The Integration of Minority Faith Groups in Acute Healthcare Chaplaincy

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Abstract

Chaplaincy provides a microcosm through which the public role of religion can be examined and interrogated. Only two studies have examined the question of minority faith involvement in chaplaincy, both conducted before the large-scale introduction of formalised substantive chaplaincy posts for minority faith groups. The rapid development of Muslim chaplaincy, from visiting ministers to lead chaplains, has begun to be explored. But it is clear that a study concerning *all* minority faith groups involved is necessary in order to fully understand how far the boundaries of inclusion and exclusion have shifted since the turn of the century. Practitioner literature barely accounts for these developments in chaplaincy, while contributions by minority faith groups are rare.

This thesis develops this literature by exploring the status and integration of minority faith groups in acute healthcare chaplaincy. This is achieved through a multi-site ethnography of five case studies of chaplaincy teams across England. Minority faith involvement is largely, but not solely, characterised by mediation, negotiation, and stagnation. These findings are situated within a broader framework of participatory parity, which not only refers to distribution and recognition, but also the socialisation 'gap' that exists for many minority faith chaplains. These factors impact on their ability to speak the language of the institution and the chaplaincy profession. These findings and analyses are then compared with the chaplaincy literature to show the situatedness of the mainstream chaplaincy discourses around spirituality, marginality, professional identity, and collegiality. The findings and analysis have significant implications for an understanding of how the roles of religious professionals adapt and change in a diasporic context, but also for understanding how religion is mediated in the National Health Service.

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Contents

1 Introduction

Regardless of what commentators say about the state of religion in Britain today, it is telling that the seventieth anniversary of the National Health Service in 2018 was celebrated in services at Westminster Abbey and York Minster. Contributions to the service at Westminster Abbey were made by the Secretary of State for Health and Social Care and the Chief Executive of NHS England, in addition to the 'testimonies' provided by staff and patients (NHS70 2018). Imam Yunus Dudhwala and Rabbi Baronness Neuberger contributed prayers, speaking from their own faith traditions and breaking from the otherwise traditional Anglican format of the service.[1] The NHS at 70 service demonstrated the enduring *cultural* significance of Anglicanism in Britain (Davie 2015), despite the increasing fragmentation in the monopoly of Anglican Establishment not only in terms of declining religious practice and influence (Guest, Olson, and Wolffe 2012) but also in relation to the provision of chaplaincy services in state institutions (Gilliat-Ray, Ali, and Pattison 2013: 101). This service encapsulated symbolically the ongoing relations between the Established Church and the state, but also pointed to a multi-faith context where Muslim chaplains in particular are being recognised in 'key public sector domains in Britain, at the highest levels' (Gilliat-Ray *et al*. 2013: 141). The growing involvement of Muslims – and minority faith groups in general – in chaplaincy indicates an 'increasingly outward-facing, proactive involvement in civil society and public institutions' (Gilliat-Ray 2012: 119).

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[1] The inclusion of a range of 'religious voices' in the 50th anniversary service at Westminster Abbey was a source of considerable debate between the Hospital Chaplaincies Council (HCC) and the Department of Health (DoH) in a consultation in October 1997 (Woodward 1998: 48).

The public facing aspect of chaplaincy has long been taken for granted by Christian chaplains and needs to be reconsidered in light of varying levels of involvement by different minority faith groups. The report *Chaplaincy: A Very Modern Ministry,* published by public theology think tank Theos, noted that minority faith chaplaincy representatives have the 'powerful ability to inform and change perceptions' about their religious traditions as 'the chaplain often represents the only person of that faith that other staff regularly come into contact with' (Ryan 2015: 41). Chaplaincy constitutes a critical microcosm through which the relationships between religion, the state, and public institutions can be examined, explored, and interrogated (Beckford and Gilliat 1996: 5; Swift 2014: 5; Gilliat-Ray *et al*. 2013: 23), while examining ways in which minority religious traditions are developing greater visibility within the public sphere. This thesis therefore aims to examine the status and integration of minority faith groups in NHS acute healthcare chaplaincy.

This chapter will first introduce the nature and scope of chaplaincy, outline its academic significance, and provide a rationale for researching healthcare chaplaincy. I will then highlight key changes in the relationship between chaplaincy and the National Health Service and link chaplaincy to major historical shifts both in the British religious and spiritual landscape and in the NHS. Healthcare chaplaincy will then be placed in social context, especially in relation to growing religious diversity, and then situated in legal and political context by exploring the key ways in which religious diversity is managed in the UK. Key concepts relating to healthcare chaplaincy will be outlined, including 'religion', 'secular' and 'faith community', which will begin to provide some theoretical groundwork for this thesis. This chapter will conclude with an outline of the coming chapters.

1.1   THE SCOPE OF CHAPLAINCY

Chaplains are 'professionals that work with people around spiritual, religious, and broad existential questions in a range of sectors' (Cadge 2017: 438). Chaplaincy has always been linked to institutions such as prisons, hospitals, and the military, each of which has developed distinct approaches to multi-faith working over the

past twenty-five years (Todd 2015a). While chaplaincy in these sectors is state-funded, higher education chaplaincy is not necessarily funded by the institution, but may also have a multi-faith orientation (Gilliat-Ray 2000). Notably, chaplaincy has been developing in non-institutional spheres, including law courts, shopping centres, town centres, transport, community chaplaincy (usually concerned with ex-offenders), agriculture, and workplaces (Slater 2013; Ryan 2015). The majority of these non-institutional forms of chaplaincy are Christian projects, some of which are considered to be 'fresh expressions' of Anglican ministry (Slater 2013: 14), while others may have more overtly evangelical motivations (Ryan 2015: 42). However, some non-institutional chaplaincy projects have an explicitly multi-faith orientation, including the chaplaincy at Canary Wharf (Ryan 2015:35; Stewart-Darling 2017), court chaplaincy (Bradford Court Chaplaincy, no date), airport chaplaincy (Ryan 2015: 24), and community chaplaincy (West Yorkshire Community Chaplaincy Project 2018).

There are at least 771 chaplains employed by the NHS in acute hospitals, with an additional 57.73 whole-time equivalents (WTEs) (BBC 2013). It is difficult to extrapolate an actual number of chaplains from the WTEs, and the figure of 771 chaplains does not indicate whether chaplains are full-time, part-time, or on alternative contracts (sessional, honorary, or bank). Swift notes that membership of the College of Health Care Chaplains (CHCC), including mental health chaplains, has remained around the 1,000 mark over the past decade (Swift 2014: 71). In 2015, the then CHCC Faiths Co-ordinator, Siddiq Diwan, presented findings from a mapping project which showed that six per cent of paid chaplains are from minority faith groups, a figure excluding volunteers (fieldnotes, annual CHCC conference, 10/09/2015). These figures show that chaplaincy is a tiny proportion of the 1.2 million strong NHS workforce (NHS Digital 2018a) yet the location of the chaplain in between faith communities and the NHS 'yields disproportionately significant insights about religion and society' (Swift 2014: 5).

1.2   THE ACADEMIC SIGNIFICANCE OF CHAPLAINCY

Chaplaincy has been of increasing interest to sociologists of religion, with academic overviews concerning religion in contemporary Britain increasingly

containing contributions acknowledging the role and location of chaplaincy as a barometer of the religious and spiritual mood of the nation (Woodhead and Catto 2012; Davie 2015). Healthcare chaplaincy remains resilient, despite sustained campaigns by hard secularists to remove state funding from the profession, increasing institutional pressures (particularly the perpetual financial crisis of the NHS), and the decline of organised religion. As Arweck and Beckford note, 'chaplaincy has expanded while attendance and regular services of worship have declined in many churches and synagogues' (2012: 363).

1.3   RATIONALE AND AIMS

The primary focus of this research arose after conducting a case study with a multi-faith chaplaincy team for an MRes degree at the University of Birmingham in 2012-2013. The project alerted me to the lack of contemporary empirical literature on minority faith involvement in chaplaincy (Bryant 2014). This absence is still evident in spite of Orchard's call for the need to document the history of minority faith involvement over fifteen years ago (2001b: 15).

As I was completing my Masters research, Gilliat-Ray *et al*.'s book, *Understanding Muslim Chaplaincy* (2013), was in press, and constituted the first major examination of Muslim chaplaincy across sectors in Britain. My proposal to examine minority faith involvement in chaplaincy was inspired by this contribution and a desire to research a broader range of minority religious groups within chaplaincy. I felt that questions concerning minority faith involvement in chaplaincy could not fully be addressed just through an examination of Muslim chaplaincy. Around the same time, non-religious involvement was becoming a lively source of debate for chaplains locally and nationally. The chaplaincy literature has barely kept pace with these rapid developments in chaplaincy, which saw the employment of the first paid non-religious pastoral carer in 2016 and the employment of the first non-religious chaplaincy manager at Buckinghamshire Healthcare NHS Trust in 2018 (BBC News 2018; Slawther 2018).

Throughout the Masters project, the preponderance of 'insider' practitioner accounts of healthcare chaplaincy and the dearth of academic contributions

became particularly evident. Many of these contributions were published through professional journals within the field of 'chaplaincy studies'. Minority faith contributions were rare, indicating a pressing academic need to recognise and document the perspectives of minority faith chaplaincy representatives. The fieldwork and subsequent interactions with chaplains exposed a significant gap between understandings of chaplaincy promoted nationally through chaplaincy bodies and publications and chaplains on the ground. Focusing on minority faith chaplaincy presents an opportunity to interrogate taken-for-granted chaplaincy discourse, especially the marginality of chaplaincy as referred to primarily by Anglican chaplains (Woodward 1998; Ballard 2010; Swift 2014). While rightly pointing to the shifting ground on which chaplaincy stands, such a discourse obscures the fact that Anglican involvement in chaplaincy was presumed from the outset, and that Anglicanism remains the dominant denomination represented within chaplaincy.

This thesis aims to offer new insights derived from otherwise unheard voices and to understand the challenges and opportunities of minority faith groups' involvement in chaplaincy. In doing so, I address gaps in chaplaincy literature by examining the role and integration of minority faith groups in healthcare chaplaincy, and contribute a non-practitioner's account to an academic body of knowledge which is primarily informed by chaplaincy practitioners.

1.4   CONCEPTUALISING THE RELATIONSHIP BETWEEN RELIGION AND THE NHS

Idler and Kellehear (2017) have produced a taxonomy of how religion is present in public health institutions, ranging from faith-saturated, faith-centred, faith-background, formal faith role, informal faith role, and faith-secular partnerships. While religion is manifested through formal and informal faith roles in the NHS, some hospitals whose establishment preceded the founding of the NHS may be referred to as faith-background institutions (Davie 2015: 114). The formal faith role in otherwise secular hospitals might include spiritual care or chaplaincy departments, and the provision of facilities for prayer and worship. The 'informal faith role' may manifest in 'ordinary interactions between professional staff (other than chaplains) and patients' (Idler and Kellehear 2017: 235). However, to

characterise chaplaincy solely as a formal faith role overlooks significant variations in how different denominations have historically been involved in chaplaincy, and the varying modes of involvement for different faith groups today. Chaplains have not always been employed directly by the NHS and, up until the 1980s, appointments were decided through faith-secular partnerships with Church authorities nominating candidates (Wilson 1971: 131; Hospital Chaplaincies Council [HCC] 1978; Beckford and Gilliat 1996: 228; Woodward 1998: 95; Ballard 2010: 188). Contemporary exceptions are Roman Catholic chaplains, where appointment to chaplaincy roles may result from deployment by the Bishop. Likewise, the liaison between the Network for Pastoral Spiritual and Religious Care in Health (NPSRCH), a multi-faith consultative body, and NHS England on matters concerning healthcare chaplaincy is a key example of faith-secular partnership.

1.5 THE HISTORICAL LOCATION OF HEALTHCARE CHAPLAINCY

The development of hospital chaplaincy provision is already well-rehearsed in the chaplaincy literature and will not be repeated (Woodward 1998; Nelson 1999: 75-76; Welford 2011; Swift 2013: 250; Swift 2014). I will instead focus on the development of chaplaincy after the nationalisation of the health services in 1948, as this constitutes a significant departure point which lays the foundations for multi-faith developments in chaplaincy. While the chaplaincy literature has already identified key moments in the development of the NHS which have significantly impacted on chaplaincy, I intend to map some of these moments onto shifts that have been identified concerning the relationship between religion and health (Norwood 2006; Woodhead 2012: 21-22). The shift from assumed to negotiated involvement of chaplaincy in healthcare, marked by reforms which introduced managerialism and internal markets to the NHS, reflects the broader shift of religion as assumed to negotiated aspect of public life (Mowat 2008: 15; Ballard 2010; Welford 2011; Swift 2014: 3). This shift has given rise to recurring discourses of marginality and liminality among Christian chaplains (Woodward 1998; Norwood 2006; Mowat 2008; Ballard 2010; Swift 2014; Kyriakides-Yeldham 2017).

The birth of the NHS in 1948 marked a significant break in the relationship between healthcare provision and the Church of England. The nationalisation of the health services essentially divorced healthcare from religious institutions and brought healthcare under state control: 'in many ways the NHS represented the triumph of… secular medicine over religious, or mixed, provision of health and healing' (Woodhead 2012: 21). This corresponds with broader processes of institutional differentiation, where control of specialist functions and institutions is transferred from religious organisations and actors to the state (Rey 2007: 65; Giordan 2007: 165; Dinham and Lowndes 2009: 3). However, the requirement for hospital managers to appoint a chaplain for 'every hospital for which they are responsible' demonstrated the continuing importance of providing religious input in the new state-run healthcare system (Orchard 2000: 20; Woodward 1998: 88-89; Beckford and Gilliat 1996: 227). As medical competence and skill developed, cure supplanted care and biomedical discourses supplanted religious ones (Woodhead 2013: 1; Norwood 2006). The role of the chaplain complemented, rather than superseded, the work of medical staff (Autton 1966, 1968; Swift 2014: 45). The chaplain was considered to be a 'priest in the hospital': invariably ordained, Anglican, and male, the chaplain was an individual whose authority was recognised by all staff and patients (Autton 1968; Swift 2014: 46). The hospital was his parish, or part of his parish. The place of the Anglican chaplain, despite the ascendancy of medical science, was stable, secure, and unquestioned in a country that was largely still Anglican.

The marketisation of the NHS in the 1980s and early 1990s prompted chaplains to professionalise and demonstrate cost-effectiveness (Woodward 1998). Reforms in 1990 situated chaplaincy more firmly within NHS structures (Ballard 2010: 189) which had been transformed into an internal market (Holliday 1995: 45-58; Woodward 1998; Webster 2002: 188-207). Chaplaincy posts shifted from short-term clerical sector ministry secondments to distinct career trajectories (Ballard 2010: 188). Swift notes that reference to 'NHS Chaplaincy' in the 2003 guidelines (Department of Health [DoH] 2003b) emphasised that the identity of healthcare chaplaincy centred on its 'common location in the health service' rather than religious identity (Swift 2014: 63). Despite the concerns raised about the external pressures of professionalisation (Woodward 1998), Orchard reported that there

was little or no managerial interest in how far chaplaincy complied with the requirements of institutional reform, exemplified by the 'absence of basic mechanisms for monitoring chaplaincies' (2000: 36, 47). Orchard suggests that professionalisation processes necessitated a 'high level of internally generated responsibility' (2000: 127). Despite attempts to professionalise, 'there is not much evidence that this matters crucially to [chaplaincy's] hosts' (Pattison 2015: 26). The incentive to professionalise may be as much about chaplains' desire to be considered part of the healthcare team and the concomitant advantages, such as access to patient information and further recognition of the chaplains' expertise (Orchard 2000: 112-115; Swinton and Mowat 2007: 53; Ballard 2010: 190; Welford 2011), as it is a matter of responding to external pressure.

By the 1970s, disillusionment with depersonalising biomedical approaches led to a new emphasis on spirituality and holistic care (Woodhead 2012: 21), demonstrated especially by the burgeoning interest in spirituality evident in nursing literature (Gilliat-Ray 2003; Paley 2007). In the 1990s, growing institutional recognition of religious and cultural diversity (DoH 1991) built on the commitment to providing holistic care, and chaplains increasingly reclassified their work as 'spiritual care' (Orchard 2000; see also Flanagan 2016: 6). With growing emphasis on patient choice and patient-centred care, the chaplain essentially became a non-judgemental broker of generic spiritual care (Pattison 2001: 41; Ballard 2010: 198). The once-assumed authority and necessity of the chaplain became an opt-in service as part of the holistic care package. Various guidelines recognised the importance of meeting the pastoral, spiritual, and religious needs of all patients (DoH 1991; NHS Management Executive 1992; National Association for Health Authorities and Trusts [NAHAT] 1996; DoH 2003b), providing chaplains with fresh justification for their work, with the additional imperative of developing multi-faith ways of working. These guidelines will be examined further in the literature review. Overall, the requirement for chaplains to negotiate their position took on a new urgency from the 1990s, especially in the midst of the development of the marketplace of healthcare provision and of religion (Woodhead 2012: 21; Welford 2011: 66).

1.6   THE POLITICS OF PROFESSIONALISATION

Swift notes that from the 1960s chaplaincy no longer denoted the work of an individual religious functionary, but referred to 'everything pertaining to the work of chaplains, their theology, pastoral practices and professional identity' (Swift 2014: 3). Autton's call for 'formal and context-specific training' set chaplaincy apart from parish ministry (1968: 114-115), challenging the assumption that 'priestly formation' is 'sufficient preparation to undertake hospital chaplaincy' (Flatt 2015: 42; see also Swift 2014: 45-46). This was not formalised until the introduction of accredited degrees at Leeds and Cardiff from 1998 onwards (Swift 2004: 62). Ecumenical team working became apparent from the 1970s and arose from the requirement to provide services for patients from a variety of Christian denominations (Wilson 1971; Autton 1982: vii-viii; Woodward 1998: 115). Chaplaincy teams across sectors have further expanded through the gradual inclusion of laypersons, and the development of volunteer bases (Davie 2015: 114). Alongside the reforms of the 1990s, managerial roles developed for (Anglican) whole-time chaplains, which afforded them 'more control over the work of chaplaincy teams than they previously had under DHSS's dispensation' (Woodward 1998: 100).[2]

The professional identity of chaplaincy also refers to the proliferation of national bodies that have an interest in and/or represent chaplaincy. The history of these organisations is complex and explored elsewhere (Woodward 1998: 96; Swift 2014), so contemporary organisations will be referred to here. The Church of England's Hospital Chaplaincies Council (HCC) has recently stepped back from its historic role as broker for chaplaincy as a whole to focus on supporting Anglican chaplains (Swift 2014: 72-73). In its place, the College of Health Care Chaplains (CHCC) provides union representation for issues concerning pay and employment for all healthcare chaplains (Swift 2014: 71). The CHCC also hosts an annual study conference and circulates two issues of its professional journal each year to members. Additionally, the UK Board of Healthcare Chaplaincy

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[2] DHSS refers to the Department of Health and Social Security, latterly the Department of Health. It is now known as the Department of Health and Social Care.

(UKBHC) was established to assist with the professional development and certification of healthcare chaplains, through the production of standards and competencies, and the introduction of the voluntary professional register (Swift 2014: 73).[3] The voluntary register is now accredited by the Professional Standards Authority in Health and Social Care (NHS England, no date). These developments consolidate the collegial identity of chaplaincy (Swift 2004: 184; De Vries, Berlinger, and Cadge 2008: 26; Swift 2010: 203).

While no longer a prominent player in healthcare chaplaincy, the HCC was central to the development of multi-faith working, especially through its role in creating and facilitating the Multi-Faith Group for Healthcare Chaplaincy (MFGHC) in 2003. The MFGHC started out as the Multi-Faith Joint National Consultation in 1997, which was a primary partner in the consultation for the development of the 2003 chaplaincy guidelines (DoH 2003b) and comprised representatives from five faith groups (Orchard 2000: 23). Longstanding tensions between the HCC (and by proxy, the MFGHC) and the CHCC were largely grounded in the debates about whether chaplains are primarily religious functionaries or healthcare professionals (Church of England 2010). The CHCC also raised concerns about representation on the MFGHC on the grounds that 'some of the faith representatives were neither employed in the NHS nor chaplains', even though this criterion would necessarily exclude representation by particular 'world faiths' (DoH 2004: 6). Swift suggests that the creation of the MFGHC was 'built to a significant degree on Anglican foundations' characterised by paternalism and patronage in a bid to 'retain authority for chaplaincy through faith leadership' (Swift 2006: 61; see also Beckford and Gilliat 1996). Over the past five years, the MFGHC has changed its name several times in order to accommodate the varying levels of involvement of Humanist representatives. The MFGHC became the Healthcare Chaplaincy Faith and Belief Group (HCFBG) and later the Network for Pastoral, Spiritual, and Religious Care in Health (NPSRCH) in order to emphasise 'what it does rather than who it represents' (Kyriakides-Yeldham 2017: 56, f.n. 17).

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[3] The UKBHC was formerly known as the Chaplaincy Academic and Accreditation Board, CAAB (see Swift 2014: 72-73).

These tensions have led to difficulties with co-ordinating the interests of these bodies. This appears to have been resolved recently by the creation of the Healthcare Chaplaincy Forum for Pastoral, Spiritual and Religious Care, featuring representatives from the Association of Hospice and Palliative Care Chaplains (AHPCC), the UKBHC, the CHCC, and NPSRCH (Free Churches Group 2017).[4] This forum is now the primary consultative body for NHS England to liaise with on matters concerning the delivery of spiritual care. Previously the Department of Health and its forebears were broadly responsible for healthcare chaplaincy, but this remit was moved to NHS England in 2014 (Kyriakides-Yeldham 2017: 56, f.n. 17).

1.7 CONTEXTUALISING MULTI-FAITH HEALTHCARE CHAPLAINCY

Recent changes made to healthcare chaplaincy provision need to be situated within broader social, legal, and political trends. The location of chaplaincy within a public institution requires some awareness among chaplains of the religious and spiritual landscape of the patients they serve. Chaplains and chaplaincy commentators have drawn on sociological literature in an attempt to make sense of the changing religious and spiritual landscape of the patients they care for (Swinton and Mowat 2007; Ballard 2010). While cursory mention is made of religious diversity, much emphasis is placed on the turn to spirituality (Swinton and Mowat 2007; Mowat 2008; Ballard 2010; Swift 2013, 2014). Below I map social trends onto developments in chaplaincy and then focus on increasing religious diversity in Britain to contextualise multi-faith developments in chaplaincy.

Additionally, varying strategies for regulating religion derive from different assessments of how to respond to religious diversity: is religion to be managed, protected, mobilised, or securitised (Nye and Weller 2012: 49; Todd 2013; Todd 2015a; Dinham 2012)? I suggest chaplaincy is part of this broader agenda of managing religious diversity. Chaplains, stakeholder organisations, and commentators have drawn upon legal frameworks to support the work of

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[4] The final stages of this process were observed first-hand when I undertook a placement with NHS England (fieldnotes, 18/10/2017). This is discussed in more detail in Chapter 3.

chaplaincy, notably with reference to the Human Rights Act 1998 (DoH 2003b; McCarthy 2011; Welford 2011) and Equality Act 2006 and 2010 (NHS England 2015a). The discussion aims to flesh out the significance of these legal frameworks for accommodating and protecting religious minorities.

Conversely, the political context of chaplaincy has largely been overlooked in the healthcare chaplaincy literature, with the exception of Swift's overview of the impact of the New Labour government on chaplaincy (2014: 57-59, 62). However, political approaches to managing diversity provide significant insights into broader motivations and agendas influencing chaplaincy and will explain the political incentives for meeting cultural, religious, and spiritual needs. This section aims to go beyond the existing chaplaincy literature in order to understand where the requirement to accommodate the needs of minority faith groups fits in the broader British context of managing religious diversity.

1.8   THE SOCIAL CONTEXT

The place of religion in modern Britain has been described by Davie (2015: 3-4) as having six different features, five of which clearly apply to chaplaincy. The continued predominance of Anglicans and other Christian denominations in chaplaincy across sectors points to the persistent influence of Britain's Christian heritage. The chaplaincy literature highlights how Christian chaplains shape sacramental, liturgical, and ritual support around the needs of patients, families, and occasionally staff (Swift 2014: 116-122; Newitt 2010; 2014). This corresponds with wider social trends of declining ecclesial authority and the shift from obligation to choice, in tandem with continued availability of religious functionaries to provide sense-making resources regardless of the degree of religious commitment of patients, families, or staff. This is a key example of 'vicarious religion' where 'churches and church leaders perform ritual on behalf of others' (Davie 2015: 81). Chaplaincy has also begun to reflect the growing diversity of religious traditions following post-war migration patterns. Finally, secular elites have campaigned for the public funding of chaplaincy to be rescinded (National Secular Society 2011, 2017), or for specifically non-religious involvement in chaplaincy (Humanists UK 2018). Chaplains must be mindful of

the sociological trends concerning religion in Britain as they attempt to meet the needs of a shifting demographic of patients (Beckford and Gilliat 1996: 230-231; Orchard 2000: 22). Here, I focus primarily on the growth of religious diversity.

A variety of 'non-Christian' religious groups have become increasingly visible in the British religious landscape as a result of post-war migration from the 1950s onwards. Works on religion in Britain have taken 1945 as the definitive turning point for mapping the changes to Britain's religious landscape (Parsons 1993, 1994; Wolffe 1993; Davie 1994; Woodhead and Catto 2012). Such a focus, however, distorts the longstanding presence of Jewish communities over several centuries (Knott 1988: 136; Kahn-Harris and Gidley 2010; Graham 2012: 89; Davie 2015: 59-60) and at least two centuries of Muslim settlement (Knott 1988: 140; Gilliat-Ray 2010b: 1) in Britain. The growth of religious diversity became more apparent with the chain migration of women and children to Britain in the 1960s. Up until this point, young male migrants seeking work in Britain operated on the basis of a 'myth of return' (Ballard 1994: 11-12; Baumann 2001: 61; Peach and Gale 2003: 474), and tended to form 'cultural' rather than religious collectivities (Vertovec 1995: 145; see also Bowen 1987). Religious diversity was *present* in Britain without necessarily being *visible*. The reunification of families had a significant effect on religious observance and prompted the building of mosques, gurdwaras, and mandirs (Baumann 2001: 61; Peach and Gale 2003: 474, 478). From the 1980s onwards, an increased demand for religious beliefs and identities to be taken seriously was exemplified by the 'Rushdie Affair' (Beckford 2012: 14; Nye and Weller 2012: 38-39; Davie 2015: 179). A key trend that marks the post-war settlements, therefore, is the growing visibility of these diverse communities, where these communities 'were not only becoming a permanent feature of British society, but were anxious to retain their own forms of religious expression' (Davie 2015: 33).

A key element of the socio-religious context of chaplaincy is the mismatch between the vague and non-committal 'religious sensibilities' of the wider British public and the outrage expressed by religious minorities, exemplified by the 'Rushdie Affair' and the *Behzti* disturbances (Davie 2015: 179, 181). Davie suggests the 'live-and-let-live' and 'low key' approach to religion was assumed to

be 'part of being British' and that 'anyone who comes to live in these islands…should conform, in public at least, to a similar view' (Davie 2015: 179; see also Nye 2012: 257). The emphasis in the chaplaincy literature on spirituality tends to focus on the 'low key' approach of the majority of the British public, and risks neglecting or minimising the sincerely, and often fervently, held convictions of religious minorities. Chaplaincy literature focuses particularly on secularising social trends and the declining influence of religious institutions, while paying little attention to the 'modest growth in other-faith communities' (Davie 2015: 43). This indicates a tendency to assume that these trends of decline not only apply to the churches (especially the Anglican church) but across the board. This tension between the 'latent', implicit religious identities of the majority of the British public (Nye 2012: 257) and the demands made for greater recognition by minority faith groups highlights a crucial contradiction in the legislative and political context of the UK: despite the decline in formal religious affiliation for the majority, there has been a growth in the public visibility and role of religion (Allen 2011: 260; Beckford 2015: 226). The next section explores the legal and political implications of this trend.

1.9   THE LEGISLATIVE CONTEXT

This section outlines a key shift in legislative strategies for managing religion, from religion as a proxy for ethnicity to religion as *sui generis*. Prior to the Human Rights Act 1998, there were no specific protections for religious minorities within the UK. Where religious protections were fought for in a court of law, plaintiffs' only recourse was to the Race Relations Act 1976, or individual petitions to the European Court of Human Rights (Sandberg 2009: 268). However, the ability of the courts to enforce the rights and freedoms under the convention were limited (ibid.). Minority religious concerns were framed in terms of race, culture, and/or ethnicity, rather than as discrete concerns that required separate protections. Consequently, social and political protections were not accorded unless groups had an ethno-religious character, which often benefited Jews and Sikhs (Nye and Weller 2012: 41; Monaghan 2014: 675), and disadvantaged Muslims. Notably, this ignored the 'ethnic heterogeneity' of Jewish minorities (Meer and Modood 2009: 483). While Knott suggests that religion was

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'ignored' as a result of the Race Relations Act (2014: 93), I suggest that healthcare providers recognised religion as an aspect of addressing racial and ethnic discrimination, which will be explored further in the next chapter.

The introduction of the Human Rights Act 1998, which enshrined the European Convention of Human Rights into UK law, decoupled the link between religion and ethnicity. The articles relating to religion and belief ensured that religious protections were no longer restricted to ethnic minorities. These steps were consolidated by the Employment Equality (Religion or Belief) Regulations 2003, the Equality Act 2006 and 2010, and the Religious Hatred Act 2006. Religion has been treated as a discrete area for protection and defined loosely, which means that protections for minority religions no longer exclude particular religious groups because they do not fit neatly within a framework of ethnicity, race, and culture. As will become clear in the literature review, chaplaincy has been reinvigorated by the introduction of the Human Rights Act 1998 and the Equality Act 2006 and 2010.

1.10 THE POLITICAL CONTEXT

The accommodation of religious diversity is not a recent concern in the British political context. A striking forerunner to the accommodation of religious needs in healthcare provision was evident in the treatment of Indian soldiers at the Brighton Pavilion during the First World War (Hyson and Lester 2012). Accommodations made for soldiers included providing religiously segregated facilities; ensuring patients could worship as desired by providing 'temporary Mosques and Gurdwaras'; freedom from proselytising activities of missionary groups; setting up advisory 'caste committees'; and ensuring suitable funeral arrangements were made for deceased soldiers (Hyson and Lester 2012: 21-24). Indian hospitals in Britain constituted 'sites of concentrated imperial anxiety' as 'any error made in regard to caste and religious procedure' might be exploited as a pretext to destabilise British rule (ibid: 18, 21). The accommodation of religious needs had a specific strategic function vis-a-vis British colonial interests. However, these accommodations were largely temporary, as it was expected that these soldiers would return to India (ibid.: 24). In contrast, later discourses around

multiculturalism and integration arose following recognition that the 'myth of return' among post-war migrants was giving way to permanent settlement of immigrant communities (Anwar 1979; Burghardt 1987: 7; Vertovec 1995: 141; Peach and Gale 2003: 474; Bolognani 2007; Gilliat-Ray 2010b).

1.10.1 Managing Diversity: Multiculturalism

Political approaches to the management of diversity are concerned with how far cultural, ethnic, and religious distinctiveness belong in the public sphere. The 1950s and 1960s were characterised by an assimilationist public policy where migrants must 'become British' (Vertovec 1995: 146; Modood 2005: 135; Ashcroft and Bevir 2018: 6). Since the mid-1960s, the British approach to managing diversity has been largely inclusive, and 'rejects the "coercive-assimilationist" or "*ius sanguinis*-exclusive" approaches of France and Germany respectively' (Meer and Modood 2009: 474; see also Ager and Strang 2008: 174). British multiculturalism encourages minority groups to maintain distinct collective identities instead of assimilating into a dominant culture and confining cultural, ethnic, and religious distinctiveness to the private sphere. This recognition and affirmation of difference was achieved first in the various permutations of the Race Relations Act (1965, 1968, and 1976) and accelerated in the 1990s with the development of racial equality policies epitomised by New Labour's concern to address institutional racism (Back *et al.* 2002; Meer and Modood 2009: 476).

Multiculturalism became controversial at the turn of the century following the urban unrest in northern towns, the Ouseley and Cantle reports in 2001 alleging self-segregation and isolationism in Muslim communities, and the 'explanatory purchase of Muslim cultural dysfunctionality' following the terror attacks of 9/11 and 7/7 (Meer and Modood 2009: 480-482; Ashcroft and Bevir 2018: 6). In spite of these controversies, the then Prime Minister Tony Blair reaffirmed multiculturalism in the mid-noughties but with a growing emphasis on 'community cohesion' and the 'assimilatory aspects of integration' (ibid.: 481, 484; Ashcroft and Bevir 2018: 6). Integration was 'increasingly premised upon greater degrees of qualification' such as the introduction of citizenship tests,

swearing of oaths, language proficiency requirements for new migrants, and calls for disavowal of radicalism and extremism from Muslims in particular (Meer and Modood 2009: 475; Ashcroft and Bevir 2018: 6). It is in this context of multiculturalism, 'cohesion', and integration that the state engages in the construction of religion.

1.10.2 The Construction of Religion by the State

The legislative shift from ethno-religion to religion *sui generis* was reflected in the concerted efforts made by New Labour to engage with a discrete 'faith sector' (Dinham and Lowndes 2008; Beckford 2015: 230). The election of the New Labour government in 1997 saw 'faith communities' develop a greater prominence in policy as part of a 'broader communitarian strategy' (Beckford 2015: 229). During this period, British policy-makers increasingly recognised 'faith communities' as 'repositories of resources' (Dinham 2012: 577; see also Beckford 2015: 233), 'key agents of social capital and community cohesion' (Dinham and Jones 2012: 186), and 'actual and potential providers in a hugely extended mixed economy of welfare' (ibid.). Beckford suggests that the increased visibility of religion should not be attributed to religion making a 'triumphant and positive return to the public sphere of Western democratic societies', but instead to 'successive governments' communitarian and neoliberal policies for managing religious and ethnic diversity' (Beckford 2015: 226). Allen argues that New Labour's 'discourse, engagement and policy relating to faith' (2011: 271) was highly exclusionary and required 'faith' actors to subscribe to governmental norms and value judgements (Gilliat-Ray 2004), and that ultimately 'its faith policy approaches could even have gone some way in undermining the broader equalities ethos' (Allen 2011: 272).

New Labour's response to the challenges of the twenty-first century accelerated an instrumentalist recognition of discrete religious groups as agents of cohesion. Dinham notes that multi-faith policies under New Labour took two directions: 'community cohesion' and 'active citizenship' (see *Face to Face and Side by Side*, Department for Communities and Local Government 2008) on the one hand and tackling religious radicalisation and violent extremism (see *Preventing*

Violent Extremism, or *Prevent*) on the other. The multi-faith paradigm was therefore frustrated by policy incoherence which simultaneously valorised and demonised faith groups (Dinham 2012).

Dinham notes that while *Prevent* was retained by the Coalition and Conservative governments which followed New Labour,[5] '*Face to Face* appears to have been set aside without comment' (2012: 578). The previous trend for government to encourage communities to be 'entrepreneurial and market-oriented' that began with New Labour continued with the Conservative-Liberal Democrat coalition. However, this is achieved primarily through the Near Neighbours programme. Unlike funding streams under the New Labour government, the Anglican parish infrastructure constituted the sole avenue for delivery, marking a shift 'from a broadly owned and distributed multi-faith paradigm in which many traditions, and none, have a stake, to one in which the Church of England gatekeeps a primary funding stream and is revalorised as "national church"' (Dinham 2012: 585). Unsurprisingly, such a model raises questions about 'what "multi-faith" really means in a context which requires all faiths and traditions to access funding via the Anglican church' (ibid.).

The developments of multi-faith healthcare chaplaincy can be situated squarely within the context of the New Labour agenda (Swift 2014: 62). The Multi-Faith Joint National Consultation in 1997 explored how the 1992 chaplaincy guidelines (NHS Management Executive 1992) could be redrafted, and involved key political figures including the Secretary of State for Health (Woodward 1998: 104). While Swift notes the attendance of the Secretary of State for Health at such an event was unprecedented (Swift 2014: 62), it seems that ministerial involvement was actively courted by the HCC, who brokered the consultation with the aim of 'putting chaplaincy onto the agenda of the new Labour Government' (Woodward 1998: 103). However, 'it was clear from the outset that a more inclusive and representative chaplaincy was at the heart of ministerial involvement' (Swift 2014: 62). It is not entirely clear, however, *why* there was

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[5] Albeit in modified form; *Prevent* has been rebalanced to account for far-right extremism and British nationalism (Dinham 2012: 578).

such close ministerial involvement, but it is not unreasonable to suggest that chaplaincy may have been perceived as a 'resource' with which institutional racism in the NHS could be addressed (Henley 1987: 4; Hopkins and Bahl 1993: 3; Parekh 2000: 176-191).

Swift's critique of the MFGHC resembles the critique of the multi-faith paradigm and the construction of 'faith communities' as outlined by Gilliat-Ray (2004), Dinham (2012) and Beckford (2015). As Swift notes, the requirements for representation within the MFGHC entailed 'a certain conformity to the government's implicit views about inclusion, such as faiths having a representative structure' where religious groups must 'accept the government's view of their place and role in society' in exchange for influence and resource (Swift 2014: 75). Such representative structures can be exclusive of, for example, women and may overlook asymmetric power relations *within* a religious group (Gilliat-Ray 2004; Swift 2014: 75; Beckford 2015: 233).

