CARDIFF CENTRE FOR CHAPLAINCY STUDIES

Supported by St. Michael's College and Cardiff University

RESEARCH PROJECT

WHAT PART DOES FAITH PLAY IN HEALTHCARE?

Conducted for the Healthcare Chaplaincy Faith and Belief Group (formerly the Multi-faith Group for Healthcare Chaplaincy)

By

The Revd Dr Andrew Todd

and

Dr Lee Tipton

CARDIFF CENTRE FOR CHAPLAINCY STUDIES

Research Project Report:

'What part does faith play in healthcare?'

Contents

	Page No.
EXECUTIVE SUMMARY	**4**
Aim	**4**
Significant points from the literature review	**4**
Aim of the qualitative research	**4**
Key findings of the qualitative research	**4**
Key points made in Discussion	**5**
Conclusion	**6**
1. Introduction	**7**
Research Team	**7**
Aim	**7**
2. Stage 1: Literature Review	**8**
Developing a coherent picture of the state of the field	**8**
Review of the Literature	**8**
2.1 Research relating to definition and conceptualisation	**9**
2.2 Overviews of the field of research	**10**
2.3 Articles concerned with issues of methodology and measurement	**11**
2.4 Examination of the nature of the connection between religion/religiosity/spirituality and health	**12**
2.5 Proposals relating to the implications of research for practice	**13**
Significant points from the literature review	**16**

3. Stage 2: Qualitative Research **18**

Aim of the qualitative research **18**

Research objectives **18**

Design and Methodology **18**

Inclusion Criteria **20**

Ethical Clearance **20**

Research Process **21**

Access and gate-keeping **22**

Data Set **23**

Qualitative Findings **23**

Summary: The discourse of faith in healthcare **26**

Particular responses from Patients **26**

Particular responses from Staff **26**

Chaplaincy responses **27**

Findings revisited **27**

Corroborating Evidence **28**

Future Research **29**

3. Discussion **30**

Why are the UK and the USA such different contexts? **31**

4. Conclusion **33**

Challenges for the future **33**

5. Bibliography **34**

EXECUTIVE SUMMARY

The Multi-Faith Group for Healthcare Chaplaincy (MFGHC), now the Healthcare Chaplaincy Faith and Belief Group (HCFBG), commissioned this research into the benefits of faith for the health and well-being of patients and staff. The research was conducted by the Cardiff Centre for Chaplaincy Studies (CCCS).

Aim:

The overall aim of the project was to investigate the benefits of faith for the health and well-being of patients and staff and the implications for the practice of chaplaincy and spiritual care. The scope of the research was limited to a literature review (stage 1) and a pilot qualitative study (stage 2).

Significant points from the literature review

There are three major points to be made, arising out of the literature review of research conducted largely in the North-American context:

1. A substantial body of well-conducted research indicates the benefits that religion and spirituality have for health
2. This body of research signals a significant interest in the relationship between religion/spirituality and health and healthcare
3. The benefits of religion/spirituality for health is realised in healthcare to some extent in and through the clinical context

Aim of the qualitative research:

The aim of this stage was to investigate perceptions of patients, NHS chaplains and other NHS staff of the relationship between a wide range of areas, such as spirituality, religion, belief, faith and the sacred, and health and wellbeing (including the experience of healthcare), in the UK context.

Key findings of the qualitative research

In summary, findings were that, in the UK context:

1. The way in which faith was articulated involved a combination of the following: I have/I had/I don't have a belief in God; I was/I am suffering/in pain; that suffering/pain creates fear, desperation; out of that fear/desperation I call to God (regardless of whether I had/have a belief in the existence of a God, or not).

2. There appears no readily available language/discourse for many staff and patients in the sites visited with which they can talk more widely about faith and health, or faith and healthcare
3. There also appeared to be a perception of an inhibitory, sometimes hostile, organizational culture, where faith and religion were the subject of some suspicion
4. Faith therefore appears to be a difficult issue to talk about in the context of healthcare
5. Chaplaincy is valued as a resource to patients, especially when chaplains sit with and listen to those of a particular faith and those of no faith
6. Chaplaincy appears to be grappling with and sensitive to the same inhibitory culture identified by patients and staff
7. There appears to be little evidence of a positive engagement with patients' faith, religion or spirituality in the clinical context. Nor do staff much deploy their own faith, religion or spirituality in this domain

Key points made in Discussion

In the discussion section of the report the following points are made:

There is some evidence in the UK of patients' religion/spirituality contributing positively to their health and experience of healthcare. But there is significantly less evidence of research exploring the health benefits (or otherwise) of religion/spirituality in the UK, in comparison with North America. And the qualitative evidence offered and cited here indicates no awareness of faith and religion in particular being perceived as beneficial for health; rather they appear highly problematic within healthcare.

There is some evidence of religion and spirituality being taken into account in the clinical context. But few UK medical schools offer appropriate resources to medical students to help them engage with religion and spirituality, and the doctors and nurses interviewed in this project were extremely cautious and lacked confidence in discussing patients' faith (or their own).

Chaplaincy has significant impact on the health of patients and their healthcare; and this impact is now being measured. Further, chaplaincy has a confident narrative and practice of spiritual care. However, in relation to the specific question of the place of

faith in healthcare, chaplains appear less confident and to be constrained by the inhibitory culture identified in the project.

Chaplains do engage with good practice in relation to enabling patients to deploy their religion and spirituality in the context of healthcare. But this good practice has not yet permeated the mainstream of clinical practice. The picture is of chaplains as the spiritual care specialists, rather than of spiritual care being a mainstream clinical concern in the UK.

Conclusion

In conclusion, the report identifies the following challenges for all those involved in healthcare in the UK:

- To raise awareness (in the UK) of the interaction of religion/spirituality and health (including the positive benefits to health and healthcare of religion/spirituality)
- To highlight (in UK healthcare) that faith can be a significant contributor to health and healthcare, within the wider spectrum of spirituality, religion and belief, in order to develop a healthcare context conducive to patients and staff appropriately sharing their faith, and drawing on faith as a resource for health and healthcare
- To conduct further research that establishes how the interaction of religion/spirituality and health works in the UK context and the context-specific benefits to patients. Such research should in particular look at the interaction of faith and health/healthcare, within the wider spectrum of spirituality, religion and belief
- To work within the UK human rights framework to establish patients' right to manifest their religion/belief within the context of healthcare, and to work specifically to promote equality and reduce health inequalities in relation to religion and belief
- To identify and promote ways in which attention to the spiritual care of patients might become a more mainstream element of clinical care, including by identifying existing good practice (globally and in the UK) and disseminating it to UK healthcare staff (especially clinicians)
- To support and enable chaplains in healthcare to develop their practice, and the narrative of that practice, in relation to the whole spectrum of spirituality, religion, faith and belief
- To support and enable chaplaincy to continue to develop its effective response to the spiritual, pastoral and religious needs of patients (and staff), but also to develop ways of integrating this with mainstream clinical practice

1. Introduction

The Multi-Faith Group for Healthcare Chaplaincy (MFGHC), now the Healthcare Chaplaincy Faith and Belief Group (HCFBG), commissioned this research into the benefits of faith for the health and well-being of patients and staff. The research was conducted by the Cardiff Centre for Chaplaincy Studies (CCCS).

Research Team

The Principal Investigator was the Rev Dr Andrew Todd, Director of the Cardiff Centre for Chaplaincy Studies. The project researcher was Dr Lee Tipton, Research Associate of the Centre. The Rev Debbie Hodge, Executive Officer for the HCFBG, was responsible for liaison between the research team and the MFGHC/HCFBG.

Aim:

The overall aim of the project was to investigate the benefits of faith for the health and well-being of patients and staff and the implications for the practice of chaplaincy and spiritual care. The scope of the research was limited to a literature review (stage 1), which sought to identify the significance of existing research for an understanding of the interaction of faith and health in relation to healthcare in the United Kingdom; and to a pilot qualitative study (stage 2), designed to begin to develop understanding of the attitudes and perceptions of patients, chaplains and other healthcare staff within NHS Trusts in England.

Existing research into the benefits of faith for health and well-being (both of patients and staff), including the role of spiritual care, is somewhat disparate and not well developed. Further, much of the existing research focuses on the North American, rather than the UK, context. Further research is timely, given both the significant development of chaplaincy within a multi-faith and multi-cultural context, and the financial stringencies applied to all areas of healthcare (and the public sector more widely), within the current political and economic climate.

