HOPE tool to the team. Then they completed and inserted the assessment into the patients chart. Over

²⁰ Anandarajah G, Hight E. (2001) Spirituality and Medical Practice: Using the Hope Questions as a practical tool for spiritual assessment. American Family Physician January 1 63:81-8 89

90% of the assessments were completed within two working days of the patients admission in the palliative care unit.

After 10 weeks a second survey of 21 staff members of the interdisciplinary team was conducted. 75 assessment forms had been completed by the chaplains. The second survey showed greater levels of comfort amongst staff over spiritual matters. Practically all staff expressed a view that it did lead to changes in the patient care plan. They give a case study example of the practical outcomes of an assessment. The introduction of the Spiritual assessment tool has enhanced staff understanding of the nature and breadth of spiritual needs, it improved the level of comfort of staff engaging with patients spiritual issues, it lead to increased referrals for chaplaincy services and led to teaching seminars led by the chaplain on the nature of spiritual distress. The spiritual assessment tool gave staff a framework to meet the physical social psychological and spiritual needs of patients in a more fruitful way. Finally it gave chaplaincy services a way in to the crucial language of assessment and treatment.

Two American authors give an idea of how assessments can be incorporated into the clinical process. Allison (1992) notes that chaplains are tending towards more frequent use of documentation in the medical record.

“Doing assessments is one thing. Communicating them to the team is another. Numerous obstacles to communicating assessments were quickly discovered. ..despite obstacles, communication of pastoral care assessments is vital to an integrated style of ministry.” (p273)

In this case study he developed a picture based visual representation of an assessment which enabled a quantification of the spiritual diagnosis. He makes a case for this as a means of “showing” the diagnosis representing the baseline and the areas of need. By using the concepts of understanding of God, meaning of present situation, relation to support system and hope and grading these items in terms of relative despair, distress or concern, he is able to produce a diagrammatic form of an assessment and the areas of need for the patient. The author maintains that in a time-pressed, money-conscious system, chaplains need to “market” their services.

Eimer (1989) gives a case study account of a method of assessing religious situation of psychiatric patients by using a narrative clinical report. This has six sections and runs to 3-5 pages in total. It is not done with all patients but only those who fit the criteria of “religious concern” so a pre assessment takes place. The six sections include

- *Basic data*
- *Reason for the assessment*
- *Interviewing process*
- *Analysis of religious belief and language*
- *History of religious affiliation*
- *Summary*

The first three sections are brief and set up the discussion for the fourth and fifth sections. These sections use structured questions derived from a psychotherapeutic perspective. The questions inquire into the presence of religious preoccupations and delusions, the value and use of authoritative religious source books and the meaning of religious rituals. There is also an opportunity for the patient to discover significant events.

This is focussed on the religious ideation and is concerned with patients who have a mental disorder. However it may be that this case study report is generalisable. Eimer makes a case for more chaplaincy involvement in assessment and identifies positive outcomes from the approach. He sees the unique contribution of chaplains as in their access to liturgy and theological training.

Kelly (2002) writing from a UK perspective advances the argument in an opinion piece that we should be cautious about embracing tools for spiritual assessment. He argues that spiritual need is something dynamic and changing and subject to change as more information becomes available to the patient during the course of the hospital visit. In this situation a static spiritual needs assessment would be inappropriate. Assessment must also be ongoing. Whilst tools have been devised to aid assessment there is a danger that the assessment itself becomes the object of the exercise rather than the content of the assessment. It becomes a tick a box exercise.

“In an already de-humanising environment it is important that assessment of an individual’s spiritual needs is done sensitively and at a pace which enables the individual concerned to feel safe enough to share with the healthcare professional involved at least part of their life story.” (p14)

Johnson (2001) takes up this argument. Again, in a wide ranging opinion piece he offers three possible routes to assessment.

1. *The problem solving approach – a formal assessment for all patients on admission. He offers an example from S. Stoll’s guidelines of spiritual assessment of 1979 in the American Journal of Nursing. This includes concept of God or deity, sources of strength and hope, spiritual practices and relation between spiritual beliefs and health.*
2. *An open ended qualitative data collection approach. This process is more adhoc and on going and notes the changing spiritual needs of patients*
3. *Self assessment. In contrast to the problem solving approach this process is designed to support patients in their existing spiritualities and avoids offering interventions which might be inappropriate.*

Johnson goes on to say that the spiritual care plan is the obvious consequence of the assessment and he acknowledges the reservations expressed by Walter that spiritual care could be taken over by flow chart language. This is where the chaplains voice needs to be heard.

Johnson acknowledges Speck’s pioneering work on the definitions of religion and spirituality and the levels of spiritual care. The chaplain, says Johnson, has got something specific to offer in this process of spiritual assessment and planning. The chaplain can be a focus for reconciliation, bring a religious resource to a care plan, give time and vulnerability to the care plan, be a facilitator or “consultant”, provide spiritual support for staff to pursue the care plan, and be a reminder to the institution of the importance of spirituality.

Cressey and Winbolt Lewis (2000) conducted some discussion groups in which the definitions of spiritual distress and the process of identifying it was discussed. They suggest 10 broad categories under which spiritual distress can go. Their suggestion is that discussion across these categories can identify spiritual need. They call this assessing need. They finish their article by noting that the evaluation of whether these needs are met is the next difficult stage in the process. They do not use the words but seem to be referring to an action research process.

Gordon and Mitchell (2004) in their pilot study to develop a competency model for the assessment and delivery of spiritual care focussing on hospice settings, share the ambivalence towards assessment tools

“A validated spiritual assessment tool has been as elusive as a definition of spirituality itself. The drive for clinical excellence and accountability in health care combined with a need for measurement and quality of care, naturally leads to the question of assessment.” (p647).

Gordon and Mitchell(2004) are sceptical about the tick a box reductionism of the assessment tool. They suggest that instincts and experience are essential components for spiritual assessment. Spiritual need requires discernment before it can be assessed. This is a really important point and perhaps highlights the distinction between a medical or nursing assessment which is the herald to action and resolution and the chaplains idea of assessment as a second stage in the careful and mutual unravelling of the problem (the discernment).

They have developed a four level competency framework, based on the idea that all staff should provide spiritual care and that chaplaincy as well as assessing and delivering spiritual care to patients had an important focus in supporting staff. Their focus for assessment was to make sure that staff and volunteers had an understanding of what was required and was true to the idea that all staff should provide and know about spiritual need.

“Spiritual and religious care competencies offer a viable alternative to assessment tools and enable the healthcare professional to utilize and develop their human and professional instincts and experience to integrate the assessment of the spiritual and religious needs of their patients and family carers into good practice. By focussing on the knowledge skills and actions of the individual healthcare professional there is the potential to enhance the spiritual and religious care offered and the beginnings of a system to audit this diverse area of care.” (p649)

Brunt and Short(2005) writing for a medical audience encourage their colleagues to see chaplains as equals and suggest that medical students are taught to include the spiritual and religious dimensions in their history taking. They suggest that chaplains could be more directly involved in student teaching. They also conflate religion and spirituality throughout their opinion based article thus rendering it less helpful.

Pause for thought

Assessment is clearly a symbolic as well as practical means of reminding and asserting the role of spiritual and religious matters in health and well being. Assessment implies follow on in terms of a plan to try and meet the needs of the person assessed. At the moment the discussion about spiritual assessment is dominated by medical and other healthcare professionals. This is not surprising since the clinical process involves history taking, assessment and then plan. The role of the chaplain as part of that process is unclear and unasserted by chaplains. Assessment does not necessarily have to be quantitative and indeed the narrative assessment involving life review discussions is probably a much more appropriate method. However it does require some work of discernment and arguably requires theological understanding. There is a need for chaplains to enter the debate around assessment.

Possible research questions – assessment

Can assessment tools be developed that offer a dynamic perspective to spiritual need?

How can spiritual assessment be incorporated into patient care plans?

Who should do/can do spiritual assessment?

4.2.7

Patient Perspective

Relevance to efficacy: the patient perspective and patient needs have been discussed as a starting point for spiritual care and intervention. Speck and Swinton as we have seen earlier, recommend starting with the patient narrative. Establishing patient perspective gives a base line for practice and the potential for measuring outcomes.