The impact of *Prevent* on chaplaincy has been commented on extensively in relation to prisons and higher education (Todd 2013; Todd 2015a; Gilliat-Ray *et al*. 2013). The person of the chaplain occupies the territory in between the ambiguous discourses concerning religion operationalised by New Labour, the Coalition government and the Conservative government. Prison chaplains are simultaneously 'neutral' facilitators of equality and diversity, while securitised as agents of the state to prevent 'extremism' and 'radicalisation'; religion is both source of the 'problem' to be addressed, as well as the resource to address it (Todd 2013). It is less clear how these paradoxical and conflicting discourses play out in the management of religious diversity within the healthcare setting.

The above discussion of the social, legal, and political context of chaplaincy provides the groundwork for exploring the development of multi-faith chaplaincy. I have explained how the legal and political conceptualisation of religious minorities has changed, with the growing expectation that the needs and demands religious minorities will be accommodated or met by the state. It is in a context where religious minorities have become increasingly visible, vocal, and recognised that multi-faith chaplaincy has developed. The discussion above also

serves to provide critical counterpoints for minority faith involvement in chaplaincy: in what ways does the multi-faith model within chaplaincy reflect ambiguities in government policy and discourse in relation to the management of religion? Are minority faith chaplains required to conform to pre-existing modes of doing chaplaincy, or can their own understandings and approaches inform chaplaincy roles (in short, must minority faith groups assimilate or integrate)? What do chaplaincy teams need to do to adjust and accommodate their minority faith colleagues?

1.11   A NOTE ON TERMINOLOGY

It is vital to clarify key terms which will be used throughout the thesis. It is more helpful to focus on concepts, because 'unlike definitions, which try to single out certain essential characteristics, concepts derive their meaning from the wider frameworks in which they are embedded' (Woodhead 2011: 122). The location of this thesis within a social constructionist theoretical framework will be outlined in the methodology chapter, but the discussion below begins to highlight the discursive construction of these terms.

1.11.1 'Religion'

Woodhead notes that religion is 'contested' and draws on Beckford's observation that religion is 'constantly being constructed, as political and legal authorities claim the right to define religion' (2011: 122; see also Beckford 2003). Definitions of religion have been criticised both for being too secular and too Christian (see Woodhead 2011: 121). Instead, attention should be paid to how religion is constructed and the agendas that accompany these constructions. Bearing in mind the construction of religion can empower or disempower particular groups, sociologists must become 'critically aware of the scope, variety, and contingency of the term' (ibid.: 138).

The five concepts outlined by Woodhead (2011) include religion as culture; religion as identity; religion as relationship; religion as practice; and religion as power. As evident in the thesis title and research questions – with the emphasis on 'integration' and 'minority religions' – religion as power is central to my

approach. The aspects of religion as power of most interest include 'religion as status and recognition' and 'religious power and status at micro-, meso- and macro-levels' (ibid.: 137).

Other aspects of Woodhead's typology have some bearing on this research. For example, issues of *identity* inform the debate about the role and relevance of ministerial formation while chaplains attempt to achieve recognition as healthcare professionals (Woodward 1998; Swift 2014; Kyriakides-Yeldham 2017). In these debates, chaplains are often presented as caught between *discourses* of religion and health, church and NHS (Norwood 2006; Church of England 2010; Swift 2014). Chaplains have also been considered to a *resource* in relation to religion in general (Beckford and Gilliat 1996; Gilliat-Ray *et al*. 2013). The daily challenges and negotiations chaplains face provide insights into *lived religion* at the coalface (Swift 2014). These are a few examples, demonstrating the many ways in which chaplaincy can contribute to a conceptualisation and understanding of religion in public life. However, this also points to Woodhead's contention that 'the concept of religion as power is the broadest of all [concepts of religion], with something important to add to all of those which precede' (Woodhead 2011: 135).

1.11.2 'Religious Diversity'

The term 'religious diversity' is used instead of 'pluralism' to circumvent the ideological associations of the latter. Pluralism refers to a normative belief that 'there should be mutual respect between different cultural systems and freedom for them all' (Beckford 1999: 56). Beckford argues for separating 'fact and value' (1999: 56). Reference to 'plurality' is also avoided to mitigate possible confusion with 'pluralism'. Yet it must be acknowledged that religious diversity has also been constructed by different agents. Davie notes that Britain has 'traditionally been more ready than many of her European neighbours to embrace diversity – a tradition that stretches back to a colonial past where "indirect rule", through or by means of a local elite, was the norm' (2015: 9). Other commentators have suggested, however, that the British ruling class actively *fostered* religious diversity through colonial divide-and-rule, through the classification, demarcation and construction of the 'world religions' (van der Veer 1995; Asad 2003;

Fitzgerald 2007; Knott 2014; Thobani 2014: 36). This tendency to create, emphasise, or exacerbate religious difference is also evident in British domestic policy and strategy (Baumann 1996, 1998; Qureshi 2014: 94; Gellner *et al.* 2014: 135; Knott 2014). Diversity is not simply state of affairs arising from post-war migrant settlements, mentioned above, but also arises from British political interests that have long actively *exacerbated* and *encouraged* diversity, initially abroad and then at home.

1.11.3 'Spirituality'

The chaplaincy literature regularly refers to the shift 'away from traditional institutional forms [of religion] to a more diffuse yet widespread valuation of spirituality' (Ballard 2010: 187; see also Swinton and Mowat 2007; Cobb 2004: 10; Pattison 2013: 194; Swift 2013). Sociological research provides empirical evidence for the declining influence of institutionalised religion in favour of subjective spiritualities (Heelas and Woodhead 2005; Davie 2015), but further claims made about the nature of spirituality in chaplaincy literature should be treated with caution. The understanding of spirituality that underpins chaplaincy has become increasingly generic; it is 'customer-led and universally applicable regardless of faith and creed' (Ballard 2010: 190) and tends to be associated with an 'existential sense of meaning' (ibid.: 198). Spirituality is often separated from religion (Mowat 2008), although the relationship between religion and spirituality is contested (Swinton 2006: 921). Religious worldviews are relativised as parochial compared to the conceptualisation of spirituality as universal and humanistic (Ballard 2010: 198). An all-encompassing understanding of spirituality is not neutral, but 'reflects the dominant cultural discourse and overlooks the role that religion continues to play in globalised societies' and dismisses difference (Pesut *et al.* 2009: 338-339, see also Pesut *et al.* 2008). The way spirituality is conceptualised has been identified as a professionalising strategy for nursing professionals and chaplains (Lee 2002; Gilliat-Ray 2003; Paley 2007), but has also been criticised for dismissing patients' own understandings (Walter 2002), and for concealing its particularistic foundations (Walter 2002; Gilliat-Ray 2003; Pesut *et al.* 2009). Chaplains in particular may strategically deploy the term 'spiritual' in order to 'transform chaplaincy from a

peripheral service, applicable only to the few "religious" patients, into an integral element of patient care for all' (Lee 2002: 340). The way spirituality is discussed in the chaplaincy literature and among chaplains themselves therefore requires close scrutiny.

1.11.4 'Secularity'

The secular refers to that which is beyond the domain of religious authority and control. This may have explicitly political implications, usually shown in the separation of religious and political authorities or institutions (Beckford 2003: 33), or social implications with reference to priests ordained to work outside the authority of their religious orders (ibid.; see also Casanova 1994: 13; Fitzgerald 2007: 172). It is unhelpful to refer to the religious and the secular as essentially separate pre-existing domains that have a 'single continuous meaning historically', as any difference between religion and the secular was historically 'subsumed in the higher unity of God and his redemptive purposes' (Fitzgerald 2007: 172). The contemporary notion of the secular is defined by the essential exclusion of religion and association with non-religion (Fitzgerald 2007:174). The location of the chaplain in contemporary times continues to closely resemble the secular in the original use of the term. However, chaplains also operate in a context where religion and the secular are distinguished, oppositional, separate, and fundamentally different from each other (Fitzgerald 2007: 172). It is perhaps, in part, this growing intellectual chasm between the religious and the secular which contributes to the 'crisis' of identity in healthcare chaplaincy (Swift 2014).

In order to understand the continuing salience of religion in British public life, there should be some consideration of political secularism. Secularism is defined as the way in which the 'norms of public life, including policy and legislation, order or constrain religion in the public domain' (Todd 2015b: 71). Following Modood (2010), I distinguish between 'hard'/ 'radical' and 'soft'/ 'moderate' secularisms as differing strategies for the management of religion in public life. British approaches to secularism exemplify a 'moderate', 'soft' and 'accommodative' secularism which do not necessitate the privatisation of religion, as demonstrated by the management and accommodation of religious diversity in

a broader framework of 'integration'. In liberal democracies, Todd notes, the boundaries drawn around religion are 'permeable, to different degrees, allowing for different degrees of interaction of religion and public life, and the participation of religion in civil society' (2015b: 72). It is in the context of moderate accommodative secularism that chaplaincy is situated.

1.11.5 'The Public-Private Distinction'

Fitzgerald notes that 'the idea that Religion[6] was essentially separate from the politic body, in the form of religion as against a secular (nonreligious) politics and state, was an idea that was not formulated rhetorically in English until the late seventeenth century' (2007: 194). The 1648 Treaty of Westphalia constituted the earliest legal articulation of the public-private distinction, which enabled the private exercise of individual religious freedom without harassment or intervention from the territorial authorities (Straumann 2008; Calhoun 2008: 15). This legal separation between public and private was accompanied by the exclusion of religious discourse from decision-making processes (Straumann 2008: 180). The proto-liberal traits of Westphalia (Straumann 2008: 182) found full realisation in Enlightenment liberal ideals about the public sphere as an arena for 'rational' debate (Fraser 1990: 60), which banishes 'irrational' religious discourse to the private sphere (Calhoun 2008: 8). The public sphere is erroneously constructed as politically 'neutral' and 'accessible', but this systematically excludes non-bourgeois, non-masculine, non-white, and non-secular concerns (Fraser 1990: 60). As Calhoun notes, 'much liberal theory conceptualises citizenship as essentially secular' (2008: 11), reproducing the religion-secular dichotomy that emerged originally from a Christian framework.

Modood notes that the public-private distinction has been operationalised in multicultural theory, and suggests that such a strict division between public and private militates against, rather than supports, multiculturalism (2005: 131). The liberal myth of the 'neutral' public sphere persists, despite the interdependence of the public and private spheres in which majoritarian 'private' interests constitute

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[6] Here religion refers to the 'different interpretations, and therefore practices, of Christian Truth' (Fitzgerald 2007: 194).

the public sphere (ibid: 131-133). In his conception of the public sphere, Habermas (2006) attempts to rehabilitate the role of religious discourse in the public sphere, but still upholds the myth of state neutrality and holds that 'only secular reasons count beyond the institutional threshold that divides the informal public sphere from parliaments, courts, ministries and administrations' (ibid.: 9). The relation of religious discourse to the public sphere is of particular interest and will be examined in later analysis of the findings.

1.11.6 'Secular Sacred'

The 'secular sacred' adds conceptual clarity to the idea of sacrality as a 'category-boundary to set things with non-negotiable value apart from things whose value is based on continuous transactions' (Anttonen 2000: 280-281). References to 'secular sacralities' problematise uncritical conflations of the sacred with religion and the profane with secularity, highlighting the ways in which sacralities persist 'irrespective of the destiny of religion and its public visibility or significance' (Knott 2013: 145). The 'secular sacred' is emerging as a central concept in the field of chaplaincy studies (Pattison 2015, Todd 2015b), enabling an exploration of the ways chaplaincy negotiates secular contexts. Within a healthcare context, Todd (2015b) identifies 'patient choice', 'patient-centred care', 'safeguarding', 'cost-effectiveness' and 'equality and diversity' as key examples of the secular sacred. The 'secular sacred' is not only applicable to soft secularist attempts to manage religion, but also to hard secularist attempts to privatise chaplaincy provision, with reference to cost-effectiveness and equality and diversity.

1.11.7 'Faith Community'

This thesis follows the critical approach to the concept of 'faith communities' outlined by Dinham (2012) and Beckford (2015). Both contend that 'faith communities' have largely been constructed by political actors and policymakers as repositories of resources (Dinham and Lowndes 2008; Dinham 2011, 2012) and partners with the British state (Beckford 2015: 229). Dinham defines 'faith communities' as '"containers" of staff, buildings, volunteers, networks, values and skills which can be 'harnessed' in key community domains' (2012: 526). The consequences of the construction of this concept include: the instrumentalisation

of religious traditions (Dinham 2012: 529; Beckford 2015: 233); the essentialisation of religious traditions (Beckford 2015: 230, 232; see also Baumann 1996, 1998; Geaves 2005); the arbitrary exclusion of particular religions, denominations, or subgroups (Weller 2009: 77; Dinham 2012: 538; Beckford 2015: 230-231); the promotion of elite voices to the detriment of disempowered voices (Beckford 2015: 232-233; see also Weller 2009: 77-78; Dinham 2012: 536); the blurring of boundaries between different types of religious organisation (Beckford 2015: 229); and the assumption that all faith communities have similar infrastructures (with the highly organised Anglican church often used as a benchmark; see Dinham 2012: 539). At the same time, the utility of 'faith communities' to the state rests on a contradictory set of discourses which emphasise both the instrumental and intrinsic value of 'faith communities' (Beckford 2015: 233). Any reference to 'faith communities' requires critical consideration of the various implications of this term for religious groups.

1.11.8 'Minority Faith'

Early works examining how religious minorities were accommodated often referred to 'other faiths' when discussing groups that were not Christian (Beckford and Gilliat 1996), although reference to 'other-faith communities' continues in more recent works (Davie 2015). This places Christianity as a default, while othering 'non-Christian' faith groups, and risks the consolidation of a single undifferentiated category of 'other' or 'non-Christian' religions.

I chose not to use the term 'minority ethnic religion' on the grounds that not all minority faith groups correspond to ethnic minorities. This is the especially the case with Baha'is, Buddhists, and Muslims. This is also true to a degree with Sikhs and Jews (Singh 2012: 179; Dusenbery 2014; Meer and Modood 2009: 483), despite case law extending the term 'racial group' in the 1980s to protect Sikhs and Jews (Meer and Modood 2009: 483; Allen 2011: 263; Sandberg 2011: 32). The term also suggests that 'majority' religions do not have adherents from minority ethnic backgrounds, an assumption easily rectified by consulting relevant scholarship (Johnson 1991; Weller 2005: 81; Weller 2008: 31-32; Isiorho 2015).

Such a close association between ethnicity and religion reproduces unhelpful understandings of religion as a subcategory within ethnicity or race.

I suggest 'minority faith groups' is a less loaded term. I follow Asad (2003), Phoenix (2001: 128), and Khawaja and Mørck (2009: 28) in their use of the term 'minority' to refer to societal power relations: '…minorities are defined as minorities only in hierarchical structures of power' (Asad 2003: 175).[7] This circumvents claims made by some Anglicans that the Church of England is becoming a 'minority' due to declining affiliations and church attendance, and accounts for the continuing power disparity that inheres in the privileges of being an Established church, including substantial property ownership and financial assets (Monaghan 2014; Norris and Inglehart 2011: 42). Despite calls for disestablishment (Herrick 1997; Weller 2005), the Church of England remains the state church, and therefore does not qualify for 'minority' status. The strong national infrastructure of the Church of England, as well as the Free Churches and Catholic Church, contrasts significantly with the 'limited capacity' and influence of minority faith groups (Dinham and Lowndes 2009: 9).[8] While I have emphasised that minority religions and minority ethnic groups should not be conflated, the association between minority faiths and minority ethnicities means that the limited power of the latter may also be reflected in the former (ibid.).

Woodhead and Catto clearly distinguish between the 'majority faith' of Christianity and 'minority religions' as they introduce a chapter about post-war settlements which covers Judaism, Sikhism, Islam, Hinduism and Buddhism (2012: 85). This excludes Jainism, Zoroastrianism, and Baha'i which comprise the remainder of the 'nine major world faiths'.[9] These omissions are also apparent in

[7] Asad observes that minorities may be numerically larger than 'the body of equal citizens from whom they are excluded' (2003: 175). This is exemplified through British colonial rule where a 'variety of constitutional devices…rendered [colonial subjects] legally and ideologically minorities' (ibid.).

[8] A notable exception is the United Synagogues, whose structures have been compared to the Church of England (Kahn-Harris and Gidley 2010: 2).

[9] Paganism is omitted from the nine major faiths. For further detail about disputes concerning the inclusion of Pagans, see Weller (2009: 77).

the recent census, which conflates these groups in the 'other religion' category (Office for National Statistics 2012), although Jains might instead identify as Hindu. A crude distinction between 'majority' and 'minority' also implies that all Christian denominations share in the advantages of majority status. I suggest that it is unhelpful to flatten the power relations within and between Christian denominations in this way, especially in relation to healthcare chaplaincy, where it is evident that Anglican chaplains continue to occupy a considerable portion of full-time and managerial posts. Likewise, the growing ecumenism of chaplaincy was documented in Wilson (1971) and has seen a growth in Free Church chaplains occupying full-time or managerial posts, as well as considerable influence in chaplaincy on a national level. The status of smaller denominations within Christianity is less clear, although it is notable that some more evangelical denominations, such as Seventh Day Adventists and Pentecostalists, would be considered 'unsuitable' for involvement in healthcare chaplaincy (Beckford and Gilliat 1996: 262). This contrasts significantly with 'minority' denominations' involvement in prison chaplaincy. In some cases, ministers from minority denominations are being appointed to managing chaplains' posts, including two Orthodox Christian and one Latter Day Saints (Todd forthcoming: 8). The ability of larger denominations to control access of these groups to healthcare chaplaincy indicates a significant power disparity which might warrant consideration as minorities, but this falls outside the scope of the thesis.

1.12 CHAPTER OUTLINE

1.12.1 Chapter 2: Literature Review

This chapter will commence with a general overview of the chaplaincy literature, focusing on key trends and highlighting the rich but limited literature on minority faith involvement. I will then draw on chaplaincy literature, primary and secondary, to address foundational questions concerning the provision of healthcare chaplaincy. These support the development of chaplaincy services as the primary method by which the pastoral, spiritual, and religious needs of patients are met. I will show that this does not always guarantee a multi-faith approach within chaplaincy. Finally, I will explore the primary issues and

challenges arising from minority faith involvement in healthcare chaplaincy which provide the basis for the research questions.

1.12.2 Chapter 3: Methodology

This chapter will outline the research design developed to address the research questions arising from the literature review. This research is situated within a social constructionist paradigm with the intention of problematising existing taken-for-granted discourses on chaplaincy. The research design proposes a multi-site ethnography comprising five case studies to allow for an examination of chaplaincy teams. Both minority faith and Christian chaplaincy representatives are involved in the study, but minority faith participants are the primary focus. After outlining the practical research design, I will focus on access in relation to entering and inhabiting the field. I will then describe the process of analysing the data, with reference to thematic analysis. The chapter will close with a brief account of a placement conducted with NHS England for the purposes of knowledge exchange, and a reflection on the methodological difficulties of the research.

1.12.3 Chapter 4: Findings – The Cases

The findings chapters are broadly structured around Yin's threefold dimensions of the case study approach: description, exploration, and explanation (Yin 2013 cited in Platt 2007: 103). The first findings chapter provides a descriptive overview of the working practices at the five cases to ground later analysis of how mundane activity and behaviours may indicate broader power relations (Certeau 1988). This will address questions of how chaplaincy and spiritual care is provided. These findings derive primarily from reports written for each chaplaincy team. Each case is outlined, and key areas common to all cases will be explored to aid comparison. The chapter will conclude by highlighting key trends and developments in multi-faith working derived from the findings of each case.

1.12.4 Chapter 5: Findings – Participatory Parity

This chapter will provide a conceptual analysis of the working practices of chaplaincy teams, which will focus largely on the exploratory and explanatory

dimensions of the case studies (Yin 2013). This chapter addresses the research questions concerned with how minority faith chaplaincy representatives understand their role, the extent to which minority faiths are integrated into chaplaincy teams, and the ways in which chaplaincies are operating as multi-faith teams. The chapter will be framed in terms of participatory parity (Fraser 2003), with reference to distribution and recognition. To assist the analysis, I will also draw on Bourdieu's concepts of field, capital, and rate of exchange (1986, 1991b; Bourdieu and Wacquant 1992; Todd 2015a). I suggest that distribution and recognition are insufficient for exploring issues relating to participatory parity and will also refer to the socialisation of chaplains, drawing broadly on organisational socialisation literature (Van Maanen and Schein 1978; Chao 1994) to illuminate an area which is otherwise under-examined and under-developed by Bourdieu and Fraser. The concluding remarks will bring these threads together under the framework of participatory parity to raise some of the key challenges arising for minority faiths.

1.12.5 Chapter 6: Critical Dialogue

This chapter is also constituted by the exploratory and explanatory aspects of the case studies. The discussion is split into two parts: the first will explore the findings in relation to Bourdieu's legitimate language (1991b). I will explore the implications of the findings on how far minority faith chaplains are able to deploy linguistic capital in order to negotiate their place within the institution and the continued reliance on senior chaplains who are usually, but no longer necessarily Christian. This provides some evidence that professionalisation is creating a more egalitarian approach to chaplaincy than the brokerage model, but that Christian chaplains still enjoy unfair advantages compared to their minority faith colleagues, especially in relation to career progression. The second part will explore the findings in light of key themes in the chaplaincy literature. The discussion in this chapter outlines new contributions to the field of chaplaincy studies by repositioning mainstream discourses as situated orthodoxies and exploring the ways in which minority faith chaplains are beginning to challenge these taken-for-granted discourses.

1.12.6 Chapter 7: Discussion and Implications

The chapter will examine two aspects of minority faith involvement in chaplaincy which contribute to the broader field of the sociology of religion. Firstly, I will consider how chaplaincy contributes to a sociological understanding of religious professionals and leaders. I will highlight the conspicuous gap in the sociological literature concerning religious leadership in a specifically British context, particularly in relation to Hinduism, Sikhism, Judaism, and Buddhism. I will explore the aspects of religious leadership that are epitomised in chaplains from these different faith groups. At the same time, I will begin to explore differential expectations of the extent to which minority faith groups and leaders are expected to engage in British civic life (Birt 2006), which will explain the focus on the development of Muslim professional leaderships in particular (Gilliat-Ray 2010).

Secondly, I will explore in detail the claim that chaplaincy constitutes the 'acceptable face' of religion (Pattison 2015) by examining the ways in which chaplains themselves may draw the boundaries around public and private to establish what constitutes 'acceptable religion' in a healthcare setting. I contend that chaplaincy is highly self-regulated, and that stakeholders are largely satisfied with this approach so long as the chaplaincy can justify their activity with reference to the legitimate language of the institution. The regulation of religion by chaplaincy will be explored with reference to gatekeeping and the compartmentalisation of religion.

1.12.7 Chapter 8: Conclusion

The conclusion will revisit the research questions and address them with reference to the threads traced throughout the thesis. I will then outline my contributions to the field of chaplaincy studies and to the sociology of religion, especially with the repurposing of analytical tools from other disciplines. Finally, I will outline possible agendas and avenues for future research within chaplaincy studies and the sociology of religion.

2 Literature Review

The recent proliferation of literature concerning healthcare chaplaincy can be attributed to three factors. Firstly, ongoing professionalisation requires chaplains to acquire profession-specific qualifications. Many chaplains go on to publish articles via professional journals, such as the Journal of Health and Social Care Chaplaincy (JHSCC).[10] Secondly, academic researchers have begun to acknowledge the significance of chaplaincy in public life (Arweck and Beckford 2012: 363; Cadge 2012; 2012: 117-119; Pattison 2015: 14; Davie 2015: 114-119). Thirdly, media scrutiny of chaplaincy has intensified over the past decade, prompted by secularist campaigns to remove public funding from healthcare chaplaincy. Alongside this growth in practitioner, academic, and polemical literature, chaplaincy is also the subject of NHS guidelines, although this 'grey' literature has been less prolific.

2.1   AIMS OF THE LITERATURE REVIEW

This literature review first outlines key trends in major studies of healthcare chaplaincy and highlights the lack of literature concerning minority faith involvement in healthcare chaplaincy. The remainder of the literature review is structured around foundational questions grounding chaplaincy provision including a) whether the NHS should provide pastoral, spiritual and religious care; b) who funds chaplaincy; c) whether spiritual care should be provided as a discrete aspect of healthcare; and d) how the needs of minority faith groups can be fairly accommodated. The first three questions address the core principles which justify the provision of chaplaincy services in the NHS, while the fourth question provides the foundations for multi-faith chaplaincy. The second part of the review focuses on the

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[10] This journal was created after the Journal of Healthcare Chaplaincy and the Scottish Journal of Healthcare Chaplaincy merged in 2013 (Swift 2014: 71).

challenges of involving minority faith representatives in chaplaincy. This literature review contextualises and locates the research, generates the questions to be explored in the fieldwork, and identifies salient themes that will be engaged in dialogue with the data.

2.2 LIMITATIONS OF THE LITERATURE REVIEW

This literature review is limited as a result of restricted access to the Journal of Health Care Chaplaincy (JHCC) and the Journal of Health and Social Care Chaplaincy (JHSCC). Attempts to obtain online access to these journals were unsuccessful despite multiple institutional logins afforded by my funding programme.[11] Additionally, unsuccessful attempts have been made to access physical copies from Cardiff University library, St Padarn's library,[12] the British Library, and Cambridge University Library. Attempts have also been made to locate the work of Seye Olumide (cited in Orchard 2000: 12 and NAHAT 1996: 19), who produced dissertations on equitable provision of spiritual, religious, and cultural care, but these were no longer being archived by the awarding institution.

2.3 A GENERAL NOTE ABOUT STUDIES IN HEALTHCARE CHAPLAINCY

While 'chaplaincy studies' is a nascent academic field, several empirical studies of healthcare chaplaincy in the UK provide significant insights. These studies focus on the identity and role of hospital chaplains with reference to professionalisation (Wilson 1971; Woodward 1998; Swinton and Mowat 2007; Swift 2014), how chaplaincy has responded to increasing religious plurality (Beckford and Gilliat 1996; Orchard 2000; Gilliat-Ray 2008; Gilliat-Ray *et al*. 2013) and the impact of NHS reforms on chaplaincy (Woodward 1998; Orchard 2000; Swift 2014). Wilson's study marked a shift from normative theoretical chaplaincy literature to empirically grounded research (1971; see also Swift 2014: 46). Studies have also drawn attention to the increasing marginality of chaplaincy in relation to the NHS and the church (Norwood 2006, Swift 2014, Kyriakides-Yeldham 2017).

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[11] The South West and Wales Doctoral Training Partnership comprises a consortium of eight institutions. As part of this funding programme, studentship holders are able to access institutional resources of these eight institutions.

[12] St Padarn's hosts the Cardiff Centre for Chaplaincy Studies.

2.3.1 Agenda-Setting Studies in Healthcare Chaplaincy: Putting Multi-Faith Chaplaincy on the Map

Excepting Beckford and Gilliat (1996), Orchard (2000), and Gilliat-Ray *et al.* (2013), the above studies tend to focus on full-time Christian (often Anglican) chaplains. The title of Beckford and Gilliat's report, *The Church of England and Other Faiths in Multi-Faith Society*, demonstrated that in the 1990s chaplaincy provision was centred on the Established role of the Anglican Church. The study highlighted the role of Anglican chaplains in brokering religious and spiritual care to minority faith groups. Orchard's study moves away from considering chaplaincy as a subset of the Church of England and instead evaluates chaplaincy as a subset of the NHS (Ballard 2010: 189-190; Swift 2014: 63). Orchard re-affirms Beckford and Gilliat's findings concerning inequitable provisions for minority faith groups. Since Orchard's study, significant changes have further impacted on the development of multi-faith chaplaincy. The influence of the HCC on chaplaincy has gradually waned (Swift 2014), while Muslim chaplaincy has developed rapidly (Gilliat-Ray *et al.* 2013), and the introduction of the religion question in the 2001 and 2011 census enables easy access to national demographic data about religious communities (Office for National Statistics 2012) that was not available to Orchard (2000: 30). Gilliat-Ray *et al.*'s study provides the first account of Muslim chaplaincy in prisons, health, the military, and higher education in Britain, with some reference to chaplains in the USA. While reference is made to multi-faith working (2013: 105-108), there are few references to chaplains from other minority faith groups. These studies will feature throughout the literature review.

The lack of minority faith voices is further reflected in the lack of contributions to professional chaplaincy journals (excepting Hegedüs 2007, 2010). Orchard's book Spirituality in Health Care Contexts (2001) attempts to address this gap by including Muslim and Jewish perspectives, and general contributions regarding multi-faith working (Mayet 2001; Gilliat-Ray 2001b; Lie 2001; van den Bergh 2001). Other edited works from the 2010s onwards also contain chapters on multi-faith developments and working (Todd 2011; Gilliat-Ray and Arshad 2015; Galashan 2015).

This thesis bridges this gap in the literature by juxtaposing the dominant chaplaincy discourses with the perspectives of minority faith representatives who rarely reach senior posts in chaplaincy. The engagement of minority faith groups in chaplaincy highlights core issues facing minority religions as they negotiate inclusion in public life and institutions today, as demonstrated by Gilliat-Ray *et al*.'s focus on chaplaincy as a case study of the development of religious leadership within British Islam (2013: 177-179).

2.3.2   Chaplaincy Literature Internationally

The growing knowledge base has also been reflected in the USA. This includes ethnographic studies by Lee (2002), Norwood (2006) and Cadge (2012; see also De Vries *et al*. 2008; Lyndes *et al*. 2012; Cadge and Sigalow 2013). Abu-Ras has made significant contributions to the literature around Muslim chaplaincy, the limitations of the interfaith model of chaplaincy, and the politicisation of patient need to justify the working practices of chaplaincy (Abu-Ras 2010, 2011a, 2011b; Abu-Ras and Laird 2011).

In contrast to the dearth of literature about minority faith chaplaincy in the UK, Jewish, Buddhist, and Muslim chaplains in the USA are contributing to the knowledge base (Tabak 1997, 2010; Silberman 2001; Monnett 2005; Sheer 2008; Lahaj 2011, 2012; Ansari 2012; Giles and Miller 2012; Abu-Shamsieh 2013; Yamaoka 2013). Despite longstanding Jewish involvement in chaplaincy in the UK (DoH 2004; Ballard 2010: 196), the outputs have not been as prolific as in the USA. Additionally, the growth of Muslim contributions might be attributed to more Muslims taking CPE programmes, where publication of articles may constitute an aspect of reflective practice. Recent PhD theses by Muslim chaplains/spiritual carers focus on the tensions of engaging with chaplaincy education with Christian underpinnings (Jalalzai 2016) and developing an Islamic approach to spiritual care (Isgandarova 2011, 2013).

2.4   FOUNDATIONAL QUESTIONS CONCERNING THE PROVISION OF PASTORAL, SPIRITUAL, AND RELIGIOUS CARE

Since the 1991 Patient's Charter, the NHS has demonstrated a commitment to the provision of care for the pastoral, spiritual, and religious needs of all patients. This guidance has since provided the grounding for multi-faith healthcare chaplaincy provision. The remainder of this chapter will explore key questions concerning the provision of pastoral, spiritual, and religious care, followed by an examination of the challenges of involving minority faith representatives in chaplaincy, which will focus primarily on secondary academic literature.

2.4.1   Should Publicly Funded Health Services Cater for Pastoral, Spiritual, Religious, and Cultural Needs?

The provision of pastoral, spiritual, and religious care has been justified in three ways: through legislative frameworks (see Welford 2011); by appealing to the values and ethos of the NHS (Welford 2011; Swift 2013; Todd 2015b; Ballard 2010); and by linking religion/spirituality and health (Welford 2011; Todd and Tipton 2015). Between the 1991 Patient's Charter and the present day the specific requirement to meet cultural needs appears to have been phased out, and an emphasis on pastoral care appears to have developed in its place. Where guidelines in the 1990s and early 2000s incorporated religious, spiritual, and cultural needs into their commitments (NHS Management Executive 1992; NAHAT 1996; DoH 2003b), neither *Caring for the Spirit* (South Yorkshire Workforce Development Confederation [SYWDC] 2003) nor the 2015 guidelines (NHS England 2015a) refer to cultural care as a discrete area of provision.

2.4.1.1   The Legislative Framework

The provision of pastoral, spiritual, and religious care is supported by the Human Rights Act 1998 (DoH 2003b: 32) and latterly the 2010 Equality Act, the Public Sector Equality Duty, and the NHS Charter (NHS England 2015a: 7). Welford argues that obligations regarding religion under the Human Rights Act are negative, where a breach of Article 9 obligations only occurs if a Trust's inaction prevents patients or staff from manifesting their beliefs (2011: 235). However, the 2003 guidelines (DoH 2003b) present the obligations as positive, highlighting the

implications of not having the appropriate mechanisms in place for meeting the needs of patients. The 2015 guidelines explicitly link chaplaincy services to the fulfilment of Article 9 obligations: 'An effective chaplaincy department is the most reliable way to ensure that the freedoms guaranteed by the European Convention on Human Rights are observed and promoted' (NHS England 2015a: 14). Chaplains are further described as an 'essential resource' for promoting 'protected characteristics of both religion and belief' (NHS England 2015a: 7). Capturing information about patients' religious beliefs is framed and justified with reference to the Public Sector Equality Duty as one way by which the NHS can 'eliminate discrimination', 'advance equality of opportunity' and 'foster good relations' (NHS England 2015a: 14, 24).

Between the 2003 and 2015 chaplaincy guidelines a significant shift occurred. The 2003 guidelines confine religion and faith to the 'nine major world faiths: Baha'i, Buddhism, Christianity, Hinduism, Jainism, Judaism, Islam, Sikhism and Zoroastrianism' (DoH 2003b: 5; SYWDC 2003: 6). A broader definition taken directly from the 2006 Equality Act informs the 2015 chaplaincy guidelines (NHS England 2015a: 6). This definition prompted the recognition of the pastoral and spiritual needs of those who are 'non-religious' and of adherents to religions outside the 'nine world faiths': 'in the light of the 2010 Equality Act new guidance is provided for the care of patients and service users *whatever their religion or belief*' (NHS England 2015a: 2, emphasis added). This emphasis on 'religion and belief' was only recognised in the chaplaincy guidelines after the introduction of the 2010 Equality Act when the 'protection afforded under Article 9 also extends beyond religious belief' (McHale 2013: 225). However, the Human Rights Act 1998 offers no definition of 'religion', suggesting that other factors contributed to the restriction of 'religion' to the 'nine major world faiths' in the 2003 guidelines. This broader understanding of religion and belief appears to be the result of changing attitudes within the bodies consulted for the chaplaincy guidelines, rather than significant changes in the scope of the law. This exemplifies the shifting boundaries of inclusion and exclusion in the ways religion is constructed (Nye 2001: 5-6; Gilliat-Ray 2004; Beckford 2015: 231).

2.4.1.2 The Institutional Framework

Chaplains have also argued for the provision of pastoral, spiritual, and religious care with reference to NHS policy. Circulars published soon after the NHS was founded demonstrated a commitment to attending to spiritual needs (Beckford and Gilliat 1996: 227; Woodward 1998: 90; Orchard 2000: 20). The 1991 Patient's Charter acknowledged the right of patients to 'respect for privacy, dignity, religious and cultural beliefs' (DoH 1991, see also Gilliat-Ray 2001b: 136), prefiguring wider national legislative frameworks for accommodating and protecting religious beliefs. This has been more recently re-affirmed by the NHS document *Essence of Care* (DoH 2010a), which outlines 'benchmarks for the fundamental aspects of care' and the continued commitment to recognising 'ethnicity, religion, belief, culture, [and] language' among the needs that are accounted for in the diagnosis, assessment, and implementation of care, and providing equality of access to services.

The development of broader discourses of patient-centred care, patient choice, and compassion support the case for chaplaincy (Swift 2013: 249). The 2015 chaplaincy guidelines cite the commitment of the NHS to deliver services that 'put patients at the heart of everything they do' by responding 'sensitively to the diverse nature of the communities it serves' (NHS 2000, cited in DoH 2003b: 3). Additionally, the 2015 guidelines cite *Putting Patients First: The NHS England Business Plan for 2013/14 – 2015/16* when highlighting the expectation for chaplaincy to provide 'high quality care for all, now and for future generations' (2015: 7, citing NHS England 2013).

At the turn of the century, NHS policy began to focus on developing and supporting workforce diversity and equal opportunities in which 'securing and developing a workforce that reflects and understands the diversity of the population is fundamental to serving the needs of all' (NHS Executive 2000: 2). This policy provides the foundation upon which the *Caring for the Spirit* guidelines builds a case for diversifying the chaplaincy workforce (SYWDC 2003: 24), to be explored later.

2.4.1.3 *The Relationship between Religion/Spirituality and Health*

The relationship between religion/spirituality and health constitutes the final justification for meeting the religious and spiritual needs of patients. Since the 1990s, chaplaincy guidelines have promoted holistic approaches to health which recognise that spiritual, psychological, and social aspects also contribute to patient care (NAHAT 1996: 6; SYWDC 2003: 10). These guidelines highlight the inadequacies of the biomedical model of healing, and spirituality is upheld as a core part of health (Scottish Government Department of Health and Wellbeing 2008: 7, citing Gibbons and Miller 1989 and WHO 1998; see also Wilson 1971).