This research project identifies, through critical evaluation of stages 1 and 2 of the research, evidence for the benefits of faith (defined broadly) for health and well-being, and examines the implications for the practice of spiritual and religious care.

2. Stage 1: Literature Review

Developing a coherent picture of the state of the field

The initial literature review of existing research was designed to establish an up-to-date picture of what has been published in relation to the interaction of faith and health, and more specifically of faith and healthcare. This literature review also generated a number of key questions for further empirical research, which were then operationalised in the qualitative stage. Further, the literature review serves to locate the evidence generated from the second qualitative stage of the project within the existing field, thus demonstrating the contribution of this research project to knowledge and practice.

Review of the Literature

In the initial identification of areas of literature, it became apparent that the challenge was to balance the following areas:

- More general overviews of the interaction of faith and health, including reviews of research in this field (e.g. George et al, 2000; Koenig, 2004; 2007; 2011; Koenig & McConnell, 2001; Koenig et al 2001; Larson and Larson 2003; Lee & Newberg, 2005; Levin, 2001; McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; Miller & Thoresen, 2003; Mueller, Plevak, & Rummans, 2001; Plante & Sherman, 2001; Powell, Shahabi, & Thoresen, 2003)
- Works which specifically consider the research agenda (e.g. George et al 2000; King et al 2005; Koenig 2011; Lee and Newberg 2005; Plante & Sherman 2001)
- Literature on the links between faith and specific healthcare areas: neuroscience (e.g. Jeeves and Brown 2009; Koenig & Cohen, 2002; Seybold, 2007), mental health (e.g Koenig, 2009; Moreira-Almeida et al 2006; Mueller, Plevak, & Rummans, 2001; Swinton, 2001), palliative care (e.g. Puchalski et al 2004), etc.
- Literature on health and specific aspects of religion such as: mindfulness (e.g. Christopher et al, 2014; Consedine & Butler, 2013; Shapiro and Carlson 2009); prayer for patients (e.g. Benson et al 2006; Masters and Spielmans 2007; Roberts et al 2009)
- Literature relating to the health benefits of spiritual care (e.g. Cobb & Robshaw 1998; Gall et al 2005; Koenig 2004; 2007; Larimore et al 2002; McSherry & Ross 2010; Miller 1999; Mueller et al 2001; Sulmasy 2009; White 2006).

The review that follows largely excludes works relating to specific healthcare areas and specific aspects of religion, unless they cast particular light on the overall picture of the interaction of faith and health/healthcare.

The most useful works consulted consist of a range of review articles or chapters, which provide meta-analysis of the field (an approach itself discussed in e.g. Koenig 2011; Miller & Thoresen 2003; Powell et al 2003). The contribution of reviews of the field to an understanding of the contribution of faith to healing and health may be summarised as follows:

2.1 Research relating to definition and conceptualisation

Those works which concentrate on the definition of spirituality include (George et al 2000; Hill & Pargament 2003; King & Koenig 2009; Koenig 2011; Miller & Thoresen 2003). Those which focus on defining religion, or religiosity, include (Hill & Pargament 2003; King & Koenig 2009; Koenig 2011; Lee & Newberg 2005).
By way of example, the following definitions are offered by King and Koenig:

> Religion is an organized system of beliefs, practices, rituals and symbols designed a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and b) to foster an understanding of one's relationship and responsibility to others in living together in a community.
>
> Spirituality is the personal quest for understanding answers to ultimate questions about life, about meaning and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community (2009:2)

Hill and Pargament, however, rightly highlight the danger of two great a bifurcation between definitions of these two aspects of human belief and practice.

> First, the polarization of religion and spirituality into institutional and individual domains ignores the fact that all forms of spiritual expression unfold in a social context and that virtually all organized faith traditions are interested in the ordering of

> personal affairs (Wuthnow, 1998). Second, implicit in the evolving definitions is the sense that spirituality is good and religion is bad; this simplistic perspective overlooks the potentially helpful and harmful sides of both religion and spirituality (Pargament, 2002). Third, the empirical reality is that most people experience spirituality within an organized religious context and fail to see the distinction between these phenomena (Marler & Hadaway, 2002; Zinnbauer et al., 1997). Finally, the polarization of religion and spirituality may lead to needless duplication in concepts and measures. Current measures of religiousness cover a full range of individual and institutional domains. Purportedly new measures developed under the rubric of spirituality may in fact represent old wine in new wineskins. (2003: 64f)

2.2 Overviews of the field of research

The most useful general overviews of the field would include (Koenig 2004; 2009; 2011: ch.1; Lee & Newberg 2005; McCullough et al 2000; Miller & Thoresen 2003; Mueller et al 2001; Powell et al 2003). These evaluate not only the findings of a wide range of studies, but also their value and rigour. As Koenig concludes:

> The majority of research conducted to date has found a positive relationship between [religion/spirituality] and both mental and physical health, whereas less than 10 percent suggest the opposite and about 25 percent indicate no association. (2011: 27)

This body of literature developed over more than a decade of research now offers strong evidence for the positive value of religion and spirituality in relation to health. This takes into account potential negative effects of belief on health, including, for example, on mental health. For a discussion of a change in perception, towards a positive research-based evaluation of religion's effect on health, see Koenig (2004).

Koenig also provides the most useful summary of areas affected including in mental health, increased positive emotions and reduced negative emotions associated with depression, suicide, anxiety and substance misuse (2011: 14-20); social health (2011: 20-22); and in relationship to physical health, the effect on health behaviours and physical disorders, including heart disease hypertension, cerebrovascular disease, dementia, immune dysfunction, endocrine dysfunction, cancer and overall mortality (2011: 22-26).

In evaluating any particular piece of research into the connections between faith and health, key questions must be asked. Does the study consider potential confounders of any link made between, say, religiosity and health; in other words other variables that might account for health outcomes, such as age, gender, ethnicity, socioeconomic status (Koenig 2011: 133)? Are there mediating factors which contribute to a link – such as increased social support resulting from religious patterns of association? Has the question of causality (e.g. whether spirituality is a causative factor in improved health outcomes) been properly explored, and, if claimed, been established (for example on the basis of a longitudinal study such as Strawbridge et al 1997).

And even if causation is established, evidence needs to be interrogated as to the nature or pathway of the causation. This is discussed below in section 4 below.

2.3 Articles concerned with issues of methodology and measurement

The most cogent articles which examine how research into the links between religion/religiosity/spirituality and health can be operationalised include (Hill & Pargament 2003; King et al 2005; Koenig 2011; Lee & Newberg 2005). A number of these, especially (Hill & Pargament 2003) provide starting points for the development of qualitative research approaches (including those adopted in this project).

Thus Hill and Pargament, as indicated above, highlight the value for research of resisting an undue polarisation between religion and spirituality. They further identify key aspects of religion/spirituality that would repay the close attention of researchers, including: 'perceived closeness to God'; religion and spirituality as orienting, motivating forces'; 'religious support'; and 'religious and spiritual struggle' (2003: 67-70). More widely they suggest attention might be paid to religious/spiritual 'outcomes' and 'change and transformation' (2003: 71). Such an approach emphasises the authors' emphasis on understanding religion/spirituality as socially embedded. This gives rise to another key aim for research in this area, identified by them: the need for contextual, and in particular cultural, sensitivity (Hill & Pargament 2003: 70). This is in keeping with the suggestion of a move beyond 'self-report' measures (2003: 70f). The methodology of this project builds on a number of these proposals as discussed below.

2.4 Examination of the nature of the connection between religion/religiosity/spirituality and health

Research which demonstrates that religion/religiosity/spirituality can be correlated with reduced mortality raises the question of how that effect comes about. Particular questions concern the way in which faith affects behaviour and coping strategies; and the possibility of biological pathways. Articles which explore evidence for the different pathways include (Chida et al 2009; Gall et al 2005; George et al 2000; Seeman et al 2003; Seybold 2007: ch.9)

Pathways considered are of broadly two kinds: social and biological. Social pathways that connect faith and health include those associated with social support; those which have to do with behaviour or lifestyle (with 'coping') and those which are to do with people's psychology, particularly their meaning making and optimism. Gall et al (2005) explore evidence for a range of coping mechanisms, in a way that is not unduly reductionist. Components include: 'spiritual appraisal'; 'person factors' (such as denomination, religious orientation, spiritual approaches to problem-solving and hope); the wider construct of 'spiritual coping behaviour' (whether institutional, individual or non-traditional); 'spiritual connections' (with nature, others or a transcendent other); and 'meaning making'. Their article is also one of the few to consider different world faith perspectives (for a much fuller consideration of this area see Henley & Schott, 1999).