Wider Reading Suggestions

Creating a Patient-led NHS: delivering the NHS Improvement Plan; Department of Health; March 2005

- *Patient Focus and Public Involvement*; NHS Quality Improvement Scotland; March 2006
- *A stronger local voice: a framework for creating a stronger local voice in the development of health and social care services*; Department of Health; July 2006

Themes that come out of this category

- *The patient perspective/patient need should be the starting point for research*
- *Patient need offers a base line for outcome measures*
- *Patient need changes depending on “illness” situation*
- *No mention of staff or relative/family needs*

A small study by Ballard et al (1999) shows the potential for patient perspective research. They carried out a small survey among cancer patients in a day care centre. 29 patients were involved in focus groups. The overall research focus was patients’ perceptions of spiritual needs and each group was asked to comment on their experience of and expectation of any chaplaincy service. The authors summarise the qualities of a chaplain as they emerged from the data.

- *being a genuine person*
- *having the ability to listen*
- *embodying a particular identity and expertise*
- *providing formal religious occasions*
- *being available*

They conclude that

“Hospital chaplaincy, in this sense, was understood in terms that were closer to industrial chaplaincy than the normal experience of congregational priest or minister.” (p31)

Flannelly et al (2006) provide the results of a questionnaire sent to 167 chaplains in the United States of America in the form of an on line survey. The questionnaire listed 28 spiritual needs that fell into seven categories. Chaplains were asked to rate the frequency of their encounters with these categories. The most frequently encountered categories were the need for belonging and love, the need to find meaning and purpose and the need for hope. They suggest a hierarchy of spiritual needs that is relatively stable regardless of the number of patients or clients visited per week. Meeting and supporting these needs

requires above all, the presence of the chaplain. They also note that the findings suggest that a spiritual needs scale can be a useful assessment tool.

Fitchett et al (2000) surveyed 202 general medical and surgical patients in the USA. They asked them if they wanted to have a chaplain talk to them, pray with them, or receive a sacrament. They claim that their work was the first published study that asked patients in hospital about their preferences for spiritual care. They discuss their findings in relation to other USA studies. The USA population of patients will have a much higher percentage of respondents who have an active religious faith. They showed that the older patients who had longer stays and had strong religious affiliations were those who requested the greatest amount of chaplaincy visits. They suggested that there was a group of people who did not request spiritual care but who needed it and that chaplains should be mindful of this. They also reported some difficulties in getting patients to acknowledge spiritual needs without giving them examples which they could then rate in order of importance. This study gives a good example of the limitations of translating findings between countries, but nevertheless generates opportunities for hypotheses in the UK setting.

Pause for thought

There are no robust studies initiated by healthcare chaplains that consider the patient perspective on spirituality and healthcare chaplaincy. Given the current interest and pursuance of patient focussed care and holistic approaches this is an area ripe for investigation.

Possible research questions – patient perspective

How do patients see the role of the healthcare chaplain in relation to their illnesses?

How do patients' perspectives change during their hospital experience?

What are the implications for assessment in patient perspective studies?

4.2.8

Multi-faith chaplaincy

Relevance to efficacy: multicultural society requires a multi-faith support for those who are ill and in need of spiritual comfort. A growing question not yet tackled in the literature to any extent is the role of the predominately Christian healthcare chaplaincy in a multicultural society. This requires thought and discussion and empirical research. Healthcare chaplaincy should be able to show both a basic understanding of the relative size of spiritual care in different world faiths but also and much more subtly the variety of needs and a method of responding to those needs. There is much to be done.

Wider Reading Suggestions

Neuberger J (2004) *Caring for dying people of different faiths* Radcliffe Publishing

Themes that have come out of the literature

- *very limited work on multi-faith chaplaincy*
- *need for more research*
- *generic chaplaincy, ecumenical and multi-faith chaplaincy*

Wright (2001) highlights the need for research into the delivery of spiritual and religious care in a multi-faith society and the need for more research into the spiritual needs and perspectives of patients and relatives as part of the conclusions of his survey, discussed earlier.

Dudhwala (2005) picks up the theme of multiculturalism and in an opinion based article suggests that although chaplaincy has traditionally been Christian, now chaplaincy can be pre fixed by different religions. The main point of the article is however, that

“While knowledge and awareness of the world’s major religions should form part of the relevant raining curricula of all hospital staff, the crucial element of good spiritual care in a diverse multi-faith multicultural society such as ours is time: time to ask patients and relatives what they deem to be important, whether or not in terms of their religious beliefs and time to help deliver what they ask for no matter how trivial this may seem.” (p15)

Johnson (2001) encourages debate about Islamic health care. He goes through the Islamic approach to health and illness and the role of the community and doctor in that. He also reports a questionnaire/interview with an Islamic chaplain colleague which he critiques. He then discusses the implications of Muslim chaplaincy for the development of chaplaincy in the NHS. His view is that there is an important place within the NHS for Muslim chaplaincy but that

“there are some issues that need to be addressed by all faith communities if their representatives are to fit comfortably alongside other healthcare workers.” (p43)

Some Christian chaplains have become ecumenical and have attempted to provide a spiritual service for all Christian denominations regardless of religious belief. Scotland has introduced the idea of generic chaplaincy which provides spiritual support for all faiths and none. Johnson calls for more research on the interface between traditional or alternative medicines and modern secular health care.

Ashworth (1999) in the context of nursing encourages a wider understanding of spiritual care to include a multi-faith perspective.

Campbell (2006) provides a useful account of the spiritual care of sick children from five world faiths. She maintains that health professionals who strive to provide good holistic care for families from different religious backgrounds should provide strong leadership and have the confidence to ask about spiritual needs. This may be a role for the healthcare chaplains.

Sheikh et al (2004) surveyed chaplaincy in England and Wales for multi-faith provision. This is the first survey of its kind. They argued that with the increasing evidence of institutional discrimination within public services in Britain it cannot be assumed that chaplaincy units are providing spiritual care equally to all faith groups. Out of 100 departments contacted 72 units agreed to participate in a telephone interview. They found that the respondents reported considerably better services to Christians than other faith groups based on place of worship for Christians, Christian background of chaplains, training and service provision to Christians. They conclude that

“Spiritual care should therefore not be the sole remit of the chaplains.” (p96)

The survey was via telephone interview, chaplains were asked to rate their perceptions using a Likert-like scale. The telephone survey was probably the best way to source this information as it allowed for data to be collected from a wide demographic area in a relatively inexpensive way. Given, the lack of research that looked at this specifically, it is a good way to establish the national perspective, although exclusion of Scotland and Northern Ireland meant that the survey was not truly national. The authors failed to identify limitations to this study. They suggest that in order to meet the multi-faith needs of patients a range of people with different skills and backgrounds should be part of the spiritual care giving team.

Hamza (2007) writes for the Journal of Muslim Mental Health in the USA. He argues for an urgent increase in Muslim Chaplaincy and identifies three models of chaplaincy. He discusses these models in relation to their accessibility for Muslim Chaplains.

The first is chaplain only model. This model requires the chaplain to be recognised as a healthcare provider and is linked to the CPE programme discussed earlier. This has the benefit of being connected with the medical team but its weakness lies in the limited connections with the community.

The second is the volunteer model which can provide access to the patients and families world. This involves generating volunteer pastoral carers who will visit in the community as well as hospital and who will be sensitive to different cultural and faith needs, probably because they are placed within their own faith community. Language and cultural needs are better attended to. This requires a great deal of sensitive training and good feedback mechanisms so that spiritual care can be continually checked for its appropriateness and the assumption of positive relationship between the spiritual care and wellbeing maintained.

The third is the volunteer – chaplain model combines the best of the previous two models. The language and cultural strengths of the volunteers can be harnessed by the trained professional healthcare chaplain. It enhances and supports the chaplains’s pivotal role in the community.

This opinion based piece is based on the USA experience and is not directly transferable. However it does allow a debate in the UK about the best construction of a multi-faith spiritual care response to illness.

Pause for thought

There is very little research on the impact and implications of multi-faith healthcare chaplaincy. The articles mentioned show that there are three important areas to focus on. Firstly to consider the philosophical and practical implications of the relationship between health, illness and faith. Much more needs to be known about how patients of all faiths really do construct their illness beliefs. Secondly to consider how patients with particular faiths can be supported appropriately in a system which is currently dominated by Christian faith. Thirdly to consider the situation and role of the Christian healthcare chaplain as ecumenical and multi-faith and to generate some empirical research on the different ways this can be achieved.