Alongside the promotion of holistic care, there has been a growth in empirical research, mainly based in the USA, suggesting that religious and spiritual beliefs support physical health (Koenig and Cohen 2002; Koenig 2004; Koenig, King, and Carson 2012; Lee and Newberg 2005; Powell, Shahabi, and Thoresen 2003). This research has three key strands: firstly, that religious traditions 'generally prescribe healthy lifestyles which accord with the healthy lifestyle the DoH thinks the public should adopt' (Welford 2011: 61, see also Laird *et al*. 2007: 923). Secondly, studies note the role of religion/spirituality in fostering resilience in relation to illness, bereavement, or pain management (Johnson and Spilka 1991; Walsh *et al*. 2002; Culliford 2000; Hill and Pargament 2003; Gall *et al*. 2005; Baeke, Wils, and Broeckaert 2012; Cheng 2017). Thirdly, some studies link religion or spirituality directly to recovery and health outcomes (Strawbridge *et al*. 1997; Seeman, Dubin, and Seeman 2003; Hill and Pargament 2003; Çoruh *et al*. 2005; Weaver, Vane, and Flannelly 2008; Chida, Steptoe, and Powell 2009). Such research may also be framed in terms of cost-benefit, where addressing spiritual need and distress may reduce the length of hospitalisation, reduce post-operative complications, reduce demand for analgesics, and facilitate a quicker recovery (NHS(E) Northern and Yorkshire Chaplains and Pastoral Care Committee 1995: 14 citing Hayward 1975; NAHAT 1996: 6; see also Fraser 2004: 30).

In contrast, Sloan and Bagiella (2002) note that religion, spirituality, or chaplaincy intervention cannot be isolated as a sole variable in improving health outcomes (see also Sloan, Bagiella, and Powell 1999). Cadge instead suggests that the focus should

be placed less on linking religion with positive health outcomes or cost-effectiveness, and instead on the potential for 'sensitively, optionally and professionally' delivered religious and spiritual care to assist people 'at their most vulnerable' (2012: 201).

2.4.2   Who Should Fund Chaplaincy?

Chaplaincy has been a state-funded aspect of care since the creation of the NHS in 1948 (Swift 2014; Welford 2011: 125). However, there have been increasing challenges to the state funding of chaplaincy. Implicit challenges are evident in the growing pressure for chaplaincy to demonstrate cost-effectiveness (Woodward 1998; Swift 2014). A Theos survey on NHS chaplaincy provision notes there have been significant cuts in chaplaincy hours, and situates this within the context of broader cuts being made across a cash-strapped NHS (2008: 14). Swift suggests, however, that the scale of cuts indicated that 'chaplaincies were being targeted to a disproportionate extent compared with other NHS services' (2014: 95). The Theos survey notes that where cuts are made to chaplaincy, services are 'lost' rather than supplemented by alternative funding arrangements (Theos 2008: 2). The matter of cuts is also contentious in relation to workforce diversity: the tensions arising from the concomitant redistribution of resources from Christian to minority faith chaplains are exacerbated when cuts become 'operationally difficult' (Swift 2014: 76-77).

In recent decades, explicit challenges have been raised by the National Secular Society (NSS), which has campaigned for the removal of state funded chaplaincy budgets. The NSS suggests that, in place of taxpayer funding, it is 'reasonable to expect religious organisations, many of which have vast wealth, to pay for religious chaplains themselves rather than the taxpayer' and that this can be achieved by setting up a charitable trust for chaplaincy supported by local faith groups (National Secular Society 2012). Such a move would disproportionately affect minority faith communities due to their lack of infrastructure and resource (DoH 2004).

Similarly, Jhutti-Johal notes that the attempts made by healthcare providers to accommodate spiritual, cultural, and religious requirements are stymied by the assumption that 'ethnic minority groups are homogenous blocks of people with similar needs' (2013: 259). Jhutti-Johal suggests that NHS professionals cannot meet

all the needs of ethnic minorities (2013: 268) and that in the context of a 'budget focused healthcare system' the accommodation of religious or cultural beliefs which are 'not directly related to treatment efficacy or outcomes' is questionable. This is especially the case when providing treatments that are costlier than standard treatments in order to satisfy religious requirements. Jhutti-Johal argues that the cost of providing chaplains, religious texts, and training material for staff should be borne by the patient or ethnic minority community (Jhutti-Johal 2013: 269).

The justification for continued public funding of chaplaincy – articulated primarily by chaplains – rests in arguments which emphasise the distinctive contribution of chaplaincy in providing spiritual care as a discrete aspect of healthcare (Fraser 2004; Cobb 2007: 7; Swinton and Mowat 2007; Welford 2011: 126; Swift 2013). Direct employment of chaplains has been linked to providing holistic care to meet the spiritual and religious needs of *all* patients (Welford 2011: 126; Johnston 2009), support for staff in times of organisational instability (Welford 2011: 126-127; Fraser 2004: 29), and ensuring accountability to the NHS (Burleigh 2013: 35; Swift 2013). Additionally, there has been a growing emphasis on conducting research to ensure the activities of chaplaincy are grounded in evidence-based practice (Speck 2005). Chaplains' responses to the challenges raised concerning the public funding of chaplaincy have largely been to redouble efforts to professionalise. The next section will examine the distinctive contribution of chaplaincy.

2.4.3   Should Spiritual Care be Provided as a Discrete Aspect of Healthcare?

The conceptualisation of spiritual care as a discrete aspect of healthcare provision is a question of professional territory (Mowat 2008: 58-61; De Vries *et al.* 2008). Should spiritual care be delivered primarily or solely by group of specialists (chaplains/spiritual care givers), or is it a diffuse aspect of care that can/should be delivered by and subsumed under the role of other healthcare professionals? Numerous guidelines highlight the role of other healthcare professionals in spiritual care (Scottish Executive Health Department [SEHD] 2002; SWYDC 2003; NHS England 2015a: 7), in which '…providing spiritual healthcare is not just the preserve of chaplaincy because the spiritual dimension is often expressed through the humanity of care offered by many health professions' (SYWDC 2003: 10). A

combined model of specialised and wider care – where healthcare staff are expected to understand the importance of spiritual needs and to be competent in spiritual assessment and making referrals – was also initially proposed in the Marie Curie *Spiritual and Religious Care Competencies for Specialist Palliative Care* (2003), and has been subsequently adopted in documents produced by NHS Education for Scotland (2008) and the UKBHC (2014: 2)

However, the sharing and delegation of spiritual care to other providers puts chaplaincy in a 'precarious position' (Mowat 2008: 50). In a context of constrained healthcare budgets, chaplains must articulate their distinct contribution to healthcare compared to healthcare professionals and community-based religious leaders (Orchard 2000: 120-123; Cobb 2004, 2007; Fraser 2004; Aldridge 2006; Pesut *et al*. 2012: 834; Swift 2013). Woodward links this preoccupation with offering a distinctive service – part of the professionalisation of chaplaincy – to strategies of 'social closure' where 'a monopoly is achieved to work in a specialised way with a particular group of clients…so that occupational groups seeking a similar role are excluded' (Woodward 1998: 44).

Various guidelines articulate the distinctive contribution of the chaplain in providing spiritual care, including the independence of the chaplain (NAHAT 1996: 8), the chaplain as someone who has time to deliver spiritual care (SEHD 2002), and the specialist training, knowledge, and expertise of the chaplain (NAHAT 1996: 8; SEHD 2002; SYWDC 2003: 12). Some guidelines also refer to the potential of the chaplain to empower other healthcare professionals to meet the needs of patients by being an 'essential resource' for meeting Trust obligations (NHS England 2015a). This model of developing the spiritual healthcare workforce to meet the needs of patients is achieved by chaplains providing training and education to other healthcare professionals (SYWDC 2003: 13, Folland 2006: 14). Thus, chaplains may not be the sole providers of spiritual care, but still have a unique role and expertise.

2.4.3.1   Can Staff Provide Spiritual Care?

Despite normative views about the role of healthcare staff in spiritual care, there is empirical evidence that nurses are reluctant to deliver spiritual care for several

reasons, including lack of confidence, feeling ill-equipped to deliver spiritual care, uncertainty about when to refer to chaplains, not knowing what spiritual care is, and viewing spiritual care as 'low priority' (Orchard 2000: 140; Walter 2002; Welford 2011: 238). This is a significant barrier to fulfilling the requirement that all patients should undergo a spiritual assessment on admission (NAHAT 1996, SYWDC 2003), with nurses reporting that they felt the 'religion question' was unnecessary, intrusive, and awkward (Beckford and Gilliat 1996: 229; Swift, Calcuttawala, and Elliot 2007: 1281). Orchard also warns that devolving patient care to staff may result in spiritual care being used as a pretext for evangelism (Orchard 2000: 141). Staff reported that patient care should be the role of chaplains, and that Trusts appointed chaplains in order to provide such care to patients (Orchard 2000: 147).

Orchard notes that Catholic and Jewish participants in her study were less likely than Anglican or Free Church colleagues to express the view that anybody can provide spiritual care (2000: 137). Orchard distinguishes between religious and existential spiritual care, as religious care requires specific training to discharge a role, whereas existential care can be delegated to others (Orchard 2000: 138; Aldridge 2006; Swinton and Mowat 2007: 51; Welford 2011: 235). Likewise, Cobb notes that 'being a representative of a faith community means having a rich tradition to draw upon, and this enables a distinctive contribution to healthcare', which has implications not only for the delivery of religious care, but also how chaplains engage dialogically in pastoral care (2004: 13). The question of how chaplaincy is distinct from community-based religious leaders who may also be able to provide religious care is explored below.

2.4.3.2   *Does Spiritual Care Require Paid Experts?*

Orchard notes that a failure to distinguish between chaplains and volunteers implies that chaplaincy could be delivered by amateurs (Orchard 2000: 118) pointing to a 'serious undervaluing by chaplains of their own expertise and lack of recognition of the importance of their formal training and qualifications' which 'weakens the professional standing of the role' (2000: 134). It is therefore in the chaplain's interest to maintain a boundary between the role of chaplains and the role of clergy and

volunteers (Fraser 2004: 27). The chaplaincy literature, however, has very little to say about the role of chaplaincy volunteers.

2.4.3.3 Distinguishing between Chaplains and Parish Clergy

Chaplains have also constructed a professionalised identity by distinguishing themselves as 'professionals with a discrete mode of ministry that is measurably different from parish ministers' (Swinton and Mowat 2007: 27). Swinton and Mowat suggest this 'myth of difference' is a 'useful device to establish their own credentials' (2007: 31). Other sources uphold this distinction by noting that chaplains' distinctiveness from community-based faith leaders arises from a greater awareness and knowledge of the institutions in which they work. Carr suggests that the chaplaincy profession 'holds a stronger sense of addressing the institutional context than is customarily found among and expected of ministers to congregations and parish clergy' (2001: 22). Swift highlights the specialist role of the chaplain in providing care after a miscarriage or stillbirth, which requires experience and skills that community-based faith leaders lack (2013: 256). Therefore 'the chaplain is uniquely placed to provide this care and does so with the mandate of the hospital as well as the endorsement of a local community' (ibid.). Swift also refers to the institutional discourse of safeguarding to further distinguish chaplains from community faith leaders:

> …There is no doubt that some religious views can be harmful to patient's wellbeing… The employment of chaplains from many different faiths in the NHS is a safeguard to the quality and practices of care being given to patients… The potential harm that can be caused by thoughtless and ill-informed action is not to be underestimated (Swift 2013: 256).

Compared to the literature which distinguishes chaplains from healthcare professionals, the literature which argues that chaplains are distinct from community leaders is relatively scant. I suggest that the distinctiveness of chaplaincy from faith community leaders is assumed and implicit in the literature (see Fraser 2004: 27-28; Cobb 2007: 7), and implied when chaplains discuss their own marginality in relation to the Church (Hancocks, Sherbourne, and Swift 2008; Swift 2014) and the shift

towards professionalisation (Swift 2004: 183; Swinton and Mowat 2007: 71; De Vries *et al*. 2008: 24).

2.4.3.4   Value Added

The distinctiveness of chaplaincy can also refer to value added, including 'convenience', 'prophylactic', 'anomalous', and 'therapeutic' value (Orchard 2000; 120-123). Firstly, 'convenience' value highlights the function of chaplains as 'gap-fillers', also identified by Cadge, who observes that chaplains often engage in the emotional 'dirty work' of the hospital (De Vries *et al*. 2008: 25). Chaplains are valued for their availability, informality, and flexibility. Secondly, chaplaincy has 'prophylactic' value as a mechanism for coping with stress; part of this remit may involve preventing escalation of complaints through patient liaison. Thirdly, chaplains have 'anomalous' value as independent agents who remind hospitals of their obligation to provide holistic care (Fraser 2004: 29; Faber 1971). Orchard describes as 'constructive uncertainty', which means chaplains are 'better placed for whistle-blowing' (2000: 122). Finally, chaplains can add 'therapeutic value' through breaking the monotony of hospital life and linking physical and mental well-being. Therapeutic value can also be linked to the provision of spiritual care as a complementary aspect of healthcare delivery. The 'convenience' and 'anomalous' value of chaplaincy relates to what Pattison calls 'vague uselessness', which is a byproduct of the 'symbolic effectiveness' of chaplaincy (2015: 25). The symbolic labour of chaplaincy continues to provide a stark contrast with the 'over-instrumentalised world' of healthcare (ibid.; see also Sedgwick 2013)

2.4.4   How Can Pastoral, Spiritual, and Religious Care Fairly Accommodate the Needs of Minority Faith Groups?

The earliest attempts to recognise the religious and spiritual needs of minority faith patients took place in the early 1980s, when the HCC (1983) published guidelines about how to engage with those of 'other faiths', and the DHSS commissioned guides for caring for Muslim, Hindu, and Sikh patients as early as 1982 (Henley 1982). The guides suggest that the needs and requirements of minority faith groups are distinct from the population at large and that healthcare staff have a role in meeting these needs. These early guides refer explicitly to caring for ethnic minority

patients (Henley 1982, 1983, 1987; Mares, Henley, and Baxter 1985; Henley and Schott 1999 Hopkins and Bahl 1993). Arguably, the meeting of religious or cultural needs as discussed in guides from the 1980s and 1990s was a proxy for addressing institutional racism (Henley 1987; Hopkins and Bahl 1993) and inequalities grounded in ethnicity or culture. Notable absences from these guides include Buddhism, Paganism, and Baha'i, which are not exclusively linked to ethnic minorities. Gilliat-Ray (2001b; 2003) notes these guides and checklists tend to offer stereotyped and inaccurate accounts of the needs and expectations of religious groups. Recent attempts to provide guides from 'insider' perspectives are exemplified in Thakrar, Das, and Sheikh (2008), Sheikh and Gatrad (2008), and Spitzer (2003). This early recognition of the distinct needs of minority faith groups was later consolidated in the 1991 Patient's Charter, which formally recognised the importance of respecting and meeting the spiritual, cultural, and religious needs of patients and staff.

2.4.4.1 *What Counts as Pastoral, Spiritual, and Religious Care and How Can Needs be Met?*

The 'entitlements' of minority faith patients were most comprehensively outlined in the 1996 NAHAT guidelines. These include provision of suitable facilities for prayer and reflection, provision for dietary requirements, access to suitably qualified staff to meet spiritual needs, protection from the unsolicited visits from external religious groups, assessment of cultural and religious needs on admission, and suitable arrangements for end of life situations and bereavement support (NAHAT 1996: 10). The 2003 guidelines emphasise the importance of ensuring 'adequate arrangements are made for the spiritual, religious, sacramental, ritual, and cultural requirements appropriate to the needs, background and tradition of all patients and staff, including those of no specified faith' (DoH 2003b: 8) which includes provision of 'chaplaincy-spiritual care for all patients, their carers and staff' (DoH 2003b: 5).

The 1991 Patient's Charter placed responsibility for spiritual and religious care on all NHS staff, and healthcare managers were afforded considerable flexibility concerning arrangements for providing spiritual care (Beckford and Gilliat 1996: 231; Gilliat-Ray 2001b: 136). While the Patient's Charter and subsequent guidance

opened up the possibility of Trusts consulting with faith communities (NHS Management Executive 1992, cited by Orchard 2000: 22; NAHAT 1996: 13), this appeared not to alter the tendency to consult full-time Christian chaplains about how best to implement policy (Beckford and Gilliat 1996: 314). Additionally, staff were given a proactive role in spiritual assessment and facilitating visits from local ministers (NAHAT 1996). However, the introduction of the 1998 Data Protection Act, which stipulated that chaplains should only have access to information following patient consent, shifted the responsibility for spiritual assessment from admissions staff (NAHAT 1996) to chaplains *after* a referral had been made (SYWDC 2003: 14-15; NHS England 2015a: 24). Chaplaincy departments continued to be seen as a 'clearing house' on matters concerning all religions (see HCC 1983: 16; Beckford and Gilliat 1996; NAHAT 1996: 9; SYWDC 2003: 27).

Since 1992, spiritual care guidelines have recommended that meeting the spiritual needs of patients and staff involves accessing 'whichever individuals are best placed to be able to give them the necessary support or to ensure that it is provided' (NAHAT 1996: 7). The way in which this could be achieved was open to interpretation, and did not require employment of minority faith representatives to substantive chaplaincy posts. An example of best practice in the NAHAT guidelines was the appointment of a 'full-time co-ordinator for non-Christian patients' who would then liaise with community representatives and provide training (NAHAT 1996: 13). A key problem with this approach was the assumption that one person can represent and facilitate care for all 'non-Christian' faith groups.

The *Caring for the Spirit* guidelines were the first to explicitly encourage a review of religious diversity in the chaplaincy workforce (SYWDC 2003: 5, see also Street and Battle 2003: 19). Chaplaincy recruitment formulas in the 2003 and 2015 guidelines reflect this concern to appoint a diverse workforce. This formula originates from policies and circulars concerning chaplaincy in 1948 (Beckford and Gilliat 1996: 227). A 'single common formula' for all appointments and sessional allocations – which linked session allocation to inpatient demographics – was promoted by the Multi-Faith Joint National Consultation from 1997 onwards (Orchard 2000: 23; see also DoH 2003b: 27 and NHS England 2015a: 16). This formula was clarified further in the 2015 guidelines to reflect demand for on-call (NHS England 2015a: 9).

Despite the provision of cultural and religious care being mandated in the NHS in 1991, the policy-based impetus for directly employing minority faith chaplains was not explicitly articulated until 2003. The diversification of the workforce and the widening of career pathways for chaplains of all backgrounds was actively promoted as part of a wider agenda to modernise chaplaincy (SYWDC 2003).

2.5 WHAT ARE THE CHALLENGES FOR THE INCLUSION OF MINORITY FAITH REPRESENTATIVES IN CHAPLAINCY?

This section will examine the key barriers and challenges for the involvement of minority faith groups in chaplaincy, drawing especially on secondary literature, with some reference to the normative underpinnings of the preceding sections. Several major studies of chaplaincy in the UK will inform the review, although some reference to the American literature will be made for comparative purposes.

Prior to the 2003 guidelines, the lack of equitable arrangements for minority faith groups was 'widely known [but] little documented' (Orchard 2001b: 16). Orchard's study revealed the 'informally mooted view that multi-faith debate is yesterday's news' (2000: 44) and found that there had been 'little indication of sustained engagement' among chaplains in relation to the formalised involvement of minority faith groups in chaplaincy. Nearly a decade later, Welford notes that despite the emphasis on equality in subsequent NHS guidelines, 'not one of the chaplains [interviewed] felt there was a total and complete equality in religious care in the NHS' (2011: 123) and concludes that 'equal access to religious care is patchy at best' (2011: 229). This finding suggests a significant disconnect between national institutional and legislative drivers and the provision made for spiritual and religious care within individual Trusts (Orchard 2000; Welford 2011). While the guidelines do allow Trusts the flexibility to make locally informed decisions, variations in demography mean that 'providing spiritual care for all patients in one locality may be harder than in another, especially if hospital managements do not choose to spend their money on multi-faith provision' (Eccles 2014: 1; see also Beckford and Gilliat 1996: 234). The remainder of this chapter will explore the possible reasons for this disconnect.

2.5.1   Precedents and Problems with 'Chaplaincy' for Minority Faith Groups

The literature emphasises the unfamiliarity of the term 'chaplain' for minority faith traditions (Mayet 2001: 173; Gilliat-Ray 2001b: 137; Cadge and Sigalow 2013: 155; Flatt 2015: 46), with some commentators questioning whether 'chaplain' is an appropriate title (Lie 2001: 187). This was anticipated in Scottish chaplaincy guidelines, which encourages faith communities to 'choose an appropriate title for its spiritual caregiver' (SEHD 2002). Revised Scottish guidelines noted that 'the word chaplain is acceptable' across faith communities (Scottish Government Department of Health and Wellbeing 2008: 6). Mayet suggests that 'chaplain' is an appropriate term in order to maintain clarity and unity in departments and the overall organisation (2001: 174).

The *Caring for the Spirit* guidelines state that 'a tradition of caring for the sick and supporting those who care for them is common to all faiths' (SYWDC 2003: 4). This may be true for the Abrahamic faiths, but less so for the 'dharmic' traditions. In Judaism, the origins of pastoral care are grounded in the practice of *Bikkur Holim* – 'the sick visit' (Sheer 2008; Tabak 2010). Van den Bergh also refers to the 'obligation to emulate God's attributes of mercy and compassion' as the basis for pastoral care (2001:164-165). Gilliat-Ray *et al*. note that while there are precedents for pastoral care within Islam, 'these do not add up to a mandate for caring for individuals instead of their families, nor do they imply the need to visit strangers, to care for all, whether or not they are Muslim, nor to adopt non-judgemental and listening methods of attending to people's needs' (2013: 170). Muslim chaplains have developed their approach to chaplaincy through a 'striking change of practice and orientation' (ibid.).

No literature was found concerning Baha'i, Hindu, Jain, or Sikh precedents for the discrete provision of pastoral care, but this does not mean that traditions cannot be reinterpreted in light of contemporary practice. Buddhist chaplains have begun to identify conceptual analogues for chaplaincy and pastoral care (Giles and Miller 2012). The compassionate orientation of the *bodhisattva* is particularly suited to healthcare chaplaincy work (Hirsch 2012: 56); Monnett links chaplaincy with 'right livelihood', the fifth principle of the Noble Eightfold Path (2005); and Hirsch

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elaborates on how the Four Noble Truths can provide a framework for contemplative care (2012).

2.5.2   Role Confusion

Potential confusion about the role of the 'chaplain' may arise as a result of different understandings of who provides care within particular faith communities. This can be examined with reference to the role of the family and the role of religious leaders or professionals.

2.5.2.1   Familial Care

Some of the literature acknowledges that, for some faith communities, the responsibilities of providing pastoral or spiritual care to the patient would usually be undertaken by family members (Welford 2011: 229; Eccles 2014: 5; Abu-Ras and Laird 2011: 51; Gilliat-Ray *et al*. 2013: 33). The role of the family is also highlighted in the wider literature concerned with caring for minority faith patients, especially in end of life situations (Neuberger 1987; Firth 1997: 70; Henley and Schott 1999; Winter 2008: 28; Lawrence and Rozmus 2001: 230; Laird *et al*. 2007: 923; Jhutti-Johal 2013: 265). Instead of being visited by religious leaders, visiting the sick is 'traditionally done by ordinary Muslims' (Henley and Schott 1999: 510) and 'often patients will prefer to be visited by devout and knowledgeable elders or relations' (Winter 2008: 28). However, the current social context has seen a growing fragmentation in the family unit among minority faith communities (Welford 2011: 237; Gilliat-Ray 2001b: 137; Jhutti-Johal 2013: 265), potentially opening up a new space for minority faith chaplaincy roles to develop.

2.5.2.2   Pastoral Care and Religious Leadership

The tendency to view minority religions through the lens of Western Christianity contributed to the assumption among healthcare managers that 'other' faith communities have dedicated professional pastoral carers (Beckford and Gilliat 1996: 253, 284). Some commentators question the assumption that minority faith communities would provide spiritual and religious care in the same way as Christians and Jews (Ballard 2010: 196; Beckford and Gilliat 1996), and suggest that minority faiths would find Christian 'priestly' pastoral care models unhelpful (Lie 2001: 188;

see also Gilliat-Ray 2001b: 137; Welford 2011: 229). Henley and Schott note that the roles of the pandit, imam, or *granthi* do not traditionally encompass pastoral care, but that this appears to be changing in the British context (1999: 489, 510, 576). The imam is 'never religiously indispensable' as he has no sacraments to deliver (Winter 2008: 28), and the imam's role can be substituted by Muslim doctors (Abu-Ras 2011: 51). These understandings suggest little or no need for a distinct Muslim chaplaincy role that needs to be fulfilled by an established religious 'leader' or 'professional'. However, Mayet notes that historically imams, *ulama*, and religious leaders acted in a personal capacity to care for patients in hospitals, and that early Muslim doctors also trained as religious scholars (2001: 173). In contrast, patient visitation is a recognised as integral to the rabbi's role (Henley and Schott 1999: 549). Gilliat-Ray suggests that rabbis have 'gradually incorporated a pastoral dimension to their role' but provides no further detail about how or why this development has taken place (2001a: 13, 135; 2001b: 137). Additionally, the role of pandits, *granthis*, and rabbis in fulfilling end of life rituals and requirements is not essential, but patients and families may request visits from these religious leaders anyway (Henley and Schott 1999; see also Firth 1997: 70). While the 'nine major world faith communities' do not necessarily have the precedents in place to support chaplaincy as a discrete religious profession, there is still potential for minority faith groups to 'approximate' new modes of delivering care (Gilliat-Ray 2001b: 137), especially as 'religious specialists serving diaspora communities are often influenced by the dominant professional roles of the religious majority' (Gilliat-Ray 2001a: 13, 135).

Beckford and Gilliat note that some chaplains queried visiting ministers' 'commitment to "empathic" support rather than commanding behaviour', suggesting a tension between authoritative roles and the expectation for religious professionals to provide pastoral care (1996: 283). This tension relates to the *relational* skills required for chaplaincy in contrast with the *didactic* approach of religious leaders (Galashan 2015: 115). This was reflected in Warden's study on Islamic social work with several participants reporting that they considered mosque-based imams to be judgemental, closed-minded, and less professional (2013: 95). However, other studies have documented the changing role of imams, who have adopted a more pastorally oriented role to meet contemporary demands of both their congregations and the state (Ali, Milstein and Marzuk 2005; Birt 2006; Gilliat-Ray 2010b).

Likewise, Gilliat-Ray *et al.* examine how Muslim chaplains have begun to adopt secular and Christian approaches to pastoral, non-judgemental care (2013: 170-171). Female Muslim chaplains in particular are carving out a new professional leadership role through their skills and experience in counselling and community-based work (2013: 93).

An analysis of how Muslim chaplains redefine the boundaries and substance of the chaplaincy 'field' in light of their faith tradition is outlined by Gilliat-Ray *et al.* (2013: 64) in the UK and Kowalski and Becker (2014) and Abu-Ras (2011a, 2011b; see also Abu-Ras and Laird 2010) in the USA. These roles often go beyond the kind of care that might characterise familial and community leaders' support of patients, especially due to chaplains' roles as mediators, troubleshooters, and advocates between the patient and the institution (Gilliat-Ray *et al.* 2013: 86-89, 126). Mayet suggests that Muslim chaplains might understand 'how to administer care in hospital' in ways which a well-meaning community representative might not (Mayet 2001: 173, cf. Swift 2013: 256 and Carr 2001: 22). However, in spite of the significant growth in literature focusing on Muslim chaplaincy, empirical explorations of how other minority faith groups are shaping – and are shaped by – chaplaincy is lacking.

2.5.3   A Diverse Workforce?

In the decade following the 1991 Patient's Charter, Lie observed that 'the bulk of chaplaincy sessions remains Christian, with at best very few paid sessions, if any, allocated to one or two other world faiths' (Lie 2001: 186). Early locally-based initiatives were exemplified by the appointment of a Muslim chaplain as early as 1971 (Wilson 1971: 57) and sessional hours allocated to Muslim chaplaincy in the 1990s (Lie 2001: 186) in Birmingham hospitals. Nevertheless, these cases were exceptional and, overall, 'national level activity was slow to start' (Orchard 2000: 22). In the 1990s, minority faith involvement was achieved either through informal contacts or the use of visiting ministers whose remuneration was variable or non-existent (Beckford and Gilliat 1996: 268). Session allocation was therefore 'incremental' rather than 'closely tied with policy development' (Orchard 2000: 58). Orchard concludes that 'the infrastructure of departments reveals a paucity of resources for faiths other than Christian' (2000: 47) and that 'formal representation is

poor', especially among Hindus, Sikhs, and Buddhists (2000: 149). This may also be attributed to the 'brokerage' model, explored later, which was 'perceived to reduce the need to recruit staff from other faiths as Anglicans oversee meeting the needs of all' (Orchard 2000: 57). Orchard offers three further 'pretexts' for lack of inclusion, including funding, complexity of management, and the 'unnatural act' pretext (2001a: 151-154). The latter refers to the lack of precedent and unfamiliarity of chaplaincy for minority faith groups, discussed earlier (Orchard 2000: 60). Given the limited paid hours allocated to minority faith representatives, it is unsurprising that department leadership was the sole domain of Anglican chaplains, and all full-time staff were Christian (ibid.: 30, 60).

Beckford and Gilliat found that in the mid-1990s there were seventy-one visiting ministers nationally, of which forty were Jewish, twenty-two were Muslim, three were Sikh, three were Hindu, two were Baha'i, and one was Buddhist (1996: 316). In 2003, a national survey of chaplaincy provision showed that there were seventy-one minority faith chaplains, although the religious backgrounds differed from Beckford and Gilliat's cohort of visiting ministers. This included forty-eight part-time Muslim chaplains, one full-time Muslim chaplain, eight part-time Jewish chaplains, six part-time Hindu chaplains, five part-time Sikh chaplains, and three part-time Buddhist chaplains (Street and Battle 2003: 5). In total, this was just under seven per cent of the sample of 1,101 chaplains (ibid.). Street and Battle did not, however, provide a religious breakdown of volunteers involved in chaplaincy, despite examining the role of volunteers elsewhere in the report (2003: 10). Gilliat-Ray *et al.* (2013) note that at the time of their study there were eighty paid Muslim chaplains, nearly double the number outlined in the 2003 survey, and a further eighty in voluntary/honorary roles. It is clear that over the past twenty years Muslim chaplaincy has developed far more rapidly than other minority faith groups.

2.5.4 Community Links

Despite emphasis in chaplaincy guidelines on fostering links with local communities (SYWDC 2003: 11), empirical evidence shows that such links between chaplaincies and faith communities tended to be tenuous and weak, with little evidence of formal or informal mechanisms for community input (Orchard 2000: 47, 149). Orchard

noted that chaplaincies tended to compile contact lists which simply listed places of worship instead of naming individuals (Orchard 2000: 60). Welford's study also highlights the difficulties of maintaining links with local communities and the impact of this on equality of access to care (2011: 229), which can be attributed to three factors. Firstly, the uneven distribution of faith communities can mean that '[s]ome chaplains have little or no contact with these communities' (Beckford and Gilliat 1996: 234). Secondly, chaplains expressed caution about approaching other faiths in order to not appear as though they were being patronising or 'pushing' Christianity (Beckford and Gilliat 1996: 254). Thirdly, the lack of recognition of the chaplaincy role, the low priority afforded to chaplaincy among minority faith traditions, and limited availability of faith leaders may lead to difficulties in maintaining external links with faith leaders (Welford 2011: 229). However, Orchard suggests that willingness among chaplains to implement recommendations for community liaison may also be a significant factor (see Orchard 2000: 38).

2.5.5 Lack of Appropriate Infrastructures and Institutions

A lack of centralised management structures significantly disadvantages minority faith groups involved in chaplaincy (DoH 2004: 7; Swift 2014: 50; Pesut *et al.* 2012: 834). Lack of infrastructures affects the ease of obtaining representation from minority faith groups (Pesut *et al.* 2012: 834; DoH 2004: 7), the level of support and mentoring available to minority faith representatives in chaplaincy (Gilliat-Ray *et al.* 2013:68), continuing professional development, authorisation of minority faith representatives, and the resource or funding to support these activities (Lie 2001; DoH 2004: 12). This lack of institutional structure also contributes to problems of representativeness in larger chaplaincy organisations (such as NPSRCH), and raises difficulties of distributing centrally allocated funding to developing infrastructures (DoH 2004). The DoH review of central funding raised broader issues about the developing national bodies, such as their reliance on volunteers, and the dependence of these national representative organisations on high profile individuals to meet the wider demands of the Government in addition to concerns relating to chaplaincy specifically (2004: 7). Some faith groups may also find such structures undesirable, preferring to locate authority in expert scholars rather than institutions (Mayet 2001: 173; Gilliat-Ray *et al.* 2013: 40). This lack of infrastructure meant minority faith

groups were initially limited by or dependent on Anglican patronage. Swift notes the HCC's facilitation of the MFGHC ultimately 're-asserted the model of chaplaincy involvement via patronage' (2014: 74-75).

2.5.6   Models of Operating

Models of chaplaincy that outline the role, nature, and working practices of chaplaincy teams are a key concern in the chaplaincy literature (Wilson 1971; Woodward 1998; Beckford and Gilliat 1996; Orchard 2000; Cobb 2004; Folland 2006; Church of England 2010; Threlfall-Holmes 2011; Swift 2014; Kyriakides-Yeldham 2017). This section will focus on and review empirical research to examine how far these chaplaincy models allow for the inclusion of minority faith groups.

2.5.6.1   *Brokerage*

Beckford and Gilliat (1996) and Orchard (2000) note the prevalence of the 'brokerage' model in the 1990s and early 2000s, where chaplains acted as brokers for the provision of spiritual care, and provided a 'clearing house' on religion (Beckford and Gilliat 1996: 258; Orchard 2000). Brokerage has three main aspects: firstly, minority faith representatives are dependent on Anglican chaplains for access (gatekeeping); secondly, minority faith representatives provide services with little or no remuneration (goodwill); and thirdly, Anglican chaplains are the primary point of contact for patients and are responsible for facilitating religion-specific care (mediation). Beckford and Gilliat acknowledge that brokerage was initially helpful for including minority faith groups but warned this approach was becoming increasingly unsuitable due to the growth of minority faith communities in England (1996: iii). Most chaplains, with a few exceptions, embraced the opportunity to be accountable for the needs of all patients and expressed 'readiness to offer appropriate care to members of other faiths' (Beckford and Gilliat 1996: 256). This openness informed well-intentioned attempts to facilitate spiritual care for all.

Both studies reported that there was a limited choice of appropriate caregivers for minority faith patients, visitors, and staff, citing the provision of rites and ceremonies for different faiths by Christian chaplains, including 'Christianised' baby funerals (Orchard 2000: 98; see HCC 1983: 13), as well as blessings for Muslim babies

(Beckford and Gilliat 1996: 285). Orchard notes that while these rites are 'appropriated' in a context of relationship and rapport with patients or relatives, this exemplifies 'structural inequity resulting in an inability to respect cultural and religious preferences' (Orchard 2000: 99-100)

2.5.6.2   Multi-Faith Teams

Indications of a 'multi-faith' or 'inclusive' approach to chaplaincy were nascent at the time of Orchard's study, which identified two of five teams in London operating in this way. This 'inclusive' model refers to the direct regular involvement of minority faith leaders who can be accessed without mediation from the Anglican chaplain (2000: 58). Orchard furthermore outlines formal inclusion as 'recognising individuals as competent and qualified representatives, agreeing appropriate remuneration, rights of access and involvement in decision making' (Orchard 2000: 101). Prior to formalised substantive involvement in chaplaincy, there was little sense of chaplains and visiting ministers working as 'multi-faith' teams (Beckford and Gilliat 1996: 338-340). Beckford and Gilliat note that visiting ministers often operated independently of the Christian chaplains (ibid.: 354-355). Concerns have been expressed about whether multi-faith teams might encourage 'tokenism', with one of Welford's participants suggesting this could lead to *over*representation (2011: 190) and other commentators suggesting that 'token' levels of involvement may result in *under*representation (Gilliat-Ray 2001b: 144; Ballard 2010: 200).

Gilliat-Ray *et al*. discuss multi-faith working since the introduction of substantive posts, noting that 'many chaplains spoke in generally positive terms about their colleagues of other faiths' (2013: 105), but that relations between Christian and Muslim healthcare chaplains were 'more fragile' due to the 'greater vulnerability of chaplaincy within the Health Service overall' (ibid.: 106). Accounts of multi-faith working focus primarily on the co-operation (and conflict) involved in sharing or negotiating multi-faith spaces (Gilliat-Ray *et al*. 2013; Gilliat-Ray and Arshad 2015).

2.5.6.3   Generic Chaplaincy

The literature has recently acknowledged the development of generic chaplaincy, where chaplains of any faith provide pastoral and spiritual care to patients regardless

of their religious background (Todd 2011: 97-98; Welford 2011: 155), as well as those without a formal faith (Newitt 2010: 164). The predominantly 'generic' approach to chaplaincy in Scotland has been contrasted with the 'multi-faith' approach in the English NHS (Swift 2013: 250). Notably, chaplains in Scotland are still predominantly Christian (Swinton and Mowat 2007: 5). The overlap between the British 'generic' chaplaincy model of visiting everyone regardless of background bears some similarities to the American 'interfaith' model (Cadge and Sigalow 2013: 149; see also Cadge 2012: 19). The strategies for doing so have been described by both British and American chaplains as 'loitering with intent', 'cold calling' or 'proactive chaplaincy' (Orchard 2000: 74; Allan and Macritchie 2007; Cadge 2012: 218; Swinton and Mowat 2007: 37-38; Gilliat-Ray *et al*. 2013: 83). Proactive approaches are contrasted with reactive approaches based on referrals (Allan and Macritchie 2007). This model presupposes an understanding of spirituality as a 'human universal which may include, but is not defined by any particular religious tradition' (Swinton and Mowat 2007: 5). It is difficult to establish when generic chaplaincy emerged as a model of operating, although the proactive 'blanket visiting' referred to in Orchard's work (2000) appears to overlap with the 'brokerage' model.

Generic chaplaincy can involve chaplains adopting innovative approaches to prayer and ritual. Cadge and Sigalow identified strategies chaplains use to negotiate in 'interfaith' pastoral encounters, including code-switching between religious languages, symbols and rituals, or neutralising religious differences (2013: 148). The use of ritual in generic chaplaincy has been linked to the facilitation and design of ritual for those with nominal religious identities, or those without a formal religious affiliation (Swift 2013; Newitt 2012: 107). Rare examples of ritual innovation usually centre on the needs of mixed-faith families, including the development of a suitable baby funeral service for parents were Christian and Hindu (Eccles 2014: 7-8).

