

# **ASSERTION AND ASSUMPTION: A SINGLE SITE STUDY OF ACUTE HEALTHCARE CHAPLAINCY**

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**A thesis submitted to the University of Birmingham for the degree of  
MASTERS BY RESEARCH (MRes)**

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September 2013**

**Word count: 19,885/20,000**

**Student ID: 1017387**

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## **ABSTRACT**

This thesis documents the study of a single acute healthcare chaplaincy team, situated within the field of practical theology as a method of critically engaging with the self-understandings of healthcare chaplains. This thesis aims to address the gaps in the current chaplaincy literature which do not consider the role and self-understandings of minority faith chaplains, and to add a localised dimension to the existing research which tends to examine chaplains in isolation rather than as teams.

The main study consisted of two weeks of observations and semi-structured interviews between April-May 2013. The findings challenge the view that chaplaincy is a unified entity, and contribute new themes to the field, including minority faith approaches to chaplaincy, inter-faith collaboration and humour. This thesis highlights significant continuities and changes in healthcare chaplaincy over the past decade, justifying further research into chaplaincy as a useful lens for examining how faith communities relate to public institutions and the public square.

## **ACKNOWLEDGEMENTS**

Thanks to all the chaplains who contributed to this study, and special thanks to the chaplaincy team who kindly agreed to participate.

Many thanks also to Stephen Pattison, Christopher Swift and my family and friends for their continued encouragement and support throughout this project.

Thanks in particular to Jo Bryant for her editorial assistance with spelling, syntax and grammar.

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# CHAPTER 1: INTRODUCTION

## Introducing Healthcare Chaplaincy

Healthcare chaplaincy, while receiving little attention from outside the NHS, lies at the nexus between religion and secular society, and is a significant talking point in debates regarding the role of religion in the public square. Healthcare chaplains are often presented as a marginal aspect of healthcare provision (Ballard 2010: 190; Orchard 2000: 46; Woodward 1998: 91), and are required now to negotiate their position in secular institutions (Ballard 2009: 21; Swift 2009: 1). Chaplaincy provides a microcosmic context for examining how the religious and the secular interact in public life (Gilliat-Ray 2012: 117; Swift 2009: 4), enabling an exploration of how a plurality of worldviews collide and co-exist within a single institutional setting.

This thesis is situated within the field of practical theology (PT), while drawing on qualitative social research methods. This focus on PT was initially influenced by the tendency in the literature to associate chaplains with practical theology (Cobb 2004: 14; Aldridge 2006: 20; Newitt 2010: 169, Swift 2009: 144). PT emphasises the interaction between experience and theology, providing an appropriate method of engaging critically with the beliefs and worldviews present in chaplaincy while acknowledging researcher reflexivity. This study is the first single site study examining how chaplains relate to each other and the NHS. In contrast, the extant literature tends to engage with individual chaplains as isolated entities and projects the findings onto an abstracted unified concept of ‘chaplaincy’. Thus the primary research question is: in what ways can a localised empirical study shed light on the issues raised by the existing chaplaincy literature?

## **Rationale**

The rationale for the project emerged from a previous study with a team of healthcare chaplains about sacred space. During this research, it became apparent that the literature on chaplaincy was underdeveloped, and I was actively encouraged to continue researching chaplaincy in an academic capacity by the team. The paucity of literature is significant in light of the National Secular Society's (NSS) recent campaign to remove state funding from chaplaincy in light of economic austerity (Newitt 2010: 170; Fraser 2010: 188), exemplifying the contested role of religion in public institutions.<sup>1</sup> At the same time, a “notable absence [of chaplaincy] from key reports and plans” for the NHS characterises the contemporary crisis of chaplaincy (Swift forthcoming). This thesis aims to engage with chaplaincy in a detailed study of one team in order to develop the knowledge base and encourage further research.

## **Background: Locating Chaplaincy**

Healthcare chaplaincy has been a standardised aspect of the NHS since its establishment in 1948, yet an adequate understanding of the profession remains elusive. The concept of chaplaincy as the “collected activities, knowledge or theory of being a chaplain” rather than chaplains as individual religious functionaries only emerged in the 1960s (Swift 2004:7). Understanding chaplaincy in recent decades has been complicated by broader socio-political changes which raise significant questions about the relevance, efficacy and distinctive contribution of chaplaincy, contributing to an ‘identity crisis’ among chaplains (Woodward 1998; Orchard 2000; Swinton and Mowat 2007; Swift 2009; Ballard 2010).

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<sup>1</sup> Notably this campaign has been largely ignored - chaplaincy is broadly recognised as an acceptable manifestation of religion in public institutions (see Pattison, unpublished article).



### *Chaplaincy in Institutional Context*

The relationship between religion and healthcare has become less obvious as contemporary confidence in medicine has challenged the place of religious discourses (Woodhead 2012: 21), while the locus of healthcare provision has shifted from the influence of the Established Church towards a government provision in the form of the NHS in 1948 (Swift 2009: 51). This growth in confidence in medical progress has led to a preoccupation with cure over care, while death and incurable illness are treated as failure and taboo (Wilson 1971:23; Ballard 2010: 190). Thus, chaplains represent the last remnants of a publicly manifested relationship between illness, health and religion (Beckford and Gilliat 1996: 225), and often feel marginalised in an institution where the role of religion is contested (Woodward 1998: 250).

Conversely, the growth of holism in response to depersonalising medical discourses acknowledges a spiritual dimension to care (Woodhead 2012: 21; Mowat 2008: 32-33). The prominence of spirituality in NHS policy and in nursing literature provides chaplains with a fresh justification for the profession (Ballard 2010: 199), and it is part of the chaplain's role to remind the institution of this dimension of healthcare.

### *Chaplaincy in Socio-Political Context*

Chaplaincy is inevitably involved in socio-political dynamics which affect the NHS as a whole (Mowat 2008: 13, 16), including the equality and diversity agenda, emphasis on patient-centred care and spirituality in NHS policy, and the growth of managerial discourses (Pattison 1997: 4; Woodward 1998: 52-53; Swift 2009: 62-65; Gilliat-Ray, Ali and Pattison 2013: 168). The rational-instrumental ethos which dominated following the reorganisation of the NHS in the early 1990s has increased the pressure for chaplaincy to emulate other

departments, develop professionally, prove its efficacy and demonstrate institutional loyalty (Ballard 2010: 187; Woodward 1998: 97; Pattison 1997: 114). These institutional factors both facilitate and hamper attempts to better integrate chaplaincy.

Vast changes in the religious demographic of Britain in recent decades have required chaplaincy to adapt in accordance with the processes of secularisation, demonstrated by declining allegiance to the Church of England in particular (Woodward 1998:91), a decrease in membership of the primary denominations in general (Davie 2005: 49), and increasing religious pluralism (Todd 2011: 91; Swift 2004: 6; Cobb 2004: 13). Significantly, the Established Church has lost its monopoly and must negotiate its position in a pluralist environment (Todd 2011: 91-93; Swift 2004: 29; Ballard 2010: 187, 199). However, there is also a growing recognition that Christianity continues to loosely inform British identity (Guest, Olson and Wolffe 2012: 65-66). Thus chaplains must offer provision in light of increasing diversity and the changing nature of religious affiliation.

## **Summary**

Chaplaincy is at the nexus of medical and religious narratives (Swift 2004: 6) while being situated within a politically charged institution where economic interests are increasingly taking priority. These contrasting discourses can either affirm or undermine the way in which chaplaincy is enacted, particularly as the status of chaplaincy has shifted from being an assumed component of healthcare provision to a “negotiated presence” (Ballard 2009: 21; Mowat 2006: 14-15). Research into healthcare chaplaincy is timely and contributes to broader questions about the meeting of worldviews, the relationship between religion and public life and how different faiths work together despite substantial differences.

## CHAPTER 2: LITERATURE REVIEW

This review will examine the primary practical and theoretical concerns present in the existing chaplaincy literature. This chapter will justify the selection of literature, identify gaps, offer a thematic review and present the aims of this thesis.

### Selecting the Literature

#### *Primary Academic Sources*

While academic literature on chaplaincy is underdeveloped, some significant contributions have been made by practitioners (Mowat 2008:10; Swift 2004: 8). This study is based in an acute hospital, thus the primary sources were selected due to their focus on acute hospitals in England and Wales, including Wilson's *The Hospital: A Place of Truth* (1971), Beckford and Gilliat's *The Church of England and Other Faiths in Multi-Faith Society*, vol. 2 (1996), Woodward's *A Study of the Role of the Acute Healthcare Chaplain in England* (1998), Orchard's *Healthcare Chaplaincy: Modern, Dependable?* (2001), and Swift's *The Function of the Chaplain in the Government of the Sick in English Acute Hospitals* (2004).

#### *Secondary Sources*

Some literature on healthcare chaplaincy also focuses on psychiatric, community or primary care chaplaincy, exemplified by Pattison (1994), as well as literature based in America (Cadge 2012; Norwood 2006) and Scotland (Swinton and Mowat 2007). These sources are secondary as this thesis focuses on acute chaplaincy in England and Wales.

The ‘directive handbooks’ of Autton (1962, 1982), Cox (1995), Faber (1971), and Speck (1988) will also inform this literature review.<sup>2</sup> While these handbooks provide a useful insight into the nature and function of chaplaincy, major socio-political shifts have taken place which leave chaplains unable to fulfil the vision of these handbooks, particularly shown by the diversification of healthcare chaplaincy. Therefore these sources are limited in their contribution to the knowledge base.

Some reference will be made to articles from the *Scottish Journal of Healthcare Chaplaincy (SJHC)*, the *Journal of Healthcare Chaplaincy (JHCC)* and *Practical Theology* (previously *Contact*), as secondary sources.<sup>3</sup> Significantly, *SJHC* and *JHCC* were difficult to access due to their status as professional rather than academic journals. References to these journals will focus more on how chaplains have reflected on their role, function and identity rather than attempts at quantifying efficacy, a predominating trend in the *JHCC*.

#### *Summary of Primary Sources*

The primary sources cover numerous aspects of chaplaincy, including the identity and function of hospital chaplains (Wilson 1971; Woodward 1998; Swift 2004; Swinton and Mowat 2007), how chaplaincy has responded to increasing religious pluralism (Beckford and Gilliat 1996; Orchard 2000), and the impact of growing managerialism in the NHS on chaplaincy (Woodward 1998; Swift 2004). The consideration of women and other faiths in chaplaincy is broadly absent from the existing literature (Swift 2004: 225-226) although sources on minority faith chaplaincy are growing, particularly in relation to Muslim chaplaincy (Gilliat-Ray, Ali and Pattison 2013). Additionally, an account of chaplaincy is yet

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<sup>2</sup> Woodward 1998: 106-119 reviews these sources more thoroughly.

<sup>3</sup> *SJHC* and *JHCC* recently merged to create the journal *Health and Social Care Chaplaincy*.

to be produced which focuses on a single team. It is hoped that this thesis will go some way towards addressing these gaps in the literature.

### **Chaplaincy as a Healthcare Profession**

A consistent thread in the literature is the struggle for chaplaincy to be recognised as professional, while some voices warn against possible risks of professionalisation.<sup>4</sup> The professionalisation agenda primarily arose from the desire to be recognised as credible healthcare professionals in light of reflections on the corporate nature of chaplaincy (Swift 2009: 2) and growing managerialism in the NHS (Swift 2004: 210; Woodward 1998). Other reflections on chaplaincy demonstrate the uneasy tension between professionalism and vocation (Swift 2010: 204), where chaplains find it difficult to discern their vocation in an increasingly consumerist environment (Woodward 1998:319; Swift 2009: 5). Two camps have emerged, where some chaplains emphasise religious identity and remain wary of the professionalisation agenda, while others emphasise their role as healthcare professionals and prioritise professionalism (Hospital Chaplaincies Council 2010: 23-24).

### **An Uncertain Future: Chaplaincy under Pressure**

Recent literature highlights the tensions faced by healthcare chaplains, particularly as the NHS has transformed into a more “business-like” entity driven by efficiency, managerialism and cost-effectiveness (Woodward 1998; Pattison 1997: 20). Woodward notes a concern among chaplains of being subject to the “tyranny of the bottom line” because their work is not quantifiable (1998: 103). Consequently, chaplains are faced with the pressure to

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<sup>4</sup> It is useful to distinguish between professionalism and professionalisation, where the former entails integrity and autonomy, with the resources to ‘do a professional job’, while the latter emphasises the development of chaplaincy into a recognised healthcare profession through formal training, bodies of knowledge, professional associations, and developing skills and competencies (Swinton 2003: 3)

justify continued financial support and to create an evidence base for their work (Mowat 2008: 45; Hospital Chaplaincies Council 2010: 29).

The crisis of chaplaincy is not merely one of accountability. Instead, broader contemporary socio-political conditions shake the foundations on which chaplaincy is built. The majority of the population are no longer active adherents of the Anglican church (Wilson 1971:58, Woodward 1998: 91), and an increasingly secular environment leads to puzzlement about the relevance and role of healthcare chaplains among patients and carers (Cobb 2007:7). Additionally, confidence in theology as an appropriate and coherent knowledge base for chaplaincy has waned (Woodward1998: 143). However, it is important to note that chaplaincy has always been a peripheral aspect of NHS provision, and the issues outlined above solidify this crisis of identity (Swift 2009: 41-42)

### **Models of Healthcare Chaplaincy**

Following the pressure to professionalise, practitioners have increasingly sought to model chaplaincy. Early attempts to link theology with chaplaincy treat theological doctrines as “static and fixed”, which chaplains have characterised as unhelpful and inappropriate (Woodward 1998: 107). Recent articulations of chaplaincy models by the Church of England (Hospital Chaplaincies Council 2010:19-20) and in NHS policy (Caring for the Spirit 2003: 12-14) demonstrate the importance wider institutions are placing on modelling chaplaincy. Contemporary models have been split into theological models and secular models (Threlfall-Holmes 2011: 116-126), although recently the issue of Christian and secular models being assimilated into Muslim chaplaincy has been raised (Gilliat-Ray, Ali and Pattison 2013:167-173). Specific models of chaplaincy will be discussed under subsequent themes in this chapter.

## **Between Discourses: Chaplain as Translator and Interpreter**

Swift (2004) and Norwood (2006)<sup>5</sup> note the significance of conflicting discourses in relation to the identity of the healthcare chaplain, where religious narratives encounter secular, therapeutic, medical and managerial discourses. Chaplains cannot be considered to be working in a vacuum where the assumed theological certainties of Cox and Autton remain unchallenged (Woodward 1998: 113). It is suggested that occasionally chaplains must “alternately embrace or distance themselves from competing discourses of religion and medicine” to survive (Norwood 2006:5). Chaplains should be critical of both religious and medical sources of authority (Cobb 2004: 12), remaining distinct from other discourses present in the hospital (Swift 2009: 157).

Chaplains must translate their theological resources into meaningful narratives for patients who lack a conceptual framework for understanding their experience of illness (Woodward 1998: 158; Swift 2004: 89; Newitt 2011:108), and for the wider institution to understand what chaplains do (Fraser 2004: 26). Chaplains have been described as interpreters and translators of experience (Swinton and Mowat 2007: 41), but should also be aware that patient narratives cannot or should not be easily interpreted (Swift 2004: 219). The literature also documents how chaplains liaise between different groups in the hospital (Aldridge 2006: 20). Overall, sources focus on chaplains as translators of religious, medical and institutional discourses rather than translators of language and culture.

## **Spirituality Discourses**

The requirement that the NHS fulfils the spiritual needs of patients of all faiths and none marks a significant shift in the enactment of chaplaincy (Cobb 2004: 10; Ballard 2010:

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<sup>5</sup> Norwood’s study was based in America, but resonates strongly with the work of Swift (2004) and Wilson (1971)

190; Beckford and Gilliat 1996: 230-231; Pattison, 2013: 194).<sup>6</sup> This shift from the ‘narrow’ confines of religion to spirituality as an essential universal requires chaplains to comply with NHS policy which emphasises the responsibility to ensure all spiritual needs are met (Orchard 2000: 22). Spirituality, while contested, is broadly defined as “the experience and process of engaging with and managing significant attachments and relationships” (Pattison 2010: 358-59). Spirituality is often separated from religion (Mowat 2008: 34), and provides the overarching framework through which ‘narrow’ religious paths are relativised, lending itself to a consumerist approach to belief, especially when spiritual needs are identifiable and measurable (Pattison 2001: 38; Ballard 2010: 198).

Consequently, the chaplain’s role is to seek and discern spiritual needs (Swinton and Mowat 2007: 36) and to nurture or develop these relationships and attachments (Pattison 2010: 360) through formalised modes of assessment and fulfilment. The shift from responding to religious needs to attending to less specific spiritual needs requires chaplains to downplay their unique expertise that is cultivated during their training within particular religious structures (Swinton and Mowat 2007: 48). Spirituality discourses become attractive to chaplains as religious language no longer resonates with patients (Swift 2004:40).

### *Chaplain as Universal*

The universality of the chaplain’s role is evident in the idea of chaplain as minister to “the wellbeing of the institution” (Ballard 2010: 191; Wilson 1971: 107). This universality was once grounded in the Kingdom of God (Wilson 1971: 94), although there has been no attempt to produce a unified basis for contemporary multi-faith chaplaincy. The idea that chaplains minister to the institution is evident in studies demonstrating the chaplains’ role in

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<sup>6</sup> Examples include the 1991 Patient’s Charter and Caring for the Spirit (2003), which recognised religious diversity and stated that spiritual care was the responsibility of all NHS staff (Gilliat-Ray 2012: 136)



broader institutional activities, such as ethics committees, consultations and staff training (Woodward 1998: 192; Orchard 2000: 66; Ballard 2010: 201). The universality of chaplaincy is associated with a more proactive approach where chaplains actively seek opportunities for more extensive involvement in hospital life by “loitering with intent” (Gilliat-Ray, Ali and Pattison 2013: 83; Swinton and Mowat 2007: 37-38; Orchard 2000: 74)

The shift towards spiritual needs has resulted in chaplaincy adopting a generic approach. This has arisen out of a concern to provide pastoral support to those without a formal faith (Newitt 2010: 164), and as a way of providing for a growing diversity of service users. The literature does not offer a substantial definition of generic chaplaincy, nor is there a study which examines how generic chaplaincy works out in practice among chaplains of different faiths.

### **Power and Pastoral Care**

Chaplains are commonly referred to in terms of their marginalisation in the NHS and in their respective faith communities. Some sources note that Anglican chaplains feel the Church does not support them in their role, and that chaplaincy is used as a dumping ground for ministers who are perceived as a cause of embarrassment for the Church (Threlfall-Holmes and Newitt 2011: 39; Hancocks, Sherbourne and Swift 2008; Hospital Chaplaincies Council 2010: 26). Similarly, the literature characterises chaplains as peripheral within the NHS due to the lack of managerial interest (Orchard 2000: 37, 46) and notes their marginalised and misunderstood status in light of medical dominance (Woodward 1998: 47).

Over time, the relationship between chaplains and patients has changed, as chaplains can no longer expect to build long-term stable relationships with patients (Orchard 2000: 43). Several sources are preoccupied with the ways that chaplains may inadvertently contribute to the depersonalisation of patients, particularly as service provision is concentrated on high-tech

acute care to the detriment of mentally ill patients, the elderly and other chronically ill patients (Ballard 2010: 190; Orchard 2000: 47). Chaplains may fall into the trap of associating success with physical healing and failure with continued illness (Chalmers 2002: 23). Similarly Pattison expresses a concern that chaplains are more concerned with individuals and fail to offer prophetic insights which challenge broader depersonalising tendencies (1994: 211-216).

### *Chaplain as Prophetic Voice*

The role of chaplain as a prophetic voice which challenges unjust structures is a significant model in the literature (Woodward 1998: 129, 268; Threlfall-Holmes and Newitt 2011: 122). However, the above considerations question whether the prophetic model can be actualised, as chaplains may be complicit in depersonalising institutional structures by adopting a ‘neutral’ standpoint (Pattison 2000: 90, 1994: 224). In practice, the prophetic approach to chaplaincy is unworkable as the push towards professionalism requires chaplains to demonstrate institutional loyalty to the NHS (Ballard 2010: 191, see also Pattison 1997:113-117, Ballard 2009: 21) while “the chaplain depends upon the hospital for validation and security” (Woodward 1998: 279).

### **Chaplaincy in a Multi-Faith Context**

While denominational differences in the enactment of chaplaincy (Wilson 1971: 147, Cadge 2012: 21, 83) and the increasingly multi-faith nature of chaplaincy (Beckford and Gilliat-Ray 1998) have been recognised, few sources specifically document inter- and intra-religious relations. This may be due to the poor integration of minority faith representatives into chaplaincy teams (Gilliat-Ray 2001: 143; Orchard 2000:30). The current literature is limited and tends to refer to the growth of multi-faith spaces (Todd 2011: 90; Gilliat-Ray

2005; Swift 2004: 2-4), how chaplains and the NHS are engaging with the pastoral care of religious minorities (Gilliat-Ray 2001: 135-144; Orchard 2000: 31), the chaplain as ‘spiritual broker’ (Orchard 2000:57), and some work on Islamic chaplaincy in particular (Gilliat-Ray, Ali and Pattison 2013; Mayet 2001). This study will be among the first which explicitly considers the relationships between chaplains of differing faiths.

### **The Distinctiveness of Chaplaincy**

Some sources express a concern that chaplaincy is in danger of being assimilated into a secular context. Wilson’s warning against full-time chaplains becoming too institutionalised (1971:72) is echoed by Woodward, who states that chaplaincy is faced with the “pressure to marginalise religious content” in order to professionalise (1998: 80). Similarly the Hospital Chaplaincies Council expresses a concern that chaplaincy will be co-opted into a “secular mind-set” (2010: 31). Swinton and Mowat also note that engaging with spirituality discourses conflicts with the unique theological training of chaplains (2007: 58), while God becomes little more than an “optional extra” in order for chaplaincy to become more acceptable (Lyll in Ballard 2010: 200). Overall a consistent concern for retaining integrity in the face of professionalism is present across the literature (Aldridge 2006: 19; Hospital Chaplaincies Council 2010: 33; Ballard 2010: 189-190).

This distinctiveness is also threatened by propositions that other healthcare professions can and should offer spiritual care (Mowat 2008: 58-61, 69), and that “no single profession can embody all the understanding and attributes needed to address the spiritual lives...of all persons and groups” (Pattison 2010: 361). The discourses surrounding spirituality that have reinvigorated chaplaincy may also endanger the profession if it does not forge its own distinctive contribution.

## **Aims of the Thesis**

In light of the review of the above literature, this thesis aims to:

- Provide an account of healthcare chaplaincy based on the self-understandings of chaplains, including women and minority faith groups
- Undertake a single-site study in order to examine the web of relationships surrounding chaplains
- Situate the knowledge base more strongly in the immediate concerns of chaplains on the ground
- Examine the distinctive contributions of healthcare chaplains and the everyday institutional factors which impact on distinctiveness.