Possible Research questions – multi-faith

What does multi-faith healthcare chaplaincy mean in practice?

What is the national picture of patient need for multi-faith healthcare chaplaincy?

What is faith based care?

4.3 Summary of Review

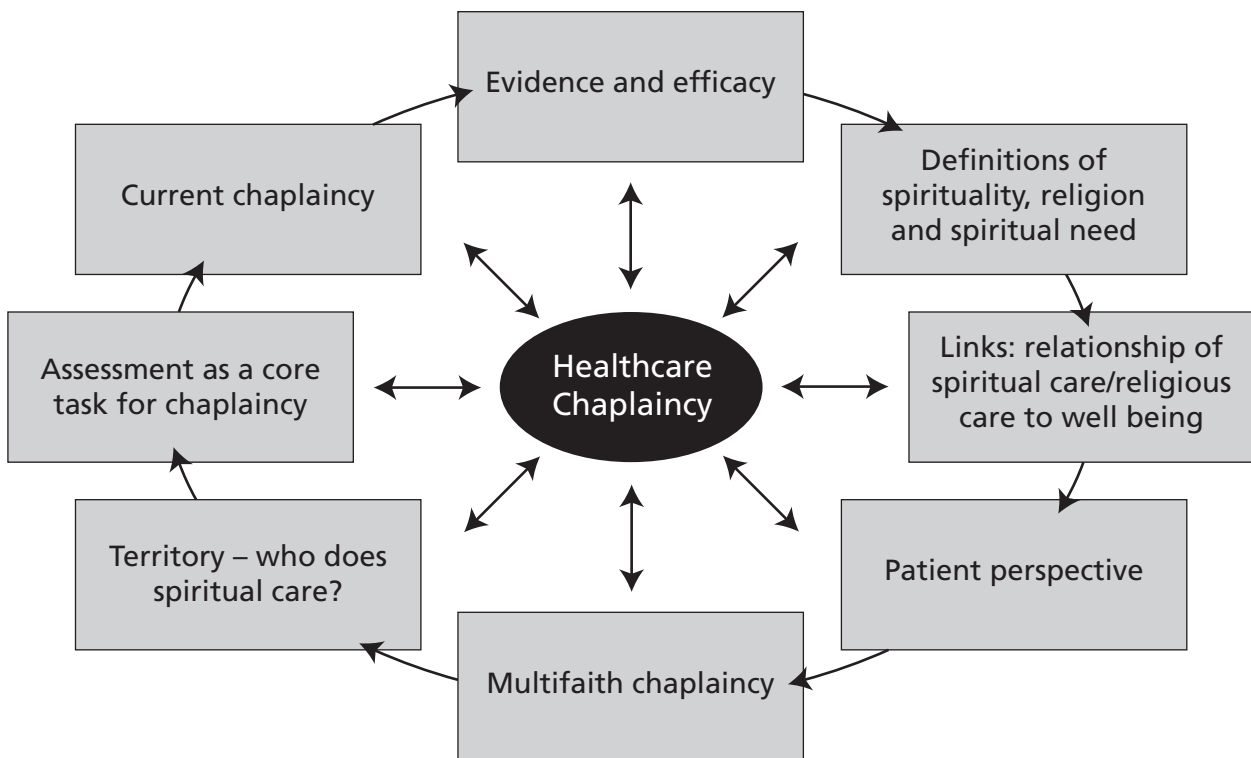
Section Four has considered the accepted literature from both the UK and overseas.

The limited empirical work on the efficacy of healthcare chaplaincy has required a broader look at the categories that emerge from the literature and the way in which they contribute to the thinking on efficacy and act as precursors to more empirical work.

These categories have been discussed and themes emerging from them identified.

The categories can be seen as a potential starting point for further research and they are presented in the table below as a flow chart where the categories are connected with each other. This is consistent with the overlap between the categories noted throughout Sections Three and Four.

4.4 Map of categories



Section 5

A Research Agenda for Healthcare Chaplains

5.1 Introduction to the section

This section will look in more detail at the categories of research interest that have been described in Section Four and that form the substance of the existing research by UK healthcare chaplains.

It is intended that this section be a stimulus to those healthcare chaplains interested in extending the evidence base for healthcare chaplaincy

In this section we consider the profile of current chaplains research as discussed in Section Four, against the hospital journey as it is experienced by patients, staff, relatives and organizationally. We suggest that there is a gap in the research around outcomes. We then make associations between the hospital journey and spiritual care and comfort and offer a model that suggests research topics that sit alongside the patient pathway through the healthcare system and which contribute to the development of evidence based healthcare chaplaincy.

5.2 The chaplains' role and the healthcare journey

Mark Cobb described three communities in which chaplains operate (2004).

- *The healthcare community*
- *The disciplinary community*
- *The faith community*

This is a helpful way of thinking about the extensive nature of the healthcare chaplains' "territory". Within the healthcare community there are further groups of participants with which the healthcare chaplain specifically engages. These are

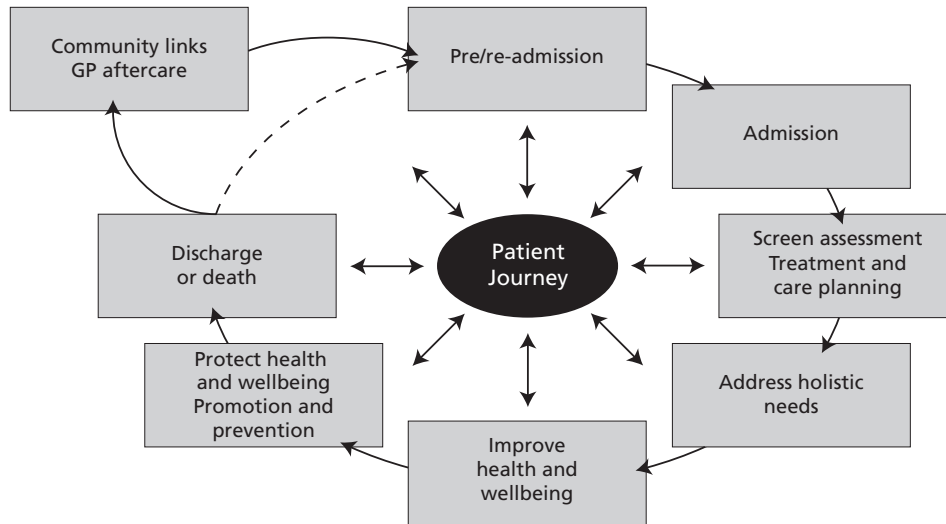
- *The patients*
- *The family and friends of patients*
- *The staff*
- *The organization*

In this section we are going to focus on these four groupings, their relationship to the patient 'journey' through the healthcare service and the current and potential possibilities for research into healthcare chaplaincy as they cluster around that journey.

Chaplains service all these groupings. The “journey” through the healthcare service requires an evidence base to show both what happens and that what happens is valuable in terms of intended outcomes and enhanced well being.

Firstly we will consider the “journeys” of these different participants. Chaplains may want to make the link between the journey as described here and the mapping of the patient experience as reflected in the NHS knowledge and skills framework (available from www.scqf.org.uk).

Figure 1



The patient journey informs the staff journey, the carer and family journey and the organisational journey. Together these can be seen as the hospital journey. By this we mean that each of these groups have work to do and therefore there will be an inter-relationship between each of these journey milestones. However they will understand the journey differently and therefore have different needs and expectations of the various stages. The healthcare chaplain’s working territory is potentially all these milestones for all these groups of participants.

Each grouping engages in the hospital journey with a faith or non faith perspective. They arrive with prior knowledge of the healthcare process or as a new admission. They arrive with a set of spiritual practices, health beliefs, values and illness experience. This affects the way different participants approach and engage in the “journey”.

The table below starts to explore the different perspectives and concerns of these groupings.

We can see in this simple table that the preoccupations and concerns for the different groupings differ. This has implications for the chaplains role and the way in which a research agenda can be formulated.