In relation to biological pathways, the concern is with the physiological effects of religious practice. In a rigorous study, Chida et al (2009) conclude that the evidence available does suggest that religiosity/spirituality has a positive effect on survival, but are cautious about the strength of the evidence, because of publication biases. Koenig is more positive, indicating that from a review of 121 studies 68% found that religion/spirituality was predictive of greater longevity, while 6% concluded that shorter longevity was predicted. Of these studies, 76% of the most rigorous (13 out of 17) predicted greater longevity (2011: 26). As indicated above there is now evidence for the effect of religion/spirituality on the following areas of physical health: heart disease hypertension, cerebrovascular disease, dementia, immune dysfunction, endocrine dysfunction, cancer and overall mortality (Koenig 2011: 24-25).

Amongst particular religious practices, the evidence for the effect of prayer is ambiguous. In considering intercessory prayer, both Masters and Spielman (2007) and Roberts et al (2009)

conclude that there is insufficient evidence for concluding that intercession has any discernible effect on health. The physiological effects of mindfulness are a significant area of research, outside the scope of this project, although Consedine and Butler (2013) and Tomfohr et al (2014), considered here, offer cautious but encouraging evaluations of particular studies of the interaction of mindfulness and health. A larger study is Shapiro and Carlson (2009).

2.5 Proposals relating to the implications of research for practice

A number of articles and books address the question of how practitioners, whether clinicians, or those with particular responsibility for spiritual care such as chaplains, might reshape their practice in the light of research. Particular practices addressed include the taking of spiritual histories by clinicians; the vexed question of clinicians praying with patients; referrals to chaplains. Ethical questions are also discussed.

Articles which seek to draw on a review of the research evidence include (Koenig 2004; Larimore et al 2002; Mueller et al 2001; Sulmasy 2009). Books which address these issues and the wider agenda include (Cobb & Robshaw 1998; Koenig 2007; McSherry & Ross 2010; Miller 1999; White 2006).

The key argument from those works which address the connection between research into the effect of religion/spirituality on physical and mental health and the implications for healthcare practice is as follows. The evidence for the positive benefits of religion/spirituality (highlighted above) demands that clinicians engage with this aspect of patients' identity and lives for the sake of the patient's health. Thus for example:

> We conclude that the evidence to date demonstrates trained or experienced clinicians should encourage positive spirituality with their patients and that there is no evidence that such therapy is harmful.' (Larrimore et al 2002: 69)

The most developed practice, recommended by such articles, is that clinicians should take the spiritual history of their patients. As discussed in (Cadge 2012: 39-40), in the USA clinicians have developed the practice of taking spiritual histories since 1980 and this is supported by the Joint Commission (that sets policies for healthcare organisations). Examples include: SPIRITual history; FICA; FAITH; HOPE, and two notable physicians,

David Larson and Christina Puchalski, have been instrumental in the development of this practice. On such tools, see further: on the HOPE tool, (Anandarajah and Hight 2001); on FICA, (Puchalski and Romer 2000); and on FACT, (LaRocca-Pitts 2012). As one example, the approach of FICA is also discussed in (Mueller et al 2001), which offers the following summary of questions to be asked by clinicians:

> Faith: Do you consider yourself spiritual? Do you have a religious faith?
>
> Importance: How important are your religious beliefs and spirituality, and how might they influence decisions relating to your health?
>
> Community: Are you part of a relgious or spiritual or other community? If so, how does this community support you?
>
> Address: How might I address your spiritual needs? (Mueller et al 2001: 1232)

A more contested area of practice is clinicians, and doctors in particular, praying with patients (discussed in Larrimore et al 2001; Sulmasy 2009). It seems clear from the evidence that doctors do pray with patients in the USA and that patients value this in that context (Sulmasy 2009: 1638), but also that an unspecified proportion of doctors feel uncomfortable with this practice. Reasons for clinicians reluctance to engage more widely with patients in relation to religion/spirituality are discussed in (Koenig 2004: 1197-98). These include: doctors not knowing why they should engage in this way; doctors' discomfort for a variety of reasons; lack of time; and an unwillingness to go outside areas of expertise. The ethical issues, including the need to respect the patient's autonomy, are discussed briefly in (Mueller et al 2001: 1231; Sulmasy 2009: 1639). In addition, (Sulmasy 2009: 1640) offers a useful consideration of the practical issues surrounding both concordance and discordance between the religiosity of patients and that of clinicians.

It would appear that in relation to clinicians' engagement with patients' religion/spirituality there are significant differences of practice between the USA and the UK. In particular, there appears to be no significant evidence of doctors in the UK taking patients' spiritual histories, although there is a reference to this area in GMC guidance on good medical practice. In advice on personal beliefs and medical practice (2013)[1], doctors are advised that, as part of good practice they must:

[1] http://www.gmc-uk.org/guidance/ethical_guidance/21171.asp [accessed 16th October 2015].

> adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values; where necessary, examine the patient.

Further, the practice is to some extent recommended, notably in the domain of psychiatry (Culliford 2007). But in a survey of the place of spirituality in the curriculum of UK medical schools (Neely & Minford 2008), only four schools included taking spiritual histories in their curriculum, out of a sample of 17 (representing 53% of the total number of schools, which is therefore 32). In the UK context the taking of spiritual histories has been explored by chaplains (see Hodge 2015), but this is not the same thing as clinicians engaging with this practice.

In the UK the practice of doctors praying with patients is highly contested. In this respect, it is worth noting (Poole & Cook 2011), but also controversy around nurses offering to pray with patients[2]. The latter indicates real suspicion about this practice in the clinical context in the UK.

A particular question of practice identified in this literature review, therefore, is about the attention paid to religion/spirituality in the clinical context, especially by doctors. The suggestion arising from the literature that the evidence for the positive health benefits of religion/spirituality indicates that clinicians should pay attention to this dimension of patients' lives generates a hypothesis: that if clinicians do pay attention to the connections between religion/spirituality and health/healthcare, the benefits of patients' religiosity/spirituality will be realised within the healthcare context. The reverse hypothesis is that if clinicians do not pay attention to such matters, then patients will not be able to benefit fully from their religiosity or spiritual orientation in the healthcare environment, to their detriment. It is clear that clinicians' practice in the North American context realises the benefits to patients of their religion/spirituality to some extent. The evidence cited suggests that this is much less the case in the UK. While the present research does not allow for a full exploration of these hypotheses, let alone their testing, it will make initial suggestions about the role patients' religion/spirituality does play in the clinical context in the UK context.

[2] See the case of Caroline Petrie, suspended and then reinstated for making such an offer in 2009, discussed in Nursing Times.net, 24th February 2009, http://www.nursingtimes.net/a-christian-nurse-suspended-for-offering-to-pray-has-sparked-health-care-and-religion-debate/1997207.article [accessed 16th October 2015].

Significant points from the literature review

There are three major points to be made, arising out of the literature review:

1. A substantial body of well-conducted research indicates the benefits that religion and spirituality have for health

This is summarised well by Koenig:

> The majority of research conducted to date has found a positive relationship between [religion/spirituality] and both mental and physical health, whereas less than 10 percent suggest the opposite and about 25 percent indicate no association. (2011: 27)

However, it needs to be noted that this research largely relates to the context of North America and in particular the USA.

2. This body of research signals a significant interest in the relationship between religion/spirituality and health and healthcare

The works surveyed in the literature review, and the much larger body of literature referred to and reviewed in those works, signal an important area of research and significant research funding. But the major location for that research interest is North America.

3. The benefits of religion/spirituality for health is realised in healthcare to some extent in and through the clinical context

Activities such as taking the spiritual histories of patients and, to a lesser extent, praying with patients, are identified in the research as specific ways of responding to the research evidence for the benefits of religion/spirituality for health and mobilising these benefits in the clinical context. However, while these practices have become relatively well-known in the North-American context, they are less used in the UK setting.

This research project seeks to be sensitive to the different social and cultural significance of religion and spirituality in different parts of the UK, in comparison with the States. The qualitative research proposed in this project was designed to begin the exploration of the

different cultural relationship between faith and health in the UK, paving the way for more large-scale quantitative research which would extend the field, while being sensitive to this context. A particular interest of stage 2 of the research was in the way in which the religion or spirituality (the 'faith') of patients and staff featured in the clinical environment, as well as more widely in the context of healthcare.