## CHAPTER 3: METHODOLOGY

Various methodological issues have arisen throughout the project, substantially affecting the overall design. First my own position and what theology means in the context of this study will be clarified, followed by an explanation of why this thesis is situated within practical theology (PT). The major theoretical barriers will then be discussed, followed by a consideration of fieldwork methods and their limitations, and a justification of the final design. This study took place between April and May 2013, and included informal observations and semi-structured interviews with chaplains from a variety of faiths, including Anglican, Free Church, Catholic, Muslim, Sikh, Hindu and Buddhist chaplains.

### **Theoretical Considerations**

#### *Confessions of a Curious Outsider*

A significant consideration is my position as an outsider. I am not a chaplaincy practitioner, nor do I belong to a particular faith tradition: my position is best described as agnostic, although my background was originally in the Baptist church. Therefore it is important to discuss the relationship between my own position and theology.

#### *Defining Theology*

Given my position as outsider, it is necessary to clarify what theology means. Here, theology is the critical engagement and evaluation of systems of belief (Pattison 1997: 5 and 2007b: 7). This study aims to work with everyday expressions of theology, which are constructed by ordinary engagement with the social world (Astley 2002: 56). Recent distinctions between 'espoused' theologies – theology as articulated verbally - and

‘embodied’ theologies – theology as enacted in everyday life – have broadened my approach to theology (Cameron et al. 2010:54). Acknowledging these different approaches enables an exploration of ‘inhabited worldviews’ such as those of healthcare chaplains, while recognising the inconsistencies between espoused and embodied theology. Thus an examination of espoused beliefs necessitates an examination of how these are enacted. This approach to theology is also informed by the concept of *habitus*, which refers to the overall context of historical conditions, inclinations and dispositions which influence practice (Bourdieu 1997: 54-55). *Habitus* reaffirms that “the individual, and even the personal, is social” (Bourdieu and Wacquant 1992: 126), therefore justifying an examination of the institutional and social influences on ‘inhabited worldviews’.

#### *Why PT?*

PT was selected because it is already associated with the work of healthcare chaplains. The focus on “everyday performance of faith” (Swinton and Mowat 2006: 4) and the evaluation and transformation of praxis (Woodward and Pattison 2000b: 13) links well with the characterisation of the work of chaplains as primarily *doing* and *being* (Aldridge 2006: 20). PT also resonates with the ways that chaplains draw on theology, where the application of static theological norms to diverse pastoral situations is inappropriate (Woodward 1999: 158).

PT also encourages the use of empirical research methods, and engages with social theory in a mutually challenging methodology (Ballard and Pritchard 1996: 121; Browning 1983: 46). This study is interdisciplinary due to its emphasis on theology in relation to lived experience, drawing on theology and social sciences in a process of “critical correlation” (Swinton and Mowat 2006: 80; Browning 1983: 45-46). PT therefore facilitates theological engagement with empirical and social phenomena.

### *Some Difficulties with PT*

The preoccupation with ‘theological integrity’ and the positing of a coherent Christian narrative as the normative framework for PT alienates inquirers without a formalised belief system (Swinton and Mowat 2006: 5-7, 93; Browning 1983:193-198). Due to my position as an outsider, it was felt that adopting these approaches would be disingenuous. Instead, Pattison suggests that outsiders “could profit from becoming critical practical theologians of their own activities” (Pattison 2000: 12). Therefore, it is possible for me to inhabit the space for reflection that PT offers, where PT is utilised as a method of engagement rather than as a normative discipline. This study is located in PT insofar as it examines how the beliefs and practices people live by ordinarily collide and co-exist (Pattison 2007b: 7).

### *Incorporating Social Sciences with Theology*

The inclusion of the social sciences in theology has been met with ambivalence among practical theologians. There is a tendency to give primacy to the latter over the former due to concerns that the social sciences relativise the normative thrust of theology (Swinton and Mowat 2006: 92-93). To avoid this oversimplified dichotomy, PT must “clarify its identity and purpose” in relation to the social sciences (Pattison 2007a:264).

This project is primarily qualitative due to the emphasis on meaning and worldview, and its status as an interpretive study which aims to understand and interpret unquantifiable phenomena (Outhwaite and Turner 2007: 582). The qualitative paradigm aims to inductively generate theories, while the overall design can be subject to change throughout the study (McQueen and Knussen 2002: 200). However, social science methodologies which encourage ‘value-free’ inquiry and bracketing out the presuppositions of the researcher are outdated and should be treated with caution. These approaches are exemplified in grounded theory and

phenomenology, which were considered in the early stages of the research. In classical grounded theory, the findings of the research dictate the research questions and themes that emerge (Glaser 1992: 15). However this fails to acknowledge that these theories are shaped by the researcher's own presuppositions. Similarly, phenomenology ignores presuppositions of the researcher and how researcher presence affects the phenomena being studied (Flood 1999: 107, 112). Instead this study aims to incorporate researcher reflexivity and dialogical understandings of the relationship between researcher and participant. Insofar as phenomenology examines the lived experience of religion, this project is still phenomenologically orientated (Finlay 2009: 9). The above approaches will be qualified by examining perspectives from theology and the study of religion which include researcher reflexivity.

#### *PT as Methodological Corrective*

PT offers a useful methodological corrective to the shortcomings of 'value-free' social research methods by encouraging researcher reflexivity and recognising dialogical or intersubjective approaches. A better understanding of the participant is facilitated by the researcher examining their own response to the participant rather than studying the participant in isolation (Astley 2002: 109, 112; Browning 1983: 38-39). Intersubjective approaches to the study of religion proposed by Orsi converge with practical theological methods where the researcher is willing to subject their presuppositions to a critical conversation with an "unfamiliar way of life" which requires "disciplined attentiveness to difference" (Orsi 2005: 198). This critical conversation takes place between the faith presuppositions of the researcher, the Christian tradition and the contemporary situation (Pattison 2000: 135-136). Browning also acknowledges this convergence by characterising social science as dialogical (1983: 91). This study therefore incorporates approaches which acknowledge intersubjectivity and



researcher reflexivity where the boundaries between theology, sociology and the study of religion are broken down.

## **Practical Considerations**

### *The Complications of Shadowing*

The possibility of shadowing was initially explored in order to become better acquainted with chaplaincy. Gilliat-Ray explains that shadowing focuses on the “daily practice of a single individual, living and working within a complex institutional social setting” (2011: 470). Cadge and Gilliat-Ray note the similarity between researchers who adopt shadowing techniques and chaplains: both require the ability to listen, empathise, maintain confidentiality, and feature the practice of ‘loitering with intent’ (Cadge 2012: 218; Gilliat-Ray 2011: 471). This method would have enabled me to become more familiar with chaplaincy and explore how chaplaincy is enacted more thoroughly.

However, shadowing was rendered problematic when considering the presence of the researcher and deciding on an appropriate sample. The presence of the researcher could provoke modifications of behaviour (Gilliat-Ray 2011: 477) and interfere with the dynamic of the patient-chaplain encounter, particularly as patients do not expect spiritual care to be observed (Swift 2001: 66-67). In light of these considerations, interviews and observations were selected as alternative fieldwork methods.

### *Ethical Considerations*

The primary ethical issues included sampling, consent, confidentiality and data storage. Due to the complexity of the NHS ethical review process, the design was limited to members of the chaplaincy team in order to be eligible for university ethical review and to avoid delays

in the project. This is not a significant limitation, as the project focuses on the self-understandings of the chaplaincy team.

*(i) Sampling*

This is a single site study, although the team have requested that the site remains anonymous. The issue of sampling had been discussed with chaplains who were concerned about the practical implications of shadowing. Due to the flexibility of a chaplains' schedule (Woodward 1998:181-182), it was difficult to estimate how many patients may be visited on any given day and pinpoint criteria for inclusion. The study was then restricted to the chaplaincy team, and all of the chaplains were invited to participate in order to obtain a diverse snapshot of male and female chaplains from different faith groups. Volunteers were also invited to participate in initial observations. An acute hospital was chosen specifically because of the range of circumstances that the chaplaincy team encounter.

During the project I informally visited two other chaplaincy teams in order to obtain further understandings about healthcare chaplaincy. Substantial differences between these teams rendered a comparative multi-site study impractical for the scale of the project. Instead, observing these teams facilitated an appreciation of the various ways in which chaplaincy is enacted. Details of these unofficial visits cannot be documented here.

*(ii) Consent*

During fieldwork, informed consent from the participants was clearly requested before they could take part. Before the interviews, chaplains were asked to read the participant information sheet and provide written consent (see Appendix C). Consent became more difficult to negotiate during the observations and it was initially suggested that involvement was assumed unless participants opted out. This was later amended so that verbal consent was requested every time a new potential participant entered the research setting.

*(iii) Confidentiality*

All of the participants have been anonymised. However, it is difficult for participants to remain completely unidentifiable, as referring to the particular faith of a chaplain was occasionally necessary when writing up in order to further contextualise quotes. Participants were asked to give permission for their faith position to be mentioned in the thesis while making it clear that this may compromise confidentiality. All of the chaplains gave permission for reference to be made to their faith position.

*(iv) Data storage*

Following difficulties locating appropriate data storage facilities in the university, negotiations with the university ethical committee allowed confidential data to be stored on password protected university computers and an encrypted memory stick. Participants were informed that anonymised fieldnotes and interview transcripts may be made available to subsequent researchers on request.

*Data Collection – The Final Design*

While narrative methodologies would have allowed a fuller impression of the ‘espoused theologies’ of the participants to be obtained, observations and semi-structured interviews were the most feasible methods of data collection due to the timescale of the project. The observations were guided by pre-selected categories, such as the relationship with the institution, professionalism and models of chaplaincy, although the primary purpose of these observations was to refine the interview questions and obtain insights into the dynamics and primary concerns of the chaplaincy team. However, this was restricted by the need to remain in the shared chaplaincy office, except when group meetings and services in

the chapel were attended. These observations were supplemented by visiting other chaplaincy teams, attending conferences and other related events.

Semi-structured interviews were the chosen method of following up on observations with individual chaplains. All of the chaplains were to be interviewed on site over the course of two weeks. The use of interviews raises questions regarding the authenticity of responses, while interviews that take place at a structured time tell the social researcher “little about a reality that is ‘external’ to the interview” (May 2001: 143). However, asking questions that participants had not previously considered provides an opportunity to “[evoke] a deep already held conviction” (Astley 2002: 102-103) while following up on important themes from the observations. Individual interviews were chosen over focus groups in order to allow chaplains to speak more openly about the personal elements of their work without having to worry about the presence of their colleagues. Similarly, some participants may dominate in focus group settings, precluding other participants from contributing fully. All participants gave consent for their interviews to be recorded using audio equipment.

### *Analysis*

Initially the data was going to be analysed using manual qualitative coding techniques. However, due to the lengthy interview transcripts (see Appendix D) and extensive fieldnotes, the qualitative data analysis software NVivo was utilised in order to manage the data. Three transcripts were manually coded in order to discern preliminary themes which were subsequently broken down into subthemes for further coding (see Appendix E)

### *Implications*

Due to the inability to shadow, detailed insights into how the “inhabited worldviews” of healthcare chaplains are enacted were unobtainable. Similarly, the inability to be immersed

in the research context for an extended period of time compromises the validity of the project findings as prolonged exposure to the research context which “lends credibility to narrative account” (Creswell 2009: 192). Nevertheless it is hoped that attendance at numerous chaplaincy events, extensive consultations with the chaplaincy team and the two week observation period will have helped with acquiring a detailed understanding of chaplaincy required to fulfil this criteria for validity.

### **Summary**

Throughout the study numerous limitations impact the overall design. PT was utilised as a method of engagement, allowing for a critical interplay between my own beliefs, theology, and the contemporary situation (Pattison 2000: 135-136). Theoretical methodologies which recognise the intersubjectivity of the researcher-participant relationship and blur the boundaries between theology, sociology and the study of religion have been utilised. The necessary changes made to the methods of data collection shift the emphasis definitively towards ‘espoused’ rather than ‘embodied’ theologies, rendering a fully sustained enquiry into the enactment of chaplaincy unobtainable.

## CHAPTER 4: THE FINDINGS

This section summarises the key themes arising during the study. Five themes have been selected in accordance with the significance attributed to them by the participants. First, *remit* was often mentioned unprompted, making a significant contribution in the literature in relation to minority faith chaplains. Then the ways in which *institutional factors* affect the team will be examined, focusing on the growing pressure for chaplains to conform structurally to the institution. *Models of chaplaincy* will then be explored, with extensive reference to generic chaplaincy as a source of considerable tension. The fourth theme is *distinctiveness* in terms of religious identity and the ways in which institutional factors may infringe on the uniqueness of chaplaincy. Finally, it was found that *humour* was an important way of characterising relationships within the team. Before continuing, a few caveats will be discussed, followed by a methodological reflection on the fieldwork.

### Some Caveats

1. *The chaplaincy team is currently undergoing significant personnel changes and anticipating a time of transition*

During the study I was informed that several chaplains would be leaving the team over the coming year. Chaplains with their own unique approaches will be replaced with chaplains who have other gifts, attributes and experiences which inform their work. Chaplain A commented that “I wouldn’t say that’s a limiting factor for the research, but it’s a significant factor... [things] are felt more acutely at the moment.” This project therefore provides a snapshot which is focused on a chaplaincy team at a particular time.

## *2. The hospital serves nationally and internationally*

On presenting the preliminary findings to the team, one chaplain observed that the hospital demographic does not reflect the broader demographic of the city in which it is situated. The hospital instead serves on a national and international basis due to its specialist status, complicating considerations of provision and representation.

## *3. Defining 'inter-faith', 'multi-faith' and 'inter-religious'*

Most chaplains referred to their working as 'multi-faith' rather than 'inter-faith'. All chaplains expressed dissatisfaction with the term 'inter-faith', which gives the impression of "pretending we're all the same" (chaplain C). However the Catholic chaplain preferred the term 'inter-religious' over 'multi-faith' for similar reasons, due to its usage in the Catholic Church's official documents. In the following chapters, the term 'multi-faith' will be used to describe the chaplaincy team as it was a term favoured by most of the team.

## *4. Recognising distinctiveness within the chaplaincy team*

The above clarification of terms relates to the importance attributed to religious distinctiveness. In a multi-faith team, with minority faith chaplains who are better integrated in the team than in other hospitals in the UK, there is a greater sense that self-definition is required.

## *5. What are 'minority faiths'?*

The use of the category 'minority faith' raises the question of which groups are included. For the purposes of this thesis, minority faith is a blanket term used with reference to Muslims, Hindus, Sikhs and Buddhists. This is primarily due to the

relatively recent addition of these communities to the British cultural and religious milieu. The status of Catholicism as a minority faith is contested, and will not be referred to as such.

#### *6. Chaplaincy as service*

During this chapter, chaplaincy will be referred to as a service rather than a profession, as many chaplains in the team displayed little interest in the professionalisation agenda. More emphasis was placed on professionally appropriate behaviour rather than formal processes of professionalisation.

### **Methodological Issues Arising**

#### *The Study in Practice*

As shadowing was not possible, long periods of inactivity in the chaplaincy office were anticipated. However, it was rare for there to be no activity for more than two hours at any given time. Whether this was because chaplains altered their working patterns to accommodate an observer is open to question.

Initially chaplains were informed that the interviews would last up to an hour, although in some instances follow-up interviews were arranged due to time constraints, or because the participants wanted to contribute more to the study. It was more difficult to arrange interviews with part-time chaplains due to other demands on their time, while full-time chaplains were more flexible and allowed me to continue the interview for longer than specified. Consequently, the study period was extended by a month. The interviews took place in the faith centre where the team is based.



### *Limitations of the Study*

This study inadvertently focuses more on the members of the team who frequently use the chaplaincy office, constituting an obvious and important disadvantage. Therefore Christian chaplains have a stronger presence, as part-time minority faith chaplains tended to work in hospitals across the city. However the absence of these part-time chaplains from the chaplaincy office gave insights into how being part time might affect efficacy.

### *Researcher Presence in the Chaplaincy Office*

My presence provoked a sense of ambivalence and uncertainty, as one chaplain asked at the beginning what I expected from the fieldwork. The team were informed that my presence should cause minimal interference, and I was in turn assured that I could ask questions. There were instances where chaplains seemed to stay in the office longer to discuss and reflect on certain issues than they would have done had a researcher not been present, constituting an additional process of meaning construction. Given that this project relates to chaplains' self-understandings, this was not viewed to be a major disadvantage. Similarly, some chaplains were uncertain about how they would be presented, asking whether fieldnotes would be censored, while others saw me as a mirror: "your presence is like having a conscience in this office. I kind of like it, but kind of resent it" (chaplain F). There were points during the study where participants asked me questions about previous events, knowing a written record had been kept.

### *(Mis)representation*

During the observations, my inability to observe chaplains on the wards caused some confusion among the participants. At one point, a chaplain joked that he could say anything, and informed me that he could have sacrificed a chicken on the ward that day. There were

occasions in the office where Christian chaplains consciously and humorously misrepresented themselves. It is possible that banter in the office was more prominent than usual due to my presence. This raised significant issues: it was not appropriate to remain completely aloof but it was difficult to discern where boundaries should be drawn in terms of my participation. Usually my involvement was dependent on familiarity with particular chaplains.

### *Confidentiality in Practice*

It soon became obvious that retaining confidentiality would be difficult due to familiarity between team members, making it easy to attribute quotes to participants during the fieldwork. I complied with all requests to omit or remove quotes from fieldnotes in accordance with the participant information sheet.

### **Remit**

#### *Broadening the Function of the Healthcare Chaplain*

Remit was the most significant category during the fieldwork, and while chaplains were asked specifically about remit during the interviews, they often referred to their role unprompted throughout the study. It became apparent that referring to 'role' confined the activities of chaplaincy to the hospital, rather than engaging with what chaplains do in the wider community, and how they relate to their respective faith communities in particular.

The espoused bottom line of the chaplain's role in the hospital was the provision of religious, spiritual and pastoral care to patients, visitors and staff (chaplains A, E, I). This was worked out variously among the chaplains. While this is the intended crux of chaplaincy practice, other responsibilities were prioritised over spiritual care, such as accountability and promotion, teaching, education and consultation. This section will first explore the boundaries set by chaplains as a point of comparison between Christian chaplains and minority faith

chaplains. Then the association of chaplaincy with bereavement will be discussed, followed by an exploration of how the remit of healthcare chaplains can be more broadly characterised. This does not include all elements of the chaplaincy remit, but instead covers aspects which received little coverage in the literature and were most significant in the fieldwork.

### *Boundaries*

During the study, chaplains referred to boundaries in terms of religion-specific provision, and how they characterised their relationship with their respective faith communities.

#### *1. Religion-specific Provision*

All chaplains agreed that there were boundaries for provision of spiritual and religious care, and for what volunteers were able to do. While the ‘generic’ role of the chaplaincy team was frequently mentioned, the team often referred to religion-specific provision where any specific requirements would always be carried out by appropriate chaplains. It was also clear that chaplains undertook religion-specific services and rejected ‘inter-faith worship’. This is an important aspect of maintaining distinctive religious identities within the team.

Chaplain K noted that when he was a religious representative visiting the hospital, before becoming a part-time chaplain, he had been unaware of the “dos and don’ts” of patient visiting. As the role of minority faith visitors was formalised, the boundaries for what was appropriate for the chaplaincy role became clearer. The boundaries for the team have been set in a Statement of Common Purpose which “recognises boundaries ...it’s saying those things we’re going to try and do together, but it’s not pretending we’re all the same” (chaplain C).

## *2. Chaplaincy in the Hospital, Chaplaincy in the Community*

While chaplain C informed me that the ‘strapline’ for the chaplaincy team is “a department which is passionate and professional at the heart of the Trust and the community”, the implications of this differ between the Anglican/Free Church chaplains, and the Catholic and minority faith chaplains. Generally, the Anglican/Free Church chaplains did not follow up their work once a patient had been discharged, instead seeing this as the responsibility of the community. Relationships were contingent on the length of the patient’s stay in hospital. Chaplain C also noted that the team are not encouraged to undertake funerals unless they were for staff. The only exception in which Anglican/Free Church chaplains engaged extensively with the wider community during the study was a consultation event hosted by the chaplaincy team, although this required the communities involved to meet with the team on NHS turf. This was for the purpose of asking “basic questions about the relationship between the Trust and those faith communities” (chaplain A). Community work was briefly mentioned by the Catholic chaplain, although this was not mentioned in detail. Conversely, the boundaries between Muslim, Sikh and Hindu chaplains and their respective communities are more fluid, primarily due to the recent “approximation” of chaplaincy for these religious communities (Gilliat-Ray 2001: 137). Consequently, most of the minority faith chaplains felt it was their responsibility to raise awareness about chaplaincy and NHS provision within their faith communities. At the same time, these chaplains had to constantly reinforce boundaries in terms of confidentiality because these communities are so small and for the sake of appearing professional (chaplain E, fieldnotes from 5<sup>th</sup> April 2013). Despite the fluidity of boundaries between minority faith chaplains and their communities, all of these chaplains

emphasised that their role in the community should be differentiated from their role as chaplain in the institution.

### *Links to Bereavement*

During the study, a recurring theme was the constant association made between chaplaincy and bereavement. Several chaplains noted that the clerical collar bolsters the expectation that the chaplain is present because a patient is dying (chaplain A), particularly as funerals are the primary context in which the clerical collar is worn (chaplain C). During the interviews, eight chaplains referred to bereavement unprompted, while minority faith chaplains in particular are often consulted for end of life situations and funeral arrangements. One Muslim chaplain demonstrated extensive knowledge about cemeteries suitable for Muslim burials, but also indicated that consultation was a vital part of the Muslim chaplain's role in order to distinguish between correct religious practice and the wishes of the family or cultural traditions (chaplain I). The requirement for practical religion-specific provision at the time of death is an important contributor to this link made between chaplaincy and bereavement. Significantly, chaplain C considered one of the primary roles of the chaplain to be the provision of the appropriate language to deal with bereavement, further reinforcing this connection between chaplaincy and bereavement:

*“The death free generation is good until death comes along! And then there isn't the language, the history, the experience even... that's where perhaps you have that role to play...” (chaplain C)*

Some chaplains tried to prioritise other aspects of their remit, or dissociate themselves from bereavement: “Of the call outs that I get, there are many more that are not to do with end of life than there are to do with end of life” (chaplain A). Chaplaincy inevitably has a

significant role in dealing with bereavement, despite attempts by some chaplains to distance themselves from this aspect of their role. However, the chaplain's role is not limited to bereavement, and the rest of this section will focus on remit beyond its immediate connotations of bereavement.

#### *Promotion, Teaching, Education, Consultation*

Most of the chaplains interviewed referred to promotion, teaching, education and consultation, although this was mentioned more frequently among the minority faith chaplains. These educational elements constituted the bulk of their work, despite the emphasis on prioritising patient visiting. However, there is a distinct difference in focus in teaching between Christian chaplains and minority faith chaplains.

For Anglican chaplains, these aspects were more generalised, focusing on facilitating spiritual care and teaching staff about spirituality, with some reference to improving religious literacy. The consultative role for these chaplains remained within the institution, particularly in relation to complaints made against the Trust (chaplain D, and fieldnotes from 8<sup>th</sup> April 2013), or as panellists on ethical committees (chaplain C). The Anglican and Free Church chaplains tended not to be involved with broader faith organisations or chaplaincy bodies in a consultative capacity, with chaplain C noting that: "I decided to...throw my hat in with the NHS."