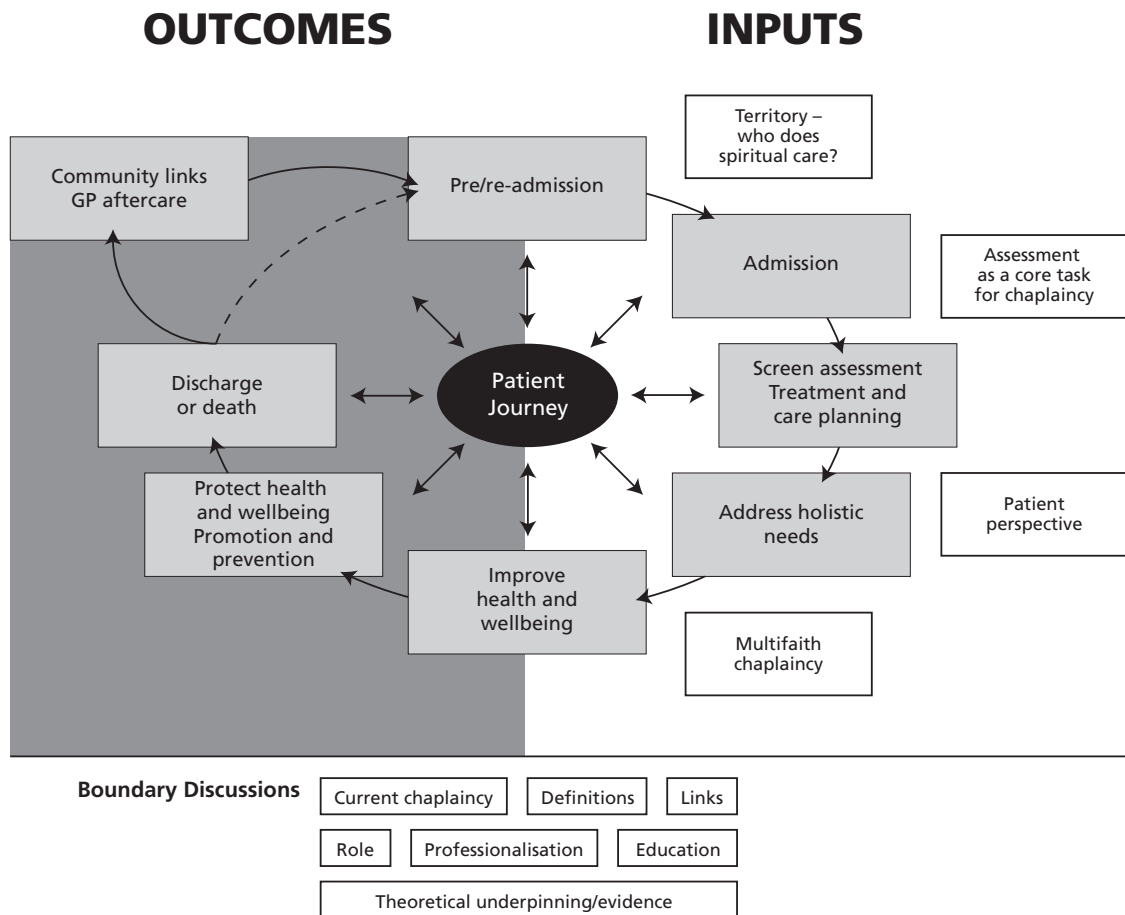
Stage of Journey	Organisational concerns	Patient concerns	Staff concerns	Family and friends concerns
Admission	Procedures Litigation complaints Accuracy Process Equality Diversity routine Records	Correct information receipt and delivery. Anxiety, fear and anger Resistance to depersonalisation Disruption Institutionalisation	Workload management, throughput, collaboration process Routine complaints Institutional behaviour	Worry, Time management Disruption visiting routines
Screening and Assessment	Resource allocation Education and training Appropriate diagnosis Time efficiency	Discomfort Disorientation Unfamiliarity with routines Correct diagnosis Correct information	Workload management Time management Routine Recording requirements Competencies Performance indicators litigation	Clear diagnosis Understanding of implications of diagnosis for subsequent care
Address Needs	Recorded treatment plan with identifiable outcomes	Knowlegable staff Known to staff Personhood understood	Evidence based Treatment plan with identifiable measurable outcomes	Unique situation of patient acknowledged – situation of carer and family acknowledged
Improve Health and Wellbeing	Outcome measurements	Feel better Treatment working Improvement Prospect of exit from hospital	Outcomes linked to potential for discharge	Patient improving and regaining status as community dweller
Protect Health and Wellbeing	Limit possibility of re admission	New information Changing life style and habits	Prevention work	Change required and implications for friends and families
Discharge	Clear beds Delayed discharge issues Bed usage and throughput Primary care and social work	Going home Support at home Avoid re admission	Safe journey home No bounce back Healthy outcomes	Sustaining cared for at home, follow up support, visits and encouragement
Community Links	Reputation of hospital in community Outreach services	Re engaging in community life with alterations to prevent re admission	Primary care sustenance	Primary care/carers support networks Maintaining progress

The chaplains role is to care for the spiritual needs of the four communities as they progress through this journey.

5.3 The relationship of current chaplains’ research to the healthcare journey

If we now consider the current chaplains research emphasis as shown in the literature review and expressed in the diagram below we can see that the current emphasis is on the theory of chaplaincy, the first half of the patient journey and on boundary and role. This is to be expected as a professional group develops.

Figure 2



One major research task is to generate more information for the left hand side of the patient journey which focuses on outputs and demonstrate the efficacy of healthcare chaplaincy input for these groupings.

As figure 2 above shows, current research tends to be on the right hand side at the start of the process rather than on outcomes. Process contributes to outcomes and much work has been done on boundary discussions and theoretical underpinning. Empirical research which demonstrates an effective spiritual service response to the patient journey is also important. The theory leads to hypotheses which suggest empirical research which produces evidence which informs practice and feeds back into theory.

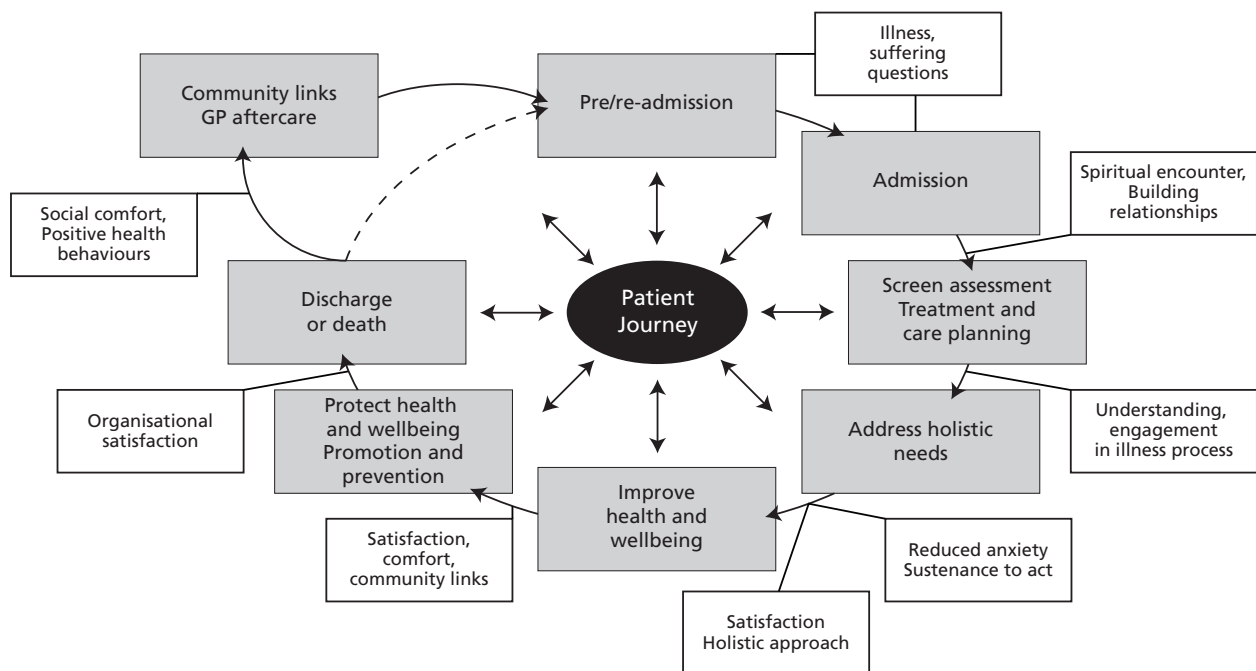
5.4 Empirical Research and Theory Building

We have then a situation where theory and empirical research are required to work together to produce evidence for practice. We know that attention to the spiritual helps and enhances well being. The model below suggests a theory to practice pathway informed by the patient journey.