3. Stage 2: Qualitative Research

Aim of the qualitative research:

The aim of this stage was to investigate perceptions of patients, NHS chaplains and other NHS staff of the relationship between a wide range of areas, such as spirituality, religion, belief, faith and the sacred, and health and wellbeing (including the experience of healthcare), in the UK context. This was designed to enable an initial comparison with extensive research conducted in the context of North America; to lay the groundwork for a large-scale quantitative UK study; and to draw out initial implications for the conduct of spiritual care. This gave rise to the following objectives.

Research objectives:

- To investigate how, within a UK context, patients, chaplains and other NHS staff define spirituality, religion, faith, belief and the sacred;
- To investigate the prevalence and character of perceptions amongst participants of connections between understandings of spirituality, religion, faith, belief and the sacred, and health and well-being;
- To investigate perceptions of aspects of healthcare practice (including spiritual and religious care) that had a significant effect on such connections (positive or negative)
- To analyse how the interaction of spirituality, religion, faith, belief and the sacred, and health and well-being is constructed by participants in the UK context (for example, whether connections are understood to be direct, or mediated; whether they relate to behaviour, social support, or perceived physiological change);
- To offer recommendations, derived from the analysis, about the implications of the research for the exercise and delivery of spiritual and religious care.

Design and Methodology

A qualitative methodology was deployed with the aim of beginning to elucidate perceptions of the relationship between spirituality, religion and belief, and health and healthcare within an under-researched (UK) context, in order to generate a comparison with much more developed body of research in the North American context, and lay the foundation for further qualitative research and a more large-scale, quantitative UK study. The methodology, therefore, sought to develop an arena in which participants might share and develop their

distinctive view points. The aim was not to test the hypothesis that spirituality/religion has a range of positive (and some negative) effects on health and the experience of healthcare, which is well established and tested in the North American setting. Rather this research asked the question: Do the perceptions of patients, chaplains and other staff suggest that a similar, related, or different hypothesis might be worth investigating within the UK context?

To this end, focus groups and interviews were conducted in two NHS Trusts in England, although approaches were also made to other sites (see further below). In each site, separate focus groups of patients, chaplains and healthcare staff other than chaplains were recruited (or in some cases individual interviews took place on request).

The aim was to investigate with each group the following:

1. Participants' response to different words offered in a non-linear order, including the following: belief, spirituality, religion, sacred, faith.
2. What significant words meant to participants; what difference they make to people's life-experience.
3. Whether significant words connected for participants with their experience of healthcare (as patients, staff, etc), and if so, how.
4. Whether significant words (and the beliefs, practices and behaviours to which they refer) affected participants' experience of health and well-being, and whether they perceived them affecting the experience of others (e.g. for whom they exercise care).
5. Whether participants' health and experience of healthcare affected their spirituality, religion or belief (a question little explored in existing research).
6. Whether participants wished to identify practices that enabled or disabled them from making helpful connections between spirituality/religion and health, including in the hospital setting. Possible questions to encourage discussion included: What might staff (nurses, chaplains, doctors) do to help you make those connections? What might they avoid, or stop, doing?

The approach to interview questions was semi-structured, ensuring comparability of data from different groups, but enough room for interviewers to probe and encourage the development of significant responses/lines of discussion. As is standard focus-group practice, the interviewers invited and affirmed a diversity of responses, emphasising that each participant's perspective was of importance.

Groups were facilitated by chaplaincy teams on site, but moderated by the researcher. Sessions were audio-recorded (with prior permission sought for this) and additional field notes made to record other significant features of the interaction (such as body language).

Data was transcribed and coded, in order to develop an iterative analysis of significant themes. Discourse analytical techniques were used to look at the fine-scale detail of particular interactions. Analysis paid attention both to themes emerging within individual groups and to themes emerging from comparison of groups.

Inclusion Criteria

The initial inclusion criteria for participants were:

1. Experience of/involvement in acute healthcare (rather than mental health or palliative care)
2. Adult patients (including former patients with recent experience of healthcare)
3. Experience of/involvement in hospital rather than primary care/community healthcare

Because this was an exploratory qualitative study seeking to begin to establish a UK picture, to start the comparison with the American context, the research team did not seek to get 'representative' samples of the population at this stage. That would be necessary for any follow-up quantitative survey designed to test the findings of our research. So, for example, the presence in groups of people who had a particular interest in spirituality and healthcare was not deemed to be a disadvantage, because that offered interesting UK narratives about health and spirituality, with the potential to begin to identify UK perceptions. However, the team did seek to encourage participation in the focus groups (especially staff and patients) from those with a variety of interests relating to spirituality/religion/belief (including those of no espoused belief). The team therefore sought participants from different cultures/ethnicities, different faith/belief groups, people who value institutional approaches, and those who have a more individual approach. A reasonable gender balance was also the aim.

Ethical Clearance

Ethical clearance was sought and gained from the appropriate Cardiff University research ethics committee and from NHS NRES Committee: London - Bloomsbury. In addition, the

agreement of the research and development department for each NHS site was sought and gained.

The ethical approach adhered to the principles outlined in the ESRC Framework for Research Ethics (REF). The sensitive nature of studying matters of belief was acknowledged and reflected in the study design. In addition ethical issues were addressed by the following:

1. Patients, staff and chaplains were briefed about the study and given the opportunity to ask questions before the focus groups commence.
2. Information sheets for participants were distributed before the focus groups commenced and left with them for a reasonable period (of at least 24 hours) before consent was sought.
3. Potential patient and staff participants were identified initially by the chaplains for the particular site being researched. But responsibility for recruiting participants, ensuring that they were fully informed about the research, and for establishing their consent to participate was the responsibility of the research team.
4. Participants were encouraged to address any questions or concerns to the researchers, or a member of the site chaplaincy team.
5. Written informed consent was taken from all those interviewed.
6. The researcher withdrew contact with any patients, staff and chaplains who did not agree to the study.
7. Participants were informed that they could withdraw from the research at any time and that, if they did, data relating to them would not be used. In transcripts of focus groups participants are anonymous and every effort has been made to remove identifying details. Sensitive details about participants were not recorded, except those which they chose to disclose within the focus groups (and these details were only recorded anonymously).
8. It was made clear that if participation in the focus groups were to cause distress to participants, support would be provided initially by the research team. If necessary, referral would then have been made to a member of the chaplaincy team at the research site.

Research Process

The following sections chart the progress of the fieldwork stage of the project, including the major challenges faced, as well as the findings.

Access and gate-keeping

Initial recruitment of sites, from a list of potential NHSW Trist in England, for the research began in December 2012 and continued in parallel with the research ethics clearance process through to May 2013. Approaches were made to Trusts via the lead chaplain in each case.

Even at this early stage, there were indications of some of the difficulties that the project would come across later in the process. In seeking to recruit one site in the South-West of England, which had been initially enthusiastic, particular concerns were received about the title of the project, and in particular about the word faith. This was despite the research brief sent to potential sites making quite clear that the interests of the research team in interviewing patients, chaplains and other staff were broad, including the part played in healthcare of a wide range of beliefs and practices including different religions and spiritualities. The concerns are detailed in the following extract from an email received by the Principal Investigator on 12th December 2012.

> We have some concerns, which we would like to share with you, before we switch on the green light. In particular, like many other Chaplaincies, we are continually in the fight of avoiding suspicions about being a faith-based organisation, providing faith-based services to essentially-religiously inclined patients and staff. This is not entirely a presentational matter: we describe ourselves as being the 'Dept of Pastoral and Spiritual Care' rather than 'The Chaplaincy', as the former is a more accurate description.'
>
> Your project's papers describe the study in terms of 'faith', while also using 'spirituality' and 'religion'. Our fear is that the subtlety of the distinctions will be lost, and our provision of the focus groups will inadvertently reinforce the 'religion' suspicions, and impact on our general work.

The full significance of this communication was not apparent at the time. In retrospect, it signals that 'faith' is a problematic term, and a problematic phenomenon in the context of UK healthcare. This is subsequently born out by the fieldwork and corroborated by other research. What looked at that stage like a particular gate-keeping issue later appeared to have wider significance as well.

