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Research papers

The myth of multifaith chaplaincy: a national survey of hospital chaplaincy departments in England and Wales

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ABSTRACT

This paper presents the findings of the first national survey of multifaith chaplaincy provision for hospital patients in England and Wales. Of the 100 NHS hospital chaplaincy departments approached, 72 agreed to participate in a telephone survey regarding chaplaincy provision for Christians, Muslims, Jews, Hindus, Buddhists and Sikhs. Findings showed that the majority of full- and part-time chaplains were Christians (93.3% and 91.4% respectively). The remaining 6.7% full-time chaplains were Muslims and the remaining 8.6% part-time chaplains comprised very few members of other faith groups. The provision of prayer rooms or places of worship showed a similar bias towards greater provision for Christians. These findings are significant given the increasing diversity of the populations of England and Wales. The legislation on human rights makes clear that all individuals have the right to practice their religion. In the context of hospital care, where individuals are frequently highly dependent on others, fulfilling this right and, more importantly, gaining access to spiritual help in times of serious illness or death, may be problematic for patients of faiths other than Christianity. We end this paper by recommending further research and development into this subject.

Keywords: chaplaincy, faith, hospital, spiritual care

Introduction

Ever since the inception of the NHS, hospital authorities have attempted to provide for the religious and spiritual needs of patients and staff (Sheikh, 1999). Underpinning this commitment is recognition that, in addition to medical treatment, patients often require an element of spiritual and religious care. Religious care and spiritual care are not synonymous. Religious care is care associated with specific beliefs and practices that may have implications for an individual's understanding of their illness and their relationship with God. It includes spiritual care which has been described (Mitchell and Sneddon, 1999) as

being 'uniquely individual' involving exploration of an individual's meaning of life, past memories, present thoughts, feeling and fears. It involves facing up to the 'why' questions and the feelings that brought these questions to the surface. Spirituality helps people maintain health and cope with illness, loss, trauma and life's transitions, by integrating body, mind and spirit. It also helps in preparation for death and supports family and friends in coping with bereavement. Spiritual care is thus about having mechanisms in place that can provide help and support for people facing difficult situations, and enabling them to feel at peace with God.

In a hospital context, spiritual care is often coordinated and provided by chaplains. Ideally, hospital chaplains do not seek to displace local religious leaders, but rather aim to work synergistically with their community colleagues in filling the specific requirements involved in delivering care in an often intense medical environment (Gibbons and Miller, 1989).

While spiritual care is usually regarded as patient focused, chaplaincies also have a role to play in assisting and supporting staff in their dealings with patients and in coping with the ethical complexities of modern healthcare. Chaplains are often regarded as neutral figures, outside the usual staffing hierarchies and thus as sources of help and support that can be accessed without risk of negative repercussions. Chaplains may also play an important role in helping staff members cope with personal problems. Their supportive consultation can enhance morale and decrease staff burnout, thus reducing employee turnover and the use of sick time. One study reports that 73% of neonatal intensive care physicians and nurses believe that providing comfort for staff is an important aspect of a chaplain's role, and 32% believe that chaplains should also be available to help staff with personal problems (Sharp, 1991).

In pluralist societies such as those in Britain, one expects that chaplains and their teams will work with clinical colleagues to serve the needs of patients and staff from diverse faith backgrounds. This is important as all patients, irrespective of faith group, have a fundamental right to such care that safeguards their personal dignity and respects their cultural, psychological, social and spiritual values (VandeCreek and Burton, 2001). As diversity increases within the NHS workforce, the need for multifaith chaplaincies that can provide spiritual help and support for staff that belong to minority faiths is likely to increase.

With increasing evidence of institutional discrimination within public services in Britain, including the NHS (Coker, 2001), it cannot be assumed that chaplaincy units are providing spiritual care equally to all faith groups. Furthermore, specific concern has previously been expressed about problems with access to hospital religious and spiritual care provision for those of minority faith groups, resulting in possible deficiencies in the quality of care and support available to patients, carers and staff (Sheikh, 1998; Street and Battle, 2003; Gatrad *et al*, 2003, 2004). In order to investigate these concerns empirically, we conducted a national survey of NHS hospital chaplaincy units in England and Wales. Our hypothesis was that access and provision of spiritual care within NHS hospitals would be better to Christians than to members of other faith groups.

Methods

A survey approach was used as this provided the most efficient means of collecting data from hospitals across England and Wales. Using NHS Gateway (www.nhs.uk/default.aspx), we identified and compiled a database of NHS acute hospital trusts in England and Wales. A total of 100 hospitals were selected by random sampling and a member of the research team attempted to contact the chaplaincy department of each hospital by telephone, to ask if they would agree to participate in this survey. In cases where chaplains were initially unavailable, a maximum of three calls were made to each unit to secure participation.

Each department was asked to nominate a chaplain to participate in the interview. A second call was then made, at a mutually convenient time, during which the interview was conducted. All participants and their respective departments were guaranteed confidentiality and anonymity in the presentation of results and no individual patient or practitioner level data were collected.

Pre-piloted semi-structured interviews were conducted by telephone. These interviews focused on worship space, chaplaincy staffing, and the perceived quality of spiritual care delivered to patients and staff belonging to six main faith communities in Britain (Census, 2001). Categorical and continuous data were collected – the latter involving use of a 10-point Likert scale which asked professionals to rate quality of care from poor (1) to excellent (10). Descriptive statistics were used to summarise results.

Results

Contact was established with 72 departments all of which agreed to participate. In an additional seven cases, we learnt from hospital switchboards that there were either no hospital chaplaincy staff employed ($n = 3$), no part- or full-time chaplaincy staff on-site ($n = 3$), or that the chaplain was on holiday ($n = 1$). We were unable to establish contact with chaplaincy staff in the remaining 21 units.

Hospitals were significantly more likely to have a dedicated place of worship for Christians than for other

faith groups. A total of 54 chaplaincy departments had a place of worship for Christians and a further 10 stated that they had multifaith prayer rooms. Provision of separate worship areas for minority faith groups was poorer for Buddhists (n = 4), Hindus (n = 6), Jews (n = 4), Muslims (n = 13), Sikhs (n = 5) and other faith groups. Fourteen 14 (19.4%) hospitals had facilities for sex segregation in prayer areas, and 34 (47.2%) had facilities for performing ablutions before prayer.

A total of 105 full-time chaplains were employed by the hospitals, of whom 98 (93.3%) were Christian, of any denomination; the other seven (6.7%) were Muslim. A total of 152 part-time chaplains were in employment of whom 139 (91.4%) were Christian. The other 13 were Muslim (n = 9), Hindu (n = 2), Jewish (n = 1) or Sikh (n = 1).

Sixteen (22.2%) chaplaincy departments stated that they had written policies on ensuring that hospital chaplains received training in cultural diversity. Thirty departments had written policies on meeting the needs of patients with special language considerations, with a further four units indicating that they either followed hospital-wide written policy (n = 3) or had an unwritten policy in place (n = 1) in relation to patients unable to communicate in English.

Informants were asked to indicate the perceived quality of chaplaincy care available to patients and staff on a 10-point Likert scale. This revealed that service provision was considered significantly better to Christians than all other faith groups (Table 1). Ten (13.9%) units had, during the last three years, conducted a survey of staff and patients' perceptions of the quality of care, and of these, nine (90%) stated that they had made specific efforts to canvass the views of non-Christian faiths.

Table 1 Reported quality of care to patients and staff of different faiths on a 10-point Likert scale, where 1 corresponds to 'terrible' and 10 to 'excellent' (n = 72)

Group	Mean Likert score	Standard deviation
Christians	7.88	1.26
Buddhists	6.55	1.99
Hindus	6.65	1.71
Jews	6.60	1.83
Muslims	7.08	1.57
Sikhs	6.44	1.95
Other religious groups	6.43	2.13

Discussion

This national survey has revealed appreciable differences in reported hospital chaplaincy provision to patients and staff for members of Christian and non-Christian faiths. We have found comparative disadvantage to non-Christians in relation to access to space for worship, chaplaincy staff and quality of chaplaincy care, resulting in poorer spiritual and pastoral care to patients who are not Christians. As part of the central government drive to tackle institutional discrimination in public services, including the NHS, and reduce health inequalities, the Department of Health and hospital trusts therefore need to actively consider national and local initiatives to improve access to and quality of spiritual care provision to minority faiths and marginalised communities.

However, we acknowledge that there are some possible limitations of this study that need to be considered. Attempts were made to minimise risk of selection bias by attempting to maximise response rates, and encouragingly all 72 of the units contacted agreed to participate. We were able to ascertain from switchboard staff that chaplaincy services were at best rudimentary in seven other units, and it is likely that this was also the case in relation to the remaining 21 units that we failed to establish contact with; it is therefore unlikely that these non-responders will have significantly biased the results. Another possible limitation is that one individual was responding on behalf of the entire unit who, in the vast majority of cases, was a Christian chaplain. Although this raises the possibility of information bias, this is likely, if anything, to have led to a bias against the hypothesis in question. An important additional limitation is that in this survey we did not canvass the views of patients and non-chaplaincy hospital staff. In the light of our findings, we suggest that this work now needs to be urgently undertaken. Any future studies should also seek to compare provision of multifaith chaplaincy care in urban and rural populations, as the proportions of those of minority faith traditions are likely to differ in these areas, with a possibly important impact on delivery of care. Future studies should also explore issues to do with the care of denominations within these faith groups, because there may be particular needs that are overlooked using a broad-brushed approach to canvassing religious affiliation.

Progress and future development

It is encouraging to see progress in relation to the appointment of Muslim chaplains and improved training provisions being made available through the innovative certificates in Muslim chaplaincy courses being run by the Markfield Institute of Higher

Education in Leicester (Department of Health, 2003; Markfield Institute of Higher Education, 2004). It is also encouraging that nine out of the ten units surveying quality of chaplaincy care reported in our study have made attempts to 'hear' the views of non-Christian faith groups.

In 2004, an independent review of Department of Health Central Funding of Hospital Chaplaincy recommended that the limited central funding for chaplaincy provided to the Free Churches Council and the Jewish Visitation Committee, which dates back to the early 1950s, be extended to members of other faith groups (James, 2004). It now seems likely that this recommendation will be taken forward through the employment of two new chaplaincy posts to facilitate delivery of spiritual care to those of the Buddhist, Bahai, Hindu, Muslim, Sikh and Zoroastrian faiths.

A recent NHS chaplaincy survey showed that the amalgamation of chaplains into the staff hierarchy of various hospital trusts is gaining momentum. One of the key observations was that the chaplains' role is made more complex by the need to work within a coherent service staffed by many part-time staff of different faiths. There are therefore co-ordinating, managerial and leadership issues arising from this complexity, which include the roles of part time chaplains and those working voluntarily whose work is presently not clearly defined, monitored or audited (Street and Battle, 2003).

There are however some signs of progress through recent guidance that has been published by the Department of Health on provision of chaplaincy services for meeting the needs of all faith communities. Its main recommendations include the heading of local chaplaincy services by a designated member of the chaplaincy spiritual care team, out-of-normal hours provision of chaplaincy services and that each member of the chaplaincy-spiritual team must retain the religious responsibility of his/her own faith community. Further, it advises that adequate arrangements should be made for the spiritual, religious, sacramental, ritual, and cultural requirements appropriate to the needs, background and tradition of all patients and staff, including those of no specified faith (Department of Health, 2003).

Conclusions

All healthcare professionals need to be aware of the importance of and be able to deliver the basics of spiritual care. Spiritual care should therefore not be the sole remit of chaplains. Training needs to be made available both through undergraduate and postgraduate curricula with provision for continuing professional development (Chaplin and Mitchell, 2001). Through such training, all health professionals need to recognise that spiritual care is underpinned by our understanding of the patient as a unique person within the context of the family and wider society. Developing good communication skills will bring comfort in talking to patients and relatives, and help them through difficult questions. Such education should ideally be multiprofessional with different professions bring different dimension of experience.

There are important roles that need to be played by chaplains and their support staff in ensuring that high-quality, appropriate and sensitive religious and spiritual care is available to all patients. While broader multifaith training of existing chaplains can certainly help to ensure that this need is met in part, for example, in terms of understanding the needs of faith communities to ensure appropriate worship space is secured, there will remain a need for faith-specific chaplains in facilitating acts of worship. Inclusion of the question on religious affiliation in the 2001 census now allows us to identify geographical areas where particular faith groups are concentrated, and to calculate the size of regional faith communities. This information may be of value in helping plan the future configuration of local NHS chaplaincy services to ensure that the needs of minority faith groups are better met (Gatrad *et al*, 2003).

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AS conceived this study, developed the study protocol and questionnaire and oversaw data analysis. US undertook interviews. SSP undertook data analysis. ARG and SS contributed to interpreting results. All authors approved the final draft of the paper; AS is guarantor.

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CONFLICTS OF INTEREST

AS, ARG, SS and US are Muslims and have (voluntary) positions with the Muslim Council of Britain. SSP is a Sikh.

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