The model suggests that an embracing of the spiritual aspects of illness and well being, already shown to be generally positive, leads to a knock on set of consequences which enhance well being across the groupings and into the community. This model draws on what we already know and proposes “sites” on the pathway that can be converted into research questions, as shown in Figure 3.

Outside of chaplaincy some evidence exists within the field of palliative care, elderly care and acute medical care which demonstrates a significant link between beliefs, values and clinical outcome such as depression, well being, recovery rates, ability to cope/adjust to diagnosis and prognosis. There is however, a lack of empirical work to highlight effective interventions to enhance the outcome.

Figure 3



Pre admission-readmission

Illness, suffering questioning

The model makes central the patient or individual who is unwell. We know that in this situation there is suffering and questioning about why this illness has happened. This questioning can be shared by family, friends and staff. The “why me” questions are phrased differently depending on the cultural and religious backgrounds of the patient.

The research question focus here is on the understanding of the patient and if and how they use a spiritual framework to make sense of their situation.

Screening and assessment: treatment and care planning

The process of spiritual encounter, connection, developing relationship

The chaplain's presence offers an opportunity for an encounter, a connection, which, if taken up, can lead to insights and understandings for both parties. The nature of the encounter depends on the patient's cultural spiritual and/or religious practices. It can involve assessment of some kind. It can involve referral to others. The Chaplain can act as the spiritual care manager or the practitioner or both. The patient illness can trigger encounter with individuals or groups other than the patient who are affected by the patient illness. For instance staff might approach the chaplain about a patient whose illness has distressed them.

Treatment plan: addressing holistic needs

Understanding, acceptance, hope, despair, anger, engagement

The connecting process and insights from this, can help with an understanding of the illness situation, it can encourage open discussion and be an information delivery mechanism. more hope for the future, acceptance for the future and a sense of comfort. Families and relatives can also be involved here.

Improvement of health and wellbeing

Staff and patients reduced anxiety, sustenance to act

The sense of understanding can reduce anxiety in the patient and also in the staff who benefit from the more relaxed and realistic approach of the patient and their family. Staff, patient and family are given sustenance to play their part in this illness narrative.

Patient and staff satisfaction, holistic approach

Patient and staff and families feel more satisfied with their situations. They benefit from the holistic approach and perhaps specific spiritual and/or religious practices. The Chaplain's presence of "being there" reinforces the holistic approach. The Chaplain is the witness to the organisational efforts to care.

Prevention and Discharge

Family Comfort, Community Links

The family are comforted by the patient's comfort. The family are able to be more positive about hospital services and to share this with their communities. The community zeitgeist is more positively disposed to illness and learns how to behave in illness and health.

Organisational satisfaction, targets met, complaints reduced

The hospital organisation is satisfied. Targets can be met, complaints reduce. The organisation responds to the need for holism and patient focus. The organisation becomes a learning environment, a school.

Discharge, death, pre admission

Social comfort. Change in health behaviours

The communities and societies in which patients and families live learn to deal with illness and health are influenced by and learn from their hospital and illness experiences.

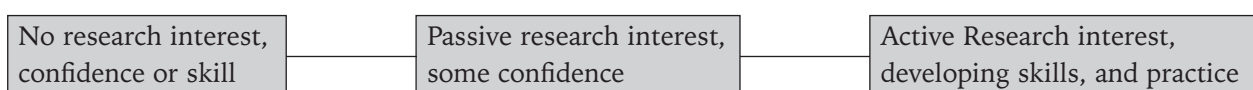
This theory generates research areas. Some suggestions are expressed below in table form.

Journey stage	Possible Empirical Research Topics
Illness, suffering and questioning	How does the patient embark on their illness narrative? How do cultural and faith issues find expression?
Spiritual Encounter	Assessing spiritual need Theological requirements of chaplains and effectiveness of training
Understanding, acceptance and hope	How do patients show these attitudes? What are the likely behaviours that go with them? How do these differ from psychological affect?
Reduced anxiety – sustenance to act	Does the presence and connection with healthcare chaplaincy reduce anxiety amongst constituent group?
Patient and staff satisfaction	What is the link between satisfaction, well being and spiritual comfort? Patients complaints and chaplains interventions
Family comfort, community links	Chaplaincy in the community Multicultural chaplaincy
Organisational satisfaction	The Chaplain as witness The educational role of the chaplain
Social comfort, positive learning from illness	The illness experience: patient perspective

5.5 Next Steps for Healthcare Chaplaincy Research?

As noted in Section One healthcare chaplaincy is required to develop a research culture in order to find its place along side other healthcare professions in the UK NHS. This does not mean that healthcare chaplaincy has to emulate the traditional “gold standard” methods used by health scientist. It gives healthcare chaplaincy an opportunity to develop a range of suitable social research methods that can answer the questions that healthcare chaplaincy is posing. We have suggested some of these questions in Section Four. However developing a unique and appropriate set of research methods requires research confidence and skill.

If we think of research confidence on a scale from no research interest, experience or confidence, through to passive research interest, to active research interest we can start to think about positioning within that scale and what needs to happen to sustain the position or change it.



Gaining confidence with research methods is a gradual process and below we suggest the kind of steps that individuals and groups might take to gain confidence. Building confidence takes time and you might care to use this checklist both as a way of establishing your base line current practice and as an aspirational list for the future.

5.6 Confidence with research methods: a personal checklist

- Do you make it a habit to read research based articles from relevant journals as part of your working week?
- Do you attend research or journal club meetings?
- Do you offer to present at journal clubs choosing your own discipline papers?
- Do you collaborate with other professional groups who have an interest in spirituality and religion?
- Do you take up the research methods training offered by your Health Care Trusts or externally?
- Do you familiarise yourself with your own local area research agenda?
- Do you include research related activity into your working week?
- Have you developed a research language?
- Have you read a “how to” social research methods text?
- Do you write up interesting case studies as part of your own reflective practice?
- Do you keep a research journal with possible research questions that interest you?
- Do you submit pieces for journals, beginning with well informed opinion pieces, letters or personal views?
- Do you try to recruit new members of staff who are research aware?

5.7 Summary of possible research topics

In the opinion of the authors and the expert panel the research agenda could usefully focus on the following questions:

Definitions of spirituality, religion and spiritual need

Is it important to distinguish religion from spirituality?

Is spirituality a particularly Western construct?

Are spiritual needs and psychological needs similar?

What do patients report as spiritual/religious needs?

In what circumstances do individuals respond to chaplaincy and spiritual care and do they feel better as a result?

Links between spirituality, religion and wellbeing

How does the healthcare chaplain act as a conduit for a positive link between spiritual development and health?

Evidence and efficacy in healthcare chaplaincy

What counts as evidence in the spiritual encounter and work of healthcare chaplains?

Current chaplaincy role

Is it possible to audit the work of the hospital chaplain and benchmark common practice?

How can chaplains market and sell their “product”?

Does professionalisation lead to specialisation?

Territory

Which aspects of the hospital chaplains role is properly understood to be specific to healthcare chaplains?

What training and educational issues arise from the discussion around territory?

What are the realities and possibilities of multidisciplinary working?

Assessment

Can assessment tools be developed that offer a dynamic perspective to spiritual need?

How can spiritual assessment be incorporated into patient care plans?

Who should do/can do spiritual assessment?

Patient perspective

How do patients see the role of the healthcare chaplain in relation to their illnesses?

How do patients’ perspectives change during their hospital experience?

What are the implications for assessment in patient perspective studies?

Multi-faith

What does multi-faith healthcare chaplaincy mean in practice?

What is the national picture of patient need for multi-faith healthcare chaplaincy?

What is faith based care?

5.8 End note

This review has demonstrated a great potential for valuable healthcare chaplaincy research. It is hoped that it can be used as a resource to help chaplains develop research awareness and act as a support to the development of healthcare chaplaincy and spiritual care in the UK National Health Service.

Some chaplains may find the prospect of engaging in research a bit daunting. However, most NHS Trusts provide a variety of learning opportunities for staff to acquire the necessary skills. Medical librarians can also be very helpful in assisting chaplains undertaking literature services and setting up “alerts” for chaplains relating to relevant recently published papers to help keep up to date. Journal clubs can also assist in developing critical faculties whether attended solely by chaplains or in a multi-disciplinary setting, such as a hospice. Chaplains may also find it helpful to network with other researchers in their NHS Trust and explore the possibilities for multi-professional collaboration. In addition to sharing a research load this can also mitigate against bias in any research undertaken by chaplains.