The American 'interfaith' model has been treated with caution among British chaplains (Welford 2011: 155; Bryant 2014: 43), particularly with reference to chaplains performing rituals and practices from other religions in order to meet the needs of patients (UKBHC 2009: 1; Cadge and Sigalow 2013: 148; Flatt 2015: 48). Lyndes *et al*. give an example of American chaplains facilitating ritual to patients of

different faiths, including a Christian chaplain performing a Hindu water ritual (Lyndes *et al.* 2012: 81). The appropriation of language and practice by chaplains who are not of the same faith as the patient is perceived by British chaplains to be an attempt to be 'all things to all people' (Cobb 2005: 85). This limits patient choice (Flatt 2015: 48) and exposes inequitable arrangements for access (Orchard 2000, 2001a). Generic chaplaincy has also been linked with financial efficiency and staff cuts, which leads some chaplains to view this model with suspicion (Flatt 2015: 47, 49). Cadge and Sigalow (2013) and Abu-Ras and Laird (2011) identify significant limitations with the interfaith model. The ability to code-switch, for example, is dependent on shared linguistic repertoires; Christian chaplains may find it difficult to code-switch for Jewish or Muslim patients as they are unable to pray in Hebrew or Arabic (Cadge and Sigalow 2013: 154). Abu-Ras and Laird observe that the interfaith spiritual care model assumes that 'Muslims have the same needs as everyone else' (2011: 55). Where chaplains cannot meet the very specific requirements of patients, an imam must be called in, sometimes from a distance (2011: 52). Abu-Ras and Laird are the only authors to highlight the significant limitations of both the interfaith and religion-specific models (2011: 47-48).

2.5.6.4   *Mixed Models*

The introduction of mixed models of chaplaincy (incorporating generic and multi-faith elements) has led to a proliferation of service models for including minority faith representatives. Chaplaincy teams no longer simply comprise full-time chaplains, part-time chaplains, visiting ministers, and community contacts (Beckford and Gilliat 1996), but a variety of arrangements that demonstrate varying degrees of integration in each chaplaincy team, from ad hoc call-outs to regular engagement. There is very little empirical data concerning the proliferation of service models, although Gilliat-Ray *et al.* note the frustrations articulated by Muslim chaplains limited by their contractual status as part-time chaplains (2013: 95). Welford's findings only refer to the involvement of minority faith volunteers and community contacts, rather than contracted minority faith chaplains (Welford 2011: 140). Eccles refers to the use of multi-faith and interfaith models in one chaplaincy team, although appears to conflate interfaith chaplaincy with generic chaplaincy (Eccles 2014: 5). I will address this lack of empirical data in the findings.

2.5.7 Awareness

Empirical literature examining the issue of patient awareness of chaplaincy provision is scarce, although raising staff awareness is often explored in terms of providing training on religious/cultural literacy, spirituality, chaplaincy, and accessing care (Beckford and Gilliat 1996: 263; Orchard 2000: 45; Gilliat-Ray *et al.* 2013: 80-81; 87-88). Cadge and Sigalow note that Muslim and Jewish chaplains code-switch to render their roles intelligible to members of their own faith communities, and to assuage any concerns members of their faith community may have about what chaplaincy is (2013: 155), suggesting that awareness about chaplaincy among Muslim and Jewish communities about chaplaincy is low.

2.5.8 Access to Resources

Beckford and Gilliat (1996: 278) and Orchard (2000: 61) note that levels of access to resources – such as chaplaincy offices, patient records and facilities for communication – indicate degrees of inclusion or exclusion within chaplaincy teams. Soon after Beckford and Gilliat's study, the implementation of the 1998 Data Protection Act restricted chaplains' access to patient records. This disproportionately affected both Roman Catholic chaplains and minority faith groups, who tended to visit in accordance with religious declaration, but had a limited impact on the referral-led working practices of Anglican chaplains (Swift 2014: 58; Welford 2011: 131). Proactive approaches to patient visiting (Orchard 2000: 74; SYWDC 2005: 4; Allan and Macritchie 2007; Swinton and Mowat 2007: 37-38; Gilliat-Ray *et al.* 2013: 83) mitigate the worst effects of Data Protection for Anglican and Free Church chaplains, allowing chaplains to visit patients who otherwise would not request a visit. However, there has been no empirical account of how data protection laws impact minority faith chaplains on the ground.

2.5.9 Professional Recognition

Despite the introduction of a voluntary register, the development of criteria for CPD, and better integration into the NHS pay system for on-call and out-of-hours working (Swift 2013: 251; Welford 2011: 91), professionalisation omits the significant proportion of minority faith chaplains or volunteers who work in an unpaid capacity and do not have the resources for CPD. A strongly demarcated boundary between

professional and volunteer excludes voluntary minority faith representatives from the possibility of developing as professionals and raises questions about whether minority faith volunteers can ever be referred to as 'chaplain' proper (De Vries *et al*. 2008: 25). The steps taken towards professionalisation that disadvantage minority faiths in chaplaincy may be linked to staking a claim as a profession. Professionalisation is not necessarily a case of competing with other professions, but also intra-professional competition (Woodward 1998; Galashan 2015: 113).

De Vries *et al*. note that 'if chaplains wish to be recognised as health professionals, they need to be able to describe…what constitutes 'quality' in their area of patient care' (2008: 24). These articulations of 'quality' are evident in the growth of professional journals, such as the JHSCC, and articles reflecting on the status of hospital chaplains. These articles are usually authored by Christian chaplains. Published material from minority faith groups is exceedingly rare, which means that minority faith approaches and understandings of chaplaincy do not inform the field. As Galashan notes, 'one of the major problems of having the future of chaplaincy debated only by the current stakeholders is the risk that the interests of minorities are not being represented' (2015: 109).

2.6   CONCLUSIONS

This literature review has identified a significant gap in the healthcare chaplaincy knowledge base concerning the involvement of minority faith groups in healthcare chaplaincy. While the work of Muslim chaplains can help illuminate minority faith involvement in chaplaincy generally (Gilliat-Ray *et al*. 2013; Pattison 2015) this cannot be taken as a substitute for empirical work across different faith groups. The lack of minority faith voices in the British knowledge base raises questions as to how far minority faiths are integrated into the national chaplaincy scene and why well-known Muslim chaplains are still largely absent from mainstream chaplaincy discourse (Gilliat-Ray *et al*. 2013: 69).

This chapter has provided the groundwork for the primary research questions. This review has outlined the policy rationale behind accommodating and providing for the religious and spiritual needs of minority faith groups, and raised some of the key

tensions concerning this provision, including who can provide such care and the models through which such care is facilitated. Beckford and Gilliat (1996) and Orchard (2000) provide comprehensive accounts of brokerage model, although there is no further empirical exploration of contemporary chaplaincy models, except for Gilliat-Ray's acknowledgement of the increasingly formalised employment of Muslim chaplains, and – in some cases – their increasing seniority (2008). I contend that different models and arrangements have a significant impact on the successful involvement and integration of minority faith groups into healthcare chaplaincy. The first question arising is 'how do NHS Trusts provide for the spiritual and religious needs of minority faith communities?'

The alleged lack of precedent for chaplaincy or pastoral care is cited as a major challenge for minority faiths, especially in relation to nomenclature and the division of labour within these faith communities. Is there a separate domain of pastoral care and who is responsible for it? Gilliat-Ray has noted a shift where imams, rather than community leaders, have been employed by chaplaincies (2008: 146), raising the question of whether chaplains transpose their religious leadership role or tailor a new role (Orchard 2000: 93). I intend to explore the role of minority faith chaplains, whether these roles differ from community-based religious leadership, and how this relates to the expectations of their Christian chaplaincy colleagues. The second research question is 'how do minority faith representatives/chaplains understand their role and work in a secular institution?'

Where minority faith groups have been discussed in the literature, only Beckford and Gilliat (1996) and Orchard (2000) offer empirical insights into their inclusion or exclusion from chaplaincy teams, although these accounts precede the large-scale formalisation of minority faith roles. I aim to examine how far the formalisation of chaplaincy roles has contributed to a greater inclusion of minority faith groups in the profession by exploring the perspectives of Christian and minority faith chaplaincy representatives alike. Are minority faith chaplains progressing to positions of seniority, as envisaged by the *Caring for the Spirit* guidelines (SYWDC 2003), or have Christian chaplains retained a monopoly on chaplaincy provision? The focus of this thesis on integration as a two-way process is more a direct successor to Beckford and Gilliat (1996) and Orchard's (2000) work rather than Gilliat-Ray *et al*. (2013).

The final research question is 'to what extent are minority faith and non-religious belief groups integrated into chaplaincy teams and the wider chaplaincy profession?'

The introduction and literature review have questioned where minority faith chaplains fit within the narratives of chaplaincy practitioners. Practitioner outputs offer little insight into the understandings, role, and status of minority faith chaplains, and such a focus has been primarily the preserve of academic researchers. In this sense, I propose mapping the findings of this study onto the existing chaplaincy narrative to establish where minority faith chaplains fit into the wider professional discourse, but also where minority faith involvement might *challenge* the discourse. With these questions and considerations in mind, the next chapter outlines the research design for this study.

3 Methodology

Since Wilson (1971) conducted the first empirical study of British healthcare chaplaincy, qualitative studies have traced the rapidly changing nature of chaplaincy. Yet there still exists a lacuna where the experiences of minority faith groups – including Baha'is, Buddhists, Hindus, Jains, Jews, Sikhs, and to a lesser degree Muslims – remains undocumented. This chapter will outline the theoretical underpinnings of the thesis and the research design devised to address this gap. The following discussion of methodology and research methods will review methodological gaps in the existing literature; construct an appropriate theoretical framework; outline the research design; reflect on the question of access before and during the fieldwork period; and outline the process of data analysis. To conclude, I will offer a brief account of a placement undertaken with NHS England to engage in knowledge exchange concerning the provision of spiritual care, followed by a reflection on the methodological challenges of the research.

3.1 METHODOLOGICAL GAPS IN THE HEALTHCARE CHAPLAINCY LITERATURE

Significant methodological gaps in the chaplaincy literature include the paucity of contributions by non-practitioners and the dearth of studies examining healthcare chaplaincy teams, rather than chaplains as individuals. The latter is evidenced by the dominance of interviews as the primary data collection method (Woodward 1998; Wright 2001; Swinton and Mowat 2007; Welford 2011; Kyriakides-Yeldham 2017), with few studies adopting observational techniques (Beckford and Gilliat 1996; Orchard 2000; Swift 2014; and Gilliat-Ray *et al.* 2013), and fewer still focusing on chaplaincy *teams* (Beckford and Gilliat 1996; Orchard 2000). While Swift (2004, 2014) and Fitchett and Nolan (2015) use case studies, these cases are bound to individual chaplains and patients. The tendency to focus on individual chaplains reflects an outdated perception of chaplaincy as the work of a single religious functionary, instead of chaplaincy as a collegial profession (Swift 2014: 3).

3.2   RESEARCH QUESTIONS

Three research questions were identified in the literature review: how do NHS trusts provide for the spiritual and religious needs of minority faith communities? How do minority faith representatives understand their role and work in a secular institution? And to what extent are minority faith and non-religious belief groups integrated into chaplaincy teams and the wider chaplaincy profession?

The research questions are concerned with the negotiation of minority faith involvement in healthcare chaplaincy from three perspectives. Firstly, I am interested in the practical implications of 'official' discourses around minority faith involvement in chaplaincy. For example, the 2003 guidelines envisage a qualified, competent, and diverse chaplaincy workforce (SYWDC 2003), yet the recent push towards professionalisation appears to have isolated rather than incorporated minority faith groups, especially in relation to endorsement and professional registration (Galashan 2015: 109). Secondly, an examination of minority faith involvement in chaplaincy requires consideration of how access to chaplaincy teams locally and representative bodies nationally is achieved. Beckford and Gilliat (1996) and Orchard (2000) refer to the extent of participation in chaplaincy teams, but little reference is made to chaplaincy organisations such as the CHCC (although Gilliat-Ray *et al.* refer to the 'lack of Muslim engagement in mainstream chaplaincy discourse' [2013: 69]). Thirdly, 'integration' is considered to be a two-way process of accommodations made by 'incumbents' (Christian chaplains) and adaptations made by 'newcomers' (minority faith and non-religious representatives). While the integration of minorities is usually conceptualised in terms of 'guest-host' relations, such a dichotomy is unhelpful because it allows 'cultural majorities a sense of exclusive ownership of the social order to which they are not entitled, and treat minorities as temporary, aberrant and excluded from the pool of possible owners' (Levy 2010: 69). Instead, the 'incumbent-newcomer' dichotomy has been taken from literature on organisational socialisation (Van Maanen and Schein 1978; Ashford and Nurmohamed 2012: 17; Chao 2012) to mitigate such power disparities. To examine these aspects, it is necessary to engage with the perspectives of minority faith and Christian chaplaincy representatives.

3.3 THEORETICAL FRAMEWORKS

3.3.1 Qualitative or Quantitative?

Much of the chaplaincy literature is concerned with how quantitative methods may be used to measure the efficacy and outcomes of chaplaincy, with several commentators noting that chaplains have difficulty orienting themselves towards 'outcomes' rather than 'processes' (Lyndes *et al.* 2012: 89; Woodward 1998; Wilson 1971; Mowat 2008). Questions relating to 'outcomes', 'impact' and 'efficiency' are not the primary concerns of this project. Instead, the question of 'integration' is concerned with the negotiations involved in minority faith groups being able to provide care. Such negotiations point to the 'economy of power relations in chaplaincy' (Gilliat-Ray et al. 2013: 62), which may involve an 'exploration of "legitimate boundaries", with disputes surrounding professional authority, and claims concerning authority, education, tradition and prior experience' (Atkinson 2017: 50).

The distribution and content analysis of questionnaires was considered as a possible data collection route, following three key studies which provide quantitative data on minority faith involvement in chaplaincy (Beckford and Gilliat 1996; Orchard 2001a; Sheikh *et al.* 2004). For Beckford and Gilliat (1996) and Orchard (2000), questionnaire methods were supplemented with observations of chaplaincy teams. The patchy response rate from visiting ministers highlighted the limitations of survey-based research design (Beckford and Gilliat 1996: 315-316, 505). The ability to capture the perspectives of minority faith representatives was a key concern, and the use of questionnaires could militate against this. Many minority faith groups tend to be involved in chaplaincy on a voluntary or sessional basis, which means their availability is more limited than their part-time or full-time colleagues. This method was also considered to be inappropriate and unhelpful as chaplains continue to receive Freedom of Information (FOI) requests from secularist campaigners. My concerns about potential 'survey fatigue' amongst chaplains were substantiated when conducting the mapping exercise, discussed later in this chapter.

Conversely, the use of qualitative techniques assists with issues surrounding access and participant recruitment, where the general availability of the researcher and the ability to create personal relationships with participants, especially volunteers, would be more effective for participant recruitment than the impersonal distribution of

questionnaires. Qualitative, ethnographic methods aim to represent phenomena fully in their everyday context, including the social meanings attributed to them, and focus on the subjective perspectives of participants (Flick 2014: 15-16). A further rationale for qualitative methods will be outlined in the section on research design.

3.3.2   Constructing Chaplaincy

In the introduction, I demonstrated that concepts often linked to chaplaincy, such as 'spirituality' (Pattison 2001; Gilliat-Ray 2003; Paley 2007; Pesut et al. 2009), 'religion' (Beckford 2003) and 'secularity' (Beckford 2003; Todd 2015b), are highly contested. So far, I have highlighted the ways in which chaplaincy has been constructed by the NHS (through policy and guidelines) and chaplains themselves (through practitioner literature and the development of the field of 'chaplaincy studies'). However, the practitioner literature has been predominantly produced by influential Christian chaplains, who have constructed an official understanding of chaplaincy with little or no reference to the understandings of minority faith chaplaincy representatives. With this in mind, this thesis is situated within a social constructionist framework. Following Shutz (1962), Berger and Luckmann (1967), and Gergen (1985, 1999), social constructionism 'inquires after social conventions, perception, and knowledge in everyday life' (Flick 2014: 76), where social reality is not taken as a given, but is instead 'socially mediated and historically situated' (Parker 1998: 1). A social constructionist approach can help 'destabilise and overcome processes of ethnic and religious othering and marginalisation' (Khawaja and Mørck 2009: 30) which are implicit in 'normative' or 'dominant' discourses. Dominant taken-for-granted chaplaincy discourses arising in conjunction with the secular sacralities of the NHS can be interrogated, potentially exposing hidden power relations and removing any veneer of 'objectivity' or 'neutrality'. While all knowledge is situated, 'not all standpoints are equally useful ones for understanding order and inequality' (Ezzy 2002: 22), and listening to the voices of minority faith representatives in chaplaincy can provide 'ways of thinking which dominant groups have a vested interest in suppressing' (New 1998: 360). Swift affirms that exploring this aspect of chaplaincy could uncover 'stories…of exclusion, paternalism, and normalisation that demand further research' (Swift 2004: 226).

Critics suggest that the relativism of the constructionist paradigm risks 'debunking' itself if it is deemed to be an objective account of reality (Berger 1990: 47; Gill 2012:

105-106). Gill notes that such accusations do not hold when constructionism (or relativism) is used as an epistemological and methodological tool rather than an ontological position (ibid.). A constructionist account therefore considers the narrative produced by the researcher to be a construction, albeit one produced in collaboration with the participants (Flick 2014: 483-484). A constructionist account of a phenomenon must necessarily be reflexive.

3.3.3 How Theory is Used

A positivistic approach to theory which sets out to prove or disprove a hypothesis is rejected. Instead, theory sets the research agenda by defining the problem and how it should be conceptualised (Jupp and Norris 1993: 39) and is used as a 'sensitising' tool for designing and conducting the research (Ezzy 2002). 'Sensitising concepts' assist with data analysis, although these are treated as 'approximate conceptions' that are 'rough and always provisional guides to a changing and complex reality' (Willis 2013: xi; see also Blumer 1954; Flick 2014: 373; Atkinson 2017: 6-7). This approach to theory is echoed by Bourdieu's insistence that he offers not a grand theory, but a 'set of thinking tools' as a 'temporary construct which takes shape for and by empirical work' (Wacquant 1989: 50, cited in Jenkins 2002: 67). These sensitising concepts will be introduced in chapter five.

3.4 OVERVIEW OF RESEARCH DESIGN

A multi-site case study design was developed in order to capture the fragmentary provision of chaplaincy services arising from localised variations in policy implementation (Orchard 2000; Gatrad, Sadiq, and Sheikh 2003; Welford 2011). Case studies provide an opportunity to examine chaplaincies as whole teams, rather than chaplains as individuals, and to contextualise chaplaincy teams in their institutional settings. The case study approach also intended to maximise access to minority faith chaplaincy representatives involved in a voluntary or irregular capacity. Data collection methods used in each case study included participant observation, shadowing, and interviews.

3.4.1 Multi-Site Ethnographic Case Studies: Contextualising Chaplaincy

Focusing on 'integration' indicates a concern with the relational aspects of minority faith involvement in healthcare chaplaincy. This is best achieved through a research

design that explores the everyday practices and interactions of healthcare chaplains, however mundane (Certeau 1988: xi), and the relationships between chaplaincy team members. Explorations of team dynamic require the use of observational techniques to collect data about the daily activities of and relationships within the team. An ethnographic approach enables immersion in the field, which generates data in ways which could not be achieved through surveys and interviews alone (Gilliat-Ray 2011: 478). Reliance on these methods decontextualises individual participants (May 2001: 143) and depends on participants' accounts of what they do (Mitchell 2007: 56) instead of observing how these participants interact and relate to one another.

It is difficult to obtain a single definition of 'case study' (Ragin and Becker 1992; Stark and Torrance 2004; Platt 2007). For this thesis, a composite definition sets out a case study as the demarcation of boundaries around places and/or time periods to define a phenomenon that is the subject of in-depth inquiry. The scope of these cases can vary, from individual to national (Ragin and Becker 1992: 2). The 'case study' is committed to producing rich and contextual data (Platt 2007: 111; Flyvbjerg 2011: 301), utilises 'information oriented' sampling criteria, and rejects the use of representative, random, stratified, or probabilistic samples in order to generalise to populations or avoid systematic bias (Flyvbjerg 2011: 304; Silverman 2013: 143-145; Stark and Torrance 2004). Case studies, unlike probabilistic statistical research, 'avoid methodological individualism…which misleadingly treats individuals as independent and equal' and conceals power disparities (Platt 2007: 103, citing Feagin, Orum, and Sjoberg 1991: 273-274). A constructionist approach to case study holds that '"social reality" is created through social interaction, albeit situated in particular contexts and histories', often emphasising detailed descriptions which emphasise particularity rather than theory confirmation or generation (Stark and Torrance 2004: 33; Platt 2007: 109). However, case studies can still explore and interrogate theory (Flyvbjerg 2011; Silverman 2013: 142; Platt 2007: 114) and potentially challenge normalised, dominant or official accounts of chaplaincy that have tended to ignore the perspectives of minority faith representatives.

Conducting a single case study risks producing highly particularised findings. The piecemeal and highly variable nature of spiritual and religious care provision across England and Wales (Orchard 2000; Welford 2011) necessitated conducting multiple case studies to capture the various ways minority faith groups are involved in

healthcare chaplaincy. The case studies will not provide a generalisable picture of hospital chaplaincies across England, but may provide some instructive findings that may 'resonate' with other chaplaincy teams (Silverman 2013: 143), whereby readers might recognise aspects of their own experience and intuitively generalise to their own context (Stark and Torrance 2006: 34). In naturalistic qualitative enquiry, the researcher contributes *working* hypotheses which can only be verified empirically between contexts (Lincoln and Guba 1985: 316). Emphasis is therefore placed on the *transferability* rather than *generalisability* of research findings (Flyvbjerg 2011: 305).

3.4.2 What Constitutes a Case Study?

Hospital Trusts are usually served by one chaplaincy team, although the number of hospitals *within* Trusts varied. Some chaplaincy teams may operate across more than one hospital. Cases focused on Trust-wide chaplaincy teams, and accounted for potential coverage of more than one hospital site. One case is an exception, in which two chaplaincy teams served one Trust. This case demonstrates how different models continue to persist under the umbrella of one organisation.

3.4.3 Sampling Methods

This study used purposive sampling methods which use substantive criteria for case selection (Bryman 2012: 418; 419; Flyvbjerg 2011; Flick 2014: 175). Due to the disparate nature of chaplaincy provision, it was difficult to tell what constituted a 'typical' or 'critical' case. Instead, I opted for 'maximum variation' sampling in order to obtain the broadest possible picture of chaplaincy by choosing sites which exemplified a range of working practices (Patton 2001; Flyvbjerg 2006: 230; Platt 2007: 114; Seawright and Gerring 2008).

The primary criterion for site selection was service model. Service models give an overview of the structure, staffing, facilities, responsibility portfolio, and client groups (Orchard 2000: 14). This incorporated paid (full-time, part-time, sessional, bank) and voluntary (honorary, chaplaincy volunteer, community contact) involvement.[13] However, a geographical and demographic element was introduced to

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[13] Sessional work refers to chaplains that work a limited, specified number of 'sessions' (units of 3.5 hours) per week. Honorary chaplains are employed by the hospital, but are not paid for their work;

avoid clustering or concentrating case studies around a particular locations such as London and Birmingham, both known for their superdiversity (Vertovec 2007; Stringer 2014). Service models were cross-referenced with the religious demography of the locality based on census data (Office of National Statistics 2012). There are significant limitations to relying on local demography, not least because inpatient populations do not necessarily match local demographics, especially if the hospital has a particular specialism (Flatt 2015: 39). However, due to limited access to accurate information about inpatient religious demographics, local demography is used as a proxy measure for inpatient demographics. Other secondary criteria included size/type of hospital (general, specialist, district, teaching) and facilities provided for religious observance (i.e. chapels, prayer rooms). A tabulated overview of how the criteria apply to the sites selected is shown in 'Case Selection'.

3.4.4   The Chaplaincy Directory

In the first year of the project, a directory was compiled to map NHS provision of chaplaincy across England and Wales. There were two key limitations to this mapping project. Firstly, minority faith group involvement in chaplaincy tends to be voluntary, resulting in a high turnover of minority faith representatives, rendering it difficult to accurately quantify how many minority faith representatives are involved in chaplaincy. Secondly, the regular reorganisation of Trusts contributes to significant changes in the composition of teams as Trusts merge (Haigh 2000; Fulop *et al.* 2002; Cortvriend 2004). This mapping exercise provided a general overview of chaplaincy provision to inform decisions about case selection, rather than to provide accurate quantitative data about sessions allocated to minority faith involvement in chaplaincy.

Initially data were collected from Trust websites and added to an Excel spreadsheet. A total of 156 acute Trusts were identified. Initially I had erroneously assumed that all Trust websites would have information about chaplaincy teams, and soon discovered that information provided was piecemeal. Some websites had descriptions of the role of the chaplain and a full list of team members complete with photographs, while others simply directed the reader to call the hospital switchboard.

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they may be given more responsibilities than a volunteer. Bank chaplains are employed by the hospital but are more likely to work ad hoc hours.

Out of 156 Trusts, fifty-seven had scant or no information about the chaplaincy team members. These fifty-seven chaplaincy teams were contacted to request further information. Six Trusts either had no chaplaincy team or had recently merged with another Trust, and enquiries at four Trusts were unsuccessful. While I considered using FOI requests, I was conscious these would not be welcomed by chaplaincy teams, particularly after the profusion of FOIs from secularist campaigners (as well as the BBC and Theos think tank). Instead I obtained the information through informal phone/email surveys conducted between January and March 2015.

The follow-up process for completing the chaplaincy directory proved to be unexpectedly rich for gathering data. Some lead chaplains commented that an FOI had been sent to them requesting similar information and asked where the request had come from. I discovered that the then Faiths Co-ordinator at the CHCC had sent the FOI to find out more about current chaplaincy provision, and that chaplains were expecting a renewed campaign from the NSS at the time I was making enquiries (personal communication, lead chaplain, 16/02/2015). Some chaplains were understandably cautious about the motivations behind the enquiries, although these concerns were alleviated when I explained who my supervisors were. Conducting a phone survey allowed chaplains to clarify what was being asked and make comments that might not have been articulated in response to an FOI request. Unfortunately, dated fieldnotes were not made during this part of the study, and it is not possible to offer citations for the information gathered. A key issue arising, however, was that chaplains tended to give either Whole Time Equivalents (WTE) or numbers/contracts for their colleagues, which meant some units of data were not consistent.

3.4.5 Case Selection

Cases were selected through a shortlisting process. Firstly, I excluded chaplaincy teams who had not responded to my enquiries within my timeframe, as these chaplaincies were also likely to be unresponsive to further enquiries. I also excluded chaplaincies that had responded but whose discomfort with the research made rapport-building difficult. Secondly, I separated out chaplaincies who involved minority faith personnel from those whose multi-faith provision relied on calling in external contacts. Chaplaincies in the latter category were set to one side, but the possibility of selecting a case from this cohort was considered in order to provide a critical contrast. Eventually, one case from this cohort was chosen because the lead

chaplain had offered an openly dissenting view about multi-faith developments in chaplaincy during the phone survey (potentially a 'deviant' or 'atypical' case).

Focusing on service models left a considerable number of teams who regularly involved minority faith personnel, so subsidiary criteria informed the shortlist. Trust chaplaincies with minority faith personnel were organised by geographical region, and the service model was cross-referenced with local demography. A handful of chaplaincy teams were shortlisted for each region. Demography was also reviewed to account for the varying forms of religious diversity, such as whether a single religious minority was concentrated in one area, or whether an area was 'superdiverse' (Vertovec 2007), where most or all religious minorities were statistically above average. The shortlisting process provided some flexibility in the event of difficulties with access. A total of ten chaplaincy teams were approached, with six allowing access (two teams formed one case). The tables below provide an overview of the cases selected:

Table 1: Cases Selected – Demographic and Background Information

The first row under demography shows national percentages for each religion in England.

Trust/Hospital Name		Type of hospital	Specialism (if applicable)	Religious demographic (percentage) based on 2011 Census								
				Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	No religion	Not stated
				59.4	**0.5**	**1.5**	**0.5**	**5**	**0.8**	**0.4**	**24.7**	**7.2**
Fairbank: Riverside		District general	Gastrointestinal	37.3	1.1	25.3	4.4	12.5	1.2	2.5	9.6	6.2
Fairbank: Northbrook		District general	N/A	43.7	1.2	8.5	0.3	15.7	7.9	0.6	15.0	6.9
Westview		General	Neonatal	47.4	0.3	3.3	0.2	24.6	1.2	0.4	16.5	6.1
Greenacre	Woodford Green	Teaching	N/A	32.4	0.4	15.2	0.1	18.6	4.4	0.6	22.8	5.6
	White Oak	General	Brain Injury									
	Birchsprings	Specialist	Cardiology, respiratory									
Stonehaven	Flaxheath	General (community care, recovery and rehabilitation)	N/A	45.9	0.2	0.9	0.1	24.7	1.0	0.3	20.7	6.2
	Thatch End	Teaching	Neonatal									
Moorlands		District general	N/A	62.3	0.3	0.2	0.1	0.5	0.1	0.3	28.9	7.3

Table 2: Cases Selected – Chaplaincy Teams and Facilities

Based on the chaplaincy directory.

Trust/Hospital Name		Service Model for Minority Faith Involvement	Regular multi-faith volunteer base?	Facilities	Non-Regular Input
Fairbank: Riverside		Sessional	Yes - Hindu, Muslim, Jewish	Chapel; multi-faith prayer room	Chaplaincy has produced directory of local places of worship and faith groups. Links with Jain and Zoroastrian representatives.
Fairbank: Northbrook		Bank/honorary	Yes - Sikh	Multi-faith prayer facility (chapel, prayer room, meeting room)	Buddhist volunteer at other site available to visit; external contact list includes Baha'i, Jain, Quakers, Jehovah's Witnesses, Baptist, Methodist
Westview		Regular volunteers	Yes - Muslim and non-religious	Chapel, prayer room	Irregular visits from Hindu volunteer; Jewish support available as necessary; list of community contacts
Greenacre	Woodford Green	Part-time and regular volunteers	Yes - Muslim, Hindu, Sikh, Baha'i, Jewish, Buddhist	Chapel, male and female Muslim prayer rooms/ablution facilities, Sikh/Hindu prayer room	Emergency and confidential contact list (usually to cover for unavailable chaplains)
	White Oak			Chapel, prayer room, quiet room	
	Birchsprings			Chapel, prayer room	
Stonehaven	Flaxheath	Full-time, part-time, and sessional	Yes - Muslim, Hindu, Baha'i, non-religious	Multi-faith place of worship including chapel	Contact list of Roman Catholic chaplains; database of external contacts.
	Thatch End			Chapel, Muslim prayer facilities (separate male and female)	
Moorlands		External contacts	No	Chapel, multi-faith prayer room	External faith representatives: Buddhist; Hindu; Humanist; Jain; Jewish; Pagan; Sikh; Jehovah's Witnesses, Latter Day Saints; Christadelphian and Christian Scientist

3.4.6 Participant Observation and Shadowing

Participant observation 'breaks down the barriers between observer and participant' and places the researcher 'at the mercy of the participants' (Burawoy 1991: 291). Consequently, the authorial voice of the researcher is not privileged as an external rational observer of a research 'object', but instead forms collaborative and dialogic relationships with research participants (ibid.). A dialogical approach helps to address issues of inevitable observer bias where the 'distinctive interpersonal dynamic of one-on-one shadowing' repositions the researcher as 'observed participant' (Gilliat-Ray 2011: 470-471).

While participant observation can involve observing numerous actors in the research setting, shadowing focuses on 'the daily practice of a single individual, living and working within a complex institutional social setting' (Gilliat-Ray 2011: 470). Literature on shadowing is sparse, although Gilliat-Ray notes that shadowing originally had a positivist underpinning, which has given way to an interpretative orientation where 'accounts of conversations, explanations, body language, mood, and expression are understood against the organisational setting in which they are situated' (Gilliat-Ray 2011: 470-471). All chaplaincy team members were involved in the participant observation, while minority faith chaplains and volunteers were the focus of the shadowing.

My positioning during the participant observation component of the research was primarily confined to the spaces demarcated for chaplaincy purposes – such as chaplaincy offices – with an interest in verbal and non-verbal interactions taking place within these spaces involving all chaplaincy team members. The primary exceptions were attendance at institutional meetings (such as Equality and Diversity and Patient Experience committees), and volunteer training events. The shadowing element involved following an individual chaplaincy representative wherever they happened to go. It was not as apparent to patients, staff, and visitors that I was present in my capacity as a researcher except when I was explicitly introduced as such.

I established my research role as the 'minimally participating observer' (Bryman 2012: 441-444), in which I would assist when I could, but would not otherwise undertake chaplaincy work myself, as this would normally require a significant period of training. Gilliat-Ray notes that while it is 'inappropriate or impossible to take on a kind of active membership role' the researcher has an active role in the 'mutual creation and production of a new, if short-term relationship' (2011: 472). Other roles materialised when it became clear that I could make myself useful to chaplaincy teams. Simply opening the door to a distressed visitor led to my facilitating a meeting with the Anglican chaplain (fieldnotes, Riverside, 09/10/2015). I also became a confidant for another participant, who disclosed sensitive personal information which they had not shared with other team members (fieldnotes, 21-07-2015). I suspected this was because of my independent and temporary presence on site. My role resembled the chaplains' role, by providing a confidential, non-judgemental, and temporary space for personal disclosure (Gilliat-Ray 2011: 471).

While literature on participant observation claims that 'everyday performance' is being observed (Lüders 2004), my presence undoubtedly disturbed the dynamic of interactions I was observing, especially as 'patients have an expectation that spiritual care is not generally observed' (Swift 2004: 67). Sometimes patients or visitors 'broke the fourth wall' and engaged with me instead of the chaplaincy representative being shadowed. However, Gilliat-Ray argues that the researcher should not expect to uncover the daily routines of the individuals being observed, and that potential alterations of behaviour are an advantage of shadowing. Shadowing provides the

opportunity to 'see, hear…and experience the implications and the cumulative outcomes of several years of work' (Gilliat-Ray 2011: 20), which may be specially curated by the chaplaincy representative observed.

Participants often had unspoken assumptions about what I expected to observe, demonstrated when they prioritised intense over against routine encounters. This was evident when a Sikh chaplain decided to visit the ICU first in order to 'throw you in the deep end so you get a real spectrum' (fieldnotes, Greenacre, 14/04/2016); the encounter that followed demonstrated how his skills and experience were deployed to comfort a distressed patient. Occasionally, chaplains were apologetic when an opportunity was missed, exemplified when a Muslim chaplain exclaimed 'you could have seen a Muslim death!' after a 'non-urgent' referral transpired to be an urgent end of life situation (fieldnotes, Stonehaven, 29/06/2016). The use of shadowing as a training method by all the chaplaincy teams also impacted participant expectations of what shadowing involved. Shadowing as a training method focused solely on ward activity or patient interaction, rather than accompanied observations from the moment representatives 'clock in' to the moment they 'clock out'.

3.4.7   Interviews

Interviews provided an opportunity to ask for explanations of issues and events raised by the fieldwork, and to discuss particular issues in depth. While the formal interview tells the researcher 'little about a reality that is "external" to the interview' (May 2001: 143), interviews help to explore the perspectives and experiences of participants and how these correspond and conflict with discourses arising in practice. This approach to interviewing is grounded in a constructionist framework where the interview is considered to be a 'co-authored conversation in context' (Poland 1995: 292, see also Lapadat and Lindsay 1999: 75).

Two types of interview were conducted. Firstly, informal and unstructured questions were asked while observing and shadowing, constituting 'a hybrid of interviewing and participant observation' (Jones *et al.* 2008; Gilliat-Ray 2010a: 422). These interviews sought explanations or clarifications of chaplaincy representatives' activities and helped with preparations for semi-structured interviews. Secondly, semi-structured interviews provided the opportunity to explore the perspectives of the chaplaincy team and related stakeholders in relation to the involvement of

minority faith groups in chaplaincy. Conducting the observations before the interviews was helpful for building trust and rapport with the participants and identified further avenues of enquiry. Semi-structured interviews used a standardised set of questions across sites, but also incorporated site- and person-specific questions (see Appendices 9-11).

A total of 105 interviews were conducted with chaplaincy team members and stakeholders. The primary priority was interviewing minority faith chaplaincy team members. Earlier theoretical considerations highlighted the importance of foregrounding minority faith voices, but exploring integration as a two-way process necessitates the inclusion of voices of Christian colleagues and also stakeholders. Some interviews were conducted in two or three parts to accommodate the participants' working commitments. The longest interview lasted four hours and thirty-eight minutes. I was surprised by the generosity of many of the chaplains who were willing to dedicate over an hour to being interviewed. In contrast, interviews with stakeholders and volunteers often lasted between twenty and forty-five minutes, although some Muslim volunteers were the exception to this rule, with one volunteer interview lasting three and a half hours (see Appendix 8).

All interviews were recorded on an encrypted digital audio recording device. To ensure good quality audio recordings (Poland 1995: 305) and privacy for participants, interviews were located in private quiet rooms, unused chaplaincy offices, or bereavement support rooms. Most interviews were clearly recorded, although on one occasion the chaplain was sat too far from the microphone. On two occasions the recording device stopped recording due to lack of memory, although this was discovered quickly, and very little data was lost. On two occasions, however, the recording device malfunctioned, which required me to make notes for one interview. However, the second malfunction was not made apparent until the recording was uploaded, and segments of the interview were missing. The interview transcript was supplemented by fieldnotes.