Conversely, the Sikh, Hindu and Muslim chaplains had a significant role in promoting NHS facilities and chaplaincy provision to their respective faith communities due to lack of awareness. This was usually in conjunction with promotional and educational work within the institution, as well as consultation at a national level with organisations which represent their faith communities and chaplaincy organisations, such as the College of Healthcare Chaplains (chaplain G). Minority faith chaplains have a significant consultative role in the institution,

particularly in the case of Muslim and Sikh chaplains and their knowledge of end of life ritual and everyday practical religion- or culture-specific issues.

Minority faith chaplains are as much ambassadors *for* the NHS to their faith communities as they are for their faith communities *within* the NHS, often informing their communities about health issues and NHS provision, including chaplaincy (Chaplain I and G). At the same time, this advocacy of the NHS is also with a view to encourage minority faith communities to *contribute* to the Trust. Three minority faith chaplains stated that they promote organ donation (chaplains I, J and K), and during the fieldwork it became apparent that staff in the NHS saw chaplaincy as an avenue for raising awareness in these communities about the employment opportunities in the Trust (fieldnotes from 11<sup>th</sup> April 2013).

Significantly, one chaplain noted that accountability measures do not acknowledge the above elements of their role (fieldnotes from 8<sup>th</sup> April 2013). Given the prominence of this aspect to the role, these accountability processes understate the workload of chaplains both inside and outside the hospital. This shall be explored more fully when examining the institutional context, in which accountability measures fail to recognise the chaplain's role as being anything other than patient support.

Several chaplains noted the importance of learning on the job, particularly in reference to other faith traditions (chaplains B, D, F). Minority faith chaplains had a pioneering role and most did not have formal qualifications relating to chaplaincy, relying instead on their previous experience in community work (chaplains E and H). Similarly, due to the increasing recognition of religious and cultural diversity, there is a growing need for chaplains to at least become culturally aware in order to understand some of the requests made by families and patients.

### *Communication and Translation*

Translation was important for minority faith chaplains, primarily due to the language barriers faced by members of their communities when entering hospital. Three chaplains spoke of the importance of speaking the language of the patient in order to make them feel welcome in the hospital. However these chaplains were also cautious to add that this was explicitly in their capacity as the chaplain, rather than being a translator for the hospital (chaplain H, chaplain I). Often minority faith chaplains have to inform staff that translation is not their primary role. Similarly, minority faith chaplains had a significant role in communicating and advocating the needs of the patients to other healthcare staff.

Communication and translation was also referred to in terms of how chaplaincy translates religious concepts so that they make sense in a secular environment, particularly as it was felt that chaplains have a responsibility to communicate their role to management (chaplain A). Mindfulness practice has been articulated in secular terms, although some wariness was expressed about the translation of these concepts might lose sight of the original meaning (chaplain A).

### *Team Dynamic*

Several chaplains noted the importance of building relationships within the team in order to develop a strong support network. This support became apparent in delegating and covering for other chaplains, while enforcing the appropriate boundaries, demonstrated by the allocation of wards among Anglican chaplains (fieldnotes from 3<sup>rd</sup> April 2013), and minority faith chaplains visiting each other's patients due to availability. Two chaplains commented that because they work part time they need support "otherwise I can't do the jobs" (chaplain G) and that it is "easy to be isolated" (chaplain B). Support was also evident when chaplains



felt they were able to share their experiences with each other (chaplains E, H, I), or in one instance where a chaplain was visited by other members of the team while he was ill (chaplain F). Additionally, an Anglican chaplain co-ordinated a group where chaplaincy volunteers could meet in order to discuss their experiences (fieldnotes from 10<sup>th</sup> April 2013), while a Muslim group supervision brought together chaplains and volunteers across several Trusts to support each other (fieldnotes from 5<sup>th</sup> April 2013). Therefore chaplains are keen to provide a support network for the wider team of volunteers. This support network was valued among chaplains, and one chaplain stated that this was one of the few teams they worked with that had the time to reflect on their work.

One chaplain saw it as an important responsibility for the team to “have a social relationship”, but also felt the team was working less collaboratively than they had done previously (chaplain F). The regular use of banter and humour demonstrated a certain level of familiarity, which will be examined in later discussions about humour.

While chaplains were keen to emphasise their differences, it seemed that the team were able to work well due to the way they conceptualised their relationships with each other. While religious conviction is an important aspect of chaplains’ identity, chaplains across faith groups often referred to each other as ‘neighbour’, ‘brother’ or ‘sister’. This was further reinforced by Hindu and Muslim chaplains stating that from their own religious perspectives, all human beings are encompassed in a wider family.

Most of the chaplains were unsure as to how the ‘team’ coheres, with one chaplain asking “are we a team or lots of little teams under one umbrella?” (chaplain A), primarily due to the vast differences between chaplains relating to remit and how generic approaches to chaplaincy work out in practice. The question of how the team coheres is difficult precisely

because the team is going through significant changes of personnel, and much of the team dynamic is dependent on personality.

### **Institutional Context**

Within the first few days of observations it became apparent that institutional factors had a significant impact on efficacy. These factors ranged from practical everyday nuisances to wider questions of ethos and worldview. The question of ethos will be discussed in order to give a context for framing smaller practical issues.

#### *The Chaplaincy 'Ethos'*

Only one chaplain explicitly mentioned a normative idea of the 'ethos' of chaplaincy during the study:

*"...chaplaincy...doesn't quite fit in... [Previously] it was a much more relaxed ethos.... There was a feeling things were taken on trust whereas [now] things aren't taken on trust... because things were taken on trust people would chronically overwork..." (chaplain F)*

This 'ethos' has also been implicitly referred to by other chaplains, and has partly been characterised as the retention of a distinctive identity within a secular institution. Chaplain A noted that it is the responsibility of chaplains to "honour our own heritage" as chaplains are employed on the grounds of their religious conviction. The idea that chaplaincy can be "isolated" (chaplain E) and "exilic" (chaplain A) was seen as a primary trait, although there was a desire for the team to be better integrated into hospital life, especially in terms of developing stronger relationships with staff (chaplain A). Additionally, flexibility is a prized

element of the chaplaincy ethos due to the unpredictability of patient need (fieldnotes from 5<sup>th</sup> April 2013).

Throughout the study a clash of ethos between the host institution and the chaplaincy team emerged, as some institutional issues prevented the team from maintaining its ethos unchallenged. Other issues raised also impact the efficacy of chaplaincy but do not necessarily threaten the core values of the chaplaincy team.

#### *Accountability Measures – Must Chaplaincy Fight its Corner?*

Accountability was a prominent concern in both in the fieldwork and in the interviews, particularly highlighted by the recent addition of the line manager to monitor team meetings, the implementation of a daily and yearly strategy for the team, and ongoing discussions about how to record patient visits. The requirement to be held accountable was articulated starkly in a team meeting when the chaplains were told that “the Trust will look at [the] chaplaincy budget and make cuts unless [the team is] held accountable” (fieldnotes from 3<sup>rd</sup> April 2013).

The push for accountability present since the reorganisation of the NHS has been reinforced by the current economic situation, which places further pressure on chaplaincy teams to make the case for financial resources. This economic strain clashes with the desire to provide a “level of care that we can’t afford” (chaplain B), while two of the chaplains commented that chaplaincy is being “downgraded”, demonstrated by the substantial decrease in pay for the replacement team leader (chaplain F, fieldnotes from 8<sup>th</sup> April 2013). The team is asked to provide quantifiable data about how their time is used, which fails to account for the entirety of their role and requires chaplains to reduce meaningful patient interactions to numbers. A corollary of this is an increased bureaucracy, adding to the workload of the team, described by one chaplain as “Kafka-esque” (Chaplain F).

While it was felt that some of the accountability measures were inappropriate and intrusive, several chaplains accepted that being held accountable was important for the continued survival of chaplaincy:

*“We need to be a bit more savvy about things, and we do need to sell ourselves more than ever...because our position is threatened from time to time, or called into question at least.” (chaplain A)*

Among the chaplains who had spent less than five years working for the NHS, these accountability measures tended to be seen as normal, and did not consider chaplaincy to be under any particular threat in comparison to other departments, but did note that quantitative accountability measures were unhelpful. However, chaplains who had worked in the Trust for longer saw the broader institutional changes over time as a threat specifically to chaplaincy:

*“I think it’s purely human nature that if people see resources being cut, you’ve gotta fight for your own corner....” (chaplain F).*

#### *“I’m chasing my tail” - The Limits of Being Part-time*

Part-time chaplains often reflected on the practical barriers to their efficiency, with chaplain D noting that “since I’ve been part-time I have found I’m chasing my tail” while chaplain E stated that being part-time also meant being “out of the loop.” These practical barriers contrast with the more abstract barriers expressed by the full-time chaplains, who reflected on how their personal circumstances affected engagement with the patients (Chaplain A), and that fewer patients and staff understand the relevance of the chaplaincy role in a secular context (chaplain C). These comments echo broader contextual issues and are less grounded in the everyday workings of the hospital or the terms of employment.

Conversely, being part-time has been a source of considerable frustration for minority faith chaplains, who “haven’t got the time to engage” (chaplain C). This affects interactions with patients and the development of relationships within the team and with other members of staff. Time constraints are inherent to the part-time role, especially as chaplains of minority faiths effectively work on a full-time basis across several hospitals and trusts. The most vivid example was when I came across a chaplain who had locked himself out of the chaplaincy office after misplacing the correct ID card. Being part-time prevents chaplains from spending as much time as they would like with patients, particularly after an operation. Part-time chaplains also find it difficult to catch up on changes made in the team, such as the implementation of a new patient database, and the only time the whole team were able to catch up was at the monthly team meeting. However, time was often problematic at these meetings, and it was common that issues were not discussed as fully as necessary.

#### *The ‘SMART’ Clocking-In System*

This clocking-in system, which requires chaplains to work standardised hours, is specific to the research setting and was the source of considerable unease among chaplains. One chaplain felt that the system was implemented to ensure chaplains are working the allocated hours (chaplain F, fieldnotes from 2nd April 2013), while another chaplain stated: “I’ve gone from working many... hours over of my allotted time to basically being told off if I’m here for ten minutes longer than I should be” (Chaplain D). The system intended to ensure that chaplains are being held accountable severely impedes efficacy in practice. However, one chaplain acknowledged that “[It’s] not designed for us. But then we’re a small part of the NHS” (fieldnotes from 11<sup>th</sup> April 2013). These constraints on flexibility restrict contact between members of the team, and leave chaplains unable to cater to the immediate and

unpredictable needs of the patients. Consequently, chaplains “sign in but we don’t leave” (fieldnotes from 11<sup>th</sup> April 2013).

### *Patient Records*

The first significant complaint made by the chaplaincy team was the poor recording of the religion of patients. This became a prominent topic of discussion during the team meetings, and the chaplains were proactive in reporting errors made by staff when recording religion. Chaplains suggested numerous reasons behind inaccurate patient information, including embarrassment about asking the religion question, not having enough time to adequately record information, genuine mistakes, and hostility towards religion or failure to take religion seriously (fieldnotes from 20<sup>th</sup> February 2013). Consequently several chaplains noted the importance of a good relationship with other healthcare staff in order to obtain referrals and for patient information to be recorded correctly.

An updated patient database was implemented just before the study commenced and has been received with enthusiasm from all team members, as this has provided the team with up-to-date and more accurate patient information, improving efficiency. Only one chaplain expressed dissatisfaction with the system used for patient records, explaining that proliferation of categories pertaining to Buddhism is unhelpful to staff who are unaware about the branches within Buddhism. While most chaplains were happy with the system, some part-time chaplains found it difficult to adapt.

### *Comparing Contexts*

During the interviews, Christian chaplains tended to compare the institutional context of the hospital with their churches. The sense of marginalisation from their churches was prominent, as chaplains either thought that chaplaincy was not seen as “proper ministry”

(chaplain A) or that the church did not adequately reflect on ministry outside parish boundaries (chaplains A, B, C). Some chaplains were keen to highlight the differences between chaplaincy and parish ministry. Chaplain A stated that “I’m nourished by [being alongside individual people] more than I am employing people and managing people and raising money [in the parish]”. Chaplain C stated he preferred working for the NHS because “you’re much more a professional and treated as a professional...they have expectations of you and standards that they set.” It was also felt that being a chaplain who goes out to meet with patients gave the opportunity to engage with those who would not ordinarily approach a minister, which was considered to be a “very rewarding ministry” (chaplain F).

Minority faith chaplains stated that their faith communities lack the institutional structure for dealing with issues such as support, authorisation and ease of co-ordination (chaplain J, chaplain G). The eagerness to differentiate themselves from their role in their faith communities was much less evident.

### **Modelling Chaplaincy**

Despite being informed during the early stages of the study that the team had a variety of models for their work, these models were not clearly articulated when chaplains were asked to elaborate during interviews. The only exception appeared to be the sacramental model of the Catholic chaplain due to the particular expectations of the patient. Six chaplains explicitly referred to operating in a ‘generic’ sense, while others referred to this generic role as ‘spiritual care’. Most chaplains referred to spiritual care; few defined or clarified it. The clearest explanation was given when I was told about the training sessions about spirituality run by

some members of the team, in which spirituality is associated with resilience promotion<sup>7</sup> and offering new definitions of healing (fieldnotes from 9<sup>th</sup> April 2013).

Despite semantic differences, most chaplains describe themselves as providing spiritual care for all, although priorities diverge depending on individual chaplains. It was evident that there was not a particularly coherent model to be articulated, with chaplain A noting that attempting to create coherent models was “disingenuous” (fieldnotes from 10<sup>th</sup> April 2013). This sentiment was echoed implicitly by the reluctance of the remainder of the chaplaincy team to articulate coherent models.

### *Generic Chaplaincy*

Generic chaplaincy was considered from the outset as it is a contemporary realisation of the chaplain as universal. It quickly became apparent that generic chaplaincy was a significant point of contestation and debate. Chaplains of different faiths had formulated ways of explaining generic chaplaincy in accordance with their own faith tradition, although one chaplain in particular was cautious about the concept of generic chaplaincy as a whole and actively spoke out against it. Three chaplains stated that they disliked the use of the term ‘generic’ because of its connotations (chaplain A), while acknowledging that they work in a ‘generic’ capacity.

Generic chaplaincy is conceptualised differently among the chaplains, leading to a lack of clarity and allowing for a proliferation of negative connotations. This is compounded by different outworkings of this model, evident by the ways in which minority faiths have variously interpreted the ‘generic’ component of their role. Several chaplains attempted to define generic chaplaincy, but often spoke of the possible risks instead. Chaplain J noted that

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<sup>7</sup> Resilience promotion is the provision of resources and support in order to help patients confront and deal with stress, trauma and adversity, often with reference to a spiritual framework (see Benson and Thistelthwaite 2008: 88; 94)



the attempt to be “all things to all people” was more widespread in America than it was in UK, while stating that this approach may “never be acceptable in the UK”. Instead he referred to generic chaplaincy simply as ‘spiritual care’, and shared most chaplains’ reluctance to use the term generic to describe their inclusive role.

### *Concerns about Generic Chaplaincy*

One of the primary concerns was that a generic approach could lead to chaplaincy becoming a “characterless sludge” which glosses over differences among a “rainbow group of people” (chaplain F). While this concern for integrity and distinctiveness was not shared by other members of the chaplaincy team, chaplain A did note that there is a danger that the institution expects generic chaplains to be all things to all people:

*“I don’t have a huge problem with [generic chaplaincy] as long as the people in post and those who employ them recognise that there is always a limitation to what those people are able to do.”*

However chaplain F also expressed a broader concern that a “two-tier chaplaincy is evolving”: generic chaplains and religion-specific chaplains. This chaplain believed that generic chaplaincy is increasingly being prized over religion-specific chaplaincy in the institutional agenda as this is more cost-effective:

*“I think at the moment the attraction [of generic chaplaincy] to a lot of Trusts is cost driven... I’m convinced in a number of these Trusts [think] that really we should evolve beyond the faith-specific thing.” (chaplain F)*

This also raises the question of who provides spiritual care. If there is no firm faith grounding for approaching chaplaincy, what prevents spiritual care provision from being left solely to other hospital staff such as nurses who are trained in spiritual care? Ultimately the primary concern is to retain religious and denominational distinctiveness and maintain the integrity of chaplaincy as a faith-based service.

### *Retaining Theological and Religious Integrity*

All of the chaplains who embraced ‘generic chaplaincy’ or ‘spiritual care’ stated that being firmly rooted in a particular faith was vital to effective chaplaincy work. These chaplains did not consider generic chaplaincy to be a threat to religious distinctiveness, but instead provided the fulfilment of fundamental religious imperatives. These included the idea that “God is in everyone” (chaplain C; chaplain K), and that humans are “all created and loved by God, and that our experiences are to be honoured” (chaplain A). The universality of God provides a significant grounding for inclusive approaches to pastoral care. Other chaplains discussed connecting with people on the level of their humanity. An inclusive approach to chaplaincy was justified by Hindu and Muslim ideas surrounding the family, while Christian and Muslim chaplains found parallels between Biblical and Qur’anic verses referring to indiscriminate hospitality (chaplain I, chaplain E).

### *Generic Chaplaincy in Practice*

Generic chaplaincy represents a shift towards more proactive approaches of chaplaincy, as opposed to the reactive approaches which simply respond to referrals made to the team. Christian chaplains are assigned to wards in order to look for patients who may require spiritual care, and refer patients to chaplains of other faiths if religion-specific

provision is required. There is a stronger tendency for Anglican chaplains to speak with and offer spiritual care to agnostics and atheists than for other chaplains.

This differs from the approach of minority faith chaplains in the team whose first priority is their own faith community and responding to referrals, primarily due to time constraints. There is still a generic proactive element to the work of minority faith chaplains, although this is more targeted than the work of Christian chaplains. One chaplain informed me that he looked for names on patient boards on the wards which sound like they come from a particular geographical region, often resulting in meeting patients whose religion is not recorded properly (chaplain I). Culture and language provide a significant point of engagement between minority faith chaplains and the patients they visit.

### **Distinctiveness and Integrity**

#### *A Distinctive Service?*

Several chaplains referred to chaplaincy as a distinctive profession due to its peripheral status in the NHS and how its approach to patient care differs from dominant medical and institutional discourses. As chaplain F noted: “we’re not... [here to] take your temperature or give you tests or horrendous things like that. So you’re on a different level than the other people.” There is a sense that, because of the marginal position of chaplains, patients may find it easier to speak with someone who is “not clinically involved...I sort of make a point of not looking at the notes and seeing what the issues are... I like the patients to take me through...tell me what they want” (chaplain B). The chaplain’s status as “exilic” (chaplain A) in relation to medical and institutional discourses often proves to be an advantage when interacting with patients, providing a distinctive and non-intrusive way of working with patients. Part of this distinctiveness is facilitated by being flexible: “we are paid

to have the time (hopefully) to get out and see the patients and offer them something that perhaps the rest of the staff can't" (chaplain D).

### *Chaplains as Facilitators of Spiritual Care*

The precedence of faith in being a chaplain was often cited as what makes chaplaincy unique. This becomes increasingly important as chaplains argued that spiritual care can be offered by anyone in the hospital. As chaplain J notes "all staff, particularly nursing staff, have their training in spiritual care, so no way is chaplaincy claiming that they're *the* spiritual carers" (italics my own), while chaplain A stated that chaplains have a responsibility to teach staff about "the role that everybody in this organisation plays" in meeting those spiritual needs. The most significant contribution to this discussion was chaplain A's anecdote of when he went to see a patient and instead saw

*"...a nurse sitting on a chair a few meters away from the patient, not doing anything, not saying anything, just being with this guy. And that really struck me ... firstly because it kind of said to me that healthcare isn't just about busyness and doing to, it's about companionship, and being with and presence, incarnation if you like...The other thing that ...made it all the more poignant for me is that [the nurse] is an atheist. And it said to me that spiritual care is something that people who don't profess a faith can do and do beautifully. And that was wonderful to see."*

While it was asserted that faith is vital to maintaining the uniqueness of chaplaincy, there was no real attempt by any of the chaplains to verbalise *how* exactly faith makes an impact on the spiritual care that they offer. This demonstrates a lack of clarity about the distinctive contribution of chaplains to spiritual care over against staff without a faith

background, and how faith offers an alternative mode of engagement to neutral professionalism.

### *Visual Distinctiveness*

Several chaplains, including those from minority faiths, mentioned the clerical collar. This prompted me to ask chaplains from other faith traditions whether they were recognised as chaplains as they did not have a particular uniform as a visible marker of their role. The distinctiveness of the clerical collar is seen as both an advantage and a disadvantage because it identified Christian chaplains, but also carries the connotation of bereavement because “the only time [people] see clergy is at funerals” (chaplain C). Interestingly, the association between death and certain types of dress was given as a primary reason by one of the Sikh chaplains for not wearing a distinctive uniform (chaplain H). For other minority faith chaplains, it was felt that wearing a uniform might be unhelpful for making connections with patients and create barriers rather than build bridges (chaplain J).

Visual distinctiveness is also signified by the faith space where the team is based, which was considered to be one of the team’s greatest achievements (chaplains C, F, I). This multi-faith centre provides structurally differentiated spaces for Christians and Muslims in the form of the prayer room and the chapel, but also has additional resources available, such as religious props and texts relevant to Hindu, Buddhist and Sikh traditions. Thus the multi-faith centre is a visual signifier of the way religious traditions are encouraged to remain distinct. However, the chaplaincy team had to make the case for such a space (chaplain C), while the continued development of the space requires negotiation with the PFI company which

manages the hospital (fieldnotes from 11<sup>th</sup> April 2013).<sup>8</sup> Both the design and the maintenance of the space have involved extensive dialogue between chaplains of different faiths.

### *A Reflexive Profession?*

Another distinctive element of chaplaincy is self-awareness and reflexivity, exemplified by chaplain A who explained that empathy is very much dependent on his own life experience: “I was very struck by how much... [my] life experience impacts the way I meet people and which lines of enquiry I choose to follow.”

This reflexivity was also demonstrated in the acknowledgement of the relative position of power that chaplains have as they tend to be healthy and able-bodied, and therefore unable to engage fully with the patient in their illness. It is this continued reflexivity about their own perspective and baggage that enables chaplains to attempt to engage honestly with patients:

*“At the end I said to her ‘I know how you feel’ and then what she said: ‘no you don’t. It hasn’t happened to you.’ That really stuck... and I said to myself ‘yes, she’s right, no matter what I do, no matter what I feel...I won’t feel the same what she’s feeling at the moment’” (chaplain G).*

Four of the chaplains, three Anglican and one Muslim, noted the importance of having a spiritual director to help them reflect on their experiences as chaplains. This tended to occur on an individual basis for the Christian chaplains, but the Muslim chaplains and volunteers from across different trusts also meet once a month for a group reflective supervision session. Conversely, the Sikh, Hindu and Buddhist chaplains made no reference to either supervision

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<sup>8</sup> Private Finance Initiatives facilitate the development of public infrastructures in conjunction with private companies.

groups or individual mentors, with Sikh and Hindu chaplains noting the lack of resources to support them in their work. Instead, chaplain H referred to spiritual discipline through prayer and meditation, rather than seeking external help.

### *A Distinctive Identity?*

Given that emphasis was placed on faith as the starting point for chaplaincy work in order to differentiate between chaplaincy and other healthcare professions, it is worth examining the distinctiveness of chaplains in relation to each other. This question can also be framed in terms of theological integrity, which was of particular concern to Christian chaplains, and how multi-faith working was negotiated by the team. There was a strong sense that chaplains should work from their own faith perspective, although the chaplains found it easier to work on a multi-faith level than an ecumenical level (chaplain A, fieldnotes from 10<sup>th</sup> April 2013). The emphasis on having a well-defined faith perspective was illustrated by chaplain F's comment that "good fences make good neighbours", and this applied as much to the different denominations among Christian chaplains as it did with the team as a whole. There were several instances where chaplains were either criticised for not being distinctive enough or for lacking integrity, exemplified when chaplain C stated that "I get Christian colleagues phoning me up and berating me because I lead a multi-faith team... What am I doing at Ram Navami and Vaisaikhi?"

While Christian chaplains emphasised establishing strong denominational boundaries during the observations and interviews, minority faith chaplains seemed less keen to categorise themselves in terms of smaller traditions within their faith communities when asked. The exception to this was the Buddhist chaplain, who stated he belonged to the Samatha school of meditation in response to the interview questions. One of the Muslim chaplains said "if I were forced to choose...then I would say that I belong to the Sunni group"

(chaplain E) while the Hindu chaplain did not identify with a particular branch within his tradition. However it became clear that resources from particular traditions were helpful to these chaplains, such as hadith about hospitality to those of all faiths for the Muslim chaplain, and the teachings about atman and Krishna from the Vaisnav tradition for the Hindu chaplain.

Some significant comments were made about praying for people of other faiths. One chaplain was under the impression that “the Catholics genuinely have a problem about...whether people of different faiths should be praying directly for each other” (chaplain D). This was true insofar as it was felt by the Catholic chaplain that prayers should always come from the respective traditions of the individual chaplains, retaining distinctiveness, and this was often echoed by other chaplains. The chaplains generally did not encourage ‘inter-faith’ prayer, although the Hindu chaplain referred to an instance where an Anglican chaplain offered a “universal” prayer for one of his patients and their family when he was unavailable.

### *Threats to Distinctiveness*

While the peripheral nature of chaplaincy is a primary way in which some of the chaplains conceptualise their distinctiveness (chaplains A and F), the chaplains were also aware of the institutional factors which hinder efficacy and attempts to encourage chaplains to structurally conform to the institutional context:

*“...[Chaplaincy is] between stalls really, and I think in the past, and still actually in the present in some other Trusts, that’s accepted and welcomed, and I think that’s very healthy. [But there] are many managers now ....that find it very hard to accept that and I think the feeling within this Trust is that ‘we’ve got to get chaplaincy really in the same box as everybody else....’” (chaplain F).*



This is illustrated by the demand to quantitatively measure the effectiveness of chaplaincy in the same ways that most other institutional departments are measured: patient interaction. These interactions are stripped of meaning and converted into numbers or the categories of assessment used by other professions, although chaplains occasionally challenged this by using language which reinforces the humanity of patients: “when I visit somebody, I need to visit like my brother or sisters...if I’m only here to see a client...then it’s like a tick mark” (chaplain G).

## **Humour**

Humour was a significant theme during the fieldwork, and provided an unexpected avenue of exploration. Banter was a major aspect of interactions between chaplains in the office, particularly between full-time and part-time Christian chaplains. Some reference had been made to humour between chaplains and other non-chaplaincy staff during the observations, although this was elaborated on more during the interviews, as was the use of humour with patients. The humour used between chaplains among themselves and between chaplains and non-chaplaincy staff was described as ‘black’ humour, as a way of dealing with everyday tensions and stress. Several chaplains commented on the usefulness of humour to rehumanise the situation with patients while having to break down barriers due to the continued links made between chaplains and bereavement. While humour was encouraged around patients, chaplains expressed the need for humour to be ‘pastorally appropriate.’ However, this account of humour between chaplains and patients or staff cannot be substantiated by observations.

While some chaplains referred explicitly to particular forms of humour, such as cheekiness (chaplain A) and political incorrectness (chaplain C), other chaplains described what is better known as light-hearted conversation which connected with patient experience,

particularly about hospital food (chaplain D), or in the case of minority faith chaplains, language and home countries (chaplain I). Only one chaplain referred to banter between himself and non-chaplaincy staff unprompted, where humour indicated affirmation of his role by a senior consultant (chaplain B).

### *Deliberate Misrepresentation*

During the observations, much humour was derived from deliberate misrepresentation, where individual chaplains feigned disrespect towards each other. Occasionally, two of the Christian chaplains presented themselves as antisocial, despite the emphasis on being a ‘people person’ as an important trait for being a chaplain (chaplains F and D). One chaplain casually stated “we’ll go and terrorise some patients” (fieldnotes from 9<sup>th</sup> April 2013) – a statement which would not be made so casually if the position of chaplaincy was not relatively comfortable, nor if there was a concern about my own interpretation of this statement. Banter also formed a significant part of how chaplains misrepresented themselves, particularly as casual references to ‘prejudice’ made between Christian denominations. As chaplain F explains: “part of our humour is implying that we’re all discriminating against each other and we all hate each other when actually we get on very well really.” Humour, for numerous members of the chaplaincy team, indicated familiarity and being welcome within the team.

### *Handling Tensions*

It became evident that humour was employed to handle and diffuse tensions relating to differences within the team and institutional constraints. The use of humour in relation to institutional constraints and intrusiveness was most apparent in the observations, particularly during team meetings. Only one chaplain referred to humour in relation to the institution in

the interviews, where, in the face of increasing bureaucracy and unquestioning acceptance of NHS policy, “the only thing you can do is laugh” (chaplain F).

Two chaplains mentioned that humour is used as a way of managing ecumenical differences, although one chaplain stated that humour is used to cover up or hide important denominational differences particularly in relation to sacramental theology, while the other thought that humour was a way of addressing differences in a safe environment. It is possible that both are true dependent on the disposition of the respective chaplains. It was suggested during the fieldwork that chaplaincy is not the appropriate forum for multi-faith dialogue, although conversely it was expressed that more effort should be put into ‘face-to-face’ encounter rather than just ‘shoulder-to-shoulder’ working (chaplain B). Thus different members of the team had varied opinions on the level of multi-faith dialogue that should take place.

### *Translating Humour*

Humour tended to be used between Christian chaplains, and the development of banter between Christian and Muslim chaplains was the product of familiarity and the negotiation of cultural differences. Both Muslim chaplains stated at first that they did not understand the humour used by the Christian chaplains, with one chaplain stating: “I laugh without understanding with everybody, then I ask what is the meaning and then laugh again” (chaplain I). Some instances where humour was used with Muslim chaplains often over-exaggerated religious differences (fieldnotes from 11<sup>th</sup> April 2013). It was difficult to examine the use of humour with other minority faith chaplains due to their rare appearances in the office, although team meetings demonstrated that humour between chaplains of all faiths tended to be well understood and received (fieldnotes from 3<sup>rd</sup> April 2013).

### *Humour as Stress Reliever*

Several chaplains noted that ‘black’ humour has a significant role in stress relief, although this was not the extent of the kind of humour that was adopted. Chaplain B presented the starkest example of black humour:

*“you’ve done end of life prayers and they’ve carried on living, how...how inconsiderate of them. You’d never say something like that... but there’s a sort of truth behind it.”*

This type of humour was associated with being a “pressure valve” (chaplain A) or a “coping mechanism” (chaplain C), which is “vital for survival” (chaplain A see fieldnotes from 3<sup>rd</sup> April 2013).

### **Summary**

The above chapter sketches some of the most important themes in the study, while providing a comparison between the ways in which chaplaincy is enacted among Christian and minority faith chaplains. This study has found that the while Christian chaplains tend to be more focused on the institution, minority faith chaplains have an extensive role in their communities. Some chaplains expressed a wish to be better integrated into the hospital, although there was also a tendency to assert distinctiveness primarily on a denominational level and also in relation to other healthcare professions. This chapter has also highlighted some ambiguities regarding what spirituality entails, particularly in terms of who can provide spiritual care and contributed new themes to the knowledge base, including humour and explicit examinations of generic chaplaincy.

## **CHAPTER 5: DISCUSSION**

### **Introduction**

This section will discuss some implications of the findings. Firstly, the findings will be compared to the primary sources from the literature review to document continuity and change. This will be followed by an exploration of specific themes arising from the findings and how these challenge or reinforce current trends in the literature.

### **Developments in Chaplaincy: Comparison with Primary Sources**

Wilson's statement that chaplains are "at the mercy of none" demonstrates the relative strength of the position of healthcare chaplains in the 1970s. Since Wilson's report, the status of chaplains has been increasingly subject to negotiation, especially as this chaplaincy team in particular is now required to present figures to the trust to "justify" the same level of budgeting, while being observed in the team meetings by their line manager. Considerable changes have led to chaplaincy being unable to fulfil many of the aspects of Wilson's normative vision for the profession, evident in later discussions of the 'universality' of the chaplain and distinctiveness.

The terms of employment of healthcare chaplains have made significant developments since Wilson's report, as his distinction between the role of full-time chaplains and part-time chaplains no longer has the obvious complementarity that Wilson envisioned. Part-time chaplains still struggle with time constraints and settling into hospital life, as well as building meaningful relationships with other members of hospital staff. While Wilson stated that part-time (Christian) chaplains are better integrated into their congregations than full-time chaplains (Wilson 1971:61), the findings suggest that part-time Christian chaplains did not

feel much better supported by their congregations than their full-time counterparts (interview B and D).

Conversely, part-time minority faith chaplains have the strong links with their respective faith communities that Wilson had initially envisioned for Christian chaplains. The relationship between the chaplains and churches that Wilson proposed is unlikely to materialise, especially as chaplains claim that the church finds it difficult to integrate the efforts of chaplains with its ministry (chaplain A, B and C). Christian chaplains are more focused on their employing institutions. Wilson's statement that "the chaplain cannot think of his job as confined to the institution" (1971: 64) has been more successfully demonstrated among minority faith chaplains who combine their duties as chaplains with their existing role in their faith communities.<sup>9</sup> Wilson's vision of increasing chaplaincy involvement in the wider community has been realised primarily among minority faith communities.

Beckford and Gilliat-Ray and Orchard's studies demonstrate that Anglican brokerage in chaplaincy teams was the norm at the turn of the century, with Anglicans overseeing service provision (Orchard 2000: 57-59). Minority faith representatives in the hospitals are referred to as "visiting ministers" who are not well integrated into the chaplaincy teams. However, the findings demonstrate that minority faith representatives who were previously volunteers are beginning to be appointed as honorary chaplains and paid part-time chaplains.<sup>10</sup> Thus significant steps have been made to integrate minority faith chaplains within the team, and several of whom are the first chaplains of their faith in the country to be employed by the NHS. As minority faith chaplains become better integrated, they acquire significant roles as

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<sup>9</sup> This included the male Muslim chaplain's role as an imam and as a consulting figure in the community for health, community development, and education. Similarly the male Sikh chaplain is involved in numerous national organisations in the UK, while the female Sikh and Muslim chaplains are involved in various community events and provide confidential listening services.

<sup>10</sup> 'Honorary chaplain' is an unpaid role where chaplains are able to attend team meetings and become involved in strategic work.

ambassadors and contributors to the NHS rather than being limited to visiting patients from their own communities. This indicates a shift from visiting ministers who are solely concerned with patients from their community, to minority faith chaplains who minister to the institution, although this remains more limited than Anglican and Free Church chaplains. The findings illustrate that the team have developed more “inclusive” approaches to service provision, moving beyond the brokerage model (Orchard 2000: 58).

Since Woodward’s thesis, it is important to note that as the generation of chaplains which worked through the reforms from the 1990s are moving into retirement, chaplaincy teams increasingly consist of those who joined the team once these reforms were well established. Woodward’s thesis traced significant changes in the NHS and the responses of the chaplains at the time but was not able to project long term responses to these reforms. As longer serving chaplains move on, the ability to compare the current situation with a time before the reorganisation of the NHS is gradually disappearing, making it increasingly difficult to critique the system that newer chaplains are familiar with. Woodward’s suggestion that there is little sign of an overarching strategy was partially reflected in the findings as chaplains tend to respond to daily individual issues as they arise on an ad hoc basis. However, part of the pressure to be held accountable has led to the chaplaincy team producing a strategy for working on a daily and yearly basis, although one chaplain noted that part of his role involved explaining to his colleagues why these strategies were necessary (chaplain B). There was little indication that chaplains were using formalised methods of assessing and fulfilling spiritual need, or adopting the models outlined in recent NHS guidance, contributing to the sense that chaplaincy has been “done to” instead of “collaborated with” (2009: 62-65).

## **Examining Team Dynamic: What Difference Does It Make?**

### *Humour and Difference*

The most obvious outcome of observing the team and their interactions within the office was the prominence of humour as a way of negotiating difference and marginality. Due to the previous emphasis in the research on individual chaplains, examinations of chaplaincy rarely discuss the significance of humour. The findings which link humour with protests against institutional practices resonate strongly with the idea of humour as a subversive tool and the image of chaplain as clown, constituting a marginal and prophetic presence (Pattison 2000: 170-171; Faber 1971: 81-83). Similarly the use of humour and laughter to rehumanise the hospital environment is in part because it is a reminder that laughter is a distinctively human trait (Pattison 2000: 184). The different manifestations of humour exemplify the difficulty of grounding its nature and purpose (Pattison 2000: 180-181), but it is significant that humour in the context of chaplaincy arises primarily out of incongruity, difference and marginality.

### *'Chaplaincy' as Entity: Questioning the Homogeneity of Chaplaincy*

Due to the scarcity of observations of how chaplains relate to each other as teams, there is little discussion of whether it makes sense to discuss chaplaincy as a coherent unit, excepting Orchard's study which comments on the disparate and vague operation of chaplaincy teams in London (Orchard 2000; see also Swift 2004: 21). This assumed coherence arises from the tendency to focus on Christian chaplains and use fieldwork methods which isolate chaplains from everyday work, often failing to appreciate how chaplains relate to each other. The question "are we a team or lots of little teams under one umbrella?" (chaplain A) demonstrates that the team have yet to find ways of articulating how they work



together, although it does appear that the team is unified by virtue of the advantages that collaboration brings. The findings suggest that the team works well as a support network, where chaplains across faiths can rely on each other to provide the appropriate spiritual care and draw on each other for support. Observations of other chaplaincy teams highlighted the various ways in which chaplaincy is enacted and the differing degrees to which their place in particular hospitals is contested. A significant finding, therefore, is that chaplaincy can potentially be described as a context *in itself* within which chaplains of many different faiths with different priorities work with particular aims.

This thesis challenges the tendency of the literature to refer to chaplaincy as if it is homogeneous, although raises the question of unity within the profession. Wilson's vision, which grounded a unified chaplaincy in the Kingdom of God when the primary differences between chaplains were denominational is no longer appropriate. Even Wilson suggested a "united but not uniform service" in order to recognise the importance of collaboration between chaplains, but this is further compounded by the presence of other faith traditions who do not share the same conceptual framework (1971: 94). The enthusiastic appropriation of generic chaplaincy may provide a unified ground for chaplaincy, although the findings show that generic chaplaincy is enacted variously among different chaplains. Ultimately unity cannot be grounded in a particular faith tradition, which means that unity is grounded either in spirituality, or in personal connections made between chaplains as a support network. As chaplaincy has diversified, finding a single specific grounding for its unity has become more problematic.

### **Professionalisation**

Significantly, professionalisation was not a primary concern for the chaplains compared to the literature. While aspects of professionalisation, such as the implementation of

strategies and accountability measures, were visible throughout the study, chaplains often spoke of “being professional”. This was characterised as adhering to standards of confidentiality and appropriate conduct, rather than a wholesale process of professionalisation. Professionalising bodies were barely mentioned during the study: only one chaplain mentioned the College of Healthcare Chaplains. Arguably, due to the fragmentation among the bodies and organisations that represent chaplaincy (Healthcare Chaplaincy and the Church of England review 2010), chaplains were mostly reluctant to mention or associate themselves with these groups.

Discussing the knowledge base of chaplaincy becomes problematic with reference to minority faith chaplains who have few resources to draw on due to their recent inclusion in the chaplaincy profession. Formal accreditation for minority faith chaplains remains elusive, as these chaplains had been appointed on the grounds of their community work rather than specific qualifications. Nearly all of the minority faith chaplains, excepting the Sikh chaplains, mentioned training, and specialist Muslim chaplaincy courses are currently being developed. Hindu, Sikh and Buddhist chaplains may find that the most likely foreseeable avenue for training and resources is to join with Christian chaplaincy courses (fieldnotes from 1<sup>st</sup> April 2013).

Overall, chaplains seemed more concerned with localised issues regarding day-to-day practice rather than broader abstracted discourses about their overall status. If comments were made about status, it was primarily in terms of finding acceptance in the institution. This is not to say that the chaplaincy team was not consciously adopting professionalising practices, but that instead the team tend to respond to these issues on an ad hoc basis. This demonstrates a large gap between the interests of chaplains on the ground and how these interests are represented by national chaplaincy organisations.

## **Modelling Chaplaincy**

### *Universal or Particular?*

Overall, the participants were reluctant to articulate a coherent model of chaplaincy, with one chaplain claiming that this would be inappropriate. This contrasts with clearly defined models presented in the literature (Threlfall-Holmes 2011: 116-126). Wilson's differentiation between the religious representative and the universal chaplain ministering to the whole hospital is an early articulation of the struggles that chaplains are now facing when deciding whether religion-specific models should take primacy over generic approaches. The study shows that general ward visiting among the Free Church and Anglican chaplains particularly is prioritised over religion-specific sacramental approaches, while minority faith chaplains focus on religion-specific needs due to time constraints, and adopt a generic role in a cultural capacity. The tension between universal and particular remains a pervasive aspect of chaplaincy, but finds different emphases among Christian chaplains and minority faith chaplains.

### *Generic Chaplaincy*

Extant empirical studies of chaplaincy teams provide no clear definition of what generic chaplaincy entails. Based on the findings, and bearing in mind that generic chaplaincy is enacted variously, a provisional definition of generic chaplaincy can be articulated as:

*the provision of spiritual and pastoral care to all those who seek it, available to those of all faiths and none. This may involve the provision made by a person of one faith to a person of another faith. Patients, visitors and staff will then be referred to the appropriate chaplain if any faith-specific requirements arise.*

During the study it was suggested that generic chaplaincy was one of the ways in which chaplaincy was trying to retain relevance and usefulness, but also to demonstrate cost-effectiveness by widening its net. Arguably, generic forms of chaplaincy are based on institutional pressures to be cost-effective rather than expectations of patients. Wilson warned of this in his report: “Roles are profaned when their importance is decided by the current demands of the social organisation without regard to the pattern of expectations that individuals have learnt and vested with moral significance” (1971: 72). At the same time, the proactive search of minority faith chaplains to speak to those who share a common culture or language was often said to exceed the expectations of these patients. Thus, the institutional remit for these chaplains often anticipates the needs of the faith communities and is often appreciated as soon as patients are aware of the provision made (chaplains E, G, H, I and K).

Arguably, the various religious imperatives which ground generic chaplaincy were sought as a way of justifying the wholehearted adoption of generic chaplaincy which initially emerged from the secular ethos of inclusivity and equality and diversity. Minority faith chaplains may be self-selecting dependent on how their values fit with the ethos of the NHS. This became clear when chaplain C discussed the statement of common purpose that chaplains and their faith communities sign: “we felt there [were] enough differences....for us to have to have a covenant and of course anybody that comes into the department, we show them all these before and say look this is literally what you are signing up to this. If you join this you can’t say ‘well I didn’t know’ because there it is.”

### *The Prophetic Voice*

Despite emphasis on the prophetic voice of the chaplain in the literature, the findings suggest that chaplains find smaller and less vocal ways of protesting against an environment which is not entirely hospitable to them or those they encounter. These protests tend to arise

out of individual instances which provoke cause for concern, rather than providing an overriding critique of institutional practices. There were only two exceptions where chaplains made comments regarding broader institutional trends (chaplains C and F). This concern was not reflected among chaplains who started working in the team within the last ten years, who view the business-like measures as standard practice. However some chaplains did comment that the ways they were being held accountable were inappropriate, echoing Wilson's statement that the "chaplains' role and work is difficult to judge by clinical criteria" (1971: 62).

## **Distinctiveness**

### *Grounded in Faith*

Throughout the fieldwork, the Christian chaplains asserted that their distinctiveness emerges from working from an explicitly faith-based perspective. Fewer minority faith chaplains referred to distinctiveness, possibly because the distinctiveness of their contribution is more obvious than that of the Christian chaplains due to differences in remit and expectations of their faith communities. Thus the question of how spiritual care is distinctive for Christian chaplains is more pertinent than it is for minority faith chaplains, as the latter tend to focus their approach to spiritual care more sharply in terms of ethnicity, culture or language.

The importance of being grounded in faith resonated with concerns in the literature about the integrity of healthcare chaplains. However this was rarely related to how faith-based practice may provide a distinct approach to patient care, except by Wilson: "[the chaplain's] steadfastness in his own faith will make him a strong, dependable person" (1971: 54). This provides some insight into how the spiritual care offered by chaplains may differ from the

spiritual care offered by members of staff. Additionally, the explicit acknowledgement of faith is distinct insofar as it provides a different kind of engagement than the neutral professionalism which distances itself from the patient. Thus any corrective to the otherwise ostensibly 'neutral' emphasis of the medical and caring professions is a distinct contribution to patient care. It is the chaplain's inability to offer "manipulative skills" in patient care (Wilson 1971: 104) which opens up this alternative "unobtrusive" avenue of encounter. If this is the case, a clear articulation of the role of faith in the work of the chaplain is required.

### *Clash of Ethos*

The findings demonstrate that a tension between the medical model of illness and the chaplain's emphasis on holistic care is congruent with Wilson's concern to expose depersonalising tendencies in healthcare. The attitude that hospitals are factories is reinforced by the cost- and consumer-driven nature of recent NHS reforms (Woodward 1998: 168; Swift 2009: 5). Consequently the depersonalisation that the literature warns of is twofold – patients are no longer reduced merely to medical objects, they are also economic opportunities. The findings illustrate the tensions of working in a consumer environment which demands that chaplains respond to individual needs, while trying to avoid the socio-economic and medical objectification of the patient.

In this study, chaplains mentioned how their views of health differed from other caring professions. These approaches to health and wellness resonated strongly with Wilson's normative approach to healing, where health incorporates spiritual healing, reconciliation and addressing existential questions. Similarly the emphasis that minority faith chaplains placed on following up in the community signifies a preoccupation with the relational context of the individual patient. Chaplains stressed that their role was not therapeutic: "We're not doctors, we can't make them get better, that's not our role... It may be that actually there is a healing

that comes through the relationship we have, not a medical healing but a sort of spiritual healing” (chaplain D). The emphasis placed on teaching other members of staff about spirituality could be seen as an attempt to explain how patient care goes beyond medical intervention, but also as a way of justifying chaplains’ contribution to the NHS.

The institutional demand for increased accountability in light of financial pressures, where chaplaincy must emulate other departments by adopting their methods of assessment and evaluation, may be seen as one of the ways in which chaplaincy is being encouraged to conform structurally to the NHS, making differentiation difficult. This compromises the distinctiveness of chaplaincy, as quantitatively measuring efficacy “fundamentally threatens the vocation and distinctiveness of religious caring” (Pattison 1997: 106). On the whole the team spent more time disagreeing about the ways in which patient interactions should be recorded: some chaplains argued that the time spent with patients should be recorded, while others preferred to keep records of numbers of patients visited. This has become the assumed method for holding the team accountable.

#### *Differentiating Ecumenically: Why is it so Important?*

Part of the drive behind the stark differentiation between denominations lay in the need to make a separate case for Catholic chaplaincy, as the needs and expectations of the Catholic community differ from other denominations. While non-Catholic Christian chaplains were able to cover for each other to perform sacramental duties, this was not the case for Catholic patients, who require a Catholic chaplain to administer the sacraments. Emphasising distinctiveness enables chaplains to make the case against cutting Catholic chaplaincy sessions.

Conversely, the chaplains from minority faiths were less assertive about distinctiveness, and this may be due to the assumed difference between the minority faith

chaplains and the Christian chaplains. The diversity of other faith traditions is not as well represented as the diversity within the Christian tradition and so the subtleties of denominational or 'sectarian' differentiation were not present in the same way. The role of minority faith chaplains is assumed to be distinct. Thus asserting difference is as much a practical issue as it is a theological one.

### **Relationship between Religion and Culture**

One of the key findings was the growing appreciation of the impact of culture on the expectations of patients and their families when making use of NHS provision. While this awareness of culture and ethnicity is helpful, it is often the case that chaplains are called upon to separate cultural attitudes from religious imperatives. There is a strong sense that religious practices take primacy over cultural practices on the premise that religion is easily dissociated from culture. This gives an indication of how healthcare staff handle problematic situations with patients and their families. In the literature, cultural and ethnic issues were not given substantial consideration, and this study has shown that minority faith chaplains in particular contribute towards a greater understanding of the cultural issues present in the NHS, while negotiating cultural barriers which prevent their faith communities from approaching the NHS.

### **Multi-faith Facilities as Concrete Signifiers of Chaplaincy Developments**

The development of chaplaincy can be traced by the emergence and growth of multi-faith spaces, both in terms of how existing spaces are converted into multi-faith facilities and the creation of purpose built multi-faith spaces. These spaces vary between hospitals, often providing an insight into how chaplaincy teams operate. While the current trend is towards bland lowest-common-denominator designs (Cadge 2012: 54), the team negotiated ways in which the purpose-built space could avoid this approach by the inclusion of structurally



differentiated spaces, including a Christian chapel and a designated Muslim prayer room. The importance of retaining integrity and maintaining difference while working side-by-side that was evident in the findings is also reflected in the faith space. This facility was cited as a significant achievement of the chaplaincy team, and the continued development of this space provides more opportunities for multi-faith dialogue, as both Christian and Muslim chaplains were involved in the planning for installing the mirhab in the Muslim prayer room. It is also important to note that the kind of facilities provided reflect the priorities of the chaplaincy team: a seminar room (teaching), a separate chapel and Muslim prayer room (religion-specific worship), a quiet room (providing a sanctuary) and a listening point (individual confidential counselling). Thus it is not only worth looking at chaplaincy as a group of people but also chaplaincy as a place in order to trace current trends in the profession.

## **Summary**

This discussion has demonstrated that the findings challenge tendencies within the literature that refer to chaplaincy as a homogenous entity and the overemphasis of professionalisation over and against professionalism. At the same time, the findings reinforce arguments about the danger of chaplaincy becoming too institutionalised, building on the concern for chaplains to remain distinctive. The comparison between Christian chaplains and minority faith chaplains and the response of chaplains to the changing structures of the NHS over time have provided useful lenses for considering the extant literature base. This discussion has emphasised aspects of chaplaincy work which are assumed, such as the religious differences between minority faith chaplains and the whole-hearted adoption of generic chaplaincy and spirituality discourses, while also referring to the aspects which are asserted, such as religious differences between denominations and the distinctiveness of chaplaincy.

## CHAPTER 6: CONCLUSION

### **The Contribution and Limitations of this Thesis**

This thesis has set an agenda for a localised examination of chaplaincy, both challenging and reinforcing trends in the extant knowledge base. While there are significant trends in the literature, these broadly fail to consider day-to-day issues. There is a lack of discussion relating to the diversity of chaplaincy which this thesis and recently published sources are beginning to rectify. It is believed that this is the first thesis in which the researcher draws on PT as an outsider to any particular faith tradition.

Throughout this thesis attention has been drawn to the limitations of the study, particularly the inability to follow up the work of chaplains beyond the boundaries of the chaplaincy facilities. Consequently, I have been unable to explore the heart of the work of healthcare chaplains: patient encounter. Therefore this thesis provides a truncated account of the work of healthcare chaplains, especially minority faith chaplains who work across numerous sites. Much has been inferred from absences in the chaplaincy office and what chaplains have told me due to the limitations of what I could observe. Therefore this study lacks a sustained engagement with the enactment of chaplaincy which is vital for developing a fuller account of the profession.

### **Primary Themes and Discussion Points**

#### *Present in the Literature, Absent in the Fieldwork*

Some of the most significant themes and factors in this study arose out of their relative absence in the fieldwork in comparison to the abundance of references to these themes within the literature. This is particularly the case in relation to professionalisation, which was rarely

mentioned by the chaplains, despite the chaplaincy team clearly taking measures towards becoming more professionalised, including accountability and strategy creation and implementation. Thus professionalising tendencies are *implicit* in the everyday work of chaplains and the language of being accepted or better integrated, rather than as an overt guide for the development of the team. The team seemed more concerned with ‘getting by’ on an everyday ad hoc basis, rather than producing a comprehensive rationale for their work.

#### *Absent in the Literature, Present in the Fieldwork*

Some of the primary themes in this study contribute fresh insights to the field or provide clarifications to the extant literature. This includes a focus on minority faith chaplains and how their role may differ from Christian chaplains, as well as considering how these chaplains work in their communities. The importance of humour as a primary method of communicating and handling difference within the team was also raised, demonstrating that new insights can be derived from examinations of chaplains in context rather than generalising results from interviews with individual chaplains isolated from their daily work. This thesis also begins to examine how chaplains differentiate themselves from their context in practice and established that, while being grounded in faith, it is difficult to discern what this entails in terms of making a distinctive provision.

#### *Collision or Co-existence? Worldviews Coming Together*

By examining everyday concrete experiences of a particular team, this thesis has raised awareness of how chaplains make sense of their relationships and negotiate between differing discourses and worldviews. Interestingly, within the chaplaincy team, co-existence was more difficult between chaplains on a denominational rather than a multi-faith level. In the case of the latter difference was assumed, while in the case of the former difference was

asserted. It also became apparent that there was a significant clash between the espoused ethos of the chaplaincy team and the institutional ethos, where the team were being forced to make quantitative records of their visits, while their flexibility to visit patients was stifled by the need to promote spirituality and limited working hours.

### *Assertion and Assumption*

One of the key strands in this study are the differing ways in which aspects of chaplaincy and how it is enacted can be assumed, and how other aspects need to be asserted. This is particularly the case with asserting distinctiveness, while the provision of generic spiritual care and the shift towards quantitative measurement of efficacy are assumed to be the best ways of surviving and making the case for chaplaincy.

### *Muddied Waters: Directions for the Clarification of Chaplaincy*

While the literature refers extensively to the lack of clarity regarding the role and purpose of chaplaincy (Swift 2004: 184; Orchard 2000: 9), this thesis has pinpointed four main areas which require further thought and clarification: professionalisation, distinctiveness, spirituality and generic chaplaincy. However, it is possible that chaplaincy thrives on this ambiguity and lack of clarity, adopting the above concepts and their accompanying assumptions loosely as a means of survival. This links strongly with the aspects of chaplaincy which are assumed. It is clear that discussions regarding professionalisation and generic chaplaincy cause some tensions within the team, and it is questionable whether these tensions positively or negatively contribute to the team dynamic.

## **Future Research**

This thesis contributes to the small but growing literature on healthcare chaplaincy written by outsiders both to chaplaincy and to religion. It is hoped that this research will encourage those without formalised religious beliefs engage with chaplaincy, and religion in society more widely, due to my own position as a sympathetic outsider.

This thesis has also drawn attention to some significant daily issues raised by the work of healthcare chaplains, and how these affect the ability of chaplaincy to differentiate itself from a secular context. Chaplaincy is a varied phenomenon across hospitals, and has to negotiate its position in some contexts more than others. There is still room for localised comparative studies to take place to discuss the diversity among and between chaplaincy teams, and to explore further the assumed and asserted elements of chaplaincy.

This project has raised further issues about the study of religion in contemporary society. Chaplaincy provides a lens for examining ecumenical and multi-faith dialogue, the status of religion in public institutions and the relationship between religion and humour. Humour could provide a fascinating new avenue of research into relationships between denominations and between faiths. Further research into how minority faith communities relate to British institutions could be invaluable to the NHS, particularly if accompanied by some propositions as to how these relationships can be strengthened and developed.

## **Summary**

New directions have been indicated for furthering research into healthcare chaplaincy, both methodologically and thematically. This study has begun to engage with the continued integration and distinctive contribution of minority faith representatives in chaplaincy. Most significantly, the findings demonstrate that the team were primarily concerned with daily

issues arising on an ad hoc basis rather than with larger trends, such as professionalisation, that currently pervade the literature. This study has also begun to develop ideas relating to the assumed and asserted aspects of chaplaincy, and particularly the way in which the assumed aspects have contributed to a lack of clarity within the team about basic elements of their work. Significant changes over the last decade have been documented, highlighting the continued relevance of chaplaincy as an indicator of the relationship between religion and public institutions, and public life in general.

## APPENDICES

### **Appendix A: Methodology Essay Submitted in Preparation for Thesis**

Originally submitted 24th April 2013. Specific references to the research site have been removed.

*What theoretical and practical considerations undergird field research into the self-understandings of chaplains in healthcare?*

This research proposed aims to contribute to a growing knowledge base in healthcare chaplaincy through a multi-method empirical study with the chaplaincy team based at [a single site]. The lack of literature regarding healthcare chaplaincy (Mowat 2008:10; Swift 2004: 8) urgently needs to be addressed due to the recent National Secular Society campaign to remove state funding from NHS chaplaincies, compounded by recent public sector austerity measures. In particular, there is yet to be a recent exploration of the self-understandings of healthcare chaplains which includes the experience of minority faith groups and women in any great detail. Despite claims in the literature that chaplains are practical, public or pastoral theologians (Cobb 2007: 9; Ballard 2009; Aldridge 2006: 20; Newitt 2010: 169), there are few substantial accounts of the relationship between theology or religious identity and chaplaincy in the light of lived experiences of healthcare chaplains. In my own attempt to bridge this gap in the literature, the research question is provisionally framed thus: “in what ways does the lived experience of acute healthcare chaplains affect religious identity and inhabited worldviews?” This question is provisional primarily because of the dangers associated with imposing a particular framework that is only informed by the literature and researcher presuppositions, rather than the actual research findings (see Glaser 1992: 25-26).

Consequently, the research question is open to alteration throughout the project. This study requires an interdisciplinary approach, drawing on practical theology (PT), sociology and empirical research methods, and other recent currents in the study of religion which emphasise researcher reflexivity.

This essay will consider key theoretical and practical elements of the proposal by first providing a qualified approach to theology in general. I will then introduce PT and why it is particularly relevant to this project. Then I will examine my own reservations regarding PT and qualitative methods as these were major theoretical barriers in the research design. Following these considerations, practical fieldwork methods and their limitations will be discussed, accompanied by a justification of the proposed design. The finalised design is a month long study including informal observations and semi-structured interviews with chaplains from a variety of faiths in order to obtain a snapshot of how chaplains understand their convictions and worldview in light of their experiences. Practical limitations such as data storage, access to resources and time restrictions have been taken into account, but cannot be examined in detail due to the constraints of this assignment.

Before continuing, it is important to consider how 'ordinary' theologies and the distinction between 'espoused' and 'embodied' theologies can provide a useful redefinition of what doing theology means and how it is undertaken. In his exposition of 'ordinary' theology, Astley explains that theology is not just an academic discipline, but an activity undertaken by those without formal theological training, and can be shaped by engaging with the social world (Astley 2002: 56). This approach expands theology beyond academic boundaries and enables us to explore experiential grassroots approaches, such as those of healthcare chaplains. This also facilitates a view of theology not as abstract, neutral activity, but as deeply embedded in a particular context in the case of academic theologians and laypersons. While



habitus is a sociological concept, it helps with characterising the overall context of beliefs, dispositions and inclinations which influence our behaviour (see Astley 2002:54), presenting us with fuller account of how habitus or ‘inhabited worldviews’ contribute to the formulation of theological views in particular. Habitus reaffirms that “the individual, and even the personal, is social, collective” (Bourdieu and Wacquant 1992:126), thus justifying an examination of the institutional and social influences on theology. The distinction is between ‘espoused’ and ‘embodied’ or ‘operant’ theology is another significant aspect of theology, as the articulation of beliefs and how these beliefs are actualised and lived out (Cameron, et al. 2010:54) can be very different. The theologies which chaplains espouse might be challenged in light of their everyday encounters, thus an examination of espoused theologies necessitates an examination of embodied theologies.

Speaking of chaplains as practical or pastoral theologians requires clarification due to the recent emergence of practical theology as an academic discipline. PT focuses on “everyday performance of faith” (Swinton and Mowat, 2006: 4) with praxis as its starting point and the subsequent transformation of praxis as its goal (Woodward and Pattison 2000b: 13). The work of chaplains is characterised by doing and being (Aldridge 2006: 20), thus a theological approach oriented toward the work of the chaplains is best carried out using PT. While ‘applied’ PT had imposed static theological norms onto pastoral situations, contemporary PT acknowledges the interplay between theology and wider social circumstances (Swinton and Mowat 2006: 6-7). This resonates strongly with current theological approaches among chaplains, as the application of theological norms to diverse pastoral situations is impracticable and unhelpful – “it is not acceptable to give neat, off-the-cuff answers. Your theology has got to really relate to people in their experience” (chaplain

quoted in Woodward 1999: 158). Thus PT is an important approach because it is already associated with the work of healthcare chaplains.

The openness of PT to other disciplines is another useful starting point, enabling the researcher to carry out empirical research as part of the theological enterprise, and engage with social theory in a mutually challenging methodology (Ballard and Pritchard 1996: 121; Browning 1983: 46). This study is multi-method and interdisciplinary due to the emphasis on both lived experience and theology, drawing on approaches from both theology and sociology. The mutual enrichment between theology and other disciplines is known as ‘critical correlation’, enabling theology to benefit from contact with the social sciences, and vice versa (Swinton and Mowat 2006: 80; Browning 1983: 45-46). While quantitative methods could be included, this project is primarily qualitative due to the emphasis on worldview and habitus in theological construction, and its status as an interpretive study. Contra the deductive, hypothesis-testing tendencies of quantitative research (Punch 2005: 16), qualitative approaches are more focused on understanding phenomena and meanings that cannot be quantified or rigorously measured (Denzin and Ryan cited in Outhwaite and Turner 2007: 582). The qualitative paradigm is usually inductive and aimed towards generating theories. This is exemplified in the approach of grounded theory in which “theory is grounded in actual data rather than imposed a priori” (McQueen and Knussen 2002: 200) while the overall design can be subject to change during the fieldwork and analysis periods. In grounded theory, the findings of the research dictate the research questions and key themes that emerge (Glaser 1992: 15). While grounded theory does place emphasis on emergence rather than forcing, it is important to note that these theories and questions are often shaped also by the researcher’s own presuppositions, posing a major problem to classical grounded theory. This will be

qualified by examining perspectives from theology and the study of religion which incorporate researcher reflexivity.

The relationship between sociology and theology is regarded with some ambivalence amongst theologians, including prominent practical theologians. The view that theology is “queen of the social sciences” (Beed and Beed 2010: 28) has been adopted by some practical theologians, ultimately reinforcing “entrenched oppositional stances [which] may no longer be appropriate”, without a detailed examination of the “alternative modes of intellectual cohabitation” between the two disciplines (Roberts 2002:191). This is exemplified in Swinton and Mowat’s insistence that theology must take precedence over sociology as a ‘resolution’ to the challenges posed by reductionist or relativist accounts of religion in sociology in opposition to the normative claims made by theologians (Swinton and Mowat 2006: 92-93; Daugherty 2009). To avoid this oversimplified dichotomy between theology and social science, PT must “clarify its identity and purpose” in order to retain distinctiveness and avoid the risk of a “paradigm takeover” by the social sciences (Pattison 2007a:264). I will present more nuanced accounts of both PT and sociology which recognise my own reservations about the nature of both disciplines, and qualify the relationship between the two.

The presuppositions of PT and the social sciences, from my own perspective, must be approached with caution. The insistence that PT has its grounding in an explicitly Christian narrative which forces me to work with a set of normative standards and assumptions (Heitink 1991: 221 quoted in Astley 2002: 103; Swinton and Mowat 2006: 5-7, 93) seemed exclusive given that I am unaffiliated with a particular faith tradition. The concern for ‘theological integrity’ demonstrated by Swinton and Mowat alienates inquirers without formalised belief system, especially as ‘theological integrity’ is interpreted narrowly as adherence to the inerrancy of gospel and revelation, while assuming that experience cannot legitimately inform

or challenge these foundational sources in theology (2006: 93). Similarly, Browning states that practical reason is informed by ‘the Christian story’, which entails a coherent and systematic set of themes specific to the Christian narrative (1983: 193-198). While Browning notes that this does not limit PT to the Christian narrative (1983: 194), he proposes that a coherent thematic structure is necessary for practical reason, while I felt that I could not propose a similarly systematic framework based on my own worldview. Postmodern approaches support my own ambivalence about such systematic approaches which have “lost credibility” due to their failure to acknowledge fragmentation, difference and the ‘other’ (see, for example, Lyotard 1984: 37, 40-41). Despite my alienation from these narrow approaches to PT, Pattison notes that “no group or individual has the monopoly” on PT and that those who are “outside the Christian religious community could profit from becoming critical practical theologians of their own activities” (Pattison 2000b: 12). If this project honestly acknowledges my own presuppositions and their role in the research, it is possible for me to also inhabit the space for reflection that PT offers.

On the other hand, caution must be exercised when dealing with social sciences, which until recently encouraged a ‘value-free’ and ‘objective’ inquiry into its subjects, exemplified in the work of Max Weber and Peter Berger. This is particularly true of phenomenology, often championed as the best method for research in the empirical study of religious phenomena. The core analytical concepts of Husserlian phenomenology include ‘bracketing out’ (epoché), ‘eidetic reduction’ and ‘empathy’ (Flood 1999; Finlay 2009). The epoché aims to obtain a value-free and ‘pure’ description of religion, achieved by the researcher recognising their own worldview and bracketing this out; the ‘eidetic reduction’ categorises religious phenomena which share the same essence, while empathy is the ability to enter and understand the life of another having abandoned one’s presuppositions (Flood 1999:93). Flood argues that

phenomenology undermines its own purposes because its sceptical external approach to religion necessarily entails a value judgement - it is impossible to ignore the presuppositions of the researcher. The idea of bracketing presupposes “a universal, rational subject who does the bracketing ...who is also the subject of religious experience” instead of acknowledging that “the observer [is] integrally bound up in the dialogical process of understanding” (Flood 1999: 107). Additionally, the positing of a ‘universal rational subject’ fails to engage with the subjectivity of the ‘other’. If we were to take intersubjectivity as a given, then we must start with “the social world in which meaning is primarily constituted within intersubjectivities” (Flood 1999: 112). However, insofar as phenomenology is concerned with lived experience, we could still argue that this project is phenomenologically orientated (Finlay 2009: 9).

In contrast, PT offers a useful methodological corrective by enabling researchers to acknowledge their presuppositions, while recognising the importance of entering into dialogue with participants. As Astley notes, we cannot understand the subject without engaging in a dialogue with them (2002: 100). Allowing the researcher to examine their own response to the participant rather than studying the participant in isolation also facilitates a more detailed understanding of the participant (Astley 2002: 109, 112; Browning 1983: 38-39). The epistemological starting point is that we do not understand the ‘phenomenon’ being studied nor the researcher as abstract and isolated, but both as caught in a web of relationships and situations in a dialogical relationship. The significance of intersubjective dialogical approaches to the study of religion featured in Orsi’s work converge with approaches suggested by PT where the researcher is willing to “make one’s own self-conceptions vulnerable to the radically destabilising possibilities of a genuine encounter with an unfamiliar way of life” where “disciplined attentiveness to difference” is vital (Orsi 2005: 198). Browning reinforces this convergence when stating that “social science is...a dialogue

between the religious horizons of researchers and the religious horizons of the subject of research” (1983: 91). Similarly, this approach to PT is demonstrated in Pattison’s model of critical conversation which is “necessarily open and dangerous” (Swinton and Mowat 2006: 80). This model suggests that PT can take the form of a conversation between the faith presuppositions of the researcher, the presuppositions of the Christian tradition and the contemporary situation (Pattison 2000b: 135-136), without dictating what the faith presuppositions of the researcher should be. This model advocates a critical conversation, allowing for gaps and disagreements, while aiming for mutual engagement and transformation (2000: 139-140). My proposal welcomes approaches which enable a dialogue between researcher and participant as demonstrated in Browning and Pattison’s approaches to PT and Orsi’s approach to the study of religion.

Having considered the theoretical problems associated with the research design, I will discuss practical considerations relating to the fieldwork and collecting/gathering data. [...]. [A single site was chosen as] a comparative multi-site study would be cumbersome and impractical for the scale of the project [...] An acute institution was chosen specifically because of the range of encounters that the chaplaincy team are faced with as a result of working in an environment of acute care. All of the chaplains have been invited to interview in order to obtain a diverse snapshot of how both male and female chaplains from different faith groups negotiate religious identity in light of their work. Volunteers are also invited to take part in the initial observations in order to get an idea of how chaplains and volunteers relate to each other in their daily activities. The team as a whole have expressed a preference for remaining anonymous for the thesis.

Due to my own inexperience in the field of chaplaincy, becoming better acquainted with chaplaincy was a key priority and the possibility of shadowing chaplains was initially

explored. Gilliat-Ray describes shadowing as ethnographic work focusing on the “daily practice of a single individual, living and working within a complex institutional social setting.” (2011:470). Gilliat-Ray notes that shadowing has much in common with the practice of chaplaincy— both require skill to listen and privilege the worldview of participants, feature the practice of ‘loitering with intent’ and the ability to preserve anonymity and confidentiality. The empathy that is required for the carrying out of this study is exemplified through the similarities in the role of the chaplain and researcher (2011: 471). Similarly, Cadge notes one chaplain observed that “my attempts to immerse myself in chaplaincy [are] parallel to chaplains trying to immerse themselves in patients and living human documents...valuing both as experientially focused learning processes” (2012: 218). This method would not only have enabled me to become more familiar with how chaplaincy works, but also to explore ‘embodied’ theologies rather than limiting my study to ‘espoused’ theologies - in other words, not just how theology is spoken about, but also how it is lived.

However, it quickly became apparent when consulting with chaplains that there were two main complications with shadowing: the presence of the researcher and deciding on an appropriate sample. The presence of the researcher as third party is a problematic aspect of shadowing as it has the potential to provoke modifications of behaviour, interfere with the dynamic of the patient-chaplain encounter and disturb the everyday fabric of the chaplains’ work (Swift 2001: 66-67). Initial consultations with chaplains brought to my attention that my status as a white, female researcher with no formal faith affiliation and who is external to the profession may impact on whether a patient feels they can be more or less open with the chaplain. Swift notes that it is a challenge to find a method that “did not disturb unduly the very work I wished to observe” while “patients have an expectation that spiritual care is not generally observed” (Swift 2001: 66-67). It is also likely that there would be some situations

for which third party observations would be inappropriate: for example, if a patient is in distress and requires privacy. Similarly there is a possibility that the chaplain might ‘perform’ to meet the expectations of the researcher, potentially obfuscating research findings (Gilliat-Ray 2011: 477). The methodological problems of modifying behaviour would require more reflection than can be undertaken in the time allotted to the study.

The issue of sampling had been brought up in consultation with chaplaincy staff who asked how many chaplains would be shadowed, and how many patients would be observed. Due to the flexibility of a chaplains’ schedule and the freedom with which they work (see Woodward 1998:181-182), it was difficult to estimate how many patients may be visited on any given day and pinpoint criteria for inclusion. Eventually shadowing was ruled out, primarily because of the ethical complications associated with the inclusion of patients when applying for approval from NHS research ethics committees – any ambiguity about sampling would not be looked upon favourably. Consequently, the study design was limited to members of the chaplaincy team, including full-time/part-time chaplains, chaplaincy volunteers and administrative staff. The study will involve an observational component, but due to my position as an outsider to chaplaincy these observations constitute an informal process of familiarisation where I can build a rapport with members of the chaplaincy team.

Consequently, it will be difficult to gain substantial insight into the ‘embodied’ theologies of healthcare chaplains and this must be acknowledged as a major limitation of the project. The concept of habitus that is core to this study is “necessarily embodied” (Graham 2000: 109), thus the insights gained from this study can only be a partial depiction of the habitus of healthcare chaplains. Similarly, the inability to immerse myself in the research context for an extended period of time means that the validity of the project findings is compromised – it is prolonged exposure to the research context which “lends credibility to



narrative account” (Creswell 2009:192; Lincoln and Guba 1985: 109, 301-302). Nevertheless it is hoped that my attendance at numerous chaplaincy events, extensive consultations with the chaplaincy team and the two week observation period will help me obtain the detailed understanding of chaplaincy in attempt to fulfil this criteria for validity.

While narrative would have been the most effective way of extrapolating worldviews and values in order to gain a fuller impression of the ‘espoused theologies’ of the participants, time constraints for both data collection and analysis have necessitated that semi-structured interviews take place in order to guide the interviews with the chaplains while giving the opportunity for participants to elaborate on their answers. Written consent to use quotes from these interviews will be requested at the beginning of the interview. The interview questions will be open questions in order to encourage honest, open and detailed responses (Astley 2002:102). Astley argues that asking questions that participants had not previously considered provides an opportunity to “[evoke] a deep already held conviction rather than a non-answer masquerading as an answer” (Astley 2002: 103). The limitations of interviews are obvious, as questions regarding reliability and the authenticity of responses are raised, as well as the problem of the interview taking place at a structured time far removed from the daily activities of healthcare chaplains. As May notes, interviews tell the social researcher “little about a reality that is ‘external’ to the interview” (2001: 143). However, the inherent limitations of the study necessitates the use of semi-structured interviews, enabling me to “enter into a dialogue with the interviewee” (May 2001: 123) to the best of my ability during this project.

The main methods for analysing the data will include qualitative coding techniques and discourse analysis, particularly for interviews. The importance of language and discourse has already been noted in the existing literature relating to chaplaincy, primarily in the sense

of chaplains working between discourses, having to learn the language of the medical environment they work in (Wilson 1971:72, 104; Norwood 2006:4, 8) as well as orienting themselves within discourse of ‘market forces’ that predominate in the current NHS structures (Woodward 1998: 98). It would be instructive to analyse the language of healthcare chaplains in order to shed light on their concerns which, for example, may suggest that chaplains may be more comfortable with the language of professionalisation than they are with an overtly religious language. Alternatively, we may find that chaplains ‘walk a tightrope’ between the two (Hospital Chaplaincies Council, 2010:21), and manage to hold these contrasting languages in tension: “The chaplain...has to mediate the language of the hospital with the vocabulary of his faith community.” (Swift 2004: 93) As noted in recent literature, there has been a substantial shift away from the language of religious certainty which chaplains now often find to be unhelpful (Woodward 1998: 160-161). In order to categorise and prepare the data for further analysis and interpretation, NVivo software may be used for quick mechanical coding and management of large quantities of data, although it is acknowledged that the scale of the project may not require the use of such complex software.

When examining the methodological issues it has become apparent that this proposed study has been met with numerous limitations which impact significantly on the overall design. At the same time, the methods that inform this study require clarification as a result of my own reservations regarding PT and qualitative research respectively. In the case of the former, specific forms of PT seemed closed off to those without a formal faith affiliation, while the latter tends to hide the presuppositions of the researcher and assume objectivity while failing to recognise researcher reflexivity. I have explained the chosen approach to PT as a mutual interplay between my own faith position, the theological tradition, and the contemporary situation (Pattison 2000: 135-136), while acknowledging my own reticence to

be forced into an explicitly Christian framework. Despite previous wariness about PT, the suggestion that the discipline should be opened up beyond the Christian community so that non-Christians to reflect on their inhabited worldviews has enabled me to re-engage with the discipline (Pattison 2000: 222-223; Campbell 2000: 84). Similarly my reservations regarding sociological methods have been assuaged by the suggestion that the lines between theology and the sociological study of religion can be blurred by recognising intersubjectivity the researcher-participant relationship. The necessary changes made to the methods of data collection and gathering from shadowing to informal observations and semi-structured interviews shift the emphasis definitively towards 'espoused' rather than 'embodied' theologies, although the limitations of this approach have been acknowledged. These changes to research design are primarily due to ethical problems such as sampling, consent and researcher presence. Overall, this proposal has been changed substantially over the course of its design, particularly in the case of being able to obtain a sustained and embodied enquiry into the habitus of healthcare chaplains. This methodological proposal demonstrates that these constraints have been recognised and a suitable design has been put forward in order to work around these limitations.

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## **Appendix B: Interview Questions Used During the Study**

### *Questions about religious background (Hindu, Sikh, Muslim chaplains only)*

- Which branch/subset of Hinduism/Islam/Sikhism do you belong to? How does this influence your work? Do chaplains tend to emerge out of particular traditions?
- How does the idea of chaplaincy fit into your faith tradition?
- What is your status in your faith community? How does this relate to your role as chaplain, if at all?

### *Approaches to chaplaincy*

- What does your role involve?
- How do you approach your work? Is there a particular model you use?
- What motivated you to become a chaplain? Has this motivation changed and what brought about this change?
- What resources from your faith tradition/theology do you draw on to support you in your work? Which ideas and influences are most important to you and why? Do you draw on resources from other faith traditions?
- What non-religious or secular resources do you draw on to support you in your work? Which ideas and influences are most important to you and why?
- What do you think is the role of humour in the chaplaincy office and interactions between chaplains?
- What traits and characteristics do you look for in a chaplain?

### *Support in the chaplaincy role*

- Do you feel that your faith community supports you? In what ways do you feel that your faith community supports you? Are there ways in which you think your faith community can offer more support?
- How do staff respond to your work? Do you feel valued by members of staff, QE and the NHS as a whole?
- Do you feel you are valued by the chaplaincy team?

### *Further reflection on chaplaincy role*

- What do you think makes this team (un)successful?
- Drawing on and giving examples from your own experience, what is the most difficult/easiest thing about working with people of other faiths? Has your attitude and approach to other religion changed since you worked in chaplaincy?
- Describe your most challenging encounter and how you responded to it. How did it challenge you? Did it affect your work in the long term?
- What are the primary barriers preventing you from fulfilling your role as chaplain?

### *Other possible questions*

- What is the most satisfying thing about being a chaplain?
- Would you say that the chaplain fits in with or works against the NHS culture?
- What makes chaplaincy effective? What is vital to the practice of chaplaincy?

## Appendix C: Participant Information Sheet and Consent Form

### *Participant Information Sheet*

#### ***What is the aim of this project?***

This project aims to:

- Collect and gather chaplains' own perspectives of working in a healthcare context
- Relate the lived experience of chaplains to questions of religious identity and self-understanding
- Plug a gap in the chaplaincy literature and knowledge base
- Lay the groundwork for a more extensive doctoral project.

#### ***Who will be conducting the project?***

I, Jo Bryant, will be undertaking this study as part of a postgraduate research programme. I am supervised by Professor Stephen Pattison from the Department of Theology and Religion at the University of Birmingham.

#### ***Who is being asked to participate?***

All members of the chaplaincy team could be involved in the initial observations. These observations will allow me to become familiar with the chaplaincy team and enable me to identify key themes for the project. Only chaplains will be asked to participate in detailed interviews. Please note that **participation is optional** and requires your consent. I will not collect information relating to individuals who are not part of the chaplaincy team.

#### ***What happens if I do not wish to participate?***

Please let me know if you do not wish to participate. You will still be able to make use of the Faith and Community Centre, but you may need to remind me that you have opted out.



***What will participation in this study involve?***

- Being observed in the Faith and Community Centre and informal conversations with me about your experiences as a member of the chaplaincy team. These observations will include events and meetings relating to the chaplaincy team
- Interviews with part-time or full-time chaplains are likely to last approximately one hour. Please inform me if you have any time constraints before starting the interview

***What are the benefits and disadvantages of taking part in this project?***

While this is not my intention, it is possible that some questions may touch on sensitive issues which may be distressing for you. If you are unhappy with what is being asked you may:

- Refuse to answer a question
- Inform me of any concerns you have about being quoted within a week of the conversation or interview
- Ask for your answer to be withdrawn at any time during the study
- Withdraw completely from the research proceedings without needing to provide a reason.

If you would like to talk in confidence or feel distressed by the research, I can speak with you in private about the study. I can also contact my supervisor, Professor Stephen Pattison, who has previous experience as a healthcare chaplain, and will be able to discuss the research with you and offer support.

The research has potential to be useful for the chaplaincy team in order to raise awareness of the self-understanding and self-perceptions of chaplains in relation to their work, contributing towards professional development and academic research in the field.

***Will the information be confidential?***

- Interviews will take place in a private meeting room in the Faith and Community Centre to ensure confidentiality
- All the data collected will be written up and stored on a password protected university computer
- Confidential information may be stored on an encrypted memory stick for future reference

- All data will be made anonymous as soon as it has been written up. Pseudonyms may be used in order to protect identity
- It is my responsibility to ensure that all data is confidential, providing it is relevant to the project. During observations and interviews I will ask permission to refer to participants by faith tradition in the thesis. However, if permission is given confidentiality may be compromised
- You will have plenty of time to review how you are being quoted during the course of the study. After the study, you will be given the opportunity to provide feedback on the research findings and the context in which they are used
- Participants are likely to be contacted by email or in person. Contact details are not required for participants who have contributed data in the form of spontaneous/informal conversation.

***Will audio equipment be used to record conversations during the study?***

Conversations during the observation period will not be recorded, but I will take notes to aid memory. Interviews will be recorded for analysis purposes only. If you feel uncomfortable about being recorded but still wish to participate, alternative arrangements can be made.

***Who has access to data and how long will it be stored for?***

- Data will be stored indefinitely for my own reference
- During the study, only my supervisor and I will have access to the research data
- After the study, any researchers who would like to view the anonymised data will have to ask me for permission to access the data.

***Who will review this project?***

This project has been reviewed and approved by the University of Birmingham Research Ethics Committee.

**If you have any more queries, comments or concerns contact Jo Bryant at [jrb287@bham.ac.uk](mailto:jrb287@bham.ac.uk), or the project supervisor Professor Stephen Pattison, at [s.pattison.1@bham.ac.uk](mailto:s.pattison.1@bham.ac.uk)**

*Informed Consent Form for Participation in Chaplaincy Study - Interviews*

It is my responsibility to ensure that any participants in the study know what the study is about and fully understand the implications of the project before giving consent to participate. This information is detailed in the Participant Information Sheet accompanying this consent form. Please let me know if you have any further questions about the study.

I have read and fully understood the participant information sheet	
I have received satisfactory answers to any questions I have about the research	
I have received enough information about the study	
I understand that I am able to withdraw during the course of the study and without having to provide a reason	
I understand that relevant information given during the course of the study will be kept confidential and stored securely. I understand that data may be kept indefinitely for the purposes of further research and may be made accessible to other academic researchers	
I understand that any information I give may be published and understand the terms of confidentiality as detailed in the participant information sheet	
I give my permission be recorded using audio equipment (if you do not wish to be recorded, alternative arrangements can be made)	
By ticking or writing my initials in this box I am giving my full consent to take part in the research project	

Participant signature:

Date:

Researcher signature:

Date:

Supervisor signature:

Date:

## **Appendix D: Sample Interview Transcript**

Only one transcript has been included in this thesis due to the vast quantity of data which emerged during the course of the interviews.

### **Chaplain B**

Age group: 50-59

Experience in chaplaincy: 0-5

Permission to refer to faith position: Y

### **Interviewer**

First I'm going to ask a few questions about your approaches to chaplaincy, beginning with what does your role as a chaplain involve?

### **Chaplain B**

Ok, so I'm an Anglican chaplain and what that means here is that I have general responsibility for several wards where I'll visit anybody of any faith, get to know the staff, get to know the issues there. And I'm also...It also means I'm on the general on call rota and the rota for the Sunday worship for the general Christian worship in the morning. So that's the basics.

### **Interviewer**

How do you approach your work? Is there a particular model that you use?

### **Chaplain B**

Wow... Probably not consciously, so I haven't... I didn't start by studying models and then seeing which one would work. I started very much at the practical end of...ah... Hmm, good question. I suppose the model I've used... I've adopted is the model that [chaplain A], [chaplain D] and [chaplain C]...the chaplains of a more general nature. And I suppose it's developed, my understanding of it has developed as I've got into the job. But it's very much...the best way of describing it it's very much about being led by the patient. I know it's a bit clichéd but it's making contact, engaging with the patients, allowing them to decide and to guide the conversation which way it goes. Although I will...I might ask about faith at some

stage but that's not where my starting point, it's more like "how are you? I'm a chaplain, how're you getting on?" sort of thing. And very much about being supportive of any patient and all patients who want it and similarly with staff. I'm in a slightly different situation because I don't wear a dog collar because I'm a lay minister so that makes the initial contact a bit different from those with a dog collar, I have to explain who I am. And...I think talking with colleagues and from my own observations sometimes that can be an advantage, not being very obviously associated with the church, particularly if people have had bad experiences with church. It can be a disadvantage in that I'm not immediately recognisable, so for example if I'm walking through a ward people won't know I'm the chaplain unless I actually engage with them, whereas if you have a clerical collar on people see you and sometimes folk say there's a chaplain and come and have a conversation. So there's a balance there, it's a...I think it's interesting having people who are in clerical garb and people who aren't. So in one sense I'm more like the minority faith folk who don't have a recognisable uniform. So that makes a difference at the initial contact, although it's pretty much the same after that.

### **Interviewer**

So you don't think that being ordained would necessarily put you in a better or worse position in being a chaplain?

### **Chaplain B**

I don't think so, it's an interesting question. I don't feel called to ordained ministry, I feel called to chaplaincy and I don't seem to need to be ordained to be able to do it. There are, if you see what I mean, there are chaplains... I couldn't conduct a marriage, that's a very rare event, I've got permission...I can take communion to people, but that's...we all do the same thing, we all take the reserved sacrament to folk. And as a reader, as a licensed lay minister I'm actually able to do most of the things in any case. But no, I don't think you need to be a priest to be a chaplain, and there are plenty of people who aren't. You need to have ordained people within the team for some things, occasional things, where you need to be ordained to do it, but most of what we do I don't find that an issue. Having said that it's a slightly different approach because you're not a chaplain you say 'hello, I'm one of the chaplains', I can't think of an occasion where anyone has questioned it. It might just be that I go in and I'm

confident and they accept it, I don't know {laughs} but it's never...nobody's ever said 'why haven't you have a clerical collar?'...except one. I'm sorry, have you got time for anecdotes?

**Interviewer**

Absolutely!

**Chaplain B**

Which I thought was hilarious... there were two sisters one on the wards I used to go to regularly, they said 'ooh there's the chaplain' and somebody said 'what' and one of the sisters says 'why doesn't he wear a clerical collar?' and the other one said 'ooh he must be one of those evangelical types!' {laughs} So that tickled me. It doesn't seem to be a barrier...which I think is good. Sorry that's a long way of answering I don't think you need to be a priest and I don't think I need to be a priest to be a chaplain.

**Interviewer**

Feel free to use anecdote throughout because I think it'll be really helpful for me as well and if it helps you explain what you're getting at...So what motivated you to become a chaplain and has this changed over time? What brought about the change?

**Chaplain B**

Sure ok. Being a lay minister, so my approach is a little bit different from some of my ordained colleagues in that I wasn't a professional minister. I've been licensed as a reader in the Church of England for about 7 years but always maintained full-time occupation and things in the parish. I came into this sort of by accident. So I started about ten years ago...in response to a request for help on Sundays to help get patients to Sunday chapel. And once a month I was part of a team of three or four of us who'd come in and go and collect patients, which I loved doing. During the process of doing that occasionally if [chaplain C] wasn't around, if there wasn't a chaplain around, a reader, as I was would come in and just take the service from time to time to cover for holiday and stuff. So when I became a reader I said to [chaplain C], 'well I'm a reader now, I could cover the odd Sunday' which I did. In fact the lady who did it was really miserable, but never mind! {laughs} So I started doing about 3 or 4 Sundays a year as well as pushing once a month and I absolutely loved it and there's

something...there's joy in it. Somehow having a group of patients, might only be a dozen, might be less, it's a very intimate thing and it's very close engagement and I found that much more joyful actually, fulfilling probably, than say talking to a church of 100 people or 50 people so that context appealed to me very much and I felt I was able to contribute to that and it was a powerful thing. So I started doing that and probably I was very dissatisfied with my job at the university which I'd been doing for a long time...nothing to do with the university, it's about me, I'd been doing the same thing and I felt that sort of itch to do something else for quite a long time. And I got to a stage about four years ago, I had a very good boss, a very understanding boss who was also a Christian actually, and understood my motivations and I said look I'd like to reduce, if I can to reduce my hours here and do some...sorry, reduce my hours at the university and perhaps do some volunteering, not just the Sunday bit but actually go and visit on the wards because I've seen people on Sunday having a nice chat and all the rest of it and I thought...and occasionally after if I'd taken a service I might go onto a ward and pray with somebody and do a bedside communion and I thought I'd like to do a bit more of that. So I had a discussion with her and she agreed that she would do that, sort of reluctantly but knowing that's what I really wanted to do, and she was director of HR so she was... a real star. And then I approached [chaplain C] and we had some conversations quite a while. [Chaplain C] originally wanted to use me because he thought I'd make a good manager to manage the Faith and Community Centre. It was going to be somewhere else and something quite different. That all fell through, and I eventually said to [chaplain C] I can do perhaps up to two days on the wards, and at that time he said there's a job, why don't you apply for that? And so I did and to my surprise I got it, so I found myself as a chaplain. So there's no plan in here at all really. As someone of faith I believe that's God calling me to come to this and giving me the most remarkable opportunity. So I became a chaplain. I did two half days a week which was very difficult, so I'd come in here on the Tuesday morning and the Thursday morning...until about quarter to one and then dash across the road to the university to do a completely different job and I loved this and I didn't like that and the contrast made me realise how little I...how much I disliked the other job. Also as a manager I had about 20 different people...completely different mindset. So I don't recommend doing half...swapping a job in the middle of the day something completely different. So I did that and I got into it and I think, I just felt... ready to do it, so I didn't feel anxious about encounters with people, the standard things people say when they...chaplains... 'oh I

wouldn't know what to say', do you know that's the classic thing, people say that about somebody's being bereaved, they don't know what to say or worried they're gonna say the wrong thing, whereas actually just being there that matters. And I sort of got that and I don't think I would have had that years before so in terms of timing I think it's right, in terms of life experience and everything I was able to do it so I was able to fit into that bit. I needed to get used to how hospitals work and all the rest of it and the fabulous team you've met, so urm...who are wonderfully involving and there's lots of banter and stuff and that was good, that was really enjoyable and I think clearly [chaplain C] could see I was competent as well. And then another opportunity arose, which was my colleague Sue going half time prior to retirement and [chaplain C] said would I like to pick up those days. Now that then put me in the position...sorry do you want to hear all this?

**Interviewer**

No, absolutely!

**Chaplain B**

That then putting me in an interesting position that would I be able to... I couldn't...didn't want to carry on at the university and it wouldn't be...and I certainly couldn't carry on just doing two days a week at the university in a fairly senior management job so I'd need to leave the university so then there was the question, could I afford it? Because I was on about nearly 70,000 over there and I come here and I'm on about 15 {laughs} part-time! But my wife also during this time just got ordained and we'd just moved into a church house and she was doing her curacy so the timing...chronology's a bit wobbly there... essentially we got to the point where the children had finished university and we could actually afford to do that. We'd nearly paid off our house, we had...we rented that out, we were given a church house so actually living costs were very low, so I did. So joy of joys I then resigned from the university, that would be a year ago now, and did three days a week here. So from being a lay minister who does things some times on Sundays to actually becoming, yes a sort of stipendiary or professional minister. Not in my plans anywhere but absolutely love it. And it's that sort of personal contact and the intimacy of it and the privilege of it really, being with people at their most vulnerable. It's very affirming {sigh}, I'm sure the other chaplains will tell you, because you turn up, say you're a chaplain and within about thirty seconds they're telling you some of



the deepest thoughts they've got, some of the things they can't share with other people. That's how I got there. The motivation for me is about my faith makes me want to, to put it in the cheesiest way, is to share the love of God in a practical way. I'm not terribly interested in church, so even though I was a reader in the parish I'd had quite a lot of focus outside so preaching on various things and always interested in things outside of church. In other words going to where people are rather than expecting people to come and conform to this funny ritually stuff {laughs}. It has its purpose, don't get me wrong, but it's always more interesting going to people where they are. So what's happened I think is that things have come together in a way that I hadn't planned but I like to think God had, so I was able to use the skills and experience I've gained through life and through what I've done and put into practice that business about sharing God's love and being alongside people and I find I can do it, and it's fab. That's a long rambling...has that sort of answered your question?

**Interviewer**

Yeah definitely. More than adequately. What resources from your faith tradition, what theological resources do you draw on to support you in your work? If any.

**Chaplain B**

Wow that's a good question. Well one of the things I think ...most chaplains aren't actually trained to be chaplains, so in ministerial training, don't know enough about ordained ministry training but certainly for the reader training that's primarily about leading services and preaching with a bit about... a little bit about pastoral...something identified myself as where I'm bit short is the theology behind that. Not totally ignorant but I haven't read a great deal around it and I've thought about it a lot. So something I think an ordained minister would have over me for example is that because they've been through theological college they'll have had some of that so I have to make up for that a little bit which I do in my own way and in my own study and so forth. I think...and I've been around long enough in terms of biblical and those sides of things to pick those up, that's not so much an issue. But the spiritual side, what coincided with this really was a journey as I became a reader it was recommended I get a spiritual director and I've had that spiritual director for about 7 years and that's helped me. He's actually a Franciscan monk and I've had retreats and so forth at their monastery. We're going there next week, 1<sup>st</sup> May. That's really given me the spiritual discipline. Having a rule

of life, not saying as a full monk would do but certainly a discipline of prayer and reading and so forth. So that's important to draw on for myself as to where I am, that's one thing you learn very quickly is if you're not in the right place, you're not going to have as good an engagement with a patient, I need to be in the right place spiritually, it's very obvious when I'm not. You don't get that spark and that engagement. You can't cover up something very well something as deep as this. So that's very important and the support that's round that and the whole retreat process and reading that's recommended and disciplines of meditation and so forth. That's been...been reading Meister Eckhart at the moment, fab! I wouldn't have got into all that if I hadn't had a spiritual director. That's a crucial bit. Quite a lot of it actually is lay experience, so at the university a significant part of my role was actually supporting staff, so I've gained a lot...actually practical skills like listening skills, because I've been trained as a mediator, I've actually done quite a lot around relationships and interactions and those sorts of things, so that sort of nicely coincides so I can draw on those practical skills. And then the other major resource is this team. Absolutely. So working with my colleagues who are hugely supportive and having a very open relationship, particularly with [chaplain A] and [chaplain D], not because they're Anglicans but because we three do the bulk of the general work, if you like. That's been hugely supportive, and the relationship... I think the relationship in the team is critical and without that I think there's a sort of...lay chaplains aren't unique, but there are quite a few around but there are not many of them and it could have been quite easy to be isolated or if I was just left to get on with it it would have been quite difficult. So that's crucial, so we've all got different things to bring, we recognise we've got lots of life experience, and actually working in a big scary organisation like the university and the politics of it which I was having to do because of working as director at senior management level they see as a big advantage to them as well to help through some of the strategy stuff and why on earth have we got to do this and I'm able to explain actually there is quite a good reason and it might seem a bit strange. So that sort of understanding of big organisations is a bit of a help. Yeah ok, so that's sort of answered a bit of that hasn't it? {laughs}

### **Interviewer**

Yeah, yeah. It's kind of also answered my next question which was what non-religious or secular sources do you draw on to support you in your work? But I'd also like you to, because

you said you'd thought a bit about theology a little bit, I wondered if you could articulate your thoughts about what you have reflected on?

### **Chaplain B**

Ok, I think...yes. So I've worried that because I've not studied pastoral theology that there's some sort of key that I'm missing. I don't think there is and those who look at me slightly puzzled and they say 'well you've got it'. And this sort of comes back to the model too, doesn't it? I'm not sure I... I don't think I can articulate a theology in the sense of what I do. It doesn't bother me that I can't because I know what I'm doing is appropriate. Do you know what I mean? I'm sort of skirting around that but I think I'd find it difficult to articulate a theology of what I'm doing other than the broad thing about being alongside people, about being there in the pain with them, not trying to...I'm trying to articulate it now...not trying to treat it, so it's not a therapy, as opposed to a psy...because people say what's the difference between you and a psychotherapist. So we're not actually treating people, not part of the therapeutic process. The mental health chaplains are actually...that's slightly different. It's very much about accompaniment, about going through the pain and the difficulties with them, sometimes offering some practical support and guidance but that's not the primary purpose...it's about the witness of being there with them, that's the sharing of God's love, so it's about being a witness of Christ in their lives. Again whether...it's not about imposing that on others either, it's very much for me that's my motivation and that's what I do, I do it because I think it's the right thing to do, not in order to in some way influence somebody to come to my point of view, that's not right. So I'm very clear about that, it's not evangelising, it's not proselytising, it's about living out faith, being alongside folks and being in pain with them, which is modelling Christ. There you go, I'm talking theology {both laugh} Got there in the end.

### **Interviewer**

Thankyou for starting to articulate something anyway. We talked about this towards the end of the fieldwork, we talked about humour and humour in the office and one of my questions is what do you think the role is of humour in the chaplaincy office and in interactions between chaplains?

## **Chaplain B**

Wow. Ok. So. It's certainly a way of coping with things which you really don't want to be in. Young people dying, people dying leaving, you know...the pain and so forth. And humour, black humour, is one way of sort of putting on a brave face on it. We're all playing the same game, we all know that's what that's about. Another point I think is my banter with [chaplain F], is that there are real differences and somehow I've worked out with [chaplain F] that the way we do it is through humour and we say things we sort of really mean but we say that in a humorous way and that seems to work. It's wonderful...I couldn't imagine this team without...just all sitting there being terribly serious would be *desperate*. It would be desperately dull and I think hard to cope. I can't imagine there are many chaplains that don't have that way of coping. I think it's like the other caring professions, this black humour. Dreadful things, like you go on to see somebody and you've done end of life prayers and they've carried on living, how...how *inconsiderate* of them. You'd never say something like that to er... but there's a sort of truth behind it. It's a way...it seems to be a way that we cope. And it's not covering up differences with [chaplain F], that's not...we're not hiding behind it. It's a way of expressing it in a way that's less harmful I think. I mean it's *fun!* {laughs} It's a bit boyish, yes. I think [chaplain D] ... and certainly a bit more careful with [chaplain E] and [chaplain D] ...[chaplain D] sort of takes...I think [chaplain D] quite relishes that, she's got two boys and she's used to boys really. And [chaplain E]'s great, but it's a...we're a bit male, white, grey, you know? We ought to try and address that. So it's a bit boyish, but it's still humour with S it's just...temper it a little bit. I think it's crucial...it's what... trying to avoid clichés, it's not about the oil that keeps things going but it seems to be an important component of coping with the things that we have to deal with. There's a lot of joy in it too, I keep saying this, most people get better and go home and life is good. Talked to a woman this morning about her own personal resurrection really, she was written off but here she is. Relishing every moment of every day that she's spending with family. So there is joy too. It's a way...I'm just going to repeat myself...it's an important way of coping with things you wouldn't really want to cope with if you had the choice.

## **Interviewer**

And do you think that's more common between the Christian chaplains than it is among the chaplains from other faith groups? That kind of banter.

**Chaplain B**

Hmm! We certainly have banter with the others. I think it's more common simply because we're the ones who are there most of the time. We certainly have banter with [chaplain I], certainly joke with [chaplain I] and [chaplain J] but they're only there when I'm there for about half a day. I don't know, is the answer to that, but I suspect it's simply because I spend more time with [chaplain A] and [chaplain F] and so there's more banter but I don't think there's a cultural or faith necessarily difference. Certainly I see it in [chaplain I] and [chaplain G].

**Interviewer**

I wonder if it's also a familiarity thing because you're spending so much time...

**Chaplain B**

That's what I mean, yeah. In one sense I feel very {sigh} confident in my relationships with [chaplain I] and [chaplain E] so I'm quite close to them. Particularly [chaplain E] because when I started one of the things was I spent a lot of time with her and got to know her so although I don't see her a lot, it's a close rela.... those are very important too, understanding how each other ticks and being able to support, when to back off, when to and when not to...the whole team thing is really important and what very clearly works here is a multi-faith element of it. My experience is only of chaplaincy [in this hospital] so it's very limited but I think we had a reputation certainly of getting into multi-faith fairly early and I think [chaplain E] is one of the first [chaplain to represent their faith community]. But also working at it and it does work. We had a lovely thing....slight change... we had a volunteer commissioning, we do volunteer training and so forth, which is multi-faith, and we had[chaplain E]praying and [a Buddhist volunteer] praying Buddhist prayers, [chaplain G] doing Hindu prayers and we had Christian prayers. And it was wonderful to see how similar they were. Acknowledging the distinct absolutely distinctness and some of the differences, but also what comes out of it for me is when you look at what we actually do, and you look at... because we make a point early on of going out with other people, and you look at the interactions and what we do and the motivations it's remarkably similar. It's about being alongside people because that's what our faith requires us to do, you know, the golden rule. And also...now the ritual is slightly

different, some of the interactions are slightly different but nonetheless it's very similar, the concerns are very similar we share patients and so forth. We wouldn't perform ritual on behalf of another faith patient, but certainly go and see them and talk to them and deal with the appropriate person. I don't know what started this off, but..! Yeah that multi-faith bit works really well and for me that's a real plus and a real joy, because I'm learning about Islam and Sikhism and Hinduism and Buddhism which I just wouldn't come across elsewhere. Interested but never actually come across it. So it's a real revelation as well, that's part of the interest of it, and having somebody... somebody of another faith who's interested in having that discussion because we're in the same context so you *need* to share it. Small anecdote, this is not about here, but my daughter, about 23, she's got a very good friend who's a Muslim, lovely chap, and he loves having conversations with me and my wife because he's a man of faith, and we're of faith and we can have some very good open discussions. And he says he doesn't often get the opportunity to talk about faith in an intelligent way, without an agenda. So that's a pleasure and in a sense that's the thing here, we can... because we're, that's our motivational interest we have those conversations about faith in an open way without feeling threatened in any way. Genuinely wanting to know because we want to make sure the patients get what they need.

**Interviewer**

So would you say chaplaincy provides a natural context for facilitating that then?

**Chaplain B**

Yes. Absolutely. It's part of our job to do it. It's great! It's like praying as part of the job. Wow! This is very naïve. If you're a professional minister and you come at this from parish ministry or something of course that's what you do but when you've been in secular employment and suddenly you're expected to pray at lunch time with everybody, *wow!*

**Interviewer**

It's very different!

**Chaplain B**

It's part of the job. So I'm still in that nice fluffy place of being a new minister, new professional minister. But with lots of non-ministerial experience. Yeah.

**Interviewer**

Going back to the humour question, I imagine the kind of humour that's used in the office would be very different to the humour out on the wards and speaking with patients.

**Chaplain B**

Absolutely.

**Interviewer**

I wondered if you could tell me a bit about that.

**Chaplain B**

About what we do with patients or...?

**Interviewer**

And staff?

**Chaplain B**

Yeah... staff...you can do black humour with staff... because they do it but you need to know who you're doing it with, that's the point. So if I just come across somebody I don't know very well and say something...well I wouldn't until I know where they're coming from. You sort of test it. You sort of say something that's a little bit...risky I suppose and then see the response you get. So normal interactions with a new person. With patients... yeah and again, it's about judging where you are with that person and how far you can go, but humour's really quite handy. So little things like...silly little things, it's not really very funny, but it is a bit humorous but I'll say to somebody "I don't want to see you again, take this the right way but I don't want to see you again!" and it always raises a smile and say "absolutely". Or some of our regulars we talk about having a loyalty card and getting a prize because you've been in every ward in the hospital, those sorts of things to slightly make light of those. It very much

depends on...you have to judge... the person you're with. And I wouldn't generally do it first time, sometimes you get on like a house on fire and the banter starts straight away. But you'll also get it if you're in a fairly intense thing... if you've developed a relationship with one person you know, you can make the odd joke, it happens probably slightly more frequently in a four bed when you can be talking with somebody and then somebody over there will throw a comment and it could be about anything, it could be about football, it could be whatever. And it lightens it and I think humour in what is a fairly serious place, you've got somebody who's got cancer, now cancer they treat very well these days but somebody sort of end of life, it's good just to lighten it a bit because it's a bit grim and serious. Sometimes somebody coming in who's...this is going into something slightly different... who's not clinically involved and I think probably like most of my colleagues I don't...I sort of make a point of not looking at the notes and seeing what the issues are. Usually if it's right near the end of life they'll tell me the situation, sometimes staff will say 'you need to know this' but I like the patients to take me through...tell me what they want. Sorry, rabbiting on, humour yeah I think it can just be, I can't give you too many examples but it's just... and I don't tell jokes, but you can sort of poke fun at things and lightening things up a bit and if you get a smile even though they're in a lot of pain and in a difficult place, just lifts the spirits. It's about lightening things, it's not all...it doesn't have to be desperately serious all the time. It can help with families too I think, I'm trying to think of .... it's terrible because I can't tell jokes to save my life, I'll think of something as we go along. But it's a very useful weapon I think...not weapon, tool! {laughs} It's not meant to harm anybody but it's quite a useful tool in the right circumstances. With me it's just sort of light humour, laughing at myself. Probably ground to a halt there.

### **Interviewer**

It seems to me that humour is an important part of being a chaplain, but what other traits and characteristics do you think are important for being a chaplain?

### **Chaplain B**

You've got to be fairly secure in your faith I think,'cause that's where your strength comes from. So you've got to be quite...you've got to be resilient because of the situations you come across and you've got to be able to keep that... you've got to be able to empathise and sympathise without....and absorb. So there's a lot of what we do is absorbing pain, in a sense sharing it, taking some...if that's right...taking some away or at least sharing it. And that can



be quite exhausting after a really intense day. So yeah you've got to be resilient, doesn't mean you don't have a...you don't care, you don't have a heart, you're not emotional, and so forth. It's... and sometimes in the most difficult situations the chaplain's the one who's supposed to hold it all together. It's a little bit like if you're conducting a funeral, there needs to be somebody there who's holding it together. So I...the sort of situation would be I'm called in in the middle of the night, somebody's in the bed, the whole family's around the bed and they're all in some distress and they're looking to you really just to hold it together, which might be prayer, might be other things. So yeah I think the resilience bit, you've got to be cool and unshockable. Because people will tell you the most amazing things, and unshockable in the sense that it's not poker face but you need to be very conscious about how you're reacting to what people are saying to you and, you know, not sort of looking appalled at the one point! {laughs} which are sort of life skills I think, they're not specifically religious skills, but they're certainly life skills. Somebody said that to me, "I feel like I can say anything to you because you're unshockable." Which was a compliment, so you've got to be able to yeah... so you've got to be resilient, you've got to be unshockable, you need to have that faith behind you as to why the heck you're doing this. It was one of the things I learnt fairly early on, is be clear about why you're there. What else...characteristics, you've got to have a sense of humour... you've got to be fairly articulate as well. Doesn't mean educated, doesn't mean that you have to have degrees and stuff, it probably helps, but certainly able to express what you're feeling, and part of the business of listening, because this is primarily a listening role, going back to the model, it's very much about listening, being alongside and hearing what people...hearing people's stories and hearing people's narratives and it's really important for people to be able to express their story as they want to. Anecdote, here we go. Probably told you this one before, somebody asked for a chaplain, not of a particular faith, and he called me in and he said...basically what he wanted to say was...he was an elderly gentleman and he had uncontrollable diarrhoea and everything, it was just horrible, and he said 'I want to die. Hand in mouth, I want to die. I can't tell my family that, I can't tell the staff that, but I need you to hear me say this.' And he sort of did that and basically just said 'right, now bugger off' and that's it. He didn't want anything else, I have seen him since briefly, but that wasn't it, he needed somewhere to put that and to express how he felt. Turns out he's got better and he's feeling fine and so forth, but he didn't think he could say that to anybody else, he needed to verbalise it, he needed to tell his story. We were able to do that because the chaplain is a

trusted place, confidential, you can do that. He said ‘no bugger off, go away’... well didn’t tell me to bugger off, but that’s what he meant. So...how did we get into that? I’m rambling now. What were we talking about?

### **Interviewer**

Traits and characteristics that are vital for being a chaplain.

### **Chaplain B**

Yeah and the other thing is that you’ve got to be able to let go. So relationship’s crucial, but you’ve got to be able to deal with just passing and have confidence. Because a lot of our interactions...some of them you get to know some very well and it’s really deep...but sometimes it’s just passing and you’ll meet somebody once or twice and you’ve got no idea what’s happened and you just have to accept that. And once they’ve left the hospital, out there there aren’t links. I think if you’d been in parish ministry, you have a relationship with your parishioners and you’d have a relationship wherever they are and you’d see it through and you’d see what happens. Here you see them until they leave and then it’s gone, so you’ve got to be able to deal with that, that sort of passing nature and be happy to let go.

And...theological terms...I don’t know whether that’s pushing it, but certainly you’re part of that process and you are part of that person’s narrative and you have to trust that that’s the right thing and that’s God’s will that you can do that and that others will pick it up. You’ve got to be very open to working with others working in your area too so it’s not something... if you’re a completer finisher, which I’m not, it might be quite tricky. I’m not sure how that term translates into a characteristics or traits. And you might have a very strong relationship, some people here for months, but when they’re gone they’re gone. They might choose to pop in and see you if they come to outpatients, but that’s it. And that can be quite difficult I think for some people. Yeah.

### **Interviewer**

And moving on to broader themes of support in the chaplaincy role. Do you feel that your faith community supports you in your role as a chaplain? In what ways do you feel your faith community does support you and are there ways in which your faith community can offer more support?

## **Chaplain B**

Yeah. So there's the support here and then there's the support out there. My parish...so I'm based in a parish mainly because...well you have to be, so as a reader I also, although my primary role is a chaplain, I also am still attached to a parish so I'll still do preaching and services and stuff, sit on various committees and things...although that's slightly more limited...and they're very supportive actually of what I do, and they're interested in what I do. I can very carefully select anonymised material, it's very useful to me in terms of preaching to others, it's some of the experiences people have. They're always interested in that and support that, just in the sense of prayer and being encouraging...encouragement. As far as the church goes, I'm sure you've heard about this from others, I'm not sure {sigh} that we do have a meeting of Anglican chaplains in the Birmingham diocese which is actually very useful as a network of meeting others. I'm not sure I feel neglected, I think others might feel that. Not sure how much the church expresses...the church expresses interest in chaplaincy but I'm not sure it does very much practically. There you are, getting to the point... I get a bit more...I get slightly more interest because I'm slightly unusual as a reader, as a chaplain. So people are interested because it's different. The Bishop knows what I do and he's quite interested in that. We pretty much get on with it and it's almost outside of the church really because they're {sigh} very tied up with parish... I mean they're looking comprehensive, I know, the diocese of Birmingham, at what ministry should be because it's still very much tied up with priests and with parishes and how we do it and how we can afford it. I think they appreciate what we do and think it's very valuable but I don't think it's very well integrated into what the rest of the church does. I do one other thing, on Tuesday I do industrial chaplaincy, a misnomer...chaplaincy in the workplace with the city council and that's sort of on the periphery...so I think we're on the periphery. There we are, getting to the point. I don't think...we're not excluded, I just don't think they quite know how to include us. I don't think they've got a big comprehensive model of what church is...it's still...I think they've got the vision for that but it's still very much based around parish and buildings and churches. But chaplaincy, if you look at what we do, it's a very significant part of the church's outreach. And they sort of recognise it but I'm not sure they know how to support it and promote it really. We're employed by the trust as well, that makes a huge difference as well. We're not employees of the church.

## **Interviewer**

Moving from one institution to another, how do staff respond to your work and do you feel valued by members staff, QE and the NHS as a whole?

## **Chaplain B**

Hmm. So personal level, interactions, yes feel valued. It's one of the things I had to work at when I started actually was that... I mean, for me, the priority was getting to work out how to attract the patients but also, an extensive priority for me is making sure I interact with the staff too because it helps. My background has been very much in staff support so I've got an interest in that. But in terms of answering that question, if you're on the wards, in the clinical areas dealing with patients, staff are usually... they usually get it, or they're fairly close to it, certainly the ones that call for chaplaincy and we do a lot of work with training and engaging with staff. They're usually quite supportive and see you as... particularly when it gets quite tricky... a good example is, I've probably told you this before, in burns for example. It's an area I've got to know quite well, it's quite small and specialist so the staff generally know me quite well. Some of the other areas I never seem to see the same staff each time I go. I was in 'ooh glad you're here, we've just talked to somebody, given them some news, it's quite difficult, it's not end of life, but it's quite difficult and they need to sit with somebody who's not medical to talk it through' and they thought chaplain... he's the person who can do that with and that's great, and they were there for about three months and I went to see them every other day, had a really good relationship through that. So that was good, and when staff get it it's fantastic, and part of my priority is to build up those relationships with staff and support them because they, particularly in bereavement, because they go through grief as well, and the nurses, they don't have decent debriefing process. It's appalling, I was quite appalled, so I'm hoping to do some work with... in bereavement about making sure we can support staff. That's come up particularly through the young person's unit so you've got teenagers with cancer who die... we get some of the more difficult cases and sometimes they die and it's quite hard to deal with. So, anyway... so... interactions on the wards, called in and seeing patients is fine and it's generally very positive, sometimes they don't get it and what are you about. Certainly if they know the patient and see you interacting with them with a bit of humour and a bit of banter. So we take the mick of out the nurse or whatever, that's great. As

an organisation or institution...I'm not sure. Individuals within it certainly see the value in it, in supporting patients. I think in one sense it's probably easier for the...I call it minority faiths, and one of the things that helps us in this is the equality and diversity agenda, I bring experience over there, because you *have* to accommodate that. Now, accommodating that for patients seems to make a lot of sense, if you've got someone who's a Muslim or a Sikh it seems fairly obvious that you should provide... I think for the generality of folk, so if you're thinking of white British people, most of whom aren't aligned to a particular religion, and I think some folk, some senior managers don't see...they don't quite get it, they don't quite see... We talk about spirituality and faith and religion as different things and I don't think as a profession and I don't think here we're articulating it in the same way. The professions talk about caring for the whole person and there's a spiritual element to that person about meaning and about purpose which might involve faith, it might not. We can...with the practitioners that seems to work quite well, but I'm not sure how much the trust board feel about it. Having said that, I don't think, I don't see that chaplaincy is particularly under attack or under threat in this trust, it's got to the same as everybody else and make its savings, and there is no reason why it shouldn't. There's no reason why, this is my senior management hat on, why chaplaincy should be any more protected than anybody else but I don't think, I don't detect, and I'm not experienced enough that there's a particular threat. It has happened in other hospitals though, basically decimated the chaplaincy in the West Midlands. I don't see that here, I see a bit of frustration that the chaplains just go off and do whatever they want {laugh} which is great, one of the joys of the job, and hang on, how do they get away with it, and we need to articulate that and need to be careful about how we record what we do and so forth. But yeah...so I guess practitioners who deal with patients generally welcome our input, not sure people...we're a very...we're tiny. There's a full-time equivalent of about 5 or 6 people maximum in a staff population of 8,000 so it's not particularly high profile. But I don't think there's a huge threat, it's more about making sure the Trust...we need to make sure they understand what we're doing, why we're doing it and the value to patients. The Trust needs to be confident that we're doing something that's of value. I don't see any harm in that actually, and we have had a recent change in the manager you report to, and that sort of created a bit of fascination and interest. But I don't see that as a threat.

**Interviewer**

And this question might be a bit...obvious, it might be quite personal. Do you feel valued by the chaplaincy team in particular?

**Chaplain B**

Yeah, yeah. That's the thing about humour so they wouldn't banter with me if I wasn't part of the team {laughs}. That's the thing...that's another bit about humour actually, if we're all doing it then you're included. I think I said this, sorry I keep saying this, I got a bit of an insult by a senior consultant, do you remember I said that to you a couple of weeks ago? He made a comment, because I cycle into work he made a comment on the ward about, 'you look better in tights' because I usually wear cycling stuff, and I thought 'I've arrived!' A senior eminent international surgeon noticed me and noticed me to make a comment! I'm there, I felt really valued then because that was a sign, that first of all he was acknowledging me because you don't need to do that...and he knew who I was and he knew me well enough to make a personal comment. Saying that it's all tidied up neatly. Yes I do, feel valued by interactions I have with patients. That's part of the deal actually. Not a good reason for doing it, feeling loved, but it's very nice.

**Interviewer**

I'm just going to move on to further reflections on the chaplaincy role. What do you think makes this team successful or unsuccessful?

**Chaplain B**

Wow. Now, you see, what do you mean by successful? You're asking me!

**Interviewer**

It depends what you think success is for this chaplaincy team.

**Chaplain B**

I think...from my experience with others, my experience with patients is that we do have very powerful engagement with patients. And I can see the difference that makes, partly because they actually express it to you, but I can also see the impact of colleagues on others and it makes a difference to people's lives, it really does. Hard to measure it, but in terms of them

expressing that and articulating usually their gratitude for the support people are able to provide, I think that's very clear from a success point of view. Where we're unsuccessful is in articulating that and demonstrating that to others who aren't a part of it. What the NHS wants is numbers, evidence based {inaudible} is the mantra. So where's the evidence? Now, there's a bit of a con with data I think, that data has to be numerical, but I'm talking to a theologian! It has to be numerical to be of value and that's nonsense. And there's lots of cheating goes on. So you do surveys and put numbers on questions and it's really just a person's opinion which is a perfectly valid thing in itself, so I think the narrative is the most powerful and we haven't yet, where we're unsuccessful, where the struggles are, is actually articulating in a way that the NHS senior management understand, their language without compromising what we do. I don't think we make it clear enough at that level, how valuable we are...even though we've got lots of supporters. We've got to be smarter, that's what we're not successful at, communicating the value of what we do and demonstrating that. And that's common to chaplaincy.

### **Interviewer**

And what is the most difficult or easiest thing about working with people of other faiths? Has your attitude and approach to other religions changed since you worked in chaplaincy?

### **Chaplain B**

Yes, it sort of goes on from the comments I was making before. Well what's easy is that you actually have...you're with people of other faiths who are established people of that faith. So when you're talking to [chaplain E], [chaplain I] and [chaplain F] or whatever you know you're talking to someone who actually steeped in it and actually understands it because people give opinions and it's part of our job to make sure we do understand. So that's a great strength, and absolutely I've learned, as I was saying before, I've learned so much about other faiths through people who practice their faith in a nice safe environment. Difficulties? [Chaplain C] put it very well before, we're very good at being shoulder to shoulder with the other faiths... not sure we do enough about being face to face. In other words, this would be my natural tendency, to look for the common shared position but actually we also need to be clear about what's not shared. Not sure that's a failing, I'm just it's...perhaps...more difficult, I don't know...that I think is...can get between say Roman Catholic and another...there's significant differences there. So the official Roman Catholic line is not to

recognise...ordination of Anglican or anybody else so in a sense they don't recognise my colleagues as priests. And certainly not a woman priest! So...and that's not voiced particularly and we sort of go along with it and maybe without starting a war...exploring differences is perhaps a little harder. We know each other enough and trust each other to do that but that's more difficult. You don't want to offend people, all the usual reasons, but sometimes I think that's... exploring the differences is more...natural instinct is always to search for a common...that's how I relate people. You find something in common...empathise.

### **Interviewer**

And this might get you into a whole load of anecdotes but describe your most challenging encounter and how you responded to it? How did it challenge you and did it affect your work in the long term? Assuming there is one...

### **Chaplain B**

Hmmm, gosh. Urm. I can tell you about serious mistakes I've made {laughs} gosh, where do you want to start? I think, I'm not sure how this is the most challenging encounter, but let me tell you about how I really messed up a couple of times, which is making assumptions about relationships in a family. So...what I've done is just dreadful, I feel ashamed to say... somebody sitting with somebody who's dying and I've assumed they were the husband when in fact they were the *son* and voiced that {laughs} which wasn't a clever thing to do, but I got away with it and it just made me think 'oh my goodness'. So not making assumptions about relationships...family relationships. That's...I've done that once or twice. I've not done it since then because I've learnt from it. Not making assumptions about faith linked with ethnicity, well they're Asian so they're not Christian or whatever. Difficult encounter...erm... certainly been challenging ones. The thing I find hardest is with somebody who's not able to verbalise, so it's somebody who's just had a stroke. And they're conscious, and because I spend so much of my time listening, that's what I try and do. If *they* can't speak, I find that very hard and er...coping with silence I can do and certainly that's something I've learnt, and that's something I've learned through sort of pastoral experience in a secular environment...actually that... And you can see, very often, it might even be two, three, four minute silence, and you can see somebody trying to process and work things through. I can



cope with that. Some people are very uncomfortable with silence. What I can't cope with very well is if somebody's not able to communicate and I just sit there looking at them and I think 'hmmm!' I think [chaplain A] is probably very good at this, I'm not so hot with that, sometimes it might be holding hands or whatever. Those are the most challenging and I wonder about... Then it goes back to 'why are you there?' and if you're there to be alongside somebody then maybe just sitting in silence is ok. I probably learned that in the particular case of a lady who was in burns for four or five months, had the most horrendous burns, shouldn't have survived, had 6 children, didn't see them for 3 months, she wasn't able to communicate at all to start with and that was...the... my wife would say my tendency is to try to fill the space and that's not appropriate and it's about getting the balance and communicating and being there with them, focusing on their needs. It's not about you. The fact that you're uncomfortable is irrelevant as long as it doesn't impact on the interaction with the other person. So that's...I find hard and I think working on a stroke ward I find quite difficult. I've sort of got better at it, but that's really hard.

### **Interviewer**

And what are the primary barriers preventing you from fulfilling your role as a chaplain? Or even just barriers generally.

### **Chaplain B**

Yeah, urm... {sigh} I think...there's never enough time is there? If you asked anybody in any job, what do you need... So I'm part-time but I'm very comfortable with doing three days a week actually, but I think what makes me feel guilty is not getting...so we have so many wards allocated to us...I feel that what tends to happen is that you get sort of quite familiar with one or two wards so burns and YPU for example, potentially to the neglect of others so I'm not spending enough time on all of my wards, it sort of goes in cycles. And then something happens on a ward or somebody wants something and I don't know about it and I think... I don't beat myself up don't get me wrong, but I think... so there is an issue. There is a sort of resource issue and I'm not naïve enough to think that we need to have more chaplains, but I do wonder whether {sigh} and not everyone wants to see a chaplain but I'm just not confident that most people get the opportunity to have access to a chaplain. So it's great, the things we do, the interactions we do, are really important and really useful and

really helpful but I suspect there's quite a few we don't get to and I think that's... I don't have an answer as to how you do that, maybe the way we use volunteers... I think with new leadership we're gonna be looking at the models we use for chaplaincy. Maybe chaplains become much more like the consultants and we have others who go out and do general stuff and the visiting and refer to us those who want... who need a chaplain. I don't know, we'll see how that goes. Yeah...but I don't think there are...I don't find there are any management barriers, ok we need to record stuff but we *need* to record stuff. There's barriers within me, my inefficiency. But the one thing I regret is that I don't get out as much as I want to or sometimes I won't get to every ward every week, that's for sure. Sometimes there's been two or three weeks where I haven't been on that ward at all. That's not right...in terms of chaplaincy profile. So part of it's me getting my act together and it maybe that we need to think about visibility and presence without just being token. I'm confident that the interactions we have are useful, my worry is about how comprehensive it is and how broad the coverage really.

### **Interviewer**

And moving onto something more positive, what is the most satisfying thing about being a chaplain?

### **Chaplain B**

Oh gosh. It's...it's the... if I can put it in a flippant way, if you're a really nosy person, it's a fantastic job {laughs} because people tell you the most intimate things about their lives and I'm always nosy and want to know about people and what they do and where they live and what their family is and all the rest of it so that's great. But, it's the interaction and it's acceptance... for me it's the affirmation of an acceptance and I'll go and see somebody and in most cases, in the vast majority of cases it's straight into acceptance and they want to share with you. And that's hugely...it's uplifting really. Then there's the inspirational people you meet, I've got two women at the moment I'm seeing in the most difficult circumstances and have the most amazing spirit which helps them to cope which is inspirational. Sometimes I'm seeing patients and I'm quite aware that it's for my benefit rather than it is for theirs. That's inspirational. Then there's being part of the most intimate moments at the end of life, which if you get it right and don't suggest that the son is the husband, if you get it

right...that... that's very powerful because you feel you've been able to support people in the most difficult time in their lives. And that's usually rewarding. So I'm very positive still, I'm new I love it and I'm amazed I'm allowed to do it. {laughs} I'm not jaded yet!

**Interviewer**

Sounds ideal.

**Chaplain B**

Yes, it's a good place to be. I'm 56, I've got perhaps another ten years. I've not got particular career ambitions, I've done all that sort of stuff, it's...other than doing this or doing something like this.

**Interviewer**

And kind of related to the question about traits and characteristics, what makes chaplaincy as a profession, as a way of doing pastoral care effective? What is vital to the practice of chaplaincy?

**Chaplain B**

Gosh, and that's different from traits and characteristics of chaplains? Just repeat that?

**Interviewer**

What makes chaplaincy as a profession, as a practice, effective? What is vital to the practice of chaplaincy?

**Chaplain B**

Ok I think history is an important part of it, in... this is where I compare where I go in the city council as a workplace chaplain where there is no history, so what the heck is a chaplain? In hospital, in a prison, in the army people know what it is, the role is understood pretty much and I think the key to it is trust. And...which is sort of the point I was making before, people know you're the chaplain and they just seem to open up and...there's this business about being trusted, about being confidential and...separate from clinical part of it. Probably separate from the church too actually. So it's a safe place you can go so it's absolutely vital

people trust you and feel that it is a safe place that they can open up. That's the key thing, and the faith element is part of that, part of the history, part of people's understanding of the idea of a priest or a confession, all that sort of stuff. That sort of answers it. I think that's key to it. If people start thinking... if they didn't trust you to do that, you're just somebody else who's coming to see them and you're after... Ok let's put it another way, pretty much everyone is who goes to see the patient is after something, they're after their blood, their blood pressure, yeah something clinical, they need them to do something or they need to do something to that person. With us... that's not there. There isn't a demand, we're not pushing something. You know, we're not saying, come to church, become a Christian, do this, that and the other. It's about... people sort of appreciate that, we're just there to spend some time with them. Hmm. That was an interesting reflection, sorry, from my point of view.

### **Interviewer**

That's most of the questions I had anyway, but if you had any particular comments or think that I've completely missed out on something very important, now is the time to say.

### **Chaplain B**

I don't think so. I think it's great to have the tables reversed as you're kind of like doing the chaplaincy bit, you're talking and letting me tell my story which most of the time we're encouraging other people to do that. No it's a really interesting time to be doing research into chaplaincy, the sort of other... there's a church/other faith perceptions of chaplains that kind of goes in cycles so in the past people have said 'oh well chaplaincy's not proper... not proper ministry' I don't hear anybody... I don't think that... but now suddenly when you look in the Church Times where they advertise jobs, chaplains are popping up everywhere. I don't know whether that's an improved understanding of the value of chaplains out there where people are doing God's work, or whether money's run out and they're pleased for somebody else to be paying it, a very cynical view. But yeah I think it's... I think as churches are looking, those that are, at ministry and how they do it, chaplaincy is quite an interesting model of doing that. But you have to work in partnership with... so we're employed by the Trust so we're members of whichever church or faith group that we're in and they have an influence on us and our theology and our practice, but they're not in control, and I think that's an interesting place for institutions to be, it's an uncomfortable place. Some churches, Roman Catholics and others

will place people, priests or ministers, they don't do job applications, in Church of England they tend to apply for a job. So when [chaplain F] goes, there will be a job advertised but the Catholic Church may well want to place somebody there. So that's a bit of...we might be able to control that by the people who apply for it, we don't know, but that's something the faith groups and institutions...it's different for other faith groups because, certainly listening to [chaplain G], the concept of a chaplain in Muslim faith is a bit of a new one, so they have a role in going out and doing it. But there isn't that control so that's quite...while you can acknowledge the value of chaplains and that they're wonderful they're not quite under your control...so I think institutions have to work...so it's much more partnership model and that's very much where I come from. Secular employment is absolutely working with staff and others and not just ploughing your own furrow. Your interactions are absolutely yours but it's making sure others are aware and comfortable of what you're doing, and trying to share with them and demonstrate that you're part of their team and you're helping them. There you are, partnership model.

**Interviewer**

Wonderful. Well unless you've got anything to else contribute I think I'll finish the recording.

**Chaplain B**

Alright, OK.

## **Appendix E: Rationale for Coding**

The categories listed below constitute all of the themes which cropped up during the course of the fieldwork.

- Role – administration, visiting patients, on-call, pastoral care, meeting RPS needs, ethics, misunderstandings and misconceptions, facilitating role, generic chaplaincy
- Motivation – faith, patient need, contact with patient, fits in with other interests
- Background – previous career, getting started in chaplaincy; status in community
- Identity – personality traits; marginalisation; theological liberalism; compromise and flexibility; dog collar; peripheral
- Theological concepts
- Other sector ministries – prison
- Parish ministry
- Ethics – confidentiality, NHS policy
- Humour – role of humour; problems of interpretation; type of humour (in particular black humour); discernment
- Denominational distinctiveness
- Context – secularism; death-denying culture; NHS bureaucracy
- Community relationships
- Inter-faith relations
- Relationships with staff
- Visibility
- Chaplain as privilege
- Methodological Issues – asking to clarify question

- Miscellaneous
- Other Interest

First I will code the interviews and fieldnotes in NVivo in accordance with broader themes, including remit, motivation, institutional context, generic chaplaincy, background, identity and humour, methodological issue and then break these down further.

The categories listed below are the ones that seem the most immediately apparent and significant from the overall fieldwork period. These codings are broad categories which will contain numerous subthemes. However more codes may emerge as the transcripts are analysed more thoroughly through NVivo QDA.

### *Generic Chaplaincy*

Generic chaplaincy came up as a significant point of contention in the literature as well as during the observations, and I felt therefore it was an important category to include in the coding strategy. This also relates broadly to role, remit and models of chaplaincy, and was often cited as the primary model of chaplaincy, second only to the ‘pastoral’ model. It might be argued here that *pastorally* the only model of chaplaincy that *is* appropriate is generic because if patient dignity were to be ensured pastorally an inclusive approach to chaplaincy would be required (see the distinction between what’s *pastorally appropriate* and retaining *theological integrity* from interview C). Only one chaplain seemed to object extensively to the concept of generic chaplaincy, and these arguments resonated strongly with current trends in the existing literature, while other chaplains argued that their ‘generic’ role, despite disliking the term, is grounded in beliefs particular to their faith (i.e. that all human beings comprise the body of God; God is in everyone; etc.). Several chaplains argued that generic chaplaincy has taken on different meanings in different contexts, such as the U.S. where it is acceptable for

chaplains to perform religion-specific tasks for patients/staff of other faiths. In this fieldwork the chaplains often reject the term 'inter-faith' in favour of 'multi-faith' in order to retain a sense of distinctiveness between faiths. It is also worth comparing how generic chaplaincy works out for chaplains who have to focus on their faith communities (Hindu, Sikh, Muslim and Catholic). Thus this particular theme deserves particular consideration because of how it relates to the current literature, but also the richness which has become apparent in the attitudes towards generic chaplaincy and how it works out in practice.

*Subtheme: Proactive/Reactive Chaplaincy*

It seems that in the framework of generic chaplaincy, Anglican and Free Church chaplains were more likely to adopt a proactive approach to chaplaincy – these chaplains were assigned to particular wards for them to 'loiter with intent'. The Anglican chaplains even have meetings to discuss which wards they will all cover, so this is quite an organised approach to proactive chaplaincy. On the other hand the generic role for Hindu, Sikh, Muslim and Catholic chaplains seems much more incidental and often generic encounters take place while the chaplains make their way towards patients of their own tradition. The line between proactive and reactive chaplaincy is, therefore blurred.

*Multi-faith/Inter-faith Prayer*

One small but significant issue that was raised was what happens when chaplains are asked to pray with people of other faiths. Some chaplains are happy to use 'general' prayers which touch upon common ground, while one emphasised that he will always pray from his own tradition.



### *Chaplaincy Remit*

The remit of chaplaincy appeared to be a better way of describing the chaplaincy role than asking directly about the role – this came through particularly when interviewing the minority faith chaplains who explained that the boundary between their work in the community and their chaplaincy work is difficult to enforce. This can also help with focusing discussions about how chaplaincy relates to the wider faith communities. When Christian chaplains were asked to discuss their role, their answers seemed to be somewhat nebulous, and focused more on emphasising the ‘generic’ aspect of their work and the response to spiritual, religious and pastoral needs. My observations, however, could provide some more substantive answers to what the role involves – for example very few chaplains seemed to want to talk about the administrative side to their work, except chaplain C as team leader and manager. Also the motivation behind minority faith chaplains (particularly Sikh and Hindu) taking up the role was because they felt chaplaincy was a viable extension to their work in the community and that they were broadening what ‘sewa’ or ‘bhakti’ meant beyond the temple and the faith community and into the hospital. Thus chaplaincy for them is more like an extension of their existing status in their faith community. However both the Hindu chaplain and a Muslim chaplain spoke about their respective ‘chaplaincy’ hat and ‘community’ hat, suggesting some demarcation between these roles. So an examination of the remit of chaplaincy provides an account of the important differences between Christian chaplains and chaplains from the minority faiths, particularly about the boundaries that are set up between chaplaincy and the community. See also chaplain G’s comments on chaplains as bridge between community and hospital.

### *Humour*

Humour became an important category because it not only pervaded the observations, but was a significant element of the interviews. Particularly in the case of interviews with Christian chaplains laughter was quite prominent. However, some differences of opinion about the role of humour and laughter could also make some rich discussion, particularly as this relates very much to ecumenical differences. The observations and interviews, however, focused on the role of humour among Christian chaplains and a few references to the Muslim chaplains. There are some important examples of the use of humour from the observations, although this is only in the context of the chaplaincy office.

### *Creativity and compromise*

This is an overarching category which can be separated into further subthemes. Here this can relate to theology, important attributes for chaplains, chaplaincy leadership styles and working within a secular environment. Overall, however, this theme can be linked to the overall concern in the literature that chaplains are 'selling out'. This seems to be a more appropriate theme for the Christian and Muslim chaplains rather than the Hindu and Sikh chaplains which needs to be explored more. Are the boundaries for Hinduism and Sikhism less rigid, so that the issue of 'compromise' is easier to negotiate? One Sikh chaplain did mention that his primary priority and duty was to support patients regardless of their decisions rather than enforce religious imperatives (i.e. in the context of abortion). In the case of chaplain G there was no clash between his role as a Hindu priest and chaplain; in this case generic chaplaincy fits in well with core teachings of the Bhagavad Gita. Another important question for chaplains is the extent to which they can actually be creative and flexible, particularly as the trust seems to be encouraging the chaplaincy team to make records of

everything they do, but also use a clocking in system which forces them to work particular hours, rather than allowing chaplains to spend more hours than they're paid for with patients. While the team leader emphasised that his leadership style is to pretty much let the chaplains get on with it, institutional pressures mean that chaplains have to hold themselves accountable; this is particularly voiced by the Catholic chaplain.

### *Institutional Context – Working in a Secular Environment*

This can be broken down to examine several key issues, such as the institutional constraints on chaplaincy (problems with patient records), staff attitudes to chaplaincy, overall issues of secularisation, the use of the 'SMART' clocking in system which restricts chaplains' flexibility, NHS policy and the increasing pressure to be held accountable and the ways in which chaplains are trying to do this. There seems to be some disparity among the chaplains about whether this is desirable, but also about whether chaplaincy really needs to 'fight its corner'.

### *Status of Minority Faith Chaplains*

While this hasn't been explicitly talked about particularly much, it is worth comparing what the status of minority faiths in chaplaincy is now in relation to what has previously been written about them. Since Beckford and Gilliat-Ray's report 'The Church of England and Other Faiths', there has been a shift from visiting ministers to the use of volunteers, honorary chaplains and paid part-time chaplains from minority faith groups. It will be worth highlighting how honorary chaplains differ from volunteers. This could also relate to the status of minority faith chaplains in their respective communities and how their journey into chaplaincy appears to have naturally evolved from their community work. Similarly then, an examination of status of chaplains in their respective faith communities will be particularly

helpful – usually minority faith chaplains come into the profession because they have already done substantial amounts of work in the community and somehow made a name for themselves as a religious representative rather than go through a system of training. Only one minority faith chaplain has received chaplaincy-specific training, while most of the Christian chaplains had been to theological college. Thus the standing of minority faith chaplains in the community is a vital criterion for involvement in chaplaincy, and may continue along this way (except for Muslims and Buddhists) because there are not really any training resources for Hindus and Sikhs, unless they join Christian chaplaincy courses.

#### *Methodological Issues in the Research*

This theme became most apparent in the fieldnotes during the observation period, in which chaplains asked me what I expected of them and even suggested they could make things up because I wasn't shadowing anyone! Thus the participants unwittingly engaged with some very important questions that came up during my methodological considerations, and some chaplains even echoed what had previously been written in chaplaincy literature, such as researcher and chaplain having a similar role in being attentive and listening.

#### *Inter-faith or Multi-Faith? Retaining Interreligious and Intra-religious Difference*

The question of ecumenical and multi-faith working is particularly significant as it relates to several prominent themes that have cropped up – the use of humour to address/cover up religious difference (it is interesting that there are two contradictory views on this); grounding generic chaplaincy in an explicit faith position; the chaplaincy remit; denominational identity.

## *Theology*

Interestingly explicit references to theology were rare, with the exception of interview A, which dealt with the nature and purpose of theology extensively, and interview C which briefly mentions the idea that God is in everyone. God was only mentioned by other chaplains when talking about the grounds for undertaking generic chaplaincy (again, God is in everyone for Hindus and Sikhs). It seems to me that this absence needs to be dealt with, particularly as several sources in the literature give a lot of emphasis on the role of pastoral theology in chaplaincy work.

The coding will not include certain topics primarily because these can helpfully be subsumed under other broader topics – for example, motivation, ethical issues, role, relationships with staff and the broader socio-political context.

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