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Annex 1

Useful Websites and Additional Information

Professional bodies/associations

Scotland

<http://www.sach.org.uk/>

Church of Scotland Health Care Chaplaincy

<http://www.chaplains.co.uk/husc.htm>

England/Wales

USA

<http://www.healthcarechaplancy.org/>

Canada

<http://www.uhn.ca/programs/chaplaincy/resources.asp>

Australia

European

European Network of Health Care Chaplaincy

<http://www.eurochaplains.org/index.htm>

Other Chaplaincy bodies

Armed forces chaplaincy Prison chaplaincies

University chaplaincies

Oil and Gas chaplaincy

Industrial chaplaincy

Guidelines

NHS

- http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4062016&chk=/B1e76
- <http://www.dh.gov.uk/assetRoot/04/06/20/28/04062028.pdf>
NHS Chaplaincy : meeting the spiritual and religious needs of patients and staff : guidance for managers and those involved in the provision of chaplaincy/spiritual care
- Report of a review of Department of Health Central Funding of Hospital Chaplaincy
<http://www.dh.gov.uk/assetRoot/04/08/79/33/04087933.pdf>
- Dept of Health response to the above report...
<http://www.dh.gov.uk/assetRoot/04/10/69/36/04106936.pdf>
- TRIP guidelines <http://www.dh.gov.uk/assetRoot/04/06/20/28/04062028.pdf>

Courses

NES Healthcare Chaplaincy Training and Development <http://www.chaplains.co.uk/>
Caabweb list <http://www.caabweb.org.uk/heicourses.asp>
Llandaff College <http://www.stmichaels.ac.uk/courses/mthchap.htm>
Ushaw College <http://www.ushaw.ac.uk/html/courses/prospectus.php>
Cambridge Theological Federation http://www.theofed.cam.ac.uk/ma_modules/AG430026.html
Loyola University Health System <http://www.luhs.org/programs/CPE.htm>
St Mary's College http://www.smuc.ac.uk/prospectus06/healthcare_chaplaincy.htm
University of Leeds <http://www.rdlearning.org.uk/coursedetails.asp?ID=5935>

Library catalogues

British Library
COPAC
National Library of Scotland
Library of Congress
Australian National Library
Association of British Theological and Philosophical Libraries (ABTAPL)
<http://www.newman.ac.uk/abtapl/index.html>

Research reports

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Kevin J. Flannelly [http://www3.interscience.wiley.com/cgi-bin/abstract/104533679/ABSTRACT?
CRETRY=1&SRETRY=0](http://www3.interscience.wiley.com/cgi-bin/abstract/104533679/ABSTRACT?CRETRY=1&SRETRY=0)
Lindsay B Carey <http://vic.uca.org.au/HospitalChaplaincyResearch/>
"Hospital chaplain" <http://www.hospitalchaplain.com/htm/articles.htm>

Spirituality and mental health

NIMHE – Spirituality and mental health
<http://www.mindincroydon.org.uk/videos.asp>
Center for the Study of Spirituality, Health and Disability, University of Aberdeen (Prof. John Swinton).

Database sources

Medline (MeSH): (*MeSH = Hospital chaplaincy*)
Scopus (database trial until December 2006)
CINAHL
Cochrane
Assia: Chaplains, Spirituality, Health care professionals, Allied healthcare professionals
Ingenta
Lexis-Nexis Professional: (Newspapers but check journals too)
Metapress
Zetoc
Emerald
AMED

Other

Intute

Chaplaincy “blogs”

Google Scholar

Google

Tools

NES e-library – Shared spaces

JiscMail **CHAPLAINCY-SPIRITUALITY-HEALTH@JISCMAIL.AC.UK**

Annex 2

Examples of Rejected Articles

Abbots J.E. (2004) Is going to church good or bad for you? Denomination, attendance and mental health of children in West Scotland *Social Science and Medicine* Feb 58 (3) 645-56

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Annex 3

Relevant Articles from the Journal of Health Care Chaplaincy

Available through College of Healthcare Chaplains (CHCC) only
Currently not on line and not available through databases.

Brown M (2005) The role of the chaplain in the multidisciplinary Palliative care team *The Journal of Health Care Chaplaincy* Vol 6 no 1

Cobb M Blackburn H, Lowe K, Grayson T and Schofield J (2006) What do people experience and expect of a chaplaincy service? *The Journal of Health Care Chaplaincy* Spring/Summer vol 7 no 1

Ellmore P (2006) On being a healthcare chaplain – prophetic, political and professional *The Journal of Health Care Chaplaincy* Spring/Summer vol 7 no 1

Fraser D (2006) Staff and patient perceptions of the role of chaplaincy in Acute Healthcare. *The Journal of Health Care Chaplaincy* Spring/Summer vol 7 no 1

Nolan S. (2006) Psychospiritual Care: a paradigm shift of care for the spirit in a non religious context *The Journal of Health Care Chaplaincy* Spring/Summer vol 7 no 1

Speck PW (2005) A standard for research in health care chaplaincy *The Journal of Health Care Chaplaincy* summer vol 6 no 1

Turner M and Lambert R (2007) Why do we need healthcare chaplains if clinical staff deliver spiritual care? *The Journal of Health Care Chaplaincy* spring/summer vol 8 no 1

Annex 4

Tables of References by Category

Definitions of spirituality

UK only articles – definitions		
Author	Date	Title of Article
Ainsworth-Smith, I	1998	The spiritual and pastoral dimensions of chaplaincy work
Cressey R W, Winbolt-Lewis M.	2000	The forgotten heart of care: a model of spiritual care in the National Health Service
Dyson J, Cobb M and Forman D	1997	The meaning of spirituality: a literature review
Hollins, S	2005	Spirituality and religion: exploring the relationship
Johnson, C.P.	2001	Assessment tools: are they an effective approach to implementing spiritual healthcare within the NHS?
Skippon, Kevin	2005	A question of faith
Walter, T	1997	The ideology and organisation of spiritual care: three approaches
Walter, T	2002	Spirituality in palliative care: opportunity or burden?
White, G	2000	An inquiry into the concepts of spirituality and spiritual care
Wright, M.C.	2002	The essence of spiritual care: a phenomenological enquiry
Wright, Michael	2004	Hospice care and models of spirituality

Proxy articles – definitions		
Author	Date	Title of Article
Ceronsky, C	1993	Creative models of spiritual care: pastoral care departments explore alternative staffing approaches
McGrath Pam	2003	Religiosity and the challenge of terminal illness
Rumbold Bruce	2003	Caring for the spirit: lessons from working with the dying

Links

UK only articles – links		
Author	Date	Title of Article
Speck, P	2005	The evidence base for spiritual care
Swinton, J & Pattison, S	2001	Come all ye faithful

Proxy articles – links		
Author	Date	Title of Article
Baker David C	2000	The investigation of pastoral care interventions as a treatment for depression among continuing care retirement community residents
Coruh B S, Ayele H, Pugh M, Mulligan T.	2005	Does Religious activity improve Health Outcomes? A critical review of the recent literature
Gleason, J.J.	2004	Pastoral research: past, present and future
Larson David B & Larson Susan S	2003	Spirituality's potential relevance to physical and emotional health: a brief review of quantitative research

Evidence and effectiveness

UK only articles – evidence and effectiveness		
Author	Date	Title of Article
Ahmed N, Ahmedzai SH, Voara V, Hillam S Paz S	2004	Supportive care for patients with gastrointestinal cancer (review)
Duffy J and Munro G	2005	Measuring the effectiveness of chaplaincy: what to audit
Folland, M	2005	Hope for the future
Fraser D J	2004	Clarity and cost effectiveness in chaplaincy
Hundley V	1999	Evidence based practice: What is it? And why does it matter?
Johnson Chris	2003	Managing chaplaincy service delivery
King M, Jones L, Barnes K, Low J, Walker C, Wilkinson S, Mason C, Sutherland J and Tookman A	2006	Measuring spiritual belief: development and standardization of a Beliefs and Values Scale
McManus, J	2006	What training should be required as an education standard for healthcare and hospital chaplains?
Speck Peter W	2004	Spiritual Care in Health Care
Swinton J	2002	Reclaiming Mystery and Wonder: towards a narrative based perspective on chaplaincy