Conducting interviews after observations occasionally proved to be an uncomfortable experience, where sensitive questions were asked based on what participants had reported in casual conversations, particularly when prejudices regarding Muslims were expressed. Unflattering comments made during observations about particular

chaplains needed to be cast into sensitive interview questions that were put to the chaplain in question. A key aspect of these considerations was that these sensitive issues were 'on the record', although a handful of participants took advantage of the offer to pause the recording. Interestingly participants had different understandings of the extent to which an interview could be manipulated or steered. One participant, who had otherwise been open and verbose in the observations was reluctant to be interviewed. During observations, he had set the agenda for our casual conversations, often covering controversial topics on gender and extremism, but appeared to be reluctant for my own topics of discussion to guide a recorded interview. In contrast, another chaplain attempted to steer the interview through allusions to 'sensitive' information by giving the impression of reluctance to disclose which seemed more like an invitation to probe.

3.5 ENTERING AND INHABITING THE FIELD

Ethnographic research raises several practical issues, including the need to negotiate access to institutions (Gilliat-Ray 2007; Cadge 2012; Gilliat-Ray 2011: 471); recording, processing, and managing large amounts of data generated from extensive fieldnotes; the physical, mental and emotional exhaustion of constant interaction; and careful consideration of self-presentation (Gilliat-Ray 2011: 471; see also Coffey 1999). Additionally, the fieldwork required me to move to new and unfamiliar locations every two or three months, uprooting me from my usual support networks. This section will examine how these issues were negotiated on entering and inhabiting the field.

Before commencing the fieldwork, I was conscious that I would be living a relatively nomadic lifestyle, and entering a research setting where I was likely to observe emotionally charged crisis events. I took steps to ensure that my emotional wellbeing was supported (Rager 2005; Dickson-Swift *et al.* 2007: 345-346), including setting up telephone support with the University Counselling and Wellbeing service ahead of the fieldwork. Ongoing supervisory meetings provided opportunities for debriefing. My fieldnotes also recorded my emotional responses (usually as close to real time as possible, in the main body of fieldnotes) which were, where possible, written up the same day. I ensured that I took weekends off, although there were two

exceptions when Muslim volunteers were shadowed on a Sunday.[14] I also ensured there was at least one week's break in between the previous case finishing and the next case starting to readjust to the displacement involved in moving to a new location.

3.5.1   Accessing the NHS

Accessing the NHS to conduct research requires negotiating institutional ethical review procedures, in addition to liaising with the chaplaincy teams being studied. Access is usually achieved by applying to NHS Research Ethics Committees (RECs), either via full review or proportionate review if 'no material issues' are raised by the research design (National Patient Safety Agency 2010: 8). A 'service evaluation' was an alternative to these routes. Relevant research documentation was prepared for all possible pathways, including a research proposal, a participant information sheet, a consent form, and a patient information letter (see Appendices 3-7). Approval for the study was also obtained from the School of History, Archaeology, and Religion Research Ethics Committee (see Appendix 2).

I chose the service evaluation route following previous experience of applying for approvals through RECs, when it became clear the process was unwieldy and unsuited for qualitative research design (see also Pearce 2002). The service evaluation route was justified on the grounds that data produced from one case study was not generalisable and that data collection methods did not involve interventions in patient treatment (Health Research Authority 2013). Additionally, as part of conducting a service evaluation, producing a report for the chaplaincy and the Trust provides a mechanism for participant feedback on the findings of the study (see Ezzy 2002). All participating Trusts approved classification of this project as a service evaluation.

Ten chaplaincy teams were approached to participate, and access was successfully negotiated with six teams. A pilot study was arranged by approaching the chaplaincy manager of the first site with the project proposal. Following initial agreement to participate from the chaplaincy manager, the R&D department classified the study as

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[14] Weekends were usually avoided as the only chaplaincy team members who routinely worked weekends tended to be those involved in the Sunday service.

a service evaluation, providing a precedent for other R&D departments. Following this decision, all references to 'research' were removed from the study paperwork. Unfortunately, this case was abandoned after the managing chaplain expressed reservations that the 'service evaluation' was unnecessary on the grounds that the team already self-audited. Access to two other chaplaincy teams was unsuccessful due to the circumstances of the team. Contact was lost with the first of these teams after the lead chaplain left post. The other chaplaincy team felt that they were unable to commit the time to support the research (fieldnotes, 18/08/2015). Only one case study was unsuccessful due to unproductive negotiations with the R&D department, who had advised that the project underwent full REC review. The expectation that informed written consent from patients should be sought in advance to observe patient encounters was unfeasible. This alerted me to the highly arbitrary judgements made by individual R&D officers, with some R&D departments waving through the project with few questions and amendments, while the R&D department mentioned above appeared to be obstructing the project. Issues with inconsistent protocols of R&D departments for multi-site studies have been noted elsewhere (Sandy *et al.* 2011: 60).

Hammersley and Atkinson note the issues arising from the researcher being perceived as both 'expert' and 'critic' which may be welcomed by stakeholders, or cause anxiety on the part of the participants (1995: 78). This may have been reinforced by framing the study as a service evaluation, where I might be expected to be a well-informed critic who can offer recommendations. Three Christian chaplains referred to me as an expert, with one noting that I would become a 'national expert in chaplaincy' (fieldnotes, Westview, 08/02/2016), while a Muslim chaplain referred to me as a 'specialist' (fieldnotes, Stonehaven, 21/07/2016). This was usually in the context of asking my views on particular issues, such as the new chaplaincy equality impact assessment (fieldnotes, Moorlands, 19/09/2016) and resources produced by the chaplaincy team (fieldnotes, Stonehaven, 21/07/2016).

Differing requirements and expectations regarding the research were also apparent among lead chaplains. Hammersley and Atkinson note that '[g]atekeepers may…attempt to exercise some degree of surveillance and control, either by blocking off certain lines of inquiry, or by shepherding the fieldworker into one direction or another' (1995: 66). This raises a key tension between engaging in

'participatory' research and avoiding both implicit and explicit attempts to steer the course of the research in unhelpful directions. For example, two lead chaplains thought the study might support the case for employing paid personnel from particular religion or belief groups, while one lead chaplain was keen to ensure that the Christian 'majority' was not 'overlooked' (personal communication, lead chaplain, 27/06/2016).

3.5.2 Ethical Considerations

Guba and Lincoln (1994) note that ethics is intrinsic to critical and constructivist qualitative paradigms, where it is the moral responsibility of the researcher to be transparent about the research. Ethics goes beyond 'doing no harm' and considers the possible implications of researcher self-presentation and attempts to represent the perspectives of the participants. Postmodern participatory approaches highlight the situatedness of ethics (Piper and Simons 2004: 58), although this 'relativist approach' relies on participant understandings of ethical behaviour (Hammersley and Atkinson 1995: 277). Instead, a pragmatic contextual approach to ethics is required, where the researcher exercises their own judgement about appropriate research design, interpersonal relationships in the field, and the consequences of publication (ibid.; see also Becker 1964). Similarly, Hammersley and Atkinson note that researcher transparency is not always feasible for some projects, particularly when encounters with participants are fleeting and providing information may be intrusive and unwelcome (ibid.).

Despite this emphasis on ethical pragmatism, the project needed to provide ethical protocols in keeping with NHS guidance, and to offer good justifications when this was not possible (DoH 2003a; DoH 2005; National Patient Safety Agency 2011; see Appendices 3-7). A primary concern was to ensure that patient involvement entailed minimal interference in the care of the patient, and to avoid unnecessary recording of patient information. The key ethical considerations are outlined below.

3.5.2.1 Recruitment

Chaplaincy teams were recruited by approaching lead/managing chaplains. Where possible, meetings with the paid personnel of each team were held to introduce the project. For two cases, I met only with the lead chaplain, although in both instances

the teams were very small (fieldnotes, 25/08/2015; fieldnotes, 29/04/2016). At one site, I was invited to discuss my research with the 'Multi-Faith User Group', comprising paid chaplains, some volunteers, and local faith community representatives (fieldnotes, 12/08/2015). At the remaining two sites I presented my research proposal at team meetings (fieldnotes, 15/10/2015; fieldnotes, 12/04/2016). It is difficult to know how the chaplaincy teams arrived at the decision to participate in the study, although it appeared that in some cases the decision lay primarily with the lead chaplain, while other lead/managing chaplains consulted with their colleagues.

Christian and minority faith chaplaincy representatives were involved in participant observation while minority faith representatives were shadowed.[15] Engagement with chaplaincy volunteers only included ward visitors, who usually visited during the week, rather than Sunday chapel volunteers. Participants to be shadowed and interviewed were identified during the observations, including Christian chaplains and stakeholders. Following the pilot study, interviews with specific stakeholders were requested through the chaplaincy team, including chaplaincy line managers (usually the Deputy Chief Nurse), Equality and Diversity officers, and Voluntary Services managers. Additional stakeholders were also recommended by the lead/managing chaplain. This liaison between chaplaincy and institutional stakeholders on my behalf indicated the nature of the relationships between the chaplaincy and key stakeholders: one chaplaincy team were reluctant to facilitate meetings with stakeholders, while another team inundated my calendar.

The indirect involvement of patients raised challenges, as there was limited opportunity to fully explain the project. This highlighted the significance of differential disclosure of project information between participants (Hammersley and Atkinson 1995: 265). Basic information was provided to patients to explain why their interactions with the chaplaincy representative were being observed (see Appendix 5). The study paperwork emphasised that the focus was on chaplaincy team members, who were referred to as 'primary participants', while patients, visitors, and non-chaplaincy staff were referred to as 'secondary participants'.

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[15] 'Chaplaincy team representatives' refers to both paid and voluntary chaplaincy team members.

3.5.2.2   Informed Consent and Withdrawal

Written informed consent was requested from all chaplaincy team members who were observed, shadowed, and interviewed. Stakeholders who were interviewed were also asked for written informed consent. It was recognised that consent was continually open to revision (Silverman 2013: 162), and participants were informed that they could withdraw or ask for data to be removed from the transcripts. Two participants withdrew from the study upon receipt of their interview transcripts.[16]

At four of six sites, any patients, visitors, or non-chaplaincy staff encountered when shadowing chaplaincy representatives were asked for verbal consent for me to observe and make notes to minimise interference with the encounter. Identifiable data about patients and staff members was not written down. However, the R&D department at Riverside stated that all patient encounters required written consent as a condition of access, but in practice chaplains found this unhelpful, as requests for written consent often confused patients. Evidence gathered showing written consent to be a hindrance supported the case for verbal consent at other sites. Study paperwork informed patients that they could provide feedback about the study by asking the ward staff to contact the chaplaincy team.

3.5.2.3   Confidentiality

Data was treated confidentially in accordance with the Data Protection Act 1998.[17] Participants were notified of the terms of confidentiality, in which data with legal or ethical ramifications beyond the remit of the project could be reported to the relevant authorities. While data was anonymised in order to maintain confidentiality, identification of individuals may still be possible (Bryman 2012: 136; Piper and Simons 2004: 57). During the fieldwork, I had limited access to university network computers for the confidential writing up of research data. Following consultation

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[16] One participant informed me she should have received the interview questions in advance in order to prepare (personal communication, 27-07-2017); the other participant informed me that the information he had received about the project was unclear about the purpose and outputs, and felt that the questions asked in the interview were not relevant to the project (personal communication, 03-07-2017).

[17] While conscious of the recent implementation of the GDPR in May 2018, this did not have substantial new implications for the management of data for this research project.

with the Information Security Framework Team at Cardiff University, research was written up on an encrypted MacBook Air, which was uploaded onto the University server using a Virtual Private Network (VPN). The details of data storage are outlined in the study paperwork (Appendices 3-7).

3.5.2.4   Anonymity

Maintaining anonymity of participants is an essential aspect of confidentiality (Saunders, Kitzinger, and Kitzinger2015). Saunders *et al.* note that anonymising strategies 'structurally [predispose] researchers toward the erasure of the experiences of minorities – precisely because their minority status may make these participants easy to identify' (2015: 625). This raises particular issues given the focus of this project on minority faith groups within a relatively small profession, which increases the risk of being identified. This was exemplified when one Hindu chaplain suggested that he knows all seven of the other Hindu chaplains and might therefore be able to identify other sites. Here, contextually situated decisions must be made which balance the integrity of the data and the maintenance of anonymity (Saunders *et al.* 2015). No participants are mentioned by name, although their religious background and gender may be mentioned where relevant and necessary for fair and accurate representation of data. Patients were automatically anonymised as their names and personal details were not written down. However, some patients at Riverside felt the requirement for written consent threatened their anonymity (fieldnotes, 20/10/2015).

Saunders *et al.* distinguish between 'internal' confidentiality, which may be compromised if other participants are able to identify and trace comments to a particular participant, while 'external' confidentiality may be compromised when the participant is identifiable by members of the intended audience for the research findings (2015: 620). Considerable issues were raised around 'internal' confidentiality, particularly in relation to the production of the service evaluation reports, but also reference to minority faith chaplains at certain sites where they are the only representative of that religious group on site.

The service evaluation reports and the thesis had two significant implications concerning anonymity which I shared with participants: firstly, the risk of being identified was higher in the report, especially if the religious background of the

participant was disclosed. Secondly, the circulation of the report was more restricted than the thesis. Participants were advised that the thesis would be accessible to the public and may have a wider readership, but that anonymity was more easily maintained given that I was working with people in comparable posts in other Trusts (e.g. Hindu chaplain, Voluntary Services manager). Some participants fully exploited this distinction, requesting that certain comments were only reported in the thesis rather than the service evaluation report. The thesis offered a layer of anonymity that could protect them from the negative repercussions of comments that might reflect badly on their colleagues or themselves. The report may have helped some participants relativise the question of anonymity and speak more freely than they might if there was no other counterbalance.

Preserving individual anonymity was assisted by anonymising the cases. During write-up, case sites were attributed letters (if there were multiple sites letters were also accompanied by numbers, e.g. Site A1, Site A2). Pseudonyms were chosen for sites to minimise the possibility of identification. Saunders *et al.* note that anonymising places compromises the integrity of the data through a decontextualisation of the site (2015: 623; see also Nespor 2000). The research design intended to mitigate this de-contextualising tendency by highlighting differences between sites, as demonstrated in the next chapter. I suggest that it is still possible to provide localised contextual information without 'outing' a particular site. Occasionally, I had to mitigate the risk of my research location being 'outed' by the chaplaincy team themselves by emphasising that my presence should not be publicised or mentioned to other chaplaincy teams.

3.5.2.5   *'Do No Harm'*

The principle of doing no harm was anticipated in the study paperwork by offering all participants the opportunity to withdraw from the observations, and for chaplaincy representatives and stakeholders to refuse to answer questions. The advantage of working with chaplains, however, was that a colleague with pastoral skills was usually available in the event of a participant requiring support.

Occasionally, participants openly and without prompt disclosed attitudes and opinions which betrayed prejudiced attitudes to individuals and groups. While participants' attitudes may affect the care they offer to patients, I decided against

disclosing these attitudes in the service evaluation reports, as these could have a direct impact on the reputation and employment circumstances of the chaplains in question.

3.5.2.6   The Crisis of Representation

A significant ethical issue is how the participants' data is represented. 'Participatory' approaches hold that it is the researcher's responsibility to cross-check the veracity of their interpretations with participants, by sending interview transcripts and distributing research reports as a form of 'communicative validation' for assessing trustworthiness (Flick 2014: 484, Lincoln and Guba 1985: 314; Long and Johnson 2000: 33; Ezzy 2002: 68, 76). In order to mitigate '[upsetting] the informational economy' (Hammersley and Atkinson 1995: 279), I circulated the service evaluation reports to the paid chaplains first for feedback before wider distribution to participating volunteers and stakeholders. However, participatory verification could 'distort' evidence (Hammersley and Atkinson 1995: 268, Jenkins 2002: 56) as participants may attempt to clarify, justify, or change aspects of what was said (Poland 1995: 305). Seeking feedback suggests that participants hold the only truthful interpretation of their experience, while concerns about feedback 'distorting' evidence suggests that the researcher 'knows better' and 'privileges analytical understanding as superior to native understanding' (Jenkins 2002: 56). The issue of representation must maintain a balance between naively assigning interpretive finality to participants and riding roughshod over participant perspectives. Participant feedback was not uncritically incorporated but treated as supplementary data. In some cases, chaplains highlighted their disagreements with their reports, which might show a disconnect between the espoused and actual practice of the chaplaincy team, raise misunderstandings or misplaced emphasis on my part, or highlight the significant changes that had occurred since the study.

While Christian chaplains were keen to offer feedback to reports and transcripts, very few minority faith participants provided feedback. As Hammersley and Atkinson note, 'responses to research reports on the part of those whose behaviour is described within them are not always negative, and are often minimal or non-existent' (1995: 271). It is difficult to establish why this was the case, although it is possible that these participants had limited time to read through reports and sometimes very lengthy transcripts.

3.5.3 Access during the Fieldwork

Negotiating access was ongoing throughout the fieldwork, as 'not all parts of the setting will be equally open to observation, and not everyone may be willing to talk' (Hammersley and Atkinson 1995: 79). Individual participants determined varying levels of access, either deliberately or unintentionally. The ability to access the chaplaincy offices independently is an obvious example. At Fairbank, I was unable to access either of the chaplaincy offices without another chaplain letting me in, also reflecting the levels of access accorded to the minority faith chaplains. At Greenacre, I was given my own set of keys for all chaplaincy offices, and at Westview I was given the code to the chaplaincy office. Stonehaven had mechanisms in place for me to access the primary chaplaincy office, although a faulty identification badge meant I was unable to access the corridor leading to the chaplaincy office.

Occasionally, it appeared that lead/managing chaplains had a significant role in persuading or co-opting some team members to participate. This was highlighted by a Hindu chaplain who was concerned that the low numbers of Hindu patients might reflect badly (fieldnotes, Stonehaven, 01/07/2016). The chaplain was eventually persuaded to participate after assurances were made by the managing chaplain. At Greenacre, two participants were under the impression I was conducting a compulsory evaluation and asked me to inform the managing chaplain that they had participated, with one even requesting a feedback session (fieldnotes, Greenacre, 10/05/2016). I also relied on lead/managing chaplains to recommend stakeholders to interview (Hammersley and Atkinson 1995: 60), while mindful that stakeholders might be recommended because they had a good relationship with chaplaincy. My requests to see particular stakeholders were often facilitated by chaplaincy teams without query. At one site, however, multiple requests to be put in touch with stakeholders were ignored and arrangements made independently with a particular stakeholder were met with consternation from the chaplaincy team (fieldnotes, Northbrook, 20/11/2015).

Chaplains also attempted to control levels of access to particular activities. For example, two Hindu chaplains did not allow me to accompany them when they engaged in staff support. There were also occasions where chaplains asked me to wait outside patients' side rooms before giving the 'all-clear'. A Muslim chaplain at

one site did not allow me to shadow him at all, on the grounds that he only visited male Muslim patients and that it would be inappropriate for me as a woman to observe (personal communication, managing chaplain, 15/10/2015). This chaplain was still willing to be interviewed.

Language constituted a significant barrier to data collection, especially when shadowing. I asked chaplaincy representatives to engage with patients as they would normally and recommended debriefing afterwards. Consequently, the meaning of some interactions was mediated by the chaplain rather than directly witnessed. At Riverside, where written consent from patients was required, patient confusion about consent was complicated by language barriers, and attempts to communicate through the chaplain disproportionately disrupted the encounter. As a consequence, I excused myself from the observations and waited for the chaplain outside the bay.

Access to patient information was also limited. R&D departments allowed access to anonymised patient information, but the disparate approaches to record-keeping between chaplaincy teams significantly impacted on access. Only two chaplaincy teams had administrators who could spend time anonymising data before passing it on. Two of six chaplaincy teams regularly collated anonymised statistics relating to inpatient religious demographic and the visits made by the chaplaincy team (including volunteers). On other occasions, requests for collated statistics were not forthcoming and I felt it was unfair on chaplaincy teams to ask them to dedicate extra time to collating information for my purposes (Hakim 1993: 133).

3.5.4 Writing the Field

3.5.4.1 Fieldnotes

Rough fieldnotes were written in an A4 notebook during the observations. The notebook used during participant observation proved cumbersome when shadowing on the wards. Instead, I attached an A6 notebook to a clipboard used for patient information letters. Fieldnotes made immediately before, during, and immediately after an interview were written in a loose-leaf notebook so that notes corresponding to the interview could be filed and stored alongside the consent form of the relevant participant. These fieldnotes intended to cover comprehensively most of what was observed and heard, although it was occasionally unfeasible to make notes,

especially during sensitive conversations where discretion was requested. Where possible, brief keywords and questions were jotted down as prompts, and timestamps were included to ensure the sequence of events was documented as accurately as possible in later write ups. I decided against immediately typing fieldnotes on a laptop during participant observation as I felt the laptop would create a barrier and render the process less transparent to participants. Fieldnotes were typed up in full on a laptop either during quiet periods, or once I returned to my accommodation so that any sparse sections of fieldnotes were fleshed out while recall was fresh. Occasionally, extensive fieldnotes from shadowing were typed out over the course of a few evenings.

3.5.4.2 *Transcription*

The transcription process started in the field, and continued until September 2017. While some literature suggests that transcribing and reviewing transcripts during the fieldwork helps with analysis and planning further interviews (Ezzy 2002: 70), I instead drew upon the fieldnotes taken alongside interviews to help plan future interviews. Most chaplaincy team interviews were fully transcribed, while abridged transcripts were produced for stakeholders. Interviews were abridged where data was given that I felt was not relevant to the research, although summaries of the participant's comments were still included (see Appendix 8).

The approach used is referred to by Lapadat and Lindsay as the 'tape-transcribe-code-interpret (TTCI) cycle' (1999: 66). Transcripts were written up using NVivo 10. The transcripts focused primarily on utterances rather than paralinguistic or non-verbal information as the primary focus was on the discourses articulated by participants. Where the speech of participants was unclear, transcripts were marked '[inaudible]'. Transcription was orthographic rather than phonetic (Lapadat and Lindsay 1999: 67), employing standard English language spellings. Transcription 'necessarily involves selection' (Lapadat and Lindsay 1999: 73), so I did not attempt to produce 'detailed and precise "objective" transcripts' (ibid.: 74).

3.5.5 Embodiment, Identity, and Positionality

Reflection on how my identity impacts the research process led me to think in terms of multiple positionalities (Fuller 1999; Khawaja and Mørck 2009: 38) rather than

the insider/outsider dichotomy. Literature relating to the insider/outsider debate is primarily concerned with whether 'outsiders' or 'insiders' can provide reliable accounts of religion (McCutcheon 2003; Knott 2010; Jensen 2011), although the 'distinction between insider and outsider becomes irrelevant when we recognise all those who participate… contribute to the co-construction of the story' (Knott 2010: 269, citing Collins 2002). A simplistic characterisation of my positionality as an 'outsider' overlooks the knowledge and experience acquired through longstanding academic engagement with religion and my prior involvement in a Baptist church that has imprinted a certain level of familiarity with particular religious practices, beliefs, and attitudes. This familiarity surfaced when observing the morning prayer at Moorlands, including the extent of sharing of personal information among relative strangers and extemporaneous prayer, which resonated (sometimes uncomfortably) with my own memories of small group meetings.

The primary issues arising from positionality include the appropriateness of self-disclosure and how far perceived and actual positionalities impact on relationship building, rapport, and participant disclosure. My status as a 'non-practitioner' researching chaplaincy and as a 'non-religious' person studying religion impacted on how chaplains responded to the research. When conducting phone surveys with lead chaplains, I often needed to provide assurances that I was trustworthy. Being a 'non-practitioner' with an 'interest' in chaplaincy was quickly linked to secularist hostility.

Relationships with participants were not simply shaped by my religious identity, but also by other 'visible markers of difference which are inscribed on the body (especially gender, age, race and ethnicity)', which can have a 'critical influence upon the nature of the data that one does – or does not – collect' (Gilliat-Ray 2010a: 416). My physical attributes as a young, white, and female researcher also impacted on my research relationships. For some participants, questions about my marital status and family life constituted attempts to build rapport and establish commonalities. My 'whiteness' appeared to inform participants' assumptions about my level of knowledge about their religious traditions and contributed to assumptions about my own religious background. The mutual learning that took place between me and my participants was a point of constant reflection throughout my fieldwork, raising tensions between 'expertise' and 'ignorance' on my part. Despite

occasionally deploying faith-specific 'jargon' to indicate my knowledge of the religious traditions of the participants, I felt that doing so excessively might appear inauthentic. I still considered it useful to see how participants explained their religious traditions to me, as it may provide insights about how they explain their religious traditions to their colleagues. Occasionally, participants *oversimplified* the information imparted, demonstrated when a Sikh chaplain referred to a priest instead of a *granthi*, and compared *prasad* to communion wafers (interview, Sikh chaplain, 02/08/2016). The terms used also signify the assumption that Anglican or Catholic terminology ('priest', 'wafer') might resonate more with my own understandings. This linked not only to my perceived lack of knowledge, but participants' construction of my identity as Christian.

My embodied presence changed the dynamic of the field, made apparent in chaplains' perceptions of ward staff responses to my presence. Two female Muslim chaplaincy representatives suggested that staff treated them better when I shadowed them: 'people treat me differently when you're here. Maybe you should stay!' (fieldnotes, shadowing Muslim chaplain, Stonehaven, 27/06/2016). One female Muslim volunteer suggested this differential treatment was because staff mistook me for a Care Quality Commission (CQC) inspector (fieldnotes, shadowing Muslim volunteer, Riverside, 20/10/2015). On one occasion, a Hindu volunteer and I were approached by ward staff who gave us a medical update on a patient under the false impression that we were a doctor and a registrar because of our smart-casual attire, identification badges, and because I was carrying a clipboard. Choice of attire is a significant aspect of impression management (Coffey 1999: 64) and I dressed smartly and modestly at all times during the fieldwork.

3.6   DATA ANALYSIS

The primary data sources available for analysis included a combination of 'naturally occurring' data (as documented in fieldnotes) and formally collected data (transcripts from interviews and chaplaincy documentation). A thematic analysis was conducted with the intention of exploring 'thematic range rather than finding a core category or theory development' (Flick 2014: 420).

3.6.1   The Analytical Process

Data analysis commenced informally alongside the fieldwork. This was achieved through writing up fieldnotes, which involved a degree of sense-making to clarify what was documented, but also prompted follow-up of particular issues in interviews (see Ezzy 2002:). Analytical insights and methodological issues arising from the interviews were documented in accompanying memos. The slow process of transcription meant that occasionally themes raised in one interview which could be followed up in other interviews were not drawn upon and opportunities missed. Yet as the fieldwork progressed, I was able to build on existing data to hone my approach to observations and interviews. I developed a standardised list of stakeholders to approach for interview, while being open to recommendations of chaplains. Particular questions informed what I looked out for when shadowing: how is the material culture of chaplaincy – posters, patient information leaflets, prayer cards – manifest throughout the hospital (see also Gilliat-Ray *et al.* 2013: 127-129)? How do chaplaincy representatives manage relationships with staff? How do chaplaincy representatives introduce themselves to staff, families, and patients? I became more confident with identifying the key issues shaping the chaplaincy team at each site, which would then inform site-specific interview questions. I also reflected extensively on themes arising across sites, such as the role of volunteer recruitment, training, and co-ordination in regulating the activities of chaplaincy team members, especially through boundary-setting. Each of these themes eventually informed the coding framework developed once the fieldwork was complete.

The full dataset was uploaded onto NVivo, which was used primarily as a data management tool; CAQDAS software should not substitute analytical method (Ezzy 2002; Flick 2014: 473). The coding frame used was a combination of key themes identified in the literature, analytical insights arising during the fieldwork, and codes arising from initial coding of selected interviews and fieldnotes. Further nodes were identified through systematic coding of the dataset, although I decided against systematically analysing stakeholder interviews due to the vast quantity of data already available. Throughout the coding process nodes were clustered and incorporated into broader 'parent' nodes. The most populated nodes, such as 'authority and leadership', 'distinctiveness of chaplaincy', 'expectation, need, and

demand', 'awareness', 'visibility' and child nodes within 'role and remit' were analysed and text segments compared in order to develop key themes.

As coding and memo-writing progressed, I began to link key nodes and themes with sensitising concepts (Blumer 1954) such as 'socialisation', 'recognition', 'capital', which encapsulated many of the nodes in the coding framework. These sensitising concepts were drawn predominantly from Bourdieu, although the discussion regarding recognition was further supported by literature on the politics of recognition (Fraser 2003), and a broader literature concerning socialisation was consulted.

3.7 PLACEMENT WITH NHS ENGLAND

Between June 2017 and December 2017, I undertook a placement with NHS England in order to facilitate knowledge exchange based on the findings of the fieldwork (see Appendices 14-15).[18] I wished to find out more about how chaplaincy is organised nationally, which was facilitated by the opportunity to attend several meetings involving national chaplaincy bodies. In these meetings, arrangements for bringing several chaplaincy bodies together in one forum were finalised. Without this placement, I might not have been able to access these meetings. In my capacity as Spiritual Support Officer, I was tasked with establishing best practice for the provision of spiritual care services to out-of-area[19] minority faith service users in the mental health sector in light of recommendations outlined in the equality impact assessment for the 2015 chaplaincy guidelines (NHS England 2015b: 9). This project culminated in a report and briefing for NHS England, and a presentation delivered to key stakeholders, including NHS Employers, in September 2018. For both outputs, I was able to draw on the knowledge and contacts made from the doctoral fieldwork, but also discovered that workforce diversity in mental health chaplaincy is limited compared to acute healthcare.

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[18] This placement was funded by the AHRC South West and Wales Doctoral Training Partnership's Skills Development Fund.

[19] Out-of-area placements refer to circumstances where 'a person with assessed acute mental health needs who requires adult mental health acute inpatient care… is admitted to a unit that does not form part of their usual local network of services' (NHS Digital 2018b).

3.8   CONCLUDING COMMENTS

This chapter provided an overview of the research design developed in order to address the research questions and methodological gaps in the field. This has been achieved through developing a multi-site ethnographic research design. This mitigated the issues arising from surveys and questionnaires, enabled me to observe chaplaincy teams in action, and increased the likelihood of engaging properly with minority faith team members (except where their involvement was highly irregular, as evidenced at Northbrook and Moorlands). By paying attention to the perspectives and attitudes of Christian and minority faith chaplains, I was able to provide a more comprehensive examination of how far minority faith groups are integrated into chaplaincy.

Allowing more time and space for reflection, especially through keeping a separate personal reflective diary, would have helped me to process some of the more difficult instances during the fieldwork (Rager 2005: 25; Punch 2012). Such instances included observing the immediate aftermath of an end of life situation on an oncology ward, and my acute discomfort when chaplaincy representatives had failed to respond sensitively to patient distress. I became increasingly aware of how my positionality as a white, female, young researcher impacted on the information disclosed to me by participants, in part due to language barriers arising. At the same time, my role as a researcher conducting a service evaluation meant that I was both seen as an 'expert' in relation to chaplaincy and a 'novice' in relation to minority faith traditions. I was acutely aware of my limitations in engaging with and representing minority faith participants, not only due to my positionality as a religious, cultural, and linguistic 'outsider', but also the limited responses from minority faith chaplaincy representatives after seeking feedback for transcripts and reports. However, the limited capacity of these groups to contribute to the discussion means that minority faith involvement in chaplaincy would otherwise remain under-researched. The research design outlined above addresses a significant gap in the knowledge base while accounting for my own limitations.

4 Findings: The Cases

This chapter introduces and outlines the preliminary findings for each case. This introduction outlines the key areas of discussion arising from the literature and the data across sites, and provides tables which show basic personnel information about each site side-by-side. Each case will provide a snapshot outline of each team following the key areas of discussion. I will conclude by highlighting the key trends and challenges emerging from these findings.

The primary areas of interest in this chapter include personnel, chaplaincy facilities, working practices, and team working. *Personnel* will focus on the steps taken by chaplaincies to diversify their personnel (see also Beckford and Gilliat 1996; Orchard 2000; Gilliat-Ray 2008; Gilliat-Ray *et al*. 2013) and the processes of volunteer recruitment and training (DoH 2003b; NHS England 2015a). *Chaplaincy facilities* will outline the chaplaincy offices, including access to space and resource, and prayer facilities available at each site (Beckford and Gilliat 1996: 278; Gilliat-Ray 2005; Collins *et al*. 2007; Cadge 2012; Eccles 2014; Hewson and Crompton 2014). *Working practices* will explore role and remit (Wilson 1971; Beckford and Gilliat 1996; Woodward 1998; Orchard 2000; Wright 2001; Swinton and Mowat 2007; Mowat 2008; Newitt 2010; Welford 2011; Swift 2014), models of operating (Allan and Macritchie 2007; Todd 2011), access to patient information (Beckford and Gilliat 1996) and auditing and record-keeping (Woodward 1998; Orchard 2000; SYWDC 2004). *Team working* will, where relevant, discuss the impact of changes in leadership and explore how far minority faith chaplaincy representatives work as part of a team (Beckford and Gilliat 1996; Orchard 2000).

This chapter will highlight the continuity and diversity of working practices within chaplaincy to lay the groundwork for a conceptual analysis in the next chapter. This chapter will therefore be a largely descriptive account of each case in order to mitigate the risk of detail becoming obscured through comparison and analysis. The following chapters will demonstrate the exploratory and explanatory applications of the case study findings (Yin 2013).

4.1 OVERVIEW OF CHAPLAINCY TEAMS

The tables below provide a breakdown of the personnel within each chaplaincy team. The first table indicates personnel by whole-time equivalent (unless otherwise stated); the second table indicates personnel by contract type; the third table gives an overview of volunteers across all sites.

Table 3: Chaplaincy Team WTEs

Trust Name (including individual hospital names)		Christian			Muslim (male and female)	Hindu	Sikh	Jewish	Non-religious	Administrator
		Anglican	Free Church	Roman Catholic						
Fairbank: Riverside		1	0	1	0.09	0.09	0	0.09	0	0
Fairbank: Northbrook		1.9	0	0.2	BANK			HONORARY	0	0
Westview		1 (+1 bank and 1 honorary)	1 bank	0.09	0					0.2
Greenacre	Woodford Green	1.6	0.9	0.3	0.35 male; 0.20 female	0.5	0.2	0	0.27	0
	Birchsprings	1		0.3						
	White Oak	0	1							
Stonehaven	Flaxheath	1	0	-	1.0 male; 1.34 female	0.19	0.19	0	0	1
	Thatch End									
Moorlands		1	1	0.16	0					-
TOTAL (excluding bank and honorary)		8.5	2.9	2.05	2.98	0.78	0.39	0.09	0.27	1.2

At Moorlands the lead chaplain reported that a total of fifteen honorary chaplains were involved in on-call provision and worship (lead chaplain, personal communication, February 2015). Their denominations were not specified.

Table 4: Chaplains by Contract Type

FT = full-time; PT = part-time

Trust Name (including individual hospital names as required)		Christian			Muslim (male and female)	Hindu	Sikh	Jewish	Non-religious	Administrator
		Anglican	Free Church	Roman Catholic						
Fairbank: Riverside		1 FT	0	1 FT	1 PT/ sessional	1 PT/ sessional	0	1 PT/ sessional	0	0
Fairbank: Northbrook		1 FT; 1 FT split across two sites; 1 PT (30 hours) split across two sites*	0	1 PT (15 hours) split across two sites*		BANK		HONORARY	0	0
Westview		1 FT; 1 bank; 1 honorary	1 bank	1 PT			0			1 PT
Greenacre	Woodford Green	2 PT (30 hours each)	1 PT (35 hours)	1 PT	1 PT male; 1 PT female	1 PT	1 PT	0	1 PT	0
	Birchsprings	1 FT								
	White Oak	0	1 FT	1 PT						
Stonehaven	Flaxheath	1 FT	0	1 PT	1 FT male; 2 PT female (25 hours each)	1 PT/ sessional	1 PT/ sessional	0	0	1 FT
	Thatch End	1 FT			1 PT/ sessional					
Moorlands		1 FT	1 FT	2 PT/ sessional (service level agreement)		0			1 PT

*Three chaplains in this team also served a site at another Trust. While some observations took place at the other Trust, they are not documented in this thesis.

Table 5: Total Chaplaincy Volunteers by Religion

Trust/Hospital Name	Christian				Muslim	Hindu	Sikh	Jewish	Buddhist	Baha'i	Jain	Non-religious	Not specified
	Anglican	Unspecified	Free Church	Roman Catholic									
Fairbank: Riverside	6	-	2	7	1	1	0	4	0	0	[1]	0	0
Fairbank: Northbrook	1	-	1	4	[1]	0	2**	0	0	0	0	0	0
Westview	3	12	3	4+	4*	1	0	0	0	0	0	1	1
Woodford Green	1	4	-	1	3*	3	3	1		0	1	0	
Greenacre — Birchsprings	-	3	-	3	1*	0	1		1	0	0		
White Oak	1	5	-	1	3*	0	0		0	1	0		
Flaxheath	0	5	0	0	0	1	0	0		0		0	0
Stonehaven — Thatch End	5	20	3	7	15	0	0	0	0	1	0	1	1
Moorlands	3	17	1	3									
TOTAL	21	66	10	30	27	6	6	5	1	2	2	2	2

* includes voluntary imams who lead Friday prayer and may not necessarily engage in patient visiting.

** includes Sikh volunteer who helps with regular Sikh prayers.

[] Denotes a volunteer who is unavailable but expected to continue volunteering or volunteers who have not officially started visiting yet

4.2 FAIRBANK UNIVERSITY HOSPITALS TRUST

The fieldwork for this case incorporated four sites within a ten-mile radius, although I focus on two sites that had been merged under one Trust. These hospitals, Riverside Hospital and Northbrook Hospital, will be treated separately here because the teams worked independently.