Two sites were successfully recruited, one in London and one in the North-East of England. The fieldwork detailed below took place in these sites during the second half of 2013. In discussion with MFGHC, as it then was, it was considered desirable to conduct research in a third site. This was designed to address the paucity of patient data reported below. Negotiations took place with two possible NHS Trusts (one in the Midlands and one in the North-West of England) between September 2013 and July 2014. In neither case were the research team successful in gaining access. In one case, this had to do with both a continuing stream of ethics related questions from the relevant Research and Development Department, together with a change of lead chaplain. In the other case it had to do with the difficulty the project researcher had in arranging meetings with the lead chaplain. In July 2014, some months after the paid hours of the project researcher had been exhausted, and following a significant voluntary commitment on his part, a line was drawn and the field work stage brought to a close.

This was a significant contrast with the experience of the same research team in their research into prison chaplaincy (Todd and Tipton 2011). Although it was the case that that research was commissioned by the National Offender Management Service, which to some extent facilitated access; nonetheless recruitment of participants, with overlapping interests that included the part played by faith, religion and spirituality in prisons, was much more straightforward.

Data Set

The following data set was developed from the two sites at which interviews were successfully conducted:

- Participant observation (recorded as field notes
- Staff, Chaplain and Patient Focus Groups
- 1 patient interview by request
- Good participation from staff and chaplains (4 groups of at least 5)
- Poor patient participation: 1 group of 4; one of 2 (plus 1 interview)

Qualitative Findings

What has proved most challenging was the inclusion of the word ‘faith’ in the project title and research and interview questions. This report is written without being able to declare with any confidence what part/s faith plays in healthcare in England because not one person who

participated engaged directly engaged with that question. Indeed, for many patients, and some staff, the concept of 'faith' is problematic, especially when mapped onto healthcare. Most respondents seemed to personalise and re-cast the question by explaining what part 'God' played in their healthcare; either the care they received as a patient or the healthcare they provided for others. The notion of faith seemed too abstract, or they simply chose not to use that word. That doesn't mean faith doesn't play its part, but it does mean that the researchers were not able to readily identify with any confidence much beyond what one patient called the 'call from the cross'. Here she was attempting to characterise the following response that was shared by most of the patients I did speak with:

1. I have/I had/I don't have a belief in God
2. I was/I am suffering/in pain
3. That suffering/pain creates fear, desperation
4. Out of that fear/desperation I call to God (regardless of whether I had/have a belief in the existence of a God, or not).

What was interesting about this 'call to God' was that many patients didn't use the word 'prayer' when describing that call but rather referred to it as a call, a plea or even a cry. Patients from a range of religious traditions (and indeed agnosticism and atheism) reported having entered into a conversation, of sorts, with God while they suffering/in pain that was unlike experiences they had prior to that state of suffering. However, unlike the research conducted in the USA, during this research no patient reported believing, or even feeling, that they were healed by God, or that the process of calling on God gave them physical respite from their suffering.

Indeed, they described the act of calling as an automatic response driven by the hope (a commonly used word) that God could/would hear them during their suffering. For many, that call was an attempted amelioration in the face of suffering, rather than a request for the cessation of pain. The act was more important than any hoped for result. In that sense, there seems a clear need for further research into patient experience and the notion of what healing actually means during such periods in terms of the impact on well-being. Patients, and staff, also reported the value they held of emotional support for patients from a non-medical professional, often in the chaplain. This was well reported throughout the research. However, this support was rarely described in religious or spiritual terms and was often more an appreciation of human contact and interaction during a period that can feel quite isolating.

This was widely corroborated by chaplains themselves during interview who often felt that their belief in God motivated, or drove, their work in healthcare settings but that the vast majority of that work on a day to day basis was not of a strictly, or explicitly religious, nature.

However, beyond reports about the need for human contact with non-medical staff, and this call to God during periods of suffering and despair, often while hospitalised, patients struggled to extend their discussion of faith. We suggest that the difficulty encountered in encouraging patients and staff to respond more fully to the research question was a result of the following:

1. Faith was a challenging concept for many, and often, conceptually interchangeable with the person of God. Thus patients, and some staff and chaplains, regularly re-cast the question to a question about belief in a God who listens and cares.
2. The actual context – being in healthcare (as a patient experiencing sickness) or working in healthcare (caring for the sick) – actually limits the scope for discussing 'faith in healthcare' as it is repeatedly done through the lens of individual suffering.
3. There was an endemic, almost obstructive, institutional gatekeeping that impacted upon the entire process.
4. There was some reluctance from chaplaincy teams to engage with the research.
5. As a result of 1 to 4 there was a very small patient data set populated with pre-selected patients known to chaplaincy who were of a particular religious tradition. These people offered thoughtful responses; but this was limiting in the context of this research.
6. There is a distinct lack of any user-friendly religious discourse, and thus language, which patients and staff can access in order to discuss the kinds of questions we asked. Some staff do have access to an institutional discourse and language but this is more akin to equal opportunities legislation/training and did not seem to equip them to address questions of a spiritual/theological nature. Indeed, many reported feeling inhibited by a culture of hyper-sensitivity to religious/non-secular matters, especially when it came to issues of patient care and their own professional duties and beliefs, or lack of them.
7. In this respect, the healthcare system appears deeply secularized to the point where staff feel inhibited, and indeed prohibited, from entering into religious discourse of any kind.

Summary: The discourse of faith in healthcare

The data raise the question as to whether there is an available discourse of faith in Healthcare, especially for patients and staff; and certainly seem to indicate that there is no established discourse (or no ready access to or awareness of such a discourse on the part of patients and staff). Further there are noticeable problems talking about faith in the context of healthcare, especially for patients and staff. The absence of any agreed language makes negotiating the question of faith in healthcare challenging for all concerned.

Particular responses from Patients

A particularly significant patient response, indicative of more widely held views was: '***Without faith there isn't any hope and without hope when ill there isn't much of anything***'. Patients found making links between faith and health very difficult, beyond faith is about hope; and hope is crucial when facing (serious) illness. Nonetheless, faith (in these terms) was important in health related crisis – especially when facing death, or serious illness.

Support provided by those with faith was regarded as useful for: those with a faith, agnostics and atheists. Such support needs to connect with people. Their most significant need is for someone to sit with them; for them to be listened to. Furthermore, prayer is an important act.

Particular responses from Staff

Particular responses that indicate something of the challenge faced by staff include the following:

'I don't bring my faith with me to work and are not sure how to but I do pray for the occasional patient after an operation'; 'I can't wear a crucifix so I had 'I love Jesus' tattooed on my wrist. They can't do anything about that, can they!'

Staff responses seem to indicate a culture of inhibition and uncertainty. Staff responses were indicative of their caution in discussing faith – either their own or patients'. There was some fear of perceived organizational repercussions. There was both a lack of confidence and of understanding in tackling issues of faith. People from a range of faith backgrounds, or indeed none, reported similar feelings and attitudes. Nurses and doctors reported being unsure about how to bring their own faith into the healthcare setting and their healthcare professional roles. These responses offer some initial confirmation of the suggestion made in the literature review above, that in the UK, the clinical context is a place where faith and religion are problematic, rather than welcomed as a resource for healthcare.

Chaplaincy responses

Throughout the project and not only in the focus groups, there was a wide divergence of opinion from chaplains with regard to the appropriate language to talk about matters of faith in the healthcare setting. Further chaplains' responses to the question of faith in healthcare were cautious and sensitive to the political context. It is clear that they are seeking a language to articulate the very good care that they offer – including the patient-centred listening that patients clearly value. However, it is also clear that finding such a language is a challenge, especially in relation to matters of faith and religion (rather than spirituality). This strongly suggests that chaplains are working in the same inhibitory cultural context identified by patients and staff.

Extrapolating from these findings, we conclude that chaplaincy does represent a resource for people as they experience the impact of healthcare on their faith. However, at present in the UK context, this appears to act as an alternative to an engagement with matters of faith, religion and spirituality that is integral to the clinical care of patients, rather than a gateway to such consideration.