Proxy – evidence and effectiveness		
Author	Date	Title of Article
Allison, D.W.	1992	Communicating clinical pastoral assessments with the healthcare team
Baker David C	2000	The investigation of pastoral care interventions as a treatment for depression among continuing care retirement community residents
Benson H, Dusek J, Sherwood J, Lam P, Bethea C, Carpenter C, Levitsky S, Hill P, Clem D, Jain M, Drumer D, Kopecky S, Mueller P, Marek D, Rollins S and Hibberd P	2006	Study of the therapeutic effects of intercessory prayer (STEP) in cardiac bypass patients: a multicenter randomised trail of uncertainty and certainty of receiving intercessory prayer
Carey L B, Newell C	2002	Clinical Pastoral Education and the value of empirical research: examples from Australian and New Zealand Datum
Carosella	2002	Incorporating spirituality into the delivery of dialysis care: one team’s perspective
Clark A, Drain M, Malone M S.	2003	Addressing patients emotional and spiritual needs
Eimer, K.W	1989	The assessment and treatment of the religiously concerned psychiatric patient
Gibbons, J.L. & Miller, S.L.	1989	An image of contemporary hospital chaplaincy
Gleason, J.J.	2004	Pastoral research: past, present and future
Hausmann E	2004	Chaplain contacts improve treatment outcomes in residential treatment programs for delinquent adolescents
Shook R & Fojut L	2004	Measuring what chaplains do
Weaver A , Flannelly L, Flannelly K, Vandecreek L, Koenig H. Handzo	2001	A ten year review of research on chaplains and community based clergy in three primary oncology nursing journals : 1990-1999

Professionalisation

UK articles – professionalisation		
Author	Date	Title of Article
McManus, J	2006	What training should be required as an education standard for healthcare and hospital chaplains?
Mitchell D	2006	Healthcare chaplaincy in Scotland and the UK: a look back to the future
O'Driscoll P	2007	The quiet servant
Swinton J	2002	Reclaiming Mystery and Wonder: towards a narrative based perspective on chaplaincy
Williams M.L. Cobb M Taylor F	2006	How well trained are clergy in care of the dying patient and bereavement support?

Proxy articles – professionalisation		
Author	Date	Title of Article
Carosella	2002	Incorporating spirituality into the delivery of dialysis care: one team's perspective
Craddock Lee Simon J	2002	In a secular spirit: strategies of clinical pastoral education
Flannelly K Weaver A and Handzo G	2003	A three year study of chaplains' professional activities at Memorial Sloan Kettering Cancer Center in New York City
Gibbons, J.L. & Miller, S.L.	1989	An image of contemporary hospital chaplaincy
Kofinas, S.	2006	Chaplaincy in Europe
Norwood Frances	2006	The ambivalent chaplain: negotiating structural and ideological difference on the margins of modern day hospital medicine
Strang S & Strang P	2006	Spiritual support for palliative care patients – a duty for hospital chaplains and/or healthcare staff?

Future

UK only – future of chaplaincy		
Author	Date	Title of Article
Aldridge A	2006	The unique role of a chaplain
Ashworth, P	1999	Spiritual care: a challenge in multicultural critical care
Campbell A	2006	Spiritual care for sick children of five world faiths
Mitchell D	2006	Health Care in Scotland: a look back to the future
Owens K	2002	The future of Roman Catholic healthcare chaplaincy

Proxy – future of chaplaincy		
Author	Date	Title of Article
Ceronsky, C	1993	Creative models of spiritual care: pastoral care departments explore alternative staffing approaches

Education and training

UK only – education and training		
Author	Date	Title of Article
Gordon, T. & Mitchell, D.	2004	A competency model for the assessment and delivery of spiritual care
Lehair	2005	Reflection on an audit: Healthcare professionals views of spiritual care
McManus, J	2006	What training should be required as an education standard for healthcare and hospital chaplains?
Mitchell D	2006	Healthcare chaplaincy in Scotland and the UK: a look back to the future
Mitchell D and Hibberd C	2004	A comparative assessment of hospice chaplaincy services
Williams M.L. Cobb M Taylor F	2006	How well trained are clergy in care of the dying patient and bereavement support?
Williams M.L. Wright M Cobb M Shiels C.	2004	A prospective study of the roles, responsibilities and stresses of chaplains working within a hospice

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Author	Date	Title of Article
Norwood Frances	2006	The ambivalent chaplain: negotiating structural and ideological difference on the margins of modern day hospital medicine
Carey L B, Newell C	2002	Clinical Pastoral Education and the value of empirical research: examples from Australian and New Zealand Datum
Gleason, J.J.	2004	Pastoral research: past, present and future
Babler John E	1997	A comparison of spiritual care provided by hospice social workers, nurses and spiritual care professionals
Shook R & Fojut L	2004	Measuring what chaplains do
Craddock Lee, Simon J	2002	In a secular spirit: strategies of clinical pastoral education

Territory

UK – territory		
Author	Date	Title of Article
Ballard, P. Finlay I, Roberts S, Searle C and Jones N	1999	A perception of hospice chaplaincy
El-Nimr, G. et al	2004	Spiritual care in psychiatry: professionals' views
Ross L	2006	Spiritual care in nursing: an overview of the research to date
Skippon K	2005	A question of faith

Proxy – territory		
Author	Date	Title of Article
Babler John E	1997	A comparison of spiritual care provided by hospice social workers, nurses and spiritual care professionals
Oates Lyle	2004	Providing spiritual care in end-stage cardiac failure
Reese D.& Brown Dean	1997	Psychosocial and spiritual care in hospice: differences between nursing, social work and clergy
Strang S & Strang P	2006	Spiritual support for palliative care patients – a duty for hospital chaplains and/or healthcare staff?

Assessment

UK – assessment		
Author	Date	Title of Article
Brunt P W, Short D S.	2005	Body, mind and spirit: what doctors need to know about the Scottish Health Departments Spirituality Initiative
Cressey R W, Winbolt-Lewis M.	2000	The forgotten heart of care: a model of spiritual care in the National Health Service
Gordon, T. & Mitchell, D.	2004	A competency model for the assessment and delivery of spiritual care
Hollins	2005	Spirituality and religion: exploring the relationship
Hunt John, Cobb M, Keeley V and Ahmedzai Sam	2003	The quality of spiritual care - developing a standard
Kelly	2002	Preparation for providing spiritual care
King M, Jones L, Barnes K, Low J, Walker C, Wilkinson S, Mason C, Sutherland J and Tookman A	2006	Measuring spiritual belief: development and standardization of a Beliefs and Values Scale
Lehair	2005	Reflection on an audit: Healthcare professionals views of spiritual care
Mitchell D and Hibberd C	2004	A comparative assessment of hospice chaplaincy services
Power Jeannette	2006	Spiritual assessment: developing an assessment tool
White G	2000	An inquiry into the concepts of spirituality and spiritual care
Wright Michael C	2001	Chaplaincy in hospice and hospital: findings from a study in England and Wales

Proxy – assessment		
Author	Date	Title of Article
Allison, D.W.	1992	Communicating clinical pastoral assessments with the healthcare team
Craddock Lee Simon J	2002	In a secular spirit: strategies of clinical pastoral education
Eimer, K.W	1989	The assessment and treatment of the religiously concerned psychiatric patient
Flannelly, K, Galek K Bucchino J and Vane A	2006	The relative prevalence of various spiritual needs
Oates Lyle	2004	Providing spiritual care in end-stage cardiac failure
O'Connor T S, O'Neill K, Staalduinen G, Meakes E, Penner C Davis K	2005	Not well known, used little and needed: Canadian chaplains experiences of published spiritual assessment tools
Pierce	2004	The introduction and evaluation of a spiritual assessment tool in a palliative care unit

Patient perspective

UK only – patient perspective		
Author	Date	Title of Article
Ballard, P. Finlay I, Roberts S, Searle C and Jones N	1999	A perception of hospice chaplaincy

Proxy – patient perspective		
Author	Date	Title of Article
Fitchett, G. Meyer P, Burton L.A. et al	2000	Spiritual care in the hospital: who requests it? Who needs it?
Flannelly, K, Galek K Bucchino J and Vane A	2006	The relative prevalence of various spiritual needs