4.2.1 Riverside Hospital

4.2.1.1 Diversifying the Team

According to the senior chaplain, the diversification of the team began with voluntary Jewish visitation, followed by the introduction of a monthly Hindu prayer service following lobbies by prominent Hindu and Jain community representatives. The senior chaplain reported that the Hindu, Muslim, and Jewish chaplains were appointed following a decision made by the Trust's Chief Executive in the mid-2000s. The same chaplains were still in post at the time of the study and their hours had not increased since their appointment.

4.2.1.2 Volunteer Recruitment

Recruitment of volunteers had stagnated at the time of the study, although the Muslim chaplain conducted an interview with a prospective Muslim volunteer during the observations. All new volunteers undertook a chaplaincy training programme. The senior chaplain agreed to fast-track the newly-approved Muslim volunteer as he had experience in prison chaplaincy and would be familiar with the relevant protocols (fieldnotes, 21/10/2015).

4.2.1.3 Chaplaincy Facilities

The chaplaincy offices were situated in the hospital chapel, which was located along the main corridor. The entrance of the chapel leads to a mezzanine with the 'multi-faith/volunteers' office located on the left. This office contained desk space but no computer. Beyond the office door was a metal gate with a lock which led to stairs down into the main chapel area. The Anglican and Catholic chaplains' offices were located towards the back of the main chapel area. The Muslim, Jewish, and Hindu chaplains did not have their own sets of keys to access the main part of the chapel.

The designated multi-faith prayer room was used primarily by Muslim staff. Since its opening, the room has accumulated prayer calendars and calligraphic plaques on the walls, giving the room a distinctly Islamic feel. The room has a curtain that can be drawn to create a separate prayer space for women. The prayer room was more difficult to find, and it was common for people to make enquiries at the chapel about how to find the 'mosque' (fieldnotes, 08/12/2015).

Due to the limited capacity of the multi-faith prayer room, Friday prayer was held in the hospital social club. Regular Hindu prayers and celebrations of festivals were hosted in the chapel rather than in the multi-faith prayer room.

4.2.1.4   Role and Remit

Ward visiting was the primary role of the minority faith chaplains and volunteers at this site. However, because the male Muslim chaplain only visited male Muslim patients, a female Muslim volunteer visited female Muslim patients. The senior chaplain reported that, while the Hindu and Muslim chaplains respond to urgent call-outs, Christian call-outs were most common, followed by Hindu call-outs (fieldnotes, 23/02/2017). The female Muslim volunteer occasionally acted as intermediary between patients and PALS,[20] and Muslim and Hindu chaplaincy representatives occasionally translated for staff and patients. This was usually for practical purposes, in order to communicate the needs of the patient to staff or for 'general care' (interview, Muslim chaplain, 14/11/2015). The Muslim, Hindu, and Jewish chaplains reported being consulted for advice on ethical issues such as organ donation and switching off life support. The Muslim chaplain briefly mentioned staff support as part of his role, while the Hindu chaplain referred extensively to enabling staff to practice their religion in the workplace (interview, Hindu chaplain, 02/12/2015).

The Hindu chaplain organised and led monthly prayers but intended to make this a weekly fixture (interview, Hindu chaplain, 02/12/2015). *Jumu'ah* prayers were organised, but not led, by the Muslim chaplain. The Muslim chaplain reported that he was responsible for the prayer room, while the Anglican chaplain removes

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[20] Patient Advice and Liaison Service.

inappropriate literature found in the chapel. The senior chaplain facilitated events in the chapel ensuring that they do not prevent others from using the facilities (interview, Anglican chaplain, 05/11/2016).

The chaplaincy organises a Multi-Faith User Group, which includes all chaplains, Trust stakeholders, and local inter-faith forum representatives. This user group has been used to discuss diet, production of an annual multi-faith calendar, production of a directory for local places of worship, volunteer training, the chaplaincy information leaflet, and baby remembrance services. The Hindu, Jewish, and Muslim chaplains had no other formal institutional roles. The Anglican chaplain was involved in several committees, including Equality and Diversity and Patient Experience, while the Catholic chaplain contributes to hospital induction.

Hospital funerals were provided by the Christian chaplains only. The Christian chaplains preside over monthly cremation services for up to six non-viable foetuses, regardless of the religious background of the parents.

4.2.1.5 Models of Operating

The team operated with a religion-specific model following an interpretation of Caldicott Guidelines which gave chaplains access to patient information but prevented them from visiting bed-to-bed.[21] The chaplaincy primarily used patient lists to guide visits. While Christian volunteers were allocated particular wards to visit Christian patients, minority faith volunteers visited patients of their own faith across the hospital. The Caldicott interpretation necessitated the appointment of

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[21] The Caldicott guidelines outline recommendations for protecting personally identifiable information within the health services, based on the 1998 Data Protection Act. The recommendations included the appointment of a Caldicott Guardian to each organisation to 'oversee the arrangements for the use and sharing of clinical information' and advise on local issues (DoH 2010b: 2). Thus, the level of access to patient information afforded to chaplaincy depends on the decision of the Trust Caldicott Guardian.

Jewish, Hindu, and Muslim chaplains, a diverse volunteer base, and an extensive contact list.

4.2.1.6 Patient Information

Despite chaplains' reliance on patient lists, minority faith chaplains did not have access to computers to print out patient lists. Instead, the Catholic chaplain was responsible for printing outpatient lists and leaving them in the 'multi-faith/volunteers' office.

4.2.1.7 Auditing and Record Keeping

All minority faith chaplains record the patients they have visited in notebooks that were kept in the 'multi-faith/volunteers' office, although Muslim call-outs were not recorded. A Jewish volunteer reported that the Jewish chaplain 'never writes down who he visits' and may not even record when he was on site (fieldnotes, 14/10/2015). This was a source of frustration for the volunteer, who valued being able to follow-up on the work done by other Jewish representatives.

4.2.1.8 Team Ethos

The team stopped having regular team meetings due to poor attendance (interview, Anglican chaplain, 05/11/2015). Communication and decision-making tended to be ad hoc and informal, usually between the Catholic and Anglican chaplains.

The setup of the chaplaincy offices prevented chaplaincy team members from communicating effectively, and it was common for chaplaincy team members to go weeks without seeing their paid colleagues. The Anglican chaplain occasionally grumbled about not knowing when the Jewish chaplain would be in, suggesting a lack of communication and issues around regular attendance (fieldnotes, 06/10/2015). The Hindu and Catholic chaplains were the only chaplains to maintain regular contact with their volunteers. Other volunteers reported feeling unsupported and had limited contact with their respective chaplains. Consequently, the Muslim and Jewish volunteers tended to operate independently. A longstanding female Jewish volunteer organised the rota for volunteer visiting (interview, Jewish volunteer, 16/12/2015).

4.2.2 Northbrook Hospital

4.2.2.1 Diversifying the Chaplaincy Team

All minority faith chaplains (Hindu, Jewish, Muslim, and Sikh) were involved on an honorary or bank basis, but were initially involved as volunteers or community contacts. Most faith community contacts had been made by the chaplaincy team approaching local places of worship to recruit volunteers, although the Jewish chaplain was deployed to the hospital by the Jewish Visitation Committee (interview, Anglican chaplain, 14/12/2015). An Anglican chaplain reported being appointed to her post with the specific remit of 'badging up' the minority faith contacts as a way of recognising representatives involved in chaplaincy (interview, Anglican chaplain, 14/12/2015). The same chaplain highlighted the link between 'badging up' the minority faith chaplains and their later involvement as bank staff, but noted that some chaplains chose to remain honorary because of the paperwork involved in being paid (interview, Anglican chaplain, 14/12/2015). The chaplaincy was supported by a small but committed team of regular Anglican, Catholic, and Sikh volunteers. Excepting the Sikh volunteers, minority faith involvement is ad hoc, so Christian chaplains formed the regular 'core' team.

During the observations, a clinical staff member raised the mono-religious nature of the core team, but the Anglican chaplain present argued that the team was *culturally* diverse because three of four chaplains hailed from Africa and South Asia (fieldnotes, 30/10/2015).[22] One Anglican chaplain reported that he speaks Urdu, Punjabi and Hindi, which enables him to speak with South Asian patients (fieldnotes, 02/11/2015).

4.2.2.2 Volunteer Recruitment

Recruitment of chaplaincy volunteers had stagnated as there was no Voluntary Services Manager in post. An Anglican chaplain reported that it had been difficult getting a Hindu volunteer on board, as one prospective representative had expected

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[22] The team members' particular countries of origin have not been specified to preserve anonymity.

remuneration. No information was given about the initial training of volunteers, but the chaplaincy team provides annual training sessions for volunteers.

4.2.2.3   Chaplaincy Facilities

The chaplaincy office was a small room located within a prayer facility complex. It has just about enough desk-space for the core team, but only one computer between them. This was not problematic as at least two members of the team worked at another Trust on any given day. The office contains multiple Christian icons and crosses. The prayer facilities look dated but have a separate chapel space, a separate prayer room primarily used for Muslim prayer, a small meeting room, and a kitchenette. The wooden divide between the chapel space and the prayer room can be folded back to create a larger space for *Jumu'ah* prayers.

4.2.2.4   Role and Remit

The role of the minority faith chaplains was confined to responding to particular referrals, although the Muslim chaplain also led Friday prayers alternate weeks. Institutional roles – including involvement in the organ donation committee, the Schwartz Round[23] steering group, mandatory training of staff and induction – were the remit of an Anglican chaplain. During the observation period, the core team presented their experiences in the Trust's Schwartz Round.

An Anglican chaplain monitored and co-ordinated the use of the prayer facilities when monthly Sikh prayers took place. S*imran* (meditative remembrance prayers) and *kirtan* (musical and devotional worship) sessions were held alternate months and organised by Sikh community members, including two chaplaincy volunteers. During Sikh prayers, Muslim staff and visitors were redirected to a smaller meeting room by the Anglican chaplain. A Sikh volunteer reported that these Sikh prayer sessions may also incorporate Vaisakhi and Guru Nanak's birthday but 'we don't have [separate celebration]. Because we've got only one hour so we have to complete in one hour' (interview, Sikh volunteer, 10/12/2015).

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[23] Schwartz Rounds provide forums that 'focus on the emotional aspects of working in health care' (Thompson 2013: 18) in a 'safe but open environment' (Reed *et al.* 2015: 365). Schwartz rounds differ from medical grand rounds, which tend to focus on problem-solving (Thompson 2013: 18).

The Anglican chaplains provided hospital funerals, although one of the Anglican chaplains expressed discomfort with her Anglican colleagues providing a 'Muslim funeral' (interview, Anglican chaplain, 07/12/2015). This transpired to be a funeral for a stillborn baby and was performed on the grounds that an imam would not be 'allowed' to (interview, lead chaplain, 17/12/2015)

4.2.2.5   Models of Operating

In contrast to Riverside, the Caldicott interpretation denied chaplains access to patient information, but permitted bed-to-bed visiting to identify patients for follow-up. The chaplaincy therefore operated with a generic model. The Sikh volunteers picked up referrals for Sikh patients from the chaplains, but also engaged in generic visiting on specific wards. While the Caldicott interpretation constrained the team's working practices, the lead chaplain also expressed a preference for operating generically (interview, lead chaplain, 17/12/2015).

The bank or honorary chaplains are called in as required by the core team. Upon receiving a request for a minority faith chaplain, chaplaincy team members were the first point of contact with patients or family in order to 'assess' need (interview, lead chaplain, 17/12/2015). When honorary or bank chaplains responded to a call, it appeared to be unnecessary for them to check in to the chaplaincy office, and the only record that was kept was the call-out book, which was completed by the duty chaplain.

4.2.2.6   Auditing and Record Keeping

Only one Anglican chaplain appeared to record the number of patients visited daily. The chaplaincy had a log book of all external call-outs. Sikh prayers were recorded in the service register (fieldnotes, 30/11/2015).

4.2.2.7   Changes in Leadership

The site lead expressed concern about the 'lack of multi-faith clarity' in the working practices of the current team compared to the approaches of the lead chaplain's

predecessor, highlighted by her frustration with the current lead chaplain's apparent reluctance to call in minority faith representatives.

4.2.2.8   Team Ethos

The core chaplaincy team met regularly for strategic development and reflective practice. Contact with minority faith chaplains was limited to occasionally making referrals and checking their availability. The team reflected on not involving the minority faith chaplains in the Schwartz Round presentation, with an Anglican chaplain suggesting that their inclusion would have been 'fakery' due to their limited engagement with chaplaincy (fieldnotes, 26/11/2015).

One of the Anglican chaplains delegated wards, distributed referrals, and debriefed with volunteers, subject to her availability in the chaplaincy office. She regularly left notes for volunteers, including appreciative messages and information about her availability (fieldnotes, 02/11/2015). The same chaplain argued that one of her Anglican colleagues had not 'nurtured' volunteers to enable them to 'offer their services to the hospital', despite relying on volunteers for religion-specific input (interview, Anglican chaplain, 07/12/2015). She attributed this to his ability to speak multiple South Asian languages, which enabled him to engage with the linguistic and cultural needs of patients without recourse to religion-specific input (interview, Anglican chaplain, 07/12/2015). Her colleagues' reluctance to call in minority faith representatives and lax record-keeping was a source of frustration for this particular chaplain.

4.2.3   An Integrated Chaplaincy Service?

Although both teams provided services to one Trust, neither of the teams were aware of how the other team operated. Trust stakeholders were reviewing the configuration of the teams, although managerial responsibility for chaplaincy changed hands regularly. Subsequent follow-ups with the chaplaincy team at Riverside revealed that all four chaplains at Northbrook had left post and a new full-time chaplain with a 'generic' brief was being appointed. At Riverside, the Jewish chaplain resigned, the Anglican chaplain was formally appointed to the lead chaplain's post, and permission was granted for the chaplaincy team to visit patients bed-to-bed.

4.3 WESTVIEW UNIVERSITY HOSPITAL

4.3.1 Diversifying the Chaplaincy Team

Diversification of the chaplaincy team was achieved through volunteer recruitment, and involved some consultation with the local inter-faith forum (fieldnotes, conversation with lead chaplain, 18/01/2016). Two Muslim volunteers had been involved in chaplaincy prior to the current lead chaplain taking up post. Representatives from the local mandir started volunteering with the chaplaincy after being approached by the previous lead chaplain ten years prior (interview, Hindu volunteer, 16/02/2016). Hindu involvement was irregular, due to issues of English language proficiency and high turnover of pandits. The Hindu volunteer at the time of the study was a mandir committee member. The chaplaincy also had contact with a freelance Hindu priest to provide funerals, although he was only available six months of the year due to regular travels to India.

Two Muslim volunteers were recruited by the current lead chaplain and had been visiting wards for a year. Prior to the study, the lead chaplain had submitted a business case for a substantive Muslim chaplaincy post with minimal success, despite support from the Deputy Chief Nurse. The lead chaplain has since informed me the Trust has released funds for a paid Muslim chaplaincy post (personal communication, lead chaplain, 11/09/2017). In addition to the growing religious diversity of the team, the Free Church chaplain hailed from India and spoke eight South Asian languages (including Urdu, Hindi, Arabic, Malayalam, Tamil, Telugu and Odia).

4.3.2 Volunteer Recruitment

The lead chaplain and voluntary services manager process all volunteer applications and interviews. Voluntary services may recruit volunteers to chaplaincy without the lead chaplain's input and have occasionally vetoed prospective volunteers approved by chaplaincy. Once successful, volunteers attend a general voluntary services induction, followed by a four-week chaplaincy training course provided by the lead chaplain. Chaplaincy offers ongoing training days for volunteers, which has included

a 'faith walk' organised by the local inter-faith group. Wards were allocated to volunteers by the lead chaplain on commencing their visiting.

4.3.3 Chaplaincy Facilities

The chaplaincy offices were situated next to the chapel on the first floor of the main hospital building. The chaplaincy offices include a communal space for the paid/honorary chaplains, administrator and volunteers, the lead chaplain's office, and a kitchenette. The layout of the offices encouraged informal team interaction and most volunteers were able to debrief with another team member on a daily basis. The lead chaplain was often available for volunteers to debrief. All chaplains and volunteers were given the code for the chaplain's office.

The area at the back of the chapel was kept clear for Muslim staff, patients, or visitors to do their prayers. A designated prayer space, known as the 'sacred space', was also available in the surgical building. The prayer room contained a curtain rail to separate men from women for prayers, as well as a built-in ablution facility. The efforts made by the lead chaplain to create a functional prayer facility has resulted in very positive relationships with two Muslim consultants who organise *Jumu'ah* prayers.

4.3.4 Role and Remit

In addition to regular routine patient visiting, the Muslim volunteers also responded to religion-specific call-outs in sensitive areas such as maternity, usually accompanied by the lead chaplain. Other volunteers tended not to proactively and deliberately engage in high intensity encounters. The Muslim volunteers and the Free Church chaplain reported that they occasionally assist medical staff who ask them to translate.

The male Muslim volunteers also contributed information and answered questions about Islamic perspectives on miscarriages and stillbirths as part of the training provided by the lead chaplain to midwives (fieldnotes, midwifery training session, 14/01/2016). Excepting this training, institutional roles were fulfilled by the Christian chaplains. This included regular attendance at the palliative care MDT and

steering group, voluntary services meetings, the clinical ethics committee, the corporate Patient Experience group, and the Equality and Diversity steering group. Chaplaincy were not involved in staff induction.

The lead chaplain planned and oversaw most hospital funerals, including funerals for non-viable foetuses. The lead chaplain and Free Church chaplain occasionally provided funerals for Hindu families (fieldnotes, 14/01/2016; interview, Free Church chaplain, 10/02/2016). The freelance Hindu priest can preside over funerals if required, although availability was limited. One male Muslim volunteer also provided funerals for Muslim families (fieldnotes, 09/02/2016; interview, Muslim volunteer, 09/02/2016).

4.3.5 Models of Operating

The team operated with a mixed model of patient visiting. Christian volunteers (and one non-religious volunteer) did the bulk of the proactive generic visiting. The chaplaincy team use patient lists to guide religion-specific visiting. When shadowing the three Muslim volunteers, a male and female volunteer engaged primarily in religion-specific visiting, while the other male volunteer visited generically. However, the female Muslim volunteer also responded to a non-Muslim visitor during ward visits (fieldnotes, shadowing female volunteer, 31/01/2016). The male Muslim volunteers engaged with patients of both sexes. When the Muslim volunteers embarked on religion-specific visits, they often visited similar wards and saw the same patients. This suggested there was minimal co-ordination about how to ensure consistent coverage of the hospital. One volunteer suggested that the lack of leadership stemmed from the lead chaplain not knowing how to manage Muslim chaplaincy and the voluntary status of all the Muslim representatives (fieldnotes, 31/01/2016).

4.3.6 Access to Patient Information

All chaplains and the administrator have access to computers and patient information. One Christian volunteer has access to the computers due to her role compiling 'faith stats' which provide a breakdown of inpatient religious demography

(fieldnotes, 10/02/2016). Other volunteers do not have access to computers, and rely on other team members to print off patient lists for them.

4.3.7   Auditing and Record Keeping

The team keeps daily quantitative records of the patient visits undertaken by chaplaincy representatives. Records indicated whether the visit included a spiritual encounter, pastoral encounter, Holy Communion, staff encounter, or relative encounter. At the time of the study no other specific religious activity was noted in the records. Volunteers complete audit sheets once returning from their visits.

4.3.8   Changes in Leadership

Since the current lead chaplain took up post in 2012, the volunteer team has trebled in size. The administrator reported that previous lead chaplain 'had a complete block when it came to Muslims' (fieldnotes, 02/02/2016) and the current lead chaplain reported that his predecessor 'got her visitors to visit generically rather than recruiting Muslim volunteers' (fieldnotes, 14/01/2016). However, the female Muslim volunteer reported that she was asked to continue volunteering by the previous lead chaplain after finishing a placement as part of her Markfield course (fieldnotes, conversation with Muslim volunteer, 17/01/2016). This 'block' seemed to relate more to the provision of appropriate prayer facilities and baby funerals for Muslim families. According to stakeholders and longstanding team members, the previous lead chaplain did little to challenge the hospital's limited provision of cremation-only funerals for non-viable foetuses, a provision which forced Muslim families to make private arrangements if they did not agree to cremation (fieldnotes, conversation with administrator, 02/02/2016). The current lead chaplain worked alongside the bereavement midwife to bring back the provision of burials for non-viable foetuses.

4.3.9   Team Ethos

The team had meetings every four to six weeks, but these meetings only included contracted chaplains. This meant there was no Hindu or Muslim involvement in team meetings.

The setup of the chaplaincy offices fostered a supportive environment for volunteers and chaplains to debrief after patient visits. The lead chaplain had strong relationships with the Muslim volunteers, demonstrated by regular knowledge exchange and the warm and respectful terms they used for each other. A Muslim volunteer noted that the lead chaplain was an 'excellent gentleman' (interview, Muslim volunteer, 09/02/2016), while the lead chaplain reported that one of the Muslim volunteers had 'taught us so much, really, about Islam, [it's] been fantastic' (interview, lead chaplain, 18/02/2016). Some tensions were evident when a bank chaplain criticised the Muslim volunteers for not complying with infection control and for their lack of availability (fieldnotes, 11/02/2016).

4.4   GREENACRE UNIVERSITY HOSPITALS TRUST

4.4.1   Diversifying the Chaplaincy Team

Two Muslim chaplains reported that they had started chaplaincy work as volunteers in the 1990s. The female Muslim chaplain noted that prior to beginning her chaplaincy volunteering in 1992, Muslim volunteers tended to lead prayers rather than visit patients. The 1998-1999 Chaplaincy Annual Report shows the team had Jewish and Muslim Pastoral Visitors and Visiting Hindu and Sikh Priests. The following year, an annual honorarium of £200 was introduced for the Muslim, Jewish and Sikh visitors (interview, Jewish volunteer, 15/05/2016; Chaplaincy Annual Report, 1999-2000) and similar arrangements were being made for the Hindu visitor (Chaplaincy Annual Report, 1999-2000). The appointment of the Muslim, Hindu, and Sikh chaplains to substantive posts arose out of a consultation with local faith communities spearheaded by the managing chaplain in 2000-2001 (interview, managing chaplain, 25/05/2016). A non-religious pastoral carer was appointed to the team in 2016. Increases in hours for minority faith chaplains were incremental and have been stagnant since 2007. Since substantive posts were introduced, the same Muslim and Hindu chaplains have been in post, but the Sikh chaplain has had two predecessors.

4.4.2   Volunteer Recruitment

Volunteer recruitment involved a preliminary interview with the chaplaincy manager, completion of an application form, and a joint interview with the

chaplaincy manager and a Voluntary Services representative. Minority faith chaplains were involved in the initial interview for minority faith candidates to ascertain whether the candidate was 'suitable to represent their faith' (interview, managing chaplain, 25/05/2016), although subsequent decisions about general suitability were made by the managing chaplain and Voluntary Services. Successful applicants attended a general induction course and were mentored for a probationary period of three months or ten visits, whichever was longer. Volunteers opting to work generically shadowed Christian chaplains, while volunteers who worked in a religion-specific way were mentored by a chaplain of the same faith. There was no discrete chaplaincy training course.

4.4.3   Chaplaincy Facilities

The chaplaincy offices at Woodford Green and White Oak were situated along the main hospital corridors. All chaplains and volunteers across sites had access to computers. The offices at Woodford Green contain an outer office used primarily by volunteers and an inner office used by the paid chaplains. Chaplaincy offices at White Oak comprise the chaplaincy manager's office adjacent to an office shared between chaplains and volunteers. The chaplaincy office at Birchsprings was not easily visible, and comprised a single room shared between the site chaplain and other volunteers, as well as other chaplains who might be on site on any given day. The offices could become busy when volunteers were in, but it was rare that team members could not access a computer as required. All chaplains have keys to the chaplaincy offices.

The prayer facilities at Woodford Green were recently refurbished, containing an 'interim' chapel,[24] separate Muslim prayer rooms and ablution facilities for men and women, and a Sikh/Hindu prayer room. Birchsprings had a multi-faith prayer room, split into 'Hindu, Muslim, and Sikh sections with curtains' (fieldnotes, 22/03/2016) and a separate chapel which contained a Hindu shrine. The facilities at White Oak included a chapel which contained a Hindu shrine, a quiet room, and a prayer room

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[24] The original hospital chapel was demolished, and a new 'proper' chapel had been promised to the chaplaincy team. The space in the prayer facility was used as an 'interim' chapel (interview, Catholic chaplain, 16/05/2016; interview Catholic chaplain, 26/04/2016; Chaplaincy Annual Report 2014-2015).

containing ablution facilities. A curtain down the middle of the prayer room could be drawn to separate men from women.

4.4.4 Role and Remit

All paid chaplains, and some minority faith volunteers, engaged in routine and emergency patient visiting. Translation for patients and staff may be an incidental aspect of patient visiting for minority faith chaplains, although a Muslim chaplain reported that he prefers not to translate (interview, Muslim chaplain, 12/05/2016). A Sikh chaplain emphasised that translation should be a boundaried role and that it was inappropriate for him to translate for 'specific medical information' (interview, Sikh chaplain, 26/05/2016). Muslim and Hindu chaplains provided advice and consultation on issues relating to end of life and organ donation, while the Sikh chaplain has mediated on issues relating to staff and patients wearing the 5Ks (fieldnotes, 08/04/2016).

The Hindu and Muslim chaplains were paid for weekend (daytime) and bank holiday on-call. Any additional out-of-hours support, and call-outs for the other minority faith chaplains, was unpaid and accrued TOIL. Conversely, when Free Church and Anglican chaplains were on call, they were paid a flat waiting rate and an additional rate while responding to call-outs. However, minority faith chaplains were not expected to make themselves available for call-outs, and volunteers may be called instead for cover. Sikh and Muslim volunteers responded to emergency calls when the relevant chaplains are unavailable (interview, Sikh volunteer, 28/04/2016; interview, Muslim volunteer, 24/05/2016).

All minority faith chaplains were involved in staff support. The Hindu chaplain had good relationships with domestic staff across faiths and advocated for staff at times of organisational overhaul (interview, Hindu chaplain, 25/04/2016). He also provided religion-specific care to staff, including advice on family issues and rites outside the hospital. The Sikh chaplain provided generic staff support through chance encounters and offering to be a presence for staff (interview, Sikh chaplain, 26/05/2016). The Muslim chaplains reported providing advice to staff (interview, female Muslim chaplain, 21/04/2016; interview, male Muslim chaplain, 26/05/2016), but the male

Muslim chaplain also reported that he supported distressed staff who had been treated badly by the family of an end of life patient (interview, Muslim chaplain, 26/05/2016).

Across sites, the Hindu chaplain organised and oversaw weekly Hindu prayer services and the male Muslim chaplain co-ordinated the Muslim prayers. The Muslim chaplain personally led Friday prayers at one site, while others were covered by volunteer imams. The Hindu chaplain reported that he incorporated Diwali and Sri Ratri celebrations into the regular Hindu prayer sessions (interview, Hindu chaplain, 25/04/2016). The National Sikh Day of Prayer was organised by the Sikh chaplain and volunteers and held in the chapel of the main site.

Christian chaplains had a watching brief for all prayer facilities. Minority faith chaplains were consulted for specific issues arising out of the use of the prayer facilities and asked to review literature found in the prayer facilities that was in a different language. Two Christian chaplains expressed discomfort about their role in monitoring facilities for different faiths (interview, Anglican chaplain, 22/04/2016; interview, Free Church chaplain, 11/05/2016).

The Hindu, Sikh, and male Muslim chaplains sit on the Equality and Diversity Advisory group, and the male Muslim chaplain regularly attended the Palliative Care MDT. Most generic institutional roles were undertaken by Christian chaplains, such as involvement Corporate Nursing meetings and delivery of training for hospital staff. The Hindu chaplain reported that all chaplains used to be involved in the Trust induction until cuts were made to the session. The chaplaincy team is visible at Trust-wide events, such as the annual Trust celebration event. The team proactively promoted the chaplaincy service through monthly multi-faith calendars, liaison with ward staff, the bimonthly chaplaincy bulletin, and the annual report. The minority faith chaplains contributed faith-specific content for these documents, but the collation was the remit of the Christian chaplains.

The Christian chaplains provided 'generic multi-faith' funerals for non-viable foetuses (fieldnotes, 18/03/2016), although standard operating procedures stated that mothers can 'choose to have a funeral within the context of their own faith/belief

system by making private arrangements' (Baby Funerals Standard Operating Procedure, January 2016). The Hindu chaplain discourages Hindu families from requesting hospital funerals, but made one exception after a patient requested it in her will (interview, Hindu chaplain, 25/04/2016). The male Muslim chaplain reported once facilitating a funeral and offering graveside prayers for a Muslim patient whose family were Christian (interview, Muslim chaplain, 26/05/2016).

4.4.5 Models of Operating

The chaplaincy team operated with a mixed model: while team members were open to generic visiting, the importance of appropriate, qualified, and professional personnel providing religion-specific care was emphasised. This reflected the managing chaplain's commitment to providing 'safe, high quality, and consistent' care (interview, chaplaincy manager, 25/05/2016). If a patient requested religion-specific care from a chaplain who was unavailable, existing Sikh and Muslim volunteers were called in rather than external community contacts. Volunteers could choose whether to be engaged in either generic, faith-specific or mixed (both generic and faith-specific) visiting roles. Two Muslim volunteers, a Sikh volunteer and a Buddhist volunteer engaged in mixed visiting. A Baha'i volunteer engaged in generic visiting but noted that if there was a Baha'i in hospital she would visit them in a personal capacity, not as a chaplaincy volunteer.

Christian chaplains prioritised reactive visiting by responding to referrals and following up 'flagged' patients before engaging in proactive generic visiting. A Free Church chaplain emphasised the importance 'being available' on the wards, especially to ward staff who might make a referral. In contrast, some Christian chaplains suggested that minority faith chaplains are less likely to visit generically (interview, Anglican chaplain, 22/04/2016). Despite time limitations, Muslim and Sikh chaplains reported that they were open to engaging in incidental or responsive (rather than proactive) generic visiting, by responding to patient cues and requests.

The Christian chaplains tended to have a primary base at one of the three hospitals but would go to other sites in order to fulfil institutional roles or attend team meetings. Conversely, the minority faith chaplains and the non-religious pastoral

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carer worked across sites and did not have a primary base. The Muslim chaplains spent less time at White Oak on the understanding that the Muslim volunteers based at this site would do the bulk of the patient visiting. Buddhist, Jewish, Jain, and Sikh volunteers visited across sites depending on demand.

4.4.6 Patient Information

The patient information system used by chaplaincy was created by the managing chaplain and enables all chaplaincy team members, including volunteers, to access patient information. The Jewish volunteer reported that previously he had to phone the chaplaincy to find out whether there were any patients to visit, but changes to the system meant that he was able to check independently (interview, Jewish volunteer, 15/05/2016).

4.4.7 Auditing and Record Keeping

Chaplaincy team members recorded their visits on the electronic patient record system. The chaplaincy kept tallies of emergency referrals and call-outs, which were collated into statistics for the annual report by the chaplaincy manager. Paid chaplains were encouraged by the Chief Nurse to put chaplaincy stickers in paper patient notes to show that chaplaincy have provided support to patients and increase the profile of chaplaincy.

4.4.8 Team Ethos

The team met regularly, with a Trust-wide paid chaplains' team meeting once every six weeks, monthly site-specific meetings for paid chaplains and volunteers that operate specifically at that site, and regular whole-time chaplains' meetings. All paid chaplains were encouraged to attend the Trust-wide meetings, but minority faith chaplains were exempt from the site meetings due to their limited working hours. Anglican, Free Church, and Sikh chaplains acknowledged that team meetings were important for encouraging team cohesion (interview, Free Church chaplain, 11/05/2016; interview, Sikh chaplain, 26/05/2016; interview, Anglican chaplain, 22/04/2016). At the beginning of Trust-wide meetings, chaplains alternately lead a meditation or reflection, usually from their own faith tradition (fieldnotes, 14/04/2016 and 26/05/2016). The whole-time chaplains' meetings involved only the

Christian chaplains due to their working hours, although an Anglican chaplain reported that he felt these meetings excluded his minority faith colleagues (interview, Anglican chaplain, 22/04/2016).

Chaplaincy team members at Woodford Green reported that there used to be morning prayer meetings. These meetings initially started with the Anglican chaplain and some Christian volunteers and later included a Sikh volunteer. Despite another Anglican chaplain's concerns about the use of 'exclusive language' by Christian volunteers (interview, Anglican chaplain, 22/04/2016), the Sikh volunteer reported she found these prayer sessions helpful (fieldnotes, 24/05/2016).

Christian chaplains expected the minority faith chaplains to have a role in co-ordinating and mentoring volunteers of the same faith. However, the managing chaplain reported that this was only the case for volunteers who visit in a religion-specific way. Both the Hindu and Muslim chaplains appeared to have a laissez-faire approach to co-ordinating volunteers, and communication was minimal.

There were some tensions about the perceived lack of engagement by some of the minority faith chaplains in team activities, including lack of attendance at team meetings and unwillingness to socialise. The lack of camaraderie from the male Muslim chaplain in particular led an Anglican chaplain, on two occasions, to suggest that he might be 'sympathetic' to extremist causes (fieldnotes, 19/04/2016; fieldnotes, 22/04/2016). Several team members noted that communication with the Hindu or male Muslim chaplains was mostly functional rather than sociable, and expressed a desire to build relationships.

4.5   STONEHAVEN TEACHING HOSPITALS TRUST

4.5.1   Diversifying the Team

The diversification of the chaplaincy team took place under the leadership of the previous chaplaincy manager. Local Hindu and Sikh communities had a significant role in campaigning for the introduction of multi-faith chaplaincy in the Trust (interview, Hindu chaplain, 29/07/2016). The male Muslim chaplain was appointed to a paid post in 1999. A female Muslim chaplain was introduced at the same time,

but the post-holder has since left and been replaced by a second generation of female Muslim chaplains. The current Hindu chaplain initially started as a volunteer whose role was extended to cover Sikhs when the previous Sikh and Hindu chaplains left post. A combination of community lobbying and advocacy from the chaplaincy manager led to the posts being reinstated and a subsequent increase in hours.

The female Muslim chaplains commented on the increasing diversity of the volunteer base. A female Muslim chaplain reported that her Christian colleague was keen to monitor the balance of faiths in the volunteer base but argued that while there was an increase in Muslim volunteers, there was a higher turnover as they tended to be younger (interview, Muslim chaplain, 29/07/2016).

4.5.2   Volunteer Recruitment

The chaplaincy team recruited volunteers independently of voluntary services. The chaplaincy team maintained strong relationships with the voluntary services manager to ensure compliance with institutional and legal requirements. Recruitment interviews were organised by the administrator and two chaplains were allocated to conduct an interview according to their availability. It was possible that the chaplains interviewing did not share the faith background of the prospective volunteer. The chaplaincy provided a four-day formal volunteer training programme.

4.5.3   Chaplaincy Facilities

Despite most services being concentrated at Thatch End, the chaplaincy team had considerably more office space at Flaxheath. At Flaxheath, the chaplaincy complex comprised four adjacent offices, including the main office (where the administrator was based), the managing chaplain's office, the volunteers' office, and the 'archive room'. In contrast, Thatch End had one very small chaplaincy office with three desks shared between five chaplains and a volunteers' office next door. All chaplains had access to a computer but occasionally needed to negotiate a place at a desk if more than three chaplains wished to use the office.

The prayer facility at Flaxheath was divided into two spaces by a curtain. On one side of the curtain was the chapel section. The other side was a 'multi-faith' prayer

area, although prayer mats were a permanent fixture on the floor of this area, suggesting that its primary purpose was for Muslim prayer. A large khanda statue on top of the drawers allocated for each faith stood out as an incongruous and visible aspect of the room. At the time of the study, a new Muslim prayer facility had been opened near the main entrance of Thatch End. This included male and female prayer rooms with corresponding ablution facilities and an office. This facility came about following a CQC inspection, where the previous facilities were considered to be inadequate. [25] The old Muslim prayer room was still in use. An adjacent disabled toilet was used as an ablution facility, with stakeholders and chaplains reporting this was not fit for purpose, either for Muslims using the prayer room or for disabled users.

The chapel, a repurposed office space which was deemed unfit for purpose by Muslim and Christian chaplains, was located along the main corridor. There were no facilities available for Hindus and Sikhs, with the Hindu and Sikh chaplains noting that they would organise more festival celebrations if they had the appropriate facilities (interview, Sikh chaplain, 12/08/2016; interview, Hindu chaplain, 09/08/2016).

4.5.4   Role and Remit

Chaplains and volunteers engaged in routine patient visits and a formal on-call mechanism was in place for the Muslim and Christian chaplains. Chaplaincy team members were not allowed to translate for staff. Chaplains occasionally engaged in community follow-up visits to patients, subject to the managing chaplain's permission (interview, female Muslim chaplain, 25/07/2016; interview, Hindu chaplain, 09/08/2016). The Muslim chaplains had a significant role as intermediaries between patients/visitors and staff. This was most apparent in the role of the male Muslim chaplain in 'crowd control' for large numbers of Muslim visitors in wards

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[25] This was reinforced when the CQC conducted a follow-up inspection, prompting the Trust to take urgent action to create a new prayer facility (fieldnotes, conversation with managing chaplain, 13/06/2016).

during emergencies or crises.[26] Muslim chaplains were also regularly called to provide advice on bio-ethical issues. At the time of the study, Christian and Muslim chaplains were also advocating a change in protocol to ensure dignity for non-viable foetuses leading up to burial (fieldnotes, 27/06/2016).