Findings revisited

In summary, key findings of the qualitative research were that, in the UK context:

1. The way in which faith was articulated involved a combination of the following: I have/I had/I don't have a belief in God; I was/I am suffering/in pain; that suffering/pain creates fear, desperation; out of that fear/desperation I call to God (regardless of whether I had/have a belief in the existence of a God, or not).
2. There appears no readily available language/discourse for many staff and patients in the sites visited with which they can talk more widely about faith
3. There also appeared to be a perception of an inhibitory, sometimes hostile, organizational culture, where faith and religion were the subject of some suspicion
4. Faith therefore appears to be a difficult issue to talk about in the context of healthcare
5. Chaplaincy is valued as a resource to patients, especially when chaplains sit with and listen to those of a particular faith and those of no faith
6. Chaplaincy appears to be grappling with and sensitive to the same inhibitory culture identified by patients and staff

7. There appears to be little evidence of a positive engagement with patients' faith, religion or spirituality in the clinical context. Nor do staff much deploy their own faith, religion or spirituality in this domain

Corroborating Evidence

Because of the difficulties with gaining access, and in particular with establishing a significant body of data from patients, the researchers are cautious about the findings indicated above, not least in reporting perceptions of a culture in healthcare in which 'faith' is perceived as problematic. However, some corroborating evidence is available from another research project conducted at the same time as this one. The 'Faithful Judgements' research project was conducted by a team from Newcastle and Durham universities. The aim of the project was: 'to explore the processes through which people who identify themselves as 'religious' make ethical evaluations of new reproductive and genetic technologies (NRGTs)'[3]; 'to examine what it means to be a member of a faith group encountering novel medical technologies, and particularly how faith affects the moral sense that people make of them.' (Leach Scully 2013: 1). When the project leader, Professor Jackie Leach Scully, spoke of the research in the tenth Norman Autton Lecture, she appeared to offer corroboration for this research's findings about the way in which faith is articulated in relation to health. In particular, the experience of engaging with NRGTs presented a particular challenge to people's faith, articulated in questions like: *Where's God in this?* (Leach Scully 2013:7). This echoes the experience of prayer as cry to God, identified above.

Equally importantly, Professor Scully also identified the challenge of talking about faith in the healthcare context:

> …while most interviewees spoke very positively of the clinical aspects of their NRGT experiences, when it came to faith issues they felt that, far from this being an alternative source of the information and support they needed, within the healthcare setting as a whole faith issues are sidelined or perceived as a problem: *Just when you're filling in consent forms. That's the only time faith's ever mentioned.* (Catholic woman) *I was this problem, this spanner in the works that were running so smoothly before.* (Shia Muslim woman). (Leach Scully 2013: 12-13)

[3] http://www.ncl.ac.uk/peals/research/project/3979 [accessed 26th October 2015].

This also appears as a significant finding on the project webpages:

> While most interviewees spoke very positively of the clinical aspects of their NRGT experiences, they felt that the healthcare system was generally unaware of faith issues and the onus was on patients to raise these issues. Most who mentioned this described faith as being sidelined or neglected, but a small minority felt they had experienced hostility. However, participants also recognized the difficulty for healthcare professionals of raising sensitive issues.[4]

Although the 'Faithful Judgements' project was described as a scoping project, nonetheless the above findings appears from a data set generated by 20 interviews with people who had had direct experience of some kind of NRGT, 18 dialogue groups, and interviews with16 faith group leaders (Scully 2013:5). The findings thus provide a significant, although not conclusive, corroboration for the findings of the research project reported here.

Future Research

More is said below in the conclusion about specific areas for future research. In pursuing those research areas, the researchers suggest that future research needs to do the following:

1. Have far more time, resources and more clearly established networks to establish proper access and recruit a larger and more diverse respondent cohort, particularly of patients. This is a topic that calls for more sustained ethnographic fieldwork.
2. Re-consider the question of faith and healthcare and how best to enable respondents to speak about this area during a particularly sensitive and challenging period of their lives.
3. Spend time writing a more supportive language into the research questions and routes so that the research team provide some of that discourse, and thus language, for the respondents and support them in using it.

[4] http://www.ncl.ac.uk/peals/research/project/3979 [accessed 26th October 2015].

4. Discussion

The most significant issues to arise from this research are the difficulty of talking about faith in the context of healthcare and the apparent absence of a clinical context that is hospitable to the contribution that faith can make to health. To set that in context, it is important to be clear what this study is not saying, as well as what is being concluded.

The researchers are not saying that there is no evidence in the UK of patients' religion/spirituality contributing positively to their health and experience of healthcare. For example, there are a number of studies of the benefits of mindfulness in the healthcare setting; amongst these, see the publications page of the Oxford Mindfulness Centre[5]. There are also studies with a UK dimension, notably in the field of psychiatry (Koenig et al. 2015; Pearce et al. 2015). Professor Michael King, one of the authors of both the articles cited is a pioneer in this respect. But there is significantly less evidence of research exploring the health benefits (or otherwise) of religion/spirituality in the UK, in comparison with North America. And the qualitative evidence offered and cited here indicates no awareness of faith and religion in particular being perceived as beneficial for health; rather they appear highly problematic within healthcare.

Similarly, we are not saying that there is no evidence of religion and spirituality being taken into account in the clinical context. There is some evidence of proposals for taking spiritual histories cited in the literature review above (e.g. Culliford 2007). But few UK medical schools offer this as a resource to medical students, and the doctors and nurses interviewed in this project were extremely cautious and lacked confidence in discussing patients' faith (or their own). Almost nowhere did we find evidence of the kind of sophisticated consideration of negotiating different dynamics between the religion/spirituality (or lack of them) of the clinician and the religion/spirituality (or lack of them) of the patient, such as that found in the American context in (Sulmasy 2009: 1640)[6].

Further, we are not saying that chaplaincy has no impact on the health of patients and their healthcare. Clearly chaplaincy has significant impact explored in recent publications such as

[5] http://www.oxfordmindfulness.org/mbct/publications/ [accessed 27th October 2015].
[6] The exception cited was (Poole and Cook 2011).

(Fitchett and Nolan 2015; Pye, Sedgwick, and Todd 2015). And this impact is now being measured. Thus Kevern and Hill in their study of the effect of primary care chaplaincy:

> There is therefore evidence that chaplaincy interventions correlate with an improvement of holistic well-being as measured by a [Warwick and Edinburgh Mental Wellbeing Scale] score. (2014:1)

Also significant here is the development of the Lothian Chaplaincy Patient Reported Outcome Measure (PROM) (NHS Lothian 2015). Nor are we saying that chaplaincy does not have a confident narrative and practice of spiritual care. This is reflected in all major policy documents that have emerged recently, such as the NHS England guidelines of 2015 (Swift 2015). What we are saying is that in relation to the specific question of the place of faith in healthcare, chaplains appear less confident and to be constrained by the inhibitory culture identified in the project.

Finally we are not saying that chaplains do not engage with good practice in relation to enabling patients to deploy their religion and spirituality in the context of healthcare, through, for example, the taking of spiritual histories (Hodge 2015). But we are saying that this good practice has not yet permeated the mainstream of clinical practice. The picture is of chaplains as the spiritual care specialists, rather than of spiritual care being a mainstream clinical concern in the UK. By way of contrast, in another piece of research conducted by Dr Todd in Hong Kong in January 2013, a striking example of the integration of spiritual care into the clinical context was provided by an account of a lead chaplain co-consulting weekly with a doctor in the hospital's pain clinic, with the chaplain having responsibility for the patient's psychological, emotional and spiritual wellbeing.

Why are the UK and the USA such different contexts?

It is worth reflecting briefly on why the experience in healthcare in the UK appears different from that of patients in North America. The report offers two suggestions.

One is that there is a marked difference in religiosity in the UK and the USA. In a Gallup survey of 2009, asking the question, 'Is religion an important part of your daily life?', the USA religiosity index was 65%; that of the UK was 27%[7]. Relating this to health, one might point to the Office for National Statistics survey of wellbeing in the UK in 2013. The size of

[7] http://www.gallup.com/poll/142727/religiosity-highest-world-poorest-nations.aspx [accessed 27th October 2015].

the reported unique contribution that different variables make to variance in personal well-being, indicated self-reported health as making a large (indeed the largest) contribution, while religion makes a small/very small contribution. (Oguz, Merad & ONS 2013)

The second is that religion/spirituality being seen as (and held in legislation and policy to be) a human right has a much longer history in the USA than in the UK. In the former, the Joint Commission that regulates healthcare has had a policy to address religious/spiritual needs since 1969 (Cadge 2012: 7). In the latter religion/belief has only been established as right nationally since the 2010 Equality Act; and this is only beginning to have full impact on healthcare policy (e.g. Swift 2015). It is interesting to note in this respect that NHS Wales recently identified religious, pastoral and spiritual care as integral to holistic care in its mainstream policy document detailing Health and Care Standards (NHS Wales 2015). But the impact of this policy shift is yet to be experienced and measured, including in the clinical context.

Neither of the above points provides an argument for not paying attention to faith in relation to health and healthcare in the UK. Clearly religiosity is still significant in the UK, even if less so than in the USA. And the more recent recognition of religion and/or belief as human right in the UK is, if anything, an indication that there is important work to be done in ensuring this right is respected in healthcare, as part of a holistic model of health (as envisaged in NHS Wales 2015). By way of comparison, care of prisoners in relation to matters of religion and belief, and their rights in this area, is significantly more advanced (see Todd 2015).

5. Conclusion

The report concludes by identifying challenges to the future that the researchers believe arise out of this research project. These challenges are for all involved in healthcare in the UK working in cooperation; for those responsible for its governance, for healthcare practitioners including chaplains, clinicians and others; for patients and others who benefit from healthcare. The challenges identified include areas for future research.

Challenges for the future

- To raise awareness (in the UK) of the interaction of religion/spirituality and health (including the positive benefits to health and healthcare of religion/spirituality)
- To highlight (in UK healthcare) that faith can be a significant contributor to health and healthcare, within the wider spectrum of spirituality, religion and belief, in order to develop a healthcare context conducive to patients and staff appropriately sharing their faith, and drawing on faith as a resource for health and healthcare
- To conduct further research that establishes how the interaction of religion/spirituality and health works in the UK context and the context-specific benefits to patients. Such research should in particular look at the interaction of faith and health/healthcare, within the wider spectrum of spirituality, religion and belief
- To work within the UK human rights framework to establish patients' right to manifest their religion/belief within the context of healthcare, and to work specifically to promote equality and reduce health inequalities in relation to religion and belief
- To identify and promote ways in which attention to the spiritual care of patients might become a more mainstream element of clinical care, including by identifying existing good practice (globally and in the UK) and disseminating it to UK healthcare staff (especially clinicians)
- To support and enable chaplains in healthcare to develop their practice, and the narrative of that practice, in relation to the whole spectrum of spirituality, religion, faith and belief
- To support and enable chaplaincy to continue to develop its effective response to the spiritual, pastoral and religious needs of patients (and staff), but also to develop ways of integrating this with mainstream clinical practice

6. Bibliography

Aldridge, D. (2000). *Spirituality, healing, and medicine: return to the silence*. London ; Philadelphia: Jessica Kingsley Publishers.

Anandarajah, G., & Hight, E. (2001). Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. *American Family Physician*, *63*(1), 81–89.

Andreescu, A. (2011). Rethinking Prayer and Health Research: An Exploratory Inquiry on Prayer's Psychological Dimension. *International Journal of Transpersonal Studies*, *30*(1-2), 23–47.

Cadge, W. (2012). *Paging God: religion in the halls of medicine*. Chicago ; London: The University of Chicago Press.

Chida, Y., Steptoe, A., & Powell, L. H. (2009). Religiosity/Spirituality and Mortality. *Psychotherapy and Psychosomatics*, *78*(2), 81–90. doi:10.1159/000190791

Christopher, M. S., Rogers, B., Hunsinger, M., Colgan, D., Reiss, A. L., & Farwood, H. B. (2014). Distinguishing Mindful Process from Outcome in the Prediction of Global Health and Perceived Stress in a Mindfulness-Based Stress Reduction Program. *Mindfulness*, 1–7. doi:10.1007/s12671-014-0305-3

Cobb, M., & Robshaw, V. (1998). *The Spiritual Challenge of Health Care*, *1e*. Edinburgh; New York: Churchill Livingstone.

Consedine, N. S., & Butler, H. F. (2013). Mindfulness, health symptoms and healthcare utilization: Active facets and possible affective mediators. *Psychology, Health & Medicine*, *19*(4), 392–401. doi:10.1080/13548506.2013.824596

Cornah, D., & Mental Health Foundation (London, England). (2006). *The impact of spirituality on mental health: a review of the literature*. London: Mental Health Foundation.

Coruh, B., Ayele, H., Pugh, M., & Mulligan, T. (2005). Does religious activity improve health outcomes? A critical review of the recent literature. *Explore (New York, N.Y.)*, *1*(3), 186–191. doi:10.1016/j.explore.2005.02.001

Cox, J., Campbell, A. V., & Fulford, K. W. M. (n.d.). *Medicine of the person: Faith, science and values in health care provision*. London: Jessica Kingsley Publishers.

Culliford, Larry. (2007). Taking a Spiritual History. *Advances in Psychiatric Treatment* 13 (3): 212–19. doi:10.1192/apt.bp.106.002774.

Duke University. (n.d.). Religion and Health: Effects, Mechanisms, and Interpretation: Background. Retrieved from http://www.spiritualityandhealth.duke.edu/images/pdfs/RFP_Background.pdf

Gall, L., Charbonneau, C., Clarke, N. H., Grant, K., & et al. (2005). Understanding the nature and role of spirituality in relation to coping and health: a conceptual framework. *Canadian Psychology*, *46*(2), 88–104.

George, L., Larson, D. B., Koenig, H. G., & McCullough, M. E. (2000). Spirituality and Health: What We Know, What We Need to Know. *Journal of Social and Clinical Psychology*, *19*, 102–116. doi:10.1521/jscp.2000.19.1.102

Gordon, T. (2011). *Spiritual care for healthcare professionals: reflecting on clinical practice*. London: Radcliffe Pub.

Greenstreet, W. (Ed.). (2006). *Integrating Spirituality in Health and Social Care: Perspectives and Practical Approaches* (1st New edition edition.). Oxford; Seattle: Radcliffe Publishing Ltd.

Henley, A., & Schott, J. (1999). *Culture, religion and patient care in a multi-ethnic society: a handbook for professionals*. London: Age Concern Books.

Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, *58*(1), 64–74. doi:10.1037/0003-066X.58.1.64

Hinnells, J. R., & Porter, R. (Eds.). (1999). *Religion, health, and suffering*. London ; New York : New York: Kegan Paul International ; Distributed by Columbia University Press.

Hodge, D. (2015). Developing a model of chaplaincy through the translation of nursing theory. In ed. Pye, J. H., Sedgwick, P. H. and Todd, A. J. *Critical Care: Delivering Spiritual Care in Healthcare Contexts*. London; Philadelphia: Jessica Kingsley Publishers.

Jeeves, M., & Brown, W. S. (2009). *Neuroscience, Psychology, and Religion: Illusions, Delusions, and Realities about Human Nature*. West Conshohocken, Pa: Templeton Press.

Kevern, P., & Hill, L. (2014). 'Chaplains for well-being' in primary care: analysis of the results of a retrospective study. *Primary Health Care Research & Development*, *FirstView*, 1–13. doi:10.1017/S1463423613000492

King, M. B., & Koenig, H. G. (2009). Conceptualising spirituality for medical research and health service provision. *BMC Health Services Research*, *9*(1), 116. doi:10.1186/1472-6963-9-116

King, M., Jones, L., Barnes, K., Low, J., Walker, C., Wilkinson, S. and Tookman, A. (2005). Measuring spiritual belief: development and standardization of a Beliefs and Values Scale. *Psychological Medicine*, *36*(03), 417. doi:10.1017/S003329170500629X

Koenig, H. G. (2004). Religion, spirituality, and medicine: research findings and implications for clinical practice. *Southern Medical Journal*, *97*(12), 1194–1200. doi:10.1097/01.SMJ.0000146489.21837.CE

Koenig, H. G. (2009). Research on religion, spirituality, and mental health: a review. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, *54*(5), 283–291.

Koenig, H. G. (2011). *Spirituality & health research: methods, measurement, statistics, and resources*. West Conshohocken, PA: Templeton Press.

Koenig, H. G. (n.d.). *Spirituality in Patient Care: Why, How, When and What* (2nd ed.). West Conshohocken, PA: Templeton Foundation Press.

Koenig, H. G., & Cohen, H. J. (Eds.). (2002). *The link between religion and health: Psychoneuroimmunology and the faith factor* (Vol. xii). New York, NY, US: Oxford University Press.

Koenig, H., King, D., & Carson, V. B. (2012). *Handbook of Religion and Health* (2 edition.). Oxford ; New York: OUP USA.

Koenig, H., & McConnell, M. (2001). *The Healing Power of Faith: How Belief and Prayer Can Help You Triumph Over Disease* (Reprint edition.). New York, N.Y.: Simon & Schuster.

Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of Religion and Health*. Oxford University Press.

Koenig, H. G., Pearce, M. J., Nelson, B. Shaw, S. F., Robins, C. J., Daher, N. S., Cohen, H. J. et al. (2015). Religious vs. Conventional Cognitive Behavioral Therapy for Major Depression in Persons with Chronic Medical Illness: A Pilot Randomized Trial. *The Journal of Nervous and Mental Disease* 203 (4): 243–51. doi:10.1097/NMD.0000000000000273.

Larimore, W. L., Parker, M., & Crowther, M. (2002). Should clinicians incorporate positive spirituality into their practices? What does the evidence say? *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine*, *24*(1), 69–73.

LaRocca-Pitts, M. (2012). FACT, A Chaplain's Tool for Assessing Spiritual Needs in an Acute Care Setting. *Chaplaincy Today*, *28*(1), 25–32. doi:10.1080/10999183.2012.10767446

Larson, D. B., & Larson, S. S. (2003). Spirituality's potential relevance to physical and emotional health: A brief review of quantitative research. *Journal of Psychology and Theology*, *31*(1), 37–51.

Leach Scully, J. (2013). *Faithful Judgements: Moral Pioneers Between Faith and Biomedicine*. 10th Norman Autton Memorial Lecture, London, 9 October 2013. Available at: http://www.nhs-chaplaincy-spiritualcare.org.uk/Lectures/NormanAutton10thlectureJackieLeachScully2013.pdf [accessed 26th Ocotber 2015].

Leach Scully, J., Banks, S., Song, R., & Haq, J. (n.d.). Faithful judgements: the role of religion in laypeople's ethical evaluations of new reproductive and genetic technologies. Retrieved November 14, 2014, from http://www.ncl.ac.uk/peals/research/project/3979

Lee, B. Y., & Newberg, A. B. (2005). Religion and Health: A Review and Critical Analysis. *Zygon®*, *40*(2), 443–468. doi:10.1111/j.1467-9744.2005.00674.x

Levin, J. S. (2001). *God, faith, and health: exploring the spirituality-healing connection*. New York: J. Wiley.

Masters, K. S., & Spielmans, G. I. (2007). Prayer and health: review, meta-analysis, and research agenda. *Journal of Behavioral Medicine*, *30*(4), 329–338. doi:10.1007/s10865-007-9106-7

McCullough, M. E., Hoyt, W. T., Larson, D. B., Koenig, H. G., & Thoresen, C. (2000). Religious involvement and mortality: A meta-analytic review. *Health Psychology*, *19*(3), 211–222. doi:10.1037//0278-6133.19.3.211

McSherry, P. W., & Ross, D. L. (2010). *Spiritual Assessment in Healthcare Practice*. M&K Update Ltd.

Miller, W. R. (Ed.). (1999). *Integrating spirituality into treatment: Resources for practitioners* (Vol. xix). Washington, DC, US: American Psychological Association.

Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist*, *58*(1), 24–35. doi:10.1037/0003-066X.58.1.24

Moreira-Almeida, A., Lotufo Neto, F., & Koenig, H. G. (2006). Religiousness and mental health: a review. *Revista Brasileira de Psiquiatria*, *28*(3), 242–250. doi:10.1590/S1516-44462006005000006

Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001). Religious involvement, spirituality, and medicine: implications for clinical practice. *Mayo Clinic Proceedings*, *76*(12), 1225–1235. doi:10.4065/76.12.1225

Neely, D. and Minford, E. J. (2008). Current Status of Teaching on Spirituality in UK Medical Schools. *Medical Education* 42 (2): 176–82. doi:10.1111/j.1365-2923.2007.02980.x.

NHS Lothian. 2015. *Healthcare Chaplaincy : The Lothian Chaplaincy Patient Reported Outcome Measure (PROM): The Construction of a Measure of the Impact of Specialist Spiritual Care.* Snowden Research. http://www.snowdenresearch.co.uk/download/healthcare-chaplaincy-the-lothian-prom-2012-revised-col-online-only.pdf. [Accessed 27th October 2015].

NHS Wales. (2015). *Health and Care Standards April 2015*. http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf. [Accessed 7th February 2015].

Oguz, S., Merad, S. & ONS. (2013). Measuring National Well-Being - What Matters Most to Personal Well-Being? http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/what-matters-most-to-personal-well-being-in-the-uk-/art-what-matters-most-to-personal-well-being-in-the-uk-.html. [Accessed 27th October 2015].

Orchard, H. C. (2001). *Spirituality in health care contexts*. London; Philadelphia, PA: J. Kingsley Publishers.

Pearce, M. J., Koenig, H. G., Robins, C. J., Nelson, B., Shaw, S. F., Cohen, H. J. and King M. B. (2015). Religiously Integrated Cognitive Behavioral Therapy: A New Method of Treatment for Major Depression in Patients with Chronic Medical Illness. *Psychotherapy* 52 (1): 56–66. doi:10.1037/a0036448.

Plante, T. G., & Sherman, A. C. (Eds.). (2001). *Faith and health: psychological perspectives*. New York: Guilford Press.

Poole, R. and Cook, C. C. H. (2011). Praying with a Patient Constitutes a Breach of Professional Boundaries in Psychiatric Practice. *The British Journal of Psychiatry* 199 (2): 94–98. doi:10.1192/bjp.bp.111.096529.

Powell, L. H., Shahabi, L., & Thoresen, C. E. (2003). Religion and spirituality. Linkages to physical health. *The American Psychologist*, *58*(1), 36–52.

Puchalski, C. M. (2006). *A Time for Listening and Caring: Spirituality and the Care of the Chronically Ill and Dying* (1 edition.). Oxford ; New York: OUP USA.

Puchalski, C. M., Dorff, R. E., & Hendi, I. Y. (2004). Spirituality, religion, and healing in palliative care. *Clinics in Geriatric Medicine*, *20*(4), 689–714, vi–vii. doi:10.1016/j.cger.2004.07.004

Puchalski, C., & Romer, A. L. (2000). Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine*, *3*(1), 129–137. doi:10.1089/jpm.2000.3.129

Roberts, L., Ahmed, I., Hall, S., & Davison, A. (2009). Intercessory prayer for the alleviation of ill health. *The Cochrane Database of Systematic Reviews*, (2), CD000368. doi:10.1002/14651858.CD000368.pub3

Seeman, T. E., Dubin, L. F., & Seeman, M. (2003). Religiosity/spirituality and health: A critical review of the evidence for biological pathways. *American Psychologist*, *58*(1), 53–63. doi:10.1037/0003-066X.58.1.53

Seybold, K. S. (2007). *Explorations in neuroscience, psychology, and religion*. Aldershot, Hants, England ; Burlington, VT: Ashgate Pub.

Shapiro, S. L., & Carlson, L. E. (2009). *The art and science of mindfulness: Integrating mindfulness into psychology and the helping professions* (Vol. xvii). Washington, DC, US: American Psychological Association.

Strawbridge, W. J., Cohen, R. D., Shema, S. J., & Kaplan, G. A. (1997). Frequent attendance at religious services and mortality over 28 years. *American Journal of Public Health*, *87*(6), 957–961. doi:10.2105/AJPH.87.6.957

Sulmasy, D. P. (2009). Spirituality, Religion, and Clinical Care. *CHEST Journal*, *135*(6), 1634. doi:10.1378/chest.08-2241

Swift, Christopher. 2015. *NHS Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual & Religious Care.* NHS England. http://www.england.nhs.uk/wp-content/uploads/2015/03/nhs-chaplaincy-guidelines-2015.pdf. [Accessed April 21st 2015].

Swinton, J. (2001). *Spirituality and mental health care: rediscovering a 'forgotten' dimension*. London ; Philadelphia: J. Kingsley Publishers.

Todd, A. J. (2015). Religion, Security, Rights, the Individual and Rates of Exchange: Religion in Negotiation with British Public Policy in Prisons and the Military. *International Journal of Politics, Culture, and Society*, 28(1): 37-50. doi:10.1007/s10767-014-9181-z.

Todd, A. J. and Tipton, L. (2011). The Role and Contribution of a Multi-Faith Prison Chaplaincy to the Contemporary Prison Service. Monograph. http://www.stmichaels.ac.uk/pdf/Todd-and-Tipton-2011-Report-on-Prison-Chaplaincy.pdf.

Tomfohr, L. M., Pung, M. A., Mills, P. J., & Edwards, K. (2014). Trait mindfulness is associated with blood pressure and interleukin-6: exploring interactions among subscales of the Five Facet Mindfulness Questionnaire to better understand relationships between mindfulness and health. *Journal of Behavioral Medicine*, 1–11. doi:10.1007/s10865-014-9575-4

White, G. (2006). *Talking About Spirituality in Health Care Practice: A Resource for the Multi-Professional Health Care Team*. Jessica Kingsley Publishers.