Multi-faith chaplaincy

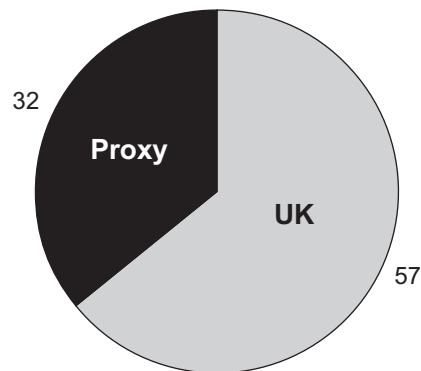
UK only – multi-faith		
Author	Date	Title of Article
Ashworth, P	1999	Spiritual care: a challenge in multicultural critical care
Campbell A	2006	Spiritual care for sick children of five world faiths
Johnson C.P.	2001	An Islamic understanding of healthcare: what can it teach us?
Sheikh A, Gatrad A, Sheikh U, Panesar S, Shafi S.	2004	The myth of multi-faith chaplaincy: a national survey of hospital chaplaincy departments in England and Wales

UK only – multi-faith		
Author	Date	Title of Article
Hamza D R	2007	Faith based practice: on models of hospital chaplaincies; which one works best for the Muslim community?

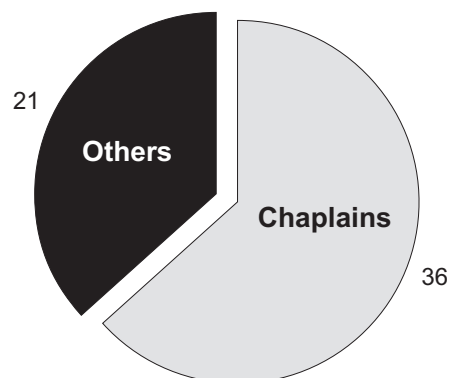
Annex 5

Distribution Characteristics

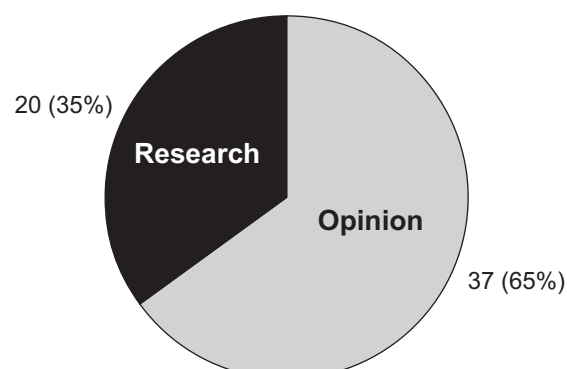
Total Accepted Articles: UK and Proxy (89 in total)



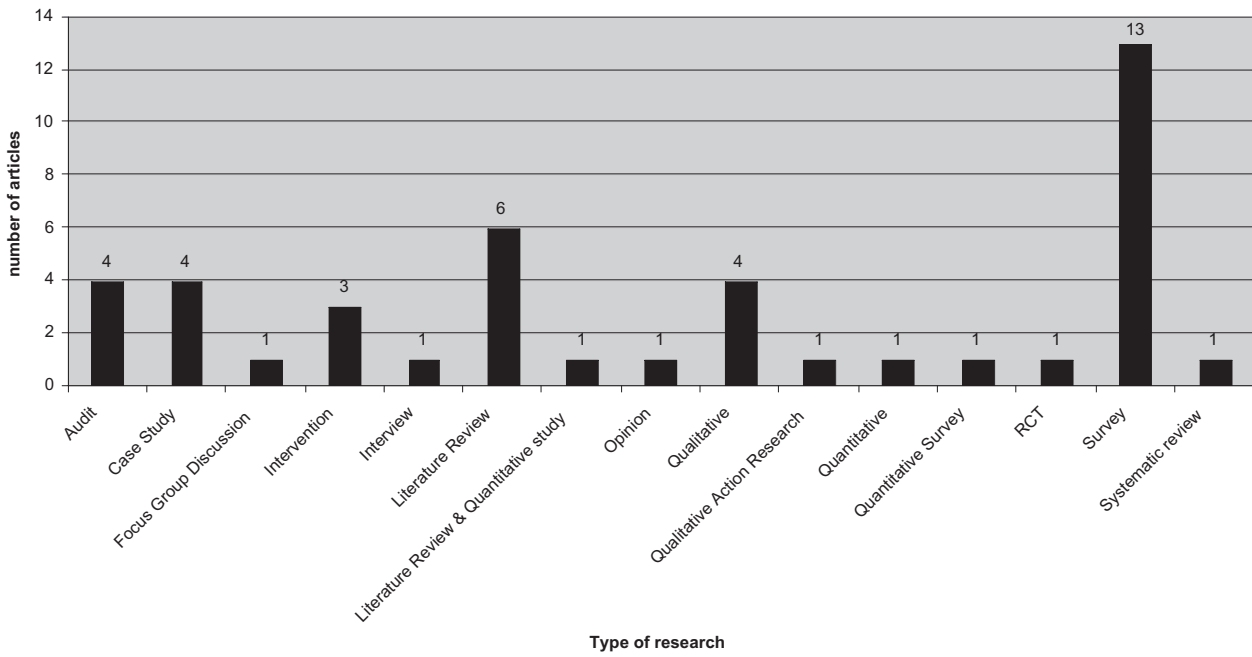
Total Healthcare Chaplains in UK and Others (57 in total)



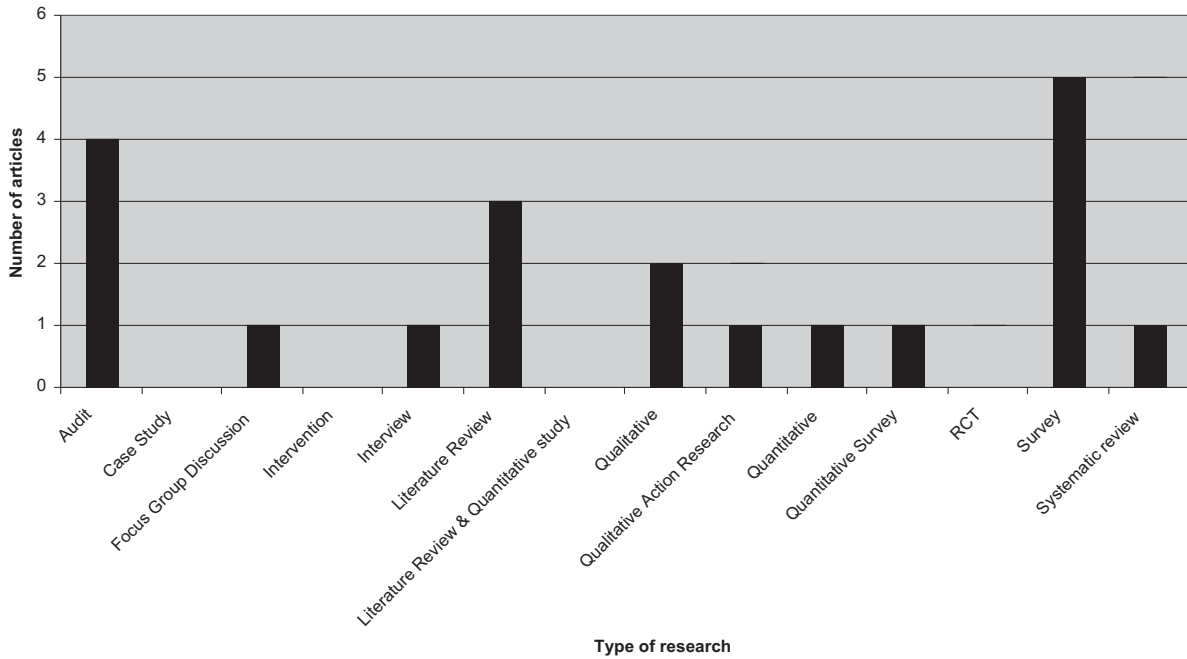
Within the UK Articles: Number of Research vs Opinion (57 in total)



Total Articles: Research Types (43 in total)



UK Articles: Research Types (20 in total)



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Published by Mowat Research Limited
Designed by The Big Picture, Aberdeen
Printed by McKenzie Print, Aberdeen

January 2008