Faith and Health Research Project Report

The question of the place and role of religion, faith, and belief in the provision of healthcare remains highly contested and under-researched. The knowledge base on this subject continues to develop in North America, but evidence emerging from the UK is comparatively scant. The Multi Faith Group for Healthcare Chaplaincy[1] commissioned research in 2012 to address this knowledge gap. The research project was undertaken by Dr Andrew Todd and Dr Lee Tipton from the Cardiff Centre for Chaplaincy Studies, and has resulted in a report which aims to answer the question, "what part does faith play in healthcare?"

Todd and Tipton's report is split into two sections: the first reviews the existing North American literature on faith and health, which identifies a positive relationship between the two and argues that it is imperative for clinicians to engage with the patient's faith to improve health outcomes. While the practice of completing spiritual assessments is better established among North American clinicians compared to their British counterparts, there is considerable controversy in the UK and the US about the appropriateness of prayer with patients.

The second section outlines findings that emerged from interviews and focus groups with chaplains, patients, and staff which focused on how they perceive spirituality, religion, faith, belief, the sacred, health and wellbeing. Participants were primarily accessed via chaplaincy teams, which led to several unsuccessful attempts to gain access to sites and significant limitations with sampling. Given these limitations, Todd and Tipton highlight the indicative nature of their findings. Despite this, the research findings raise salient take-home messages for health and spiritual care providers to consider.

Most tellingly, Todd and Tipton pinpointed unease among participants regarding the use of the word "faith". This unease is attributed to an inability of patients and staff to articulate and discuss faith in a healthcare context, which may be further compounded by the perception among staff that there was an institutional culture which is "inhibitory" and "suspicious" of faith and religion. Clinical staff do not feel comfortable with engaging with a patient's faith, religion or spirituality, nor with drawing on their own faith, religion, or spirituality as a resource. Consequently, the report contends that the chaplain's role as spiritual care specialist enables healthcare providers to distance themselves from engaging with faith as a part of mainstream clinical care.

The qualitative pilot study does not provide conclusive answers to the question of whether faith benefits the health and wellbeing of patients and staff, and indeed did not set out to. However, there are numerous corollaries of this research which health providers should consider further:

- While the question of whether religion or belief affects health outcomes remains inconclusive, the beliefs and worldview of any given patient can impact the experience of care and healthcare decision-making, as corroborated by the Faithful Judgements research (Leach Scully 2013).
- Patients and staff find it difficult to discuss and articulate issues relating to religion and/or belief. This may in part be a result of a lack of awareness, confidence, and literacy among staff surrounding religion and/or belief, as well as the demographic changes in how Britons relate to religion.[2]

[1] This body has changed its name twice since the study commenced; between 2012 and 2016 it was known as the Healthcare Chaplaincy Faith and Belief Group, and is now referred to as the Network for Pastoral, Spiritual and Religious Care in Health.

[2] Most notably evidenced by the growth of Britons identifying as 'non-religious', religious nominalism, and increasing religious diversity (see Davie 2015).

- At present, spiritual care is peripheral to healthcare provision. There should be further consideration of where pastoral, spiritual and religious care sits within healthcare provision, and whether it should be the preserve of chaplaincy/pastoral care "specialists" or the remit of all staff.
- Spiritual and pastoral care must be taken seriously in order to promote equality and reduce health inequalities that arise in relation to religion or belief as mandated by the 2010 Equality Act.
- This report raises more questions than it answers. Further multi-disciplinary research on the interaction between religion or belief (as manifested among patients, visitors and staff) and the healthcare setting is therefore essential.

Since the report was first published, chaplaincy has made considerable steps forward with the inclusion of non-religious colleagues. The experience of non-religious representatives in chaplaincy has further enriched the key findings and challenges, particularly around staff understandings of how to address patient needs and care requirements based on religion or belief, confusion about the non-religious pastoral carer's role, and a broader lack of understanding of non-religious beliefs and worldviews. This unease with the term "faith" highlighted in the report has been echoed by non-religious pastoral carers, who have noted the ambiguity and lack of precision of the term. The future research agenda should therefore reconsider the terms of reference; to move away from the fuzziness of the term "faith" and towards an exploration of religion or belief and how these protected characteristics relate to healthcare provision and, in particular, patient-centred care.