Chaplains reported that demand for staff support has risen recently following the increased presence of chaplains on the wards (interview, Muslim chaplain, 29/07/2016). The support offered by chaplaincy includes both structured (scheduled, referral-based sessions) and unstructured (ad hoc, chance encounter) support; practical support (advising on professional or personal issues or 'crowd control'); institutional advocacy (for employment issues such as bullying and discrimination); and regular check-ins (support offered in the context of longstanding relationships with staff).

The male Muslim chaplain led daily prayers and *Jumu'ah* prayers, usually at Thatch End. While there were no Sunday services at Stonehaven, there was an annual Christmas carol service. The National Sikh Day of Prayer was organised by the Sikh chaplain, which takes place in the chapel at Thatch End. There were no Eid celebrations, but Muslim chaplains ensured there were enough supplies for Muslim staff to observe *iftar* during Ramadan.

During the study, the Muslim chaplains had a significant role maintaining the newly opened prayer facilities. Much time was spent informing cleaning staff of the etiquette around prayer spaces (such as the removal of shoes) with minimal success, which required the Muslim chaplains to take on cleaning responsibilities themselves. Chaplains proactively monitored literature left in the hospital or donated to the chaplaincy, although literature was not as thoroughly reviewed at Flaxheath (fieldnotes, 04/07/2016).

While all paid team members were encouraged to be present at corporate events and initiatives to increase the profile of chaplaincy (such as a chaplaincy 'launch' and

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[26] The female Muslim chaplains occasionally reported engaging in 'crowd control', although this was primarily a role carried out by the male Muslim chaplain.

manning a stand at the Trust's AGM), the provision of training to hospital staff, and attendance at MDTs and committees was most common among the Muslim and Christian chaplains. MDT involvement usually arose in response to ad hoc requests for specialist input from Muslims chaplains on complex cases. This included end of life decision making for families, cases of domestic abuse, and one case where the cause of illness was thought to be 'spiritual' rather than 'medical' by the family and the physiotherapist (interview, Muslim chaplain, 28/07/2016). Muslim chaplains identified specialisms such as ICU, oncology, and infectious diseases as 'the usual suspects' for requesting chaplaincy input (interview, Muslim chaplain, 08/08/2016). Additionally, the Muslim chaplains and the Sikh chaplain were consulted by various stakeholders on specific issues relating to religion or culture. Muslim chaplains responded to bio-ethical matters (procedural advice on end of life issues, concerns about halal diet and medication, and the use of milk banks by new mothers) and issues arising that linked to health equalities (ensuring pregnant women attended scans during Ramadan and raising staff awareness about cultural understandings of chronic pain), while the Sikh chaplain tended to address issues around wearing the 5Ks in hospital.

Hospital funerals were most often conducted by the Christian chaplain. Minority faith chaplains were rarely involved in conducting funerals, instead taking on a facilitative role and mobilising their local communities (interview, Muslim chaplain, 15/08/2016), especially in the event of a funeral for a mixed-faith family (interview, Sikh chaplain, 02/08/2016). The Muslim chaplain and Christian chaplain jointly presided over trimonthly communal burials of pre-term babies.

4.5.5   Models of Operating

Chaplaincy team members operated using a mixed model of chaplaincy. The Muslim, Sikh, and Hindu chaplains prioritised visiting patients of their own faith, with two Muslim chaplain making specific reference to their job descriptions (interview, Muslim chaplain, 25/07/2016; interview, Muslim chaplain, 15/08/2016). The Christian chaplain's primary approach was to generically visit on a bed-to-bed basis where possible. Volunteers also operated generically but were encouraged to refer patients to chaplaincy if specific religious support was required.

Religion-specific visiting was guided by patient lists and referrals, and by proactively seeking patients to speak to (for example, the Sikh chaplain checking the bowel screening unit and A&E for Sikh patients, or Muslim chaplains asking ward staff if any patients would benefit from a visit). The Hindu chaplain tended to keep to patient lists and referrals. However, the Muslim and Sikh chaplains reported that they also respond to patients who flag them down and start a conversation, or visit any patient referred to them by ward staff. The female Muslim chaplains also reported that there were particular wards that they visit generically including maternity, wards associated with women's health, and paediatrics (interview, female Muslim chaplain, 01/08/2016). Paid chaplains tended only to visit Flaxheath if they knew a patient of their faith was on site, although a Muslim chaplain reported making general visits to the dialysis unit (interview, female Muslim chaplain 01/08/2016).

4.5.6 Patient Information

All paid chaplains had access to patient information. However, patient information was often inaccurate, with ward staff regularly informing chaplains that patients had been discharged or transferred to another ward. The proactive approach of the chaplains helped mitigate these issues, and one chaplain commented that the posters featuring the chaplaincy team were helpful for generating referrals (interview, Muslim chaplain, 01/08/2016).

4.5.7 Auditing and Record Keeping

Volunteers recorded the number of patients visited and referrals for the chaplains. One of the Muslim chaplains used the data about volunteer visits earlier in the week to prioritise wards that have not been visited (fieldnotes, 04/07/2016). The chaplaincy administrator collated volunteer records, referrals received in the main chaplaincy office, approved community visits, and call-out sheets for urgent referrals. Chaplaincy team members reported that data was collected on chaplaincy activity for a year, but that the report produced seemed to have little impact. This may explain why there was no formal mechanism in place for recording chaplains' routine daily ward visits. While a female Muslim chaplain reported that chaplains were able to write in hard copies of patient notes, there was no evidence of this

happening when shadowing the chaplains. The administrator commented that community and word-of-mouth referrals for the managing chaplain were not always recorded (interview, administrator, 16/08/2016).

A review was conducted in 2012 to assess how far the service model of the chaplaincy was fit for purpose. The managing chaplain reported that the review was prompted by his request for chaplaincy to stop engaging in income-generating activities when he was appointed. These income-generating activities included the previous Free Church and Anglican chaplains providing private funerals and the Muslim chaplains providing external training, which were 'taking us away from our core work within the hospital' (interview, managing chaplain, 19/08/2016). One team member had been concerned that the review would reduce the hours allocated to chaplaincy, but suggested that the managing chaplain was instrumental in ultimately securing extra hours for the team (interview, administrator, 16/08/2016).

At the time of the study, some team members were optimistic about the potential of the Electronic Patient Records System to help with auditing and record keeping, but it has since transpired that chaplaincy do not have access (personal communication, Christian chaplain, 20/07/2018).

4.5.8   Changes in Leadership

Team members and stakeholders alike commented on the changes brought about by the change of management. The current managing chaplain referred to the previous managing chaplain not challenging the Trust when the old chapel was re-appropriated for other uses, and when the team was required to supplement their own income. In contrast, the current managing chaplain had a significant role in lobbying the Trust for new prayer facilities and to maintain or increase hours for the Sikh, Hindu and Muslim chaplains, as well as the chaplaincy administrator.

4.5.9   Team Ethos

The team had monthly formal team meetings, although these tended only to include the Christian and Muslim chaplains, and the administrator. Hindu and Sikh chaplains were instead invited to contribute to team meetings on an issue-specific basis due to

their limited hours. This partial involvement reflected the managing chaplain's concern that attendance at team meetings did not interfere unduly with the routine patient visits of the Hindu and Sikh chaplains. The team go on annual away days with the managing chaplain's line manager, the Deputy Chief Nurse, in order to strategise for the year.

The setup of the chaplaincy offices at Thatch End often militated against casual informal encounters and debriefing opportunities between chaplains and volunteers. Due to the location of the Thatch End chaplaincy offices, the chaplaincy team had set up signing in points for volunteers throughout the main hospital. Volunteers were allocated mentors from among the Muslim and Christian chaplains, although the Sikh chaplain was also willing to offer informal support to volunteers. The Muslim chaplains also commented that they worked hard to ensure that they did not spend too much time in the office adjacent to the new prayer facilities in order to maintain positive team relationships. Some unresolved tensions between the Christian and Muslim chaplains became apparent during the fieldwork. These related to practical issues such as expenses and differing approaches to providing spiritual care.

4.6   MOORLANDS HOSPITAL

The chaplaincy team was ecumenical and any minority faith involvement was facilitated through external community-based contacts. The recent CQC inspection report noted that the contact list for religious leaders was 'limited and rarely used' and that 'availability of other faith leaders was variable' (CQC Report, August 2016).

4.6.1   Volunteer Recruitment

Recruitment of chaplaincy volunteers was the joint responsibility of the lead chaplain and the voluntary services manager. The lead chaplain conducted an informal interview with volunteers before a joint formal interview with the voluntary services manager. The Anglican chaplain expressed concerns that the volunteer recruitment process was undergirded by a narrow view of 'churchmanship' (interview, Anglican chaplain, 23/09/2016) and felt that the opportunity to volunteer should be offered to 'people of all faith and none' (interview, Anglican chaplain, 22/09/2016).

Excepting Trust induction, initial volunteer training appeared to be 'on the job', where volunteers were encouraged to engage in 'reflective practice' based on their experiences on the wards (interview, lead chaplain, 27/09/2016). The chaplaincy also organised three training sessions each year for volunteers, including training on 'how to share faith' (interview, lead chaplain, 27/09/2016), and training delivered by Muslim doctors about Islamic understandings of end of life (fieldnotes, 06/09/2016).

4.6.2 Chaplaincy Facilities

The chaplaincy offices were based in the chapel on the main corridor. The chapel contains the lead chaplains' office, an office for the Anglican chaplain and administrator, and a volunteers' office. There was also a separate multi-faith prayer room in the chapel, and a disabled toilet that doubles as an ablution facility. The multi-faith room contained a basket of prayer mats and a *qibla*, some cushions and a kneeler. The room was primarily used by Muslim staff for daily prayers. Outside the multi-faith prayer room, a 'faiths' bookcase holding five baskets that were each labelled with a religion contained holy texts and prayer books. The multi-faith prayer room was adequate for daily *salat* but too small for *Jumu'ah* prayers, which took place in the chapel. The chapel had a wooden divide separating the main chapel space from the back area where there were easy chairs, which was often drawn when Friday prayers were taking place (fieldnotes, 09/09/2016).

4.6.3 Role and Remit

Chaplains engaged in both emergency and routine visits. Emergency call-outs are covered by paid and honorary chaplains. Volunteers engaged with all patients, some of whom routinely offered prayer and left laminated Bible verses with patients. Volunteer stewards brought patients to weekly Sunday services, which were also broadcast on hospital television. The chaplaincy also ran a 'chaplaincy friend' service which provided community-based support to discharged patients. One volunteer also noted that chaplaincy can be a bridge between patients and staff when patients are uncertain about aspects of their care (interview, volunteer, 14/09/2016). Chaplains and volunteers alike offered staff support.

One of the volunteers had a particular remit for maintaining the chapel by ensuring that the 'faith baskets' contained appropriate resources for different religions, monitoring prayer cards and leaflets, removing unsuitable literature (such as evangelical leaflets), and keeping the notice boards updated (interview, volunteer, 14/09/2016).

The lead chaplain was involved in the organ donation committee, MAJAX (major accident/incident planning) committee, and End of Life Care meetings. The chaplaincy also hosted an induction session in the chapel, during which a Gideon's representative explained his role in replenishing the Bibles in patient lockers and distributed Bibles to new staff. The chaplains offer training which introduces staff to spirituality (interview, lead chaplain, 27/09/2016). The lead chaplain also dealt with a one-off staff enquiry about time off during Ramadan, but had to request assistance from outside the hospital in order to respond to the enquiry.

The chaplaincy provided adult hospital funerals and a woodland burial for non-viable foetuses. Adult funerals were provided for patients without next of kin, but also for those patients and families the chaplaincy has developed strong relationships with (interview, stakeholder, 23/09/2016).

4.6.4 Models of Operating

Volunteers were allocated wards and proactively visited patients bed-to-bed. The Anglican chaplain noted that her first priority was referrals and follow ups, followed by visiting particular areas of responsibility (including maternity, the children's ward and the Macmillan unit) and then maintaining a regular presence in wards across the hospital (interview, Anglican chaplain, 23/09/2016). The Catholic chaplains operated with a religion-specific model. Volunteers may also respond to routine 'non-urgent' referrals, but only the honorary, Roman Catholic, and paid chaplains provide urgent, on-call, and sacramental support.

The lead chaplain expressed concerns about the trend towards 'generic chaplaincy', which he perceived as requiring a change in his beliefs/identity from person to person (interview, lead chaplain, 27/09/2016). At the same time, the lead chaplain

appeared reluctant to adopt a multi-faith approach. While the chaplaincy had a community contact list, facilitating religion-specific support appeared to be a 'bottom line' (interview, lead chaplain, 27/09/2016), where Muslim patients were encouraged to find their own imam before chaplaincy facilitated religion-specific care. Similarly, when responding to the enquiry about time off during Ramadan, the lead chaplain seemed only to request advice from Christian colleagues and appeared reluctant to consult Muslim chaplains (fieldnotes, 05/09/2016 and 27/09/2016).

4.6.5   Patient Information

The lead chaplain and Anglican chaplain had access to patient information, but this access did not extend to the Roman Catholic chaplains, honorary chaplains, or volunteers. Catholic chaplains depended on referrals from the presbytery and referrals picked up on the wards by other chaplaincy team members (fieldnotes, 06/09/2016; interview, Anglican chaplain, 23/09/2016).

4.6.6   Auditing and Record Keeping

All volunteers recorded the number of patients encounters in notebooks that were kept in the volunteers' office. The lead chaplain also completed a daily log of his activities, as requested by his line manager (fieldnotes, 08/09/2016). Where necessary, chaplains completed a log of emergency call-outs (fieldnotes, 08/09/2016).

Requests for follow up, communion, or to attend the Sunday service were written on paper forms and written up in a referral database set up by the lead chaplain. According to the lead chaplain, the chaplaincy received just under 600 referrals between February and September 2016 (fieldnotes, 05/09/2016). A notebook for the Roman Catholic chaplains was kept in the volunteers' office where chaplaincy colleagues wrote down referrals for the Roman Catholic chaplains (fieldnotes, 15/09/2016).

4.6.7   Changes in Leadership

Significant differences were evident in the leadership of the current chaplain and his predecessor regarding multi-faith working. In a sabbatical report, the previous lead

chaplain outlined a more 'inclusive' multi-faith approach to chaplaincy, including the appointment of an honorary Muslim chaplain, developing links with Muslim staff, keeping an appropriate supply of prayer leaflets for different faiths, and maintaining working links with the local inter-faith form through the Chaplaincy Multi-Faith Working Group.[27] In the same report, emphasis was placed on ensuring that 'Christians are also not discriminated against' when implementing a multi-faith approach (p. 9).

The current lead chaplain also expressed concerns about the multi-faith approach to chaplaincy, but this appeared to extend to the involvement of different faith or belief representatives in chaplaincy:

> I think we have a rich heritage and I'm afraid we might be
> throwing some of it away because we are... if I say soft, do you
> know what I mean? We're not standing up for what we believe to
> the extent I would like us to. We've allowed others to take our
> territory… (interview, lead chaplain, 27/09/2016)

This quote highlights the lead chaplain's view that chaplaincy is a fundamentally Christian endeavour. This was reflected in volunteer badges which displayed a cross alongside their names, the content of the morning prayer sessions (see below), and the regularity of volunteers offering prayer, reading the Bible, or giving laminated scriptural quotes to patients. A relaxed approach to evangelism was apparent in the regular unsupervised involvement of the Gideons. No reference was made during the study to the honorary Muslim chaplain mentioned in the sabbatical report. The lead chaplain facilitated the use of chapel space by Muslim staff for *Jumu'ah* prayers and reported organising 'multi-faith meetings' but stated that only the Equality and Diversity officer and one or two Muslim staff might attend. The lead chaplain noted that the local inter-faith forum need not attend these meetings (interview, lead chaplain, 27/09/2016).

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[27] A citation was not given here in order to preserve the anonymity of the site.

4.6.8   Team Ethos

The team gathered for prayer meetings every morning before and after the volunteers went for their visits. The first set of prayers were open to the public, while the second prayer session was not advertised, as it also doubled as a debriefing session. Most volunteers valued both prayer meetings and felt supported as a result of attending. The lead chaplain commented that the daily prayers contribute to the distinctive Christian ethos of chaplaincy: 'so we start off, like Christians start off the first day of the week, they give the first day of the week to Christ, we give the first half hour of our working day to the Lord…' (interview, lead chaplain, 27/09/2016). In contrast, a volunteer within the team expressed his hopes that one day someone from a different faith might join the prayers: 'I know that they are always Christian in their delivery, but I do live in hope that a Sikh, a Jew, a Muslim, a Hindu, somebody may feel that they want to join for that…' (interview, volunteer, 14/09/2016). The Catholic chaplains tended not to attend morning prayers due to their limited working hours. The deputy chaplain was often absent, and expressed concern about the 'tenor' of the prayer meetings where she thought 'sometimes it just reinforces people's particular preferences in terms of their expression of their faith' (interview, Anglican chaplain, 22/09/2016).

The Anglican chaplain also expressed discomfort with the banter amongst the chaplaincy team, which she reported to include anti-Catholic sentiment and would occasionally involve 'gender joshing', reinforcing her concerns that the volunteer base were a 'common lot' (interview, Anglican chaplain, 23/09/2016). The combination of these factors led to tensions between the Anglican chaplain and lead chaplain after the Anglican chaplain reported these issues to the lead chaplain's line manager.

4.7   CONCLUSIONS: CONTINUITY AND CHANGE

This chapter has explored the working practices of each chaplaincy team, especially in relation to minority faith involvement. These overviews confirm Gilliat-Ray *et al.*'s findings that chaplaincy has diversified considerably since the turn of the century, with increasingly formalised roles for minority faith chaplains (see also Gilliat-Ray 2008). The recognition of the role of minority faith chaplains was most

explicitly expressed in the creation of paid minority faith chaplaincy posts at Riverside, Greenacre, Stonehaven, and eventually Westview, and in the 'badging up' process at Northbrook Hospital (interview, Anglican chaplain, Northbrook, 14/12/2015). It is clear, however, that substantive paid roles are less common (if not non-existent) for Buddhist, Jain, and Baha'i representatives.

4.7.1 From 'Visiting Minister' to 'Chaplain'

There has been some commentary on the transition from visiting ministers to Muslim chaplains (Gilliat-Ray 2008; Gilliat-Ray *et al*. 2013: 49). This was partially reflected in the data, where five of twelve minority faith chaplains reported that they had begun their chaplaincy work as regular volunteers and had latterly taken up substantive posts. Minority faith post-holders were appointed through standard hospital recruitment procedure, in contrast with the informal recruitment of visiting ministers and volunteers (Beckford and Gilliat 1996; Orchard 2000). At three sites, Muslim and Hindu chaplains reported that they had started their paid roles between 1999 and 2006, echoing Gilliat-Ray's findings that the early to mid 2000s constituted a key milestone for the development of multi-faith chaplaincy (2008: 149). The appointments of the first minority faith chaplains at Greenacre and Stonehaven preceded the *Caring for the Spirit* guidelines (SYWDC 2003), while substantive minority faith posts were introduced at Riverside three years after the guidelines launched. Some more recent appointments are successors to these initial pioneers.

4.7.2 Formalising Voluntary Involvement

Contemporary voluntary involvement in chaplaincy has only received cursory comment in the empirical literature (Faith Matters 2010; Gilliat-Ray *et al*. 2013: 102, 104, 105, 139; Bryant 2014), despite featuring in chaplaincy guidelines (DoH 2003b; NHS England 2015a). The findings show a trend towards increasingly formalised methods of volunteer recruitment and training, which will be explored in more detail in subsequent chapters.

4.7.3 Factors Contributing to Multi-Faith Developments

Despite significant developments in 'multi-faith' chaplaincy, the findings echo observations made by chaplains that multi-faith provision was 'patchy at best'

(Welford 2011: 229). Localised factors contributed to the involvement of minority faith team members. The commitment and 'personal initiative' of lead chaplains continues to be an essential aspect of developing multi-faith chaplaincy teams (or not), showing little change from Beckford and Gilliat's observations twenty years ago (1996: 508). This was apparent at Westview, which was relatively late to develop a multi-faith approach to chaplaincy, partly due to the different attitudes of lead chaplains and the institutional context. Some other factors also contributed to the development of multi-faith working, including a community consultation organised by hospital managers at Stonehaven[28] and spearheaded by the lead chaplain at Greenacre, and executive decision-making at Riverside (interview, Anglican chaplain, 05/11/2016). This contrasts with Orchard's finding that chaplains were concerned about whether Trust senior management were 'on board' with the multi-faith agenda (Orchard 2000:44). Even when the lead chaplain at Westview struggled to secure funding for a Muslim chaplaincy post, stakeholders were broadly supportive of diversifying the chaplaincy team, but the main consideration appeared to be the cost implications.

On two occasions, the Care Quality Commission (CQC) had prompted multi-faith developments. At Stonehaven, the chaplaincy had long campaigned for improved multi-faith facilities, although the provision of adequate Muslim prayer facilities arose only when the CQC intervened (fieldnotes 13/06/2016). At Moorlands, the CQC raised concerns about how chaplaincy was addressing 'multi-faith' issues and the lead chaplain had been required to propose an action plan to address this (interview, stakeholder, 15/09/2016).

4.7.4   Models of Chaplaincy

While all teams were able to call in minority faith contacts, four of six teams regularly involved minority faith groups (either paid or voluntary). Two of six teams (Greenacre and Stonehaven) had developed multi-faith teams with regular hours, autonomous working, and some degree of involvement in team meetings and

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[28] It is difficult to tell how far chaplaincy was involved or consulted about the involvement of minority faith chaplains. The Hindu chaplain commented that chaplaincy services were only provided by one Christian chaplain at the time (interview, Hindu chaplain, Stonehaven, 29/07/2016).

institutional roles for minority faith chaplains. Developing a multi-faith team was ongoing for Westview, but Muslim volunteers offered a regular service and engaged in institutional roles. Minority faith involvement was regular at Riverside, although the minority faith chaplains lacked autonomy, did not fully participate as team members, and their roles were limited to patient visiting and organising regular prayers or festivals. In contrast, for Northbrook Hospital and Moorlands Hospital, minority faith representatives were kept at arms-length and lead chaplains appeared reluctant to facilitate visits, suggesting that issues of access and gatekeeping identified by Beckford and Gilliat (1996) and Orchard (2000) are still live in the contemporary chaplaincy context.

Three teams – Westview, Greenacre, and Stonehaven - operated with a 'mixed' model of chaplaincy, using both generic and religion-specific approaches. The two chaplaincy teams serving Fairbank operated with polar opposite models. Moorlands operated outside of these models, by providing a distinctively Christian service with an evangelical orientation. Team members described the model as 'ecumenical', but the lead chaplain's vision of a distinctively Christian team indicates that 'single-faith' model might be a more flexible term to use.

There was some evidence that the model of chaplaincy used impacts on the demand for minority faith chaplaincy provision. While availability of statistics on referrals varied between sites, a key example can be seen in the comparison between the statistics for Northbrook (generic model) and Greenacre (mixed model, with emphasis on religion-specific care). The table below indicates the referrals for minority faith support at Northbrook and Greenacre over a three-year period (2012-2015).

Table 5: Referrals received by chaplaincy at Northbrook and Greenacre, 2012-2015

		Referrals April 2012-April 2015			
		Hindu	Muslim	Sikh	Other
Northbrook		8	15*	9	N/A
Greenacre		281	61	41	13
	Woodford Green	193	42	26	8
	White Oak	23	7	7	0
	Birchsprings	65	15	10	5

*This includes a referral where the imam was not available to visit the patient

A three-year period was selected due to the records kept by the team at Northbrook, which started in January 2012 through to October 2015 (fieldnotes, 02/11/2015) but also due to the variable demand year on year. The figures for Greenacre were obtained from chaplaincy reports which run from April-April each year (again 2012-2015). Any referrals at Northbrook made before April 2012 and after April 2015 were excluded from the comparison.

The table shows that there were significantly higher numbers of referrals at Greenacre than at Northbrook across faiths, although Greenacre includes statistics across three hospitals. It is notable, however, that number of Hindu call-outs at any one of the hospitals at Greenacre far exceed the number of call-outs for Northbrook. While the local demographic for Greenacre (15.2%) has nearly twice as many Hindus as that of Northbrook (8.5%), it is clear that referrals are not simply made in proportion to the local population, but that other factors contributed to patient 'demand'. Tellingly, even though Northbrook has nearly twice as many Sikhs locally (7.9%) as Greenacre (4.4%), only White Oak Hospital had fewer call-outs over a three-year period. It must be noted that Northbrook and each site within Greenacre have different catchments, with Birchsprings Hospital offering specialist cardiology services which bring in patients from across the region, from locations which are not as religiously diverse. While the 'demand' for a Hindu chaplain at Greenacre far exceeds Northbrook, this cannot be solely accounted for by local demographic. A correlation cannot be made between demography and demand: while Greenacre's local demography had a higher proportion of Muslims than Hindus, the number of call-outs for the Muslim chaplain was lower across all sites.

4.7.5 Room for Regression

It is easy to assume that once chaplaincy teams have diversified, the multi-faith model will be maintained or developed. However, at two sites any progress concerning multi-faith involvement had been reversed: 'It's odd to me that you come now at a time when ironically I think we're doing less multi-faith work than I've ever done…' (interview, Anglican chaplain, Northbrook, 07/12/2015). At Northbrook and Moorlands, changes in leadership led to minority faith representatives being side-lined when they had previously had been accommodated.

Regressions in provision might also result from decisions made external to the chaplaincy team. At Stonehaven, stakeholder concerns for cost-effectiveness had meant that no immediate attempts were made to replace the first-generation Sikh and Hindu chaplains that had retired. At this site, the local Hindu and Sikh communities and the managing chaplain were instrumental in lobbying the Trust to reinstate paid Hindu and Sikh chaplaincy posts, and at later stages increasing the hours allocated.

At three sites, while the multi-faith model was retained, there was little evidence of career progression for minority faith chaplains, especially for Hindu and Sikh chaplains. Only one male Muslim chaplain was able to trace a straightforward trajectory of incremental increase in hours and an eventual promotion to a senior position. Conversely, Hindu, Muslim, and Jewish chaplains at Riverside saw no increase in hours from when they started ten years prior. This stagnation also applied to the Muslim, Hindu, and Sikh chaplains at Greenacre, whose hours had not increased since 2007. Any previous increase in hours had been small and incremental. Likewise, increases in allocations of hours were incremental for Sikh and Hindu chaplains at Stonehaven, contrasting sharply with their Muslim colleagues.

Gilliat-Ray *et al*.'s findings provide a helpful insight into the role and politics of Muslim chaplaincy, although they do not fully explain why some Muslim chaplains appear to have successfully reached senior positions, while others have barely seen an increase in hours since starting their chaplaincy roles nearly twenty years ago. The distinction between paid and full-time begins to explain this gap (Gilliat-Ray *et al*.

2013: 95), although other potential factors must be considered. The boundaries of inclusion and exclusion do not just vary between different kinds of public institution (Gilliat-Ray *et al*. 2013: 103), but also between Trusts. The use of case studies helps explore more localised politics which impact on the career progression on minority faith chaplains generally.

4.7.6 Three Challenges Facing Minority Faith Chaplains: Negotiation, Stagnation, Mediation

Three key problems have been identified concerning the integration of minority faiths in chaplaincy. Firstly, minority faith involvement in chaplaincy is highly contested, negotiated, and unstable, as shown by the changing fortunes of minority faith chaplains over the past decade. Secondly, career stagnation affects a significant proportion of minority faith chaplains, although some Muslim chaplains are an exception. Thirdly, the variability of demand highlighted above points the differential ways in which demand is mediated by different actors. Demand is often treated as an unproblematic metric for supporting or undermining minority faith involvement, and determines the way in which resources (personnel, finance, office space) are distributed between different faiths. Demand can also be mediated through the varying levels of recognition from patients, staff, and chaplaincy colleagues. With these challenges in mind, the next two chapters will begin to explore these issues through the lenses of distribution, socialisation, and recognition.

5 Findings: Parity of Participation

Following Gilliat-Ray *et al*.'s observation that the 'economy of power relations in chaplaincy is marked by the unequal distribution of…social, religious, and educational capital' (2013: 62), this chapter focuses on the challenges of negotiation, stagnation, and mediation implicated in minority faith involvement identified in the previous chapter. First, I will outline the overarching theoretical framework of 'participatory parity' (Fraser 2003), and the concomitant conceptual lenses of redistribution and recognition. Within this framework, I draw on Bourdieu's concepts of field and capital (Bourdieu 1986; Bourdieu and Wacquant 1992), the differing but complementary uses of Bourdieu and Fraser's accounts of (mis)recognition (James 2015, see also Lovell 2007), and processes of organisational/occupational socialisation (Van Maanen and Schein 1978; Atkinson and Delamont 1985; Chao *et al*. 1994). Secondly, I provide further information about the backgrounds of the chaplaincy representatives involved in the study as groundwork for the ensuing discussion. Thirdly, I will discuss the findings with reference to the organising themes above in order to highlight economic, educational, and cultural dimensions of participatory parity in chaplaincy.

5.1.1 Participatory Parity and The Politics of Recognition

Participatory parity refers to the extent to which social arrangements 'permit all (adult) members of society to interact with one another as peers' (Fraser 2003: 36). Parity of participation requires satisfaction of two requirements: redistribution and recognition. Redistribution requires that 'the material distribution of resources must…ensure participants' independence and voice', while recognition requires that 'institutionalised patterns of cultural value express equal respect for all participants and ensure equal opportunity for achieving social esteem' (ibid.).

Both redistribution and recognition should be considered as separate analytical counterpoints through employing a 'perspectival dualism' (Fraser 2003: 93). This analytical approach emerged in conjunction with data analysis and correspondence with themes identified the literature review. The findings of Orchard (2000) and Beckford and Gilliat (1996) highlighted that parity of participation for minority faith representatives in chaplaincy was hindered by the brokerage model. The brokerage model denied autonomy and voice to largely unremunerated minority faith representatives through reliance on the goodwill of Anglican chaplains as institutional gatekeepers, and exclusion from decision-making mechanisms such as team meetings (Beckford and Gilliat 1996: 339; Orchard 2000: 29). The lack of minority faith contributions to the chaplaincy literature contributes to this lack of voice in the present day. Concomitantly, the view expressed by a chaplain that 'in Anglicanism there is a spirit of fairness and justice that is not in other denominations' (Orchard 2000: 58) justified the continued dominance of Anglicanism due to its 'inclusive' oversight of all patients. Cultural value is attributed to 'openness' to meet the needs of all patients, while contrasted with other denominations and religions which are implicitly constructed as exclusive. Until Anglican chaplains recognised the potential contribution of different denominations and religious groups to chaplaincy, equal respect, and equal opportunity was not forthcoming.

5.1.2   The 'Fields' Chaplaincy Inhabits

Reference will also be made to the 'fields' that chaplaincy inhabits. Bourdieu defines a field as a 'network, or a configuration, of objective relations between positions' (Bourdieu and Wacquant 1992: 97). While Bourdieu's language of struggle characterises Bourdieu's understanding of field elsewhere (such as Bourdieu and Wacquant 1992: 17-18; Bourdieu 1986: 50; Bourdieu 1991b: 58), it is more instructive to view relationships between positions in the field in terms of negotiation, which can involve *both* struggle and co-operation. The analogies of the 'battlefield' (McKinnon, Trzebiatowska, and Brittain 2011: 357) or the 'game' (Bourdieu 1986: 46; Bourdieu 1991b: 179-180; Bourdieu and Wacquant 1992: 99) which support this concept must account for co-operation *and* conflict.

5.1.3 Capital and Rate of Exchange

Capital refers to the 'differential resources of power' which position actors within the social field (Schuller, Baron, and Field 2000: 3-4). Capital also links cultural and economic analyses of inequalities, overlapping with Fraser's approach. Following Bourdieu (1986), cultural capital has three forms: institutionalised capital (accreditation, credentials, qualifications); embodied capital ('dispositions of the mind and body' such as manners, demeanour, and language); or objectified capital (in the form of cultural goods/property such as books, equipment, clothing). Additionally, social capital is the sum of resources arising from 'possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition' (Bourdieu and Wacquant 1992: 119), and symbolic capital refers to 'accumulated prestige or honour' (Guest 2007: 185). Later in this thesis, I will also refer to the concept of religious capital in relation to the 'religious competencies' of chaplains (Bourdieu 1991a; Verter 2003: 157) and the linguistic capital of chaplains (Bourdieu 1991b).

Norwood (2006) identifies the need for chaplains to translate discourse between the domains of religion and medicine. Similarly, I argue that recognition is largely dependent on the successful transfer of a chaplain's capital between the fields of religion and medicine, and across institutional and professional domains. I draw on Bourdieu's 'rate of exchange' (Todd 2015a; McKinnon *et al.* 2011: 359) in order to explore how minority faith chaplains transpose or tailor their role (Orchard 2000: 93). This chapter will highlight the disconnect between the requirements of the transfer of capital from the religious field to the medical field and the requirements for minority faiths to be recognised in the professional domain.

5.1.4 Socialisation

Socialisation is defined as the 'comprehensive and consistent induction of an individual into the objective world of a society or a sector of it' (Berger and Luckman 1967: 150). Bourdieu does not offer a substantive definition of socialisation and focuses on *primary* socialisation, which refers to childhood and schooling (Nash 1990). Concrete processes of socialisation were apparent in the findings (as seen in the nodes 'learning on the job', 'chaplaincy-specific

qualifications' and 'volunteer training', 'mandatory training' and 'CPD'), and require theoretical frameworks which account for both *organisational* (Van Maanen and Schein 1978; Chao 1994; Kyriakides-Yeldham 2017: 61-65) and *occupational* (Atkinson and Delamont 1985; Hicks 2008) socialisation. This distinction relates to the *organisational* or institutional requirements placed on chaplains and the *occupational* expectations of chaplaincy colleagues and bodies. Focusing on socialisation helps to address the findings concerning career progression, especially as an individual's career effectiveness depends on successful socialisation (Chao *et al*. 1994: 737, citing Hall 1976).

5.1.5   Conceptualising (Mis)recognition: The Utility of Bourdieu and Fraser

While some commentators have drawn parallels between Bourdieu and Fraser (Lovell 2007), James suggests that their approaches to misrecognition relate to different processes (2015: 98). Fraser's perspectival dualism helps examine issues relating to the injustices of inclusion, exclusion, and marginalisation (James 2015: 99). Bourdieu's approach refers to the ways in which the 'underlying processes and generating processes of fields are not consciously acknowledged in terms of the social differentiation they perpetuate' (Grenfell and James 1998: 23-24). For Bourdieu, symbolic domination involves a 'largely below-conscious complicity on the part of those subjugated, and processes of misrecognition are what make this possible' (James 2015: 101). I suggest that both forms of misrecognition are in operation in relation to minority faith involvement in chaplaincy.

5.2   CHAPLAIN PROFILES: RELIGIOUS AND COMMUNITY LEADERSHIP

The background of a minority faith chaplaincy representative has considerable impact on how they understand and practice chaplaincy, especially if their involvement is determined by their religious authority or community standing. The following sections will explore the implications of these findings in terms of participatory parity.

The table below demonstrates that most minority faith chaplains, especially if male, had received formal religious training to become religious leaders or professionals prior to their involvement in chaplaincy. Muslim chaplains' theological training

mostly took place in the UK, although one Muslim chaplain and two Muslim volunteers had received their training abroad (in Pakistan, Saudi Arabia, and Bangladesh respectively). Two of three Hindu chaplains received their training in India. Unusually, one Hindu chaplain was not a priest and had not received any formal religious training.

Table 5: Chaplains - Religious Leadership (Interviewees Only, Excluding Volunteers)

	Total number of chaplains	Formal religious training		Informal religious training	No religious training	Not specified	Formal chaplaincy-specific training
		Domestic	Abroad				
Jewish	1		1				0
Sikh	2			2			0
Hindu	3		2		1		1
Muslim	6	4	1		1		3
Anglican	12	10				2*	3
Catholic	7	2	5				1
Free Church	5	5					2

*Both ordained but no further information

Sample: Jewish (n=1); Sikh (n=2); Hindu (n=3); Muslim (n=6); Anglican (n=12); Catholic (n=7); Free Church (n=5).

None of the female Muslim chaplains in the study were qualified 'alima. Two female Muslim chaplains had received a formal Islamic education which provided a sufficient foundation for knowledge, but not enough to demonstrate institutionalised capital (Bourdieu 1986). Instead, female Muslim chaplains had prior experience in community development (interview, Muslim chaplain, Stonehaven, 25/07/2016), work with children with disabilities (interview, Muslim chaplain, Stonehaven, 29/07/2016) and a career in the caring profession (interview, Muslim chaplain, Greenacre, 21/04/2016). These findings reflect observations made by Gilliat-Ray *et al.* that nearly all the religious professionals who were employed as chaplains were men (2013: 46). Female Muslim chaplains are more likely to draw on embodied capital gained through previous roles and experience in counselling, community work, and health care (ibid.) rather than institutionalised capital.

Unlike their Muslim, Jewish, and Hindu counterparts, religious education for Sikh chaplains took place in the gurdwara, which does not necessarily confer leadership status within the community. The lack of formal priestly roles within Sikh communities (Cole 2004: 14; Cole and Sambhi 1998: 65) meant the suitability of Sikh chaplains derived from extensive community involvement. The Sikh chaplain at Stonehaven was an active member of the gurdwara committee, but also had experience of volunteering for community-based projects, social services, and the police (interview, Sikh chaplain, Stonehaven, 02/08/2016). The Sikh chaplain at Greenacre was active in the local Sikh community and on the local interfaith scene as a 'resource person' (interview, Sikh chaplain, Greenacre, 26/05/2016). Both Sikh chaplains had cultivated social and embodied cultural capital which enables them to be recognised by patients from a diverse range of religious and cultural backgrounds. Overall, Sikh and female Muslim chaplains cultivated considerable capital through religious and secular roles. This has led to a considerable expertise in relation to community-based issues which impact healthcare such as domestic violence (interview, female Muslim chaplain, Stonehaven, 25/07/2016) and social isolation of the elderly (fieldnotes, conversation with Sikh chaplain, Stonehaven, 24/06/2016).

Female Muslim chaplains were the only paid female minority faith chaplains in the study.[29] This could be attributed to the recognition of the need for female Muslim chaplains to meet the distinct healthcare needs of Muslim women which specifically require the support of a 'religiously knowledgeable Muslim (preferably a woman)' (Gilliat-Ray 2012: 117, Mayet 2001: 180). At Stonehaven and Greenacre, male and female chaplains were employed at the same time, and distinct roles were advertised. However, there was no evidence that distinct gendered roles were advertised for other religious minorities. This is most likely to affect Hindu involvement chaplaincy, where there are currently no women in post. This is unlikely to change due to the current emphasis on recruitment of religious professionals.

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[29] There are female Sikh and Jewish chaplains elsewhere, but not involved in the case studies in this project.

5.2.1 Recruiting Minority Faith Representatives

When developing community links or recruiting volunteers informally, chaplains at Riverside, Northbrook, Westview, and Stonehaven approached religious leaders or places of worship directly. Only one chaplain from Northbrook referred to national level organisations, such as the Jewish Visitation Committee (United Synagogue)[30] and Sikh Chaplaincy UK, when discussing the recruitment of volunteers. Where it was not possible to reach a religious leader, temple committees were often contacted to request input for chaplaincy services (interview, Hindu volunteer, Westview, 16/02/2016). Approaching places of worship through managing committees and religious leaders engages with the formal, orthodox structures of that faith community that are usually occupied by male elders (Qureshi 2013: 96), replicating some of the power disparities and local politics involved in committee management (Beckford 2015: 233).

5.2.2 Endorsement

The legitimacy of chaplains and volunteers to 'represent' their communities was conferred through endorsement by their respective faith communities. Most minority faith volunteers reported being endorsed by local places of worship rather than through national level organisations. The only exception was the deployment of Jewish chaplains at Riverside and Northbrook by the Visitation Committee. The assessment of the quality of the endorsement/reference was often conducted by chaplains. There was only one occasion reported when endorsement was rescinded from a Sikh bank chaplain who had been outed as an alcoholic (fieldnotes, conversation with Anglican chaplain, Northbrook, 26/10/2015). The decision to terminate employment was not made by the chaplaincy, but as a result of the community withdrawing their support. Westview and Stonehaven, however, did not require a faith community endorsement unless volunteers were engaged in 'religious' roles such as eucharistic ministry. Endorsement will be further explored as an aspect of regulation in Chapter 7.

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[30] Now known as Chesed.

5.2.3   Other Roles

The prevalence of part-time work among minority faith chaplains meant that it was common for minority faith chaplains to hold other paid or voluntary chaplaincy posts, including other hospitals,[31] hospices, airports, and further education. A Muslim chaplain (Riverside), Jewish chaplain (Riverside), and Hindu chaplain (Greenacre) each maintained their positions as imam, rabbi, and pandit respectively. Notably, the Muslim chaplain saw his voluntary roles in other hospital chaplaincies as a part of his role as imam, but distinguished between his role as paid chaplain and imam (interview, Muslim chaplain, Riverside, 04/11/2015). Some volunteers also did chaplaincy work in other contexts, with Sikh, Jewish, and Muslim volunteers reporting involvement in prison chaplaincy. For the Jewish volunteer at Greenacre, prison and hospital visiting were part of his rabbinical role.

5.3   DISTRIBUTION

This section will explore how participatory parity for minority faith chaplaincy representatives is affected by the distribution of resources. Distribution refers to the allocation of paid hours to chaplaincy representatives; how far chaplaincy teams rely on unremunerated labour and goodwill; and access to office space and patient information (Beckford and Gilliat 1996: 278; Orchard 2000: 61).

Swift notes that funding for minority faith involvement in chaplaincy is highly politicised due to the requirement to redistribute funds previously allocated to Christian chaplains (2014: 76). This was clearly the case at Greenacre:

> Nobody said that the argument for minority faith chaplains was
> weak, but the question was, well… you've got a budget, what you
> need to do is to use your existing budget and make this provision.
> So that means when a Christian leaves, we used that money
> (interview, managing chaplain, Greenacre, 25/05/2016).

In contrast, chaplaincies at Riverside and (eventually) Westview were allocated additional funding to support the development of a multi-faith team. The lead

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[31] Including mental health units.

chaplain at Westview explained his rationale for requesting more funding from the Trust:

> I've toyed with...when we get our bank budget back, using some of that money for regular Muslim input but […] that doesn't quite feel right to me […] I mean it's not a huge amount of money, but I think it would say, you know, 'this is something to which we are committed and we value' (interview, lead chaplain, Westview, 18/02/2016).

At Westview, the lead chaplain and a female Muslim volunteer linked redistribution with greater recognition. The lead chaplain focused on institutional recognition (interview, lead chaplain, Westview, 18/02/2016), while the Muslim volunteer suggested that being paid might help with being recognised within her faith community (fieldnotes, conversation with female Muslim volunteer, Westview, 17/01/2016).

5.3.1   Demographic and Demand

Chaplains may use demographic data as a proxy measure to gauge demand for religion-specific chaplaincy. The lead chaplain at Westview linked the introduction of a substantive Muslim post with the inpatient demographics of the hospital (fieldnotes, Westview, 25/01/2016). This reflects formulas from the chaplaincy guidelines which allocate hours corresponding to inpatient religious demographics (DoH 2003b; NHS England 2015a). Chaplains reported issues with the quality of inpatient demographic data available, including lack of specificity (for example, Jains were usually conflated with Hindus) and inaccurate information (either recorded incorrectly or the religion question not asked). Inpatient demographic was skewed by poor record keeping, and further obscured when supplemented with local demographic information, especially in light of increasing specialisation of hospital Trusts which brings in patients from greater distances (Flatt 2015: 39).

Chaplaincies had different approaches to the inclusion of very small religious groups. At Riverside, Jain and Zoroastrian volunteers were available, on an ad hoc basis, while a Jain volunteer visited weekly at Greenacre. At Greenacre and Stonehaven,

Baha'i volunteers did not expect to provide care to Baha'i patients because the community was so small, and worked generically instead. Voluntary Buddhist involvement at Greenacre was a mixture of generic and religion-specific due to the small Buddhist population. Delegating generic work to Baha'i and Buddhist volunteers appears to resolve the problem of providing care to very small religious groups, while ensuring that volunteers continue to be held accountable to the chaplaincy.

Conversely, chaplains at Riverside and Moorlands argued that the involvement of volunteers from smaller faith communities could only be supported by a level of 'demand':

> There isn't a Sikh chaplain here, we don't have a Sikh volunteer and we haven't got a very big Sikh community in this part of [location] [...] And we've never called them out, 'cause we've never been asked to (interview, Anglican chaplain, Riverside, 05/11/2016).

> The way the hospitals that I've been involved in haven't had many of different faiths... the demographics of the hosp-... area hasn't lent itself to it (interview, lead chaplain, Moorlands, 27/09/2016).

The restrictive religion-specific model that was in place at Riverside partially explains this approach. However, Moorlands does not operate on a religion-specific basis, but instead the argument from demography constitutes one of several gatekeeping strategies to ensure the chaplaincy service remained a Christian endeavour. Demography can be appealed to as a pragmatic strategy for achieving particular ends, from persuading Trusts to allocate more funds to chaplaincy, or excluding particular religious groups from participating in the chaplaincy team.

5.3.2 Access

The level of access to resources for minority faith chaplaincy representatives varied across sites. At Riverside, chaplains employed ten years prior still depended on their full-time colleagues to provide patient lists and access to the chaplaincy offices. This

echoes some concerns raised by visiting ministers about proportionate distribution of resources including office space and access to patient information (Beckford and Gilliat 1996: 354). Conversely, chaplains and volunteers at Greenacre were able to access computers and patient information, demonstrating considerable autonomy. Chaplaincy teams have apparently circumvented issues raised by the 1998 Data Protection Act by negotiating access to information locally, although minority faith groups are still disadvantaged when patient information is not accessible. This was evident when the chaplaincy team at Stonehaven had no access to patient information for a day (fieldnotes, Stonehaven, 06/07/2016). Minority faith chaplains and representatives have also been adversely affected by poor quality patient information, where patient religion is mis-recorded by staff, or information is out of date.

5.3.3 Goodwill and Unremunerated Labour

The findings demonstrated continued reliance on unremunerated labour by chaplaincy teams. This 'subjective labour' (see De Vries *et al*. 2008) is evidenced by the on-call arrangements at Greenacre, routine visiting at Riverside and Westview by Muslim volunteers, and the provision of staff training at Westview by Muslim volunteers. Unremunerated labour should be distinguished from voluntary work, as highlighted by the *Charter for Strengthening Relations Between Paid Staff and Volunteers*: 'the involvement of volunteers… should not be used to displace paid staff or undercut their pay and conditions of service' (TUC 2009). At Riverside and Westview, volunteers were providing labour usually undertaken by paid staff at other Trusts, suggesting that these were 'core' tasks that should be remunerated (Orchard 2000: 77). The starkest example was at Riverside, where the male Muslim chaplain was remunerated for his work, while the female Muslim volunteer – who worked the same hours each week and visited all the female Muslim patients – received no remuneration. Without the labour of this female Muslim volunteer, female Muslim patients would have remained unvisited. In this instance 'official' and 'subjective' labour were gendered and may have been justified with reference to the leadership position of the male Muslim chaplain.

The lead chaplain at Westview acknowledged the goodwill associated with the 'subjective labour' of the Muslim volunteers, who regularly provided a service for Muslim patients without the support of a paid Muslim chaplain:

> We're entirely dependent on their goodwill, which they could withdraw tomorrow, you know, we could be stuck tomorrow without anybody, and... that's not a position I want to be in (interview, lead chaplain, Westview, 18/02/2016).

However, goodwill at other sites tended to refer to the availability of chaplaincy representatives who were paid but gave *additional* time to meet the needs of patients or families. A Free Church chaplain at Greenacre recognised the problems of relying on goodwill:

> [The Free Church chaplain] turns to me and says "the ethics of asking someone to come in when they're on leave…" He leaves a message for [the Sikh chaplain], gives date of message and says treatment is being withdrawn and the family would like prayers. "If he comes in it's out of the goodness of his heart, and we don't want to exploit that" (fieldnotes, Greenacre, 16/03/2015).

At Greenacre, goodwill was explicitly linked to religious obligation and duty, particularly among Sikh chaplains and volunteers (interview, Free Church chaplain, Greenacre, 18/05/2016). A Hindu chaplain noted that his community obligations also apply in the hospital context (interview, Hindu chaplain, Greenacre, 25/04/2016).

5.3.4   Conclusions

While significant improvements have been made to the distribution of hours and access to resources, issues arising still echo concerns raised by Beckford and Gilliat (1996) and Orchard (2000). There has been a greater formalisation of work, which leads to more regular involvement of minority faiths, compared to the ad hoc approaches evident in the 1990s and early 2000s. Autonomy, goodwill and unremunerated labour still proved to be significant issues at some sites.

5.4   SOCIALISATION

5.4.1   Levelling the Playing Field

The tendency to recruit religious leaders as chaplains led to significant issues in relation to skillset. While educational routes were standardised for male Muslim and Jewish chaplaincy representatives (graduation from *darul ulooms* or Jewish seminaries respectively), the three Hindu chaplains had very different educational backgrounds. Unlike Abrahamic religious leaders, there was no single seminary-based route to religious leadership for pandits. Their routes to priesthood included apprenticeship and a university degree in Sanskrit (interview, Hindu chaplain, Riverside, 02/12/2015) and boarding school (interview, Hindu chaplain, Greenacre, 25/04/2016). The Hindu chaplain at Stonehaven was not a pandit, and did not receive formal religious training, except guidance from his guru (interview, Hindu chaplain, Stonehaven, 29/07/2016). He did, however, have a doctorate from a secular institution.

Religious leaders who were approached through their places of worship often lacked embodied cultural capital for engaging in chaplaincy, including language proficiency and computer literacy. These challenges became apparent following the lead chaplain's unsuccessful attempts to recruit a Hindu priest as a chaplaincy volunteer at Westview (fieldnotes, conversation with lead chaplain, Westview, 11/01/2016; interview, Hindu volunteer, Westview, 16/02/2016). For all three Hindu chaplains, English was not a first language, and in two cases this appeared to be an impediment to engaging with chaplaincy colleagues. This was also true of the two Muslim volunteers at Westview, with two team members reporting that they had difficulty understanding them (interview, non-religious volunteer, Westview, 17/02/2016). The lack of 'basic skills' was reflected when a Hindu chaplain explained how he first got involved in chaplaincy:

> When I came from India in 1997, the chaplaincy team visited my
> temple and they asked me can you help us […] I say I can't
> understand English, because I came from India [...] Then first
> thing I don't know about what can I do in hospital with patient,
> because the chaplain told me can give support of a religious...if a

person need it... Second thing, I can't have knowledge about the computer because I don't see in my country computer at all, before '97. Then they teach me how to use the computer, chaplaincy... it was good for me, they helping me with my English skill and computer skill, and day by day routine. Because my temple is closed 12-4 and I go every day 12-4 in hospital and I learned about the chaplaincy by them (interview, Hindu chaplain, Greenacre, 25/04/2016).

Chaplains at Northbrook also suggested that minority faith chaplains were unable to adapt to life outside their places of worship, where their symbolic capital is not automatically recognised:

Very difficult with [the imam] because he hasn't built up the confidence outside of the mosque. Because in the mosque, no-one question him, when he comes outside, some people will question to him (interview, Anglican chaplain, Northbrook, 30/12/2015).

… when I approached [the temple] they gave me that pandit [from India], but he had no idea of how things work here. He was a very religious man, he knew exactly what he would do in his temple but take him out of the temple, bring him into the hospital, he's lost (interview, lead chaplain, Northbrook, 17/12/2015).

These issues were most often related to pandits and occasionally linked to imams. However, Gilliat-Ray (2008) has shown that a growth in British trained 'homegrown' imams demonstrates continually evolving educational infrastructures for Islamic leadership. All three male Muslim chaplains in this project were British born, and two were educated in British *darul ulooms*.[32] *Darul uloom* graduates have linguistic competence and are aware of procedures and protocols of British public institutions (Gilliat-Ray 2008:149-150). Further, a growth in institutions offers imams the opportunity to apply and contextualise their learning from the *darul*

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[32] The remaining chaplain was British born, but trained abroad.

ulooms (fieldnotes, conversation with Muslim chaplain, Stonehaven, 23/06/2016).[33] In contrast, there is very limited access to UK-based theological education for Hindu priests, with Bhaktivedanta Manor as the sole provider of training (Knott 2000: 94).

5.4.2 Anticipatory Socialisation

All Christian chaplains, bar two female Catholic chaplains, were ordained, with some commenting that they had received chaplaincy-specific or pastoral care training as 'part of the training when you become a priest' (interview, Anglican chaplain, Riverside, 05/11/2016). Christian chaplains had received some degree of *anticipatory* socialisation (Ashford and Nurmohamed 2012: 9-10; Feldman 1977, 1981) into chaplaincy. In contrast, only two Muslim volunteers and a Muslim chaplain (all imams) attended chaplaincy-specific courses hosted by the Muslim Council of Britain (MCB) and Markfield Institute of Higher Education *prior* to their involvement in chaplaincy. Pastoral care is not a component of *darul uloom* training (Gilliat-Ray 2008: 149; Gilliat-Ray *et al.* 2013: 45) so these courses, and word-of-mouth recommendation, were the primary ways these imams discovered chaplaincy.

In some cases, anticipatory socialisation is experiential. Two Jewish chaplaincy representatives reported being involved in visitation from a young age (interview, Jewish chaplain, Riverside, 24/11/2015; interview, Jewish volunteer, Greenacre, 15/05/2016), while a Muslim chaplain and Sikh volunteers at Greenacre considered their chaplaincy work to be an extension of their community roles and saw no distinction between these roles (interview, female Muslim chaplain, Greenacre 21/04/2016; interview, male Sikh volunteer, Greenacre, 28/04/2016; interview, female Sikh volunteer, 01/06/2016). Jewish and Sikh representatives often subsumed chaplaincy under a broader framework of community service and/or welfare provision ('visitation' and '*sewa*' respectively) that have longstanding histories within their respective traditions.

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[33] For example, the Diploma in Contextual Islamic Studies and Leadership run by the Cambridge Muslim College, see Cambridge Muslim College (2018) http://cambridgemuslimcollege.ac.uk/programmes/ [Accessed: 7th September 2018].

5.4.3   Organisational Socialisation

Formal organisational socialisation for chaplains and volunteers was limited to attendance at Trust inductions and ongoing mandatory training. Chaplains most often reported that mandatory training covered infection control, fire safety, information governance and confidentiality, and safeguarding.[34] One Muslim chaplain reported that he did not receive an induction with the Trust when he started as a chaplaincy volunteer (interview, Muslim chaplain, Greenacre, 12/05/2016), but now attends regular mandatory training sessions. Volunteers received similar inductions and mandatory training. The limited processes of organisational socialisation are therefore supplemented by *occupational* socialisation.

5.4.4   Occupational Socialisation: Chaplaincy-Specific Training

The level of occupational socialisation received by minority faith chaplaincy representatives is highly variable. Below I will examine how far paid chaplains have been socialised into the chaplaincy profession with reference to 'chaplaincy-specific training' (see Ryan 2015), followed by an examination of how volunteers have become professionalised. I distinguish between the training provided in-house by chaplaincy teams and training provided by external bodies.

Out of thirty-seven minority faith chaplaincy representatives interviewed, six had engaged in chaplaincy-specific training offered by external organisations. This included two Muslim volunteers and a Muslim chaplain who completed the chaplaincy certificate at Markfield; a Muslim chaplain who attended two MCB chaplaincy residential courses;[35] and a Hindu chaplain who did the National Council of Hindu Temples (NCHT) chaplaincy course. A female Muslim chaplain from Greenacre reported that she attended 'study days' at other hospitals. For chaplains that undertook religion-specific courses, there appeared to be little incentive to attend more 'generic' chaplaincy courses. However, the religion-specific courses (excepting Markfield) tend to be very short, lasting a few days, compared to the longer-term

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[34] Prevent training is considered under the framework of safeguarding. In contrast to the prison setting (Todd 2013), healthcare chaplaincy appears not to be tasked with primary responsibility for Prevent.
[35] Chaplaincy training provided by the MCB is now defunct; training has not been provided for at least five years.

academic chaplaincy courses. For the Muslim volunteers at Westview, funding was a significant determining factor for accessing chaplaincy-specific courses. While these volunteers had been partially funded to do the Markfield certificate by the UK Islamic Mission, they were unable to do the Masters degree due to lack of funding.

Two Muslim chaplains, a Jewish chaplain, and two Hindu chaplains reported that they started out as volunteers, some of whom joined before the implementation of formal volunteer recruitment and training procedures. These chaplains referred to 'learning on the job' when they first started. Shadowing other more experienced volunteers or chaplains was a common training method, suggesting a 'serial', 'individual' and informal' approach to socialisation where a mentor is found for the individual newcomer (Van Maanen and Schein 1978: 232). Experience volunteering was apparently sufficient when these volunteers were later appointed to substantive chaplaincy posts; one female Muslim chaplain reported that the managing chaplain had suggested further formalised training in chaplaincy was unnecessary due to her experience volunteering (interview, female Muslim chaplain, Greenacre, 21/04/2016).

For many minority faith chaplains, their appointment preceded the development of faith-specific chaplaincy programmes. A Muslim chaplain felt that the chaplaincy courses at the time did not meet the needs of minority faith chaplains due to their Christian orientation:

> I did like a study day, one or two study days at Hinsley Hall [...] but I was told when I did it it was a very Christian perspective, they didn't do anything like any Islamic Muslim chaplaincy, so again it was learning that but then adapting it to Muslim chaplaincy… (interview, Muslim chaplain, Stonehaven, 29/07/2016).

The limitations of providing 'generic' training courses are not isolated to the UK but have also been raised as an issue in the training of American hospital chaplains from different faiths, through the Clinical Pastoral Education (CPE) programme. Cadge (2012) and Sullivan (2014) have highlighted the liberal Protestant framework from

which CPE emerged. While providing a standardised, accredited training course, Jewish and Muslim graduates have begun to reflect on the challenges CPE and other leadership courses raise for them (Cadge 2012: 36; Taylor and Zucker 2002; Jalalzai 2017).

5.4.5 Professionalising Volunteers

Chaplains at Greenacre and Stonehaven reported that their teams had 'tightened up' the volunteer recruitment process and subsequent training in recent years. Recruitment processes informally socialised prospective volunteers into the who, how, what and why of chaplaincy, even before an application form is submitted.

Prior to starting their visiting, volunteers underwent a period of formal socialisation into the norms, values, and boundaries of chaplaincy practice through the provision of formalised volunteer training programmes at Riverside, Westview, and Stonehaven. It appears this has only developed within the past decade or so. Longer term volunteers reported that their training primarily consisted of mandatory training alongside all new Trust volunteers and then informal shadowing of a chaplain or chaplaincy volunteer. This suggests that, while the shadowing is necessary for transmitting embodied, implicit, or tacit knowledge (Emmerich 2015; Atkinson 2017), it is now insufficient for newer cohorts of chaplaincy volunteers.

One outcome of volunteer socialisation at Greenacre and Stonehaven appeared to be the compartmentalisation of religious identity, a process of 'divestiture' which 'seeks to deny and strip away certain personal characteristics of a recruit' (Van Maanen and Schein 1979: 250). This was evident when observing a volunteer recruitment interview with some Seventh Day Adventists where they were told they 'wouldn't be visiting as Seventh Day Adventists' (fieldnotes, Greenacre, 31/03/2016). This was also apparent in the way volunteers at Greenacre and Stonehaven talked about their work: 'I'm not here as a Muslim, I'm here as a chaplaincy visitor' (fieldnotes, shadowing Muslim volunteer, Stonehaven, 03/08/2016) or 'I'm not here as a Baha'i, but as a general ward visitor' (fieldnotes, shadowing Baha'i volunteer, Greenacre, 18/04/2016), suggesting that their religious identity was irrelevant or incidental to their role as generic chaplaincy volunteers.

5.4.6 Conclusions

A socialisation 'gap' has been identified between minority faith chaplains and other chaplaincy team members (including volunteers), especially as some minority faith volunteers received more extensive and formalised training than the paid minority faith chaplains when they first started. The socialisation gap was exacerbated by the uneven playing field from which minority faith chaplains started their chaplaincy roles, including a lack of anticipatory socialisation and formalised training. This demonstrates that 'there is now a critical mass of experienced chaplains whose educational needs are unmet' (Gilliat-Ray *et al*. 2013: 66), an observation which can now be applied to chaplains across different faiths.

5.5   RECOGNISING THE ROLE OF MINORITY FAITH CHAPLAINCY REPRESENTATIVES

This section explores the extent to which patients, staff, and chaplaincy colleagues recognise the role of minority faith chaplains and the tensions arising from being recognised by these different groups. Recognition from patients and visitors often relies on the symbolic, religious, and social capital that inheres in religious leadership. However, institutional and professional recognition requires chaplains to reconfigure their religious authority or tailor their role according to the demands of the institution and wider chaplaincy profession (Orchard 2000: 93; Gilliat-Ray *et al*. 2013: 91).

Christian chaplains had particular expectations about the role and demeanour of their minority faith colleagues, and misrecognition may occur when these expectations are not fully met. These expectations include an openness to visit all patients (the generic/religion-specific debate), the provision of primarily spiritual and pastoral care over against religious care, and a commitment to team working. Some Anglican chaplains occasionally distinguished between the 'educational' and 'pastoral' role of minority faith representatives, suggesting that 'some of them are more theological, high-brow, educational, sacramental and not so good at the conversational and the pastoral needs of the human being […] but that isn't the sort of person we want' (interview, Anglican chaplain, Northbrook, 14/12/2015). The expectations of Christian chaplains may be unmet because of the different ways in which minority faith chaplaincy representatives understand their role and issues arising from an

uneven playing field in terms of distribution and socialisation. I also suggest some of these expectations rely on hidden assumptions that are not present in minority faith traditions, especially concerning the boundaries between pastoral, spiritual, and religious care. This will be explored further in subsequent chapters.

5.5.1 Symbolic, Embodied, and Objectified Capital

Most male minority faith chaplains were appointed on the grounds that their faith communities would recognise their social, symbolic, and religious capital as religious leaders. Christian (of all denominations), Muslim, and Jewish chaplaincy representatives referred to the reassurance authority figures can give to patients. The importance of the objectified capital of a religious professional, shown through specific identity markers and symbolism, was highlighted by an Anglican chaplain:

> In a contemporary context, a Catholic lady asks to see a Catholic priest, because [...] within that relationship...she may not even know the Catholic priest, you know, she's out of town, but...she sees in that figure with the dog collar and the authority that he...that he has because he's a representative, she sees him, that's something which she can relate to, and that's a comfort and a support (interview, Anglican chaplain, Greenacre, 28/04/2016).

While Christian chaplains debate whether wearing a clerical collar is a help or a hindrance, minority faith chaplaincy representatives have varied approaches to the visibility of particular identity markers. For example, both Sikh chaplains wore smart workwear, while male Muslim chaplains often wore traditional Pakistani, Arabic, or Bangladeshi clothing. Most male Muslim chaplains wore the *kufi* or *topi* (prayer cap) when visiting patients. This provides a distinctive identity marker familiar to Muslim patients but also highlights one of the Muslim chaplain's roles as someone who will pray or perform rituals (such as *tawba* or the *adhan*) for patients.[36] A Muslim volunteer who chose to wear Gujarati clothing was mistaken for an imam, a mistake which he left uncorrected. Instead, he discussed the positive response his presence elicited from a brain injury patient who projected authority onto him:

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[36] *Tawba* is a repentance prayer; the *adhan* is a call to prayer whispered in the right ear for newborn babies.

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He thinks I'm an imam, so... the imams are usually called

maulana and he...that's what he calls it, 'maulana's been' […]

[H]e likes, you know...that chapter read, so hence, it's become a

habit now of reading it to him, 'cause it makes him happy as well

(interview, Muslim volunteer, Greenacre, 20/04/2016).

Hindu chaplains' practice was mixed: the Hindu chaplains at Riverside and Stonehaven wore smart casual workwear, while the Hindu chaplain at Greenacre always wore Gujarati clothes. However, the Hindu chaplain at Riverside wore traditional robes for ceremonial purposes, such as overseeing *arti* and *puja* for a Diwali celebration (fieldnotes, 06/11/2015).

The embodied and objectified capital of the Muslim and Hindu chaplains provides a shorthand for patients to understand their role. For Sikh and female Muslim chaplains, it was imperative to explain what chaplaincy is as they were unable to draw directly on the symbolic and objectified cultural capital of religious leadership. A Sikh chaplain emphasised the importance of 'laying out the buffet cart' so patients know how a chaplain can help them (interview, Sikh chaplain, Greenacre, 26/05/2016). When explaining what chaplaincy is, Sikh and female Muslim chaplaincy representatives often had to explain their role:

The Asian...sort of Muslim patients, they won't know what the

word chaplain is so I have to describe, say 'look, this is what part

of my role is, we visit the people who are not well, just generally

to say hello, how are you getting on?' And I said 'if there's

anything specific that you do need, any prayers or anything, that's

what we're here for as well' and they just generally 'oh, I didn't

really appreciate, we didn't know there was this role' (interview,

female Muslim chaplain, Stonehaven, 01/08/2016).

Likewise, the non-religious pastoral carer at Greenacre had trouble explaining her role, with many patients mishearing her title as being 'religious' (fieldnotes, shadowing non-religious pastoral carer, 06/04/2016). The question of whether non-religious representatives can be referred to as 'chaplains' has been contentious among Humanists (interview, non-religious pastoral carer, Greenacre, 27/04/2016),

and raises significant issues about what symbolism and shorthand can help with understanding the non-religious role.

Sikh and female Muslim chaplains noted that patients valued confidentiality, especially in relation to sensitive issues such as alcohol abuse or domestic violence. Chaplains of all faiths who were religious professionals, or mistaken as religious professionals, reported that they were often seen as trustworthy keepers of confidentiality (fieldnotes, conversation with Muslim chaplain, Riverside, 07/10/2015; interview, Free Church chaplain, Greenacre, 18/05/2016; interview, Muslim volunteer, Greenacre, 18/04/2016). In contrast, Sikh and female Muslim chaplains reported they had to assure patients that information will not be disclosed more widely. A Sikh chaplain suggested that patients were more likely to decline visits if they did not receive sufficient assurance of confidentiality because 'they don't want anybody to know' about their illness (interview, Sikh chaplain, Stonehaven, 02/08/2016). These chaplains needed to work harder to be afforded the same recognition by patients.

5.5.2   Continuity and Change: Chaplain or Priest/Imam/Rabbi in the Hospital?

A key aspect of the transposition/tailoring dichotomy is the question of how far the role of minority faith chaplains is distinct from an imam, pandit, or rabbi in the hospital. A Jewish volunteer at Greenacre saw visitation as part of his rabbinical role:

> I see it to be integral, part and parcel of [my rabbinical role], it's not an extension...we're here to be able to teach, the rabbi's a teacher, a person who's there to look after the physical and spiritual welfare of Jewish people... (interview, Jewish volunteer, Greenacre, 15/05/2016).

In contrast, most chaplaincy representatives acknowledged their role to be distinct from their community roles, but still used their community titles to explain their role to patients (see also Cadge and Sigalow 2013). A Hindu chaplain at Greenacre and a Muslim chaplain at Stonehaven acknowledged that with patients they may refer to themselves as 'pandit' or 'priest' and 'imam' respectively because patients would not

understand the term 'chaplain', but conceded that ultimately the institution officially recognised them as chaplains.

5.5.2.1 Community Obligations

One of the Hindu chaplains, who maintained his role as freelance pandit, reported that his work in the community was essential for his livelihood, pointing to a symbiotic relationship with the community where the boundaries between his community role and chaplaincy role were occasionally unclear. While these obligations were mostly enacted within the community in the form of availability for late-night home visits, the sense of religious obligation to his community also permeated his chaplaincy work:

> We are not a medical profession, we are a priest, and a priest need to give up something, even my regular annual leave, normally I not take if I not need it. I give up my annual leave also, because if I'm...spending at home time there's nothing meaning for me. And sometime I'm…off for my holiday or something ...but I say "if you need me you can call up me, I can come" (interview, Hindu chaplain, Greenacre, 25/04/2016).

However, Hindu, Sikh, and Muslim chaplains at Stonehaven and Greenacre also referred to the ways in which they managed community expectations that they would provide updates on family and friends. One Muslim chaplain reported that he had experienced 'backlash' from families because of upholding confidentiality protocols (interview, Muslim chaplain, Greenacre, 12/05/2016). Chaplains affirmed the importance of maintaining confidentiality in spite of community expectations.

5.5.2.2 Distinction between Chaplaincy and Community-Based Religious Leadership

Muslim chaplaincy representatives provided the clearest articulations of the ways in which chaplaincy differed from religious leadership. The necessity of adapting was noted by a Muslim chaplain who consulted a senior Muslim chaplain for advice when he first started:

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> …the advice he gave me was how to adapt your role, an imam's
> role, a Muslim… in a hospital, to do with spiritual care, pastoral
> care…how to get things done in emergency, to do with end of
> dying, rituals and….the procedures of end of life…. the key point
> of being communication within the setting and how to work as a
> team player (interview, Muslim chaplain, Riverside, 14/11/2015).

Muslim chaplains also referred to being employed by the NHS as an indicator of quality assurance (interview, Muslim chaplain, Riverside, 14/11/2015), and the ability to mediate between different requirements arising from mixed-faith families (usually end of life scenarios and arranging funerals) and tensions between Muslim families and hospital staff (interview, male Muslim chaplain, Stonehaven, 15/08/2016; interview, female Muslim chaplain, Stonehaven, 01/08/2016).

A Muslim volunteer at Westview emphasised the importance of patient-centred care rather than simply providing end of life support (especially by reciting the *shahadah*) or leading prayer. While he initially anticipated *transposing* his role as imam to the hospital context, the volunteer noted that

> …[the] idea of chaplaincy changing to it's more about person, the
> hospital user… to giving him comfort, that's the thing. So is not
> about religion, it's more about the person […] it's more about
> person's...patient's belief and patient's comfort, rather than my
> belief and my comfort. It's less about worship and more about his
> comfort… (interview, Muslim volunteer, Westview, 09/02/16).

The volunteer acknowledged that the *shahadah* and *tawba* may feature in his visits, but only at the request of patients. Religious ritual was not a routine aspect of the chaplain's role in comparison to the role of the religious leader. Likewise, Hindu and Muslim chaplaincy representatives emphasised that their primary focus was on patient need and that they do not preach:

> If I'm going in the community then I am a preacher, but when I
> coming in the chaplaincy, I am not a preacher, I am part of the...I

am...support their needs, I can provide (interview, Hindu

chaplain, Greenacre, 25/04/2016).

It is not my job to preach here in the hospital, although I do in

my...role in the masjid, so this is not part of my job to preach here

(interview, Muslim volunteer, Westview, 25/02/2016).

Yet Muslim chaplains (and at one site, volunteers) still exercised authority when giving advice to patients and staff based on rulings about DNRs, switching off life support machines, and permissible medications. As one Muslim volunteer reported: '[The family] will not allow anyone switch off the life support machine unless any imam say that it's OK for you' (interview, Muslim volunteer, Westview, 22/02/2016). The enactment of authority through dispensing religious and ethical advice, common among Muslim chaplains, raises tensions with the focus on non-judgemental, patient-centred care. As Gilliat-Ray *et al*. note, 'a number of chaplains thought that taking a person-centred, non-judgemental, listening approach was the necessary prelude to the delivery of more sensitive and appropriate religious advice. This would be completely counter-indicated in the counselling world, intrusive or even abusive' (2013: 56). However, one Muslim chaplain emphasised that

…these are very spiritual decisions, they affect a person's

afterlife, they affect their life after death, I'm not going to be held

accountable and responsible for that so it's a privilege to be in

that position to give them that guidance and information but...

and also actually as human beings they're gonna have to take

responsibility for themselves… (interview, Muslim chaplain,

Stonehaven, 01/08/2016).

The non-judgemental discourse has not only been imported from 'Christian and secular professional practice' by Muslim chaplains (Gilliat-Ray *et al*. 2013: 86), but also by Sikh chaplains. A Sikh chaplain at Greenacre distinguished between instructing patients and giving guidance:

Sometimes they will ask you for Sikh guidance and what is the

Sikh perspective on this and I will always temper my answer by

saying you have the freedom to choose whether you want to take

this on board or not… (interview, Sikh chaplain, Greenacre, 26/05/2016).

The religious authority manifested in giving advice to patients is softened in both instances by shifting emphasis onto patient choice and responsibility. Chaplains recognised that sometimes providing patient-centred care will involve exercising authority in some way and that patients will expect chaplains to 'find the "right" answer' (Gilliat-Ray *et al*. 2013: 90).

However, the non-judgemental approach is not just symptomatic of the appropriation of Christian and secular professional practices. Both rabbis involved in chaplaincy were affiliated with Chabad Lubavitch, an ultra-orthodox Jewish outreach organisation, which adopts a 'non-judgemental' approach to its outward facing engagement with Jews (Kahn-Harris and Gidley 2010: 64; Yoffie 2013).[37] As one Jewish chaplain reported, 'that's we how communicate with others, it's just pure love, pure care, there's no... non-judgemental aspects to it. Just pure unadulterated love' (interview, Jewish chaplain, Riverside, 24/11/2015). For this chaplain, a non-judgemental demeanour was consonant with the rabbinical role.

5.5.2.3 *Religion-Specific or Generic*

The involvement of minority faith chaplains is predicated on the recognition of their religious capital by patients, chaplaincy colleagues, and the employing institution. It is unsurprising, therefore, that nearly all minority faith paid chaplains saw and enacted their role as primarily religion-specific. Several chaplains derived their understanding of their role from their job description:

> We are appointed for particular faiths or else we wouldn't be
> called Muslim chaplain and Sikh chaplain and Hindu chaplain
> and Christian chaplain. We do have that particular element to visit

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[37] While there is little literature on this approach, the Chabad Lubavitch website claims that 'Chabad is inclusive and non-judgmental' and that Chabad recognises that '[e]ach individual makes his or her own respective religious lifestyle decisions at his or her own pace', see http://www.chabad.org.uk/templates/articlecco_cdo/aid/706525/jewish/Myths-vs-Facts.htm [Accessed: Wednesday 18th July 2018]

people of our faith and other faiths and no faith, so if you know,
Alice, for example, is in the next bed, and she says 'hi, can I have
a word?' then we're happy to do that [...] So it's fine, it works both
ways (interview, male Muslim chaplain, Stonehaven,
15/08/2016).

Others linked their religion-specific role to time constraints and level of seniority:

If he's a Muslim chaplain, then he should or she should focus on
his or her faith-based chaplaincy, because that will demand so
much of her that she can, now or then, extend her hand…or his
hand towards generic chaplaincy, but that would be very limited
(interview, Muslim chaplain, Riverside, 14/11/2015).

I have to balance this out with the fact that I'm a Sikh chaplain
here in the hospital and therefore I will have to in some senses
prioritise my time but that doesn't mean that I won't make time
available for anyone else who wants to talk (interview, Sikh
chaplain, Greenacre, 26/05/2016).

Regardless of the justifications for providing primarily religion-specific care, nearly
all minority faith chaplaincy representatives expressed an openness to visiting
patients generically, and in some cases transgressed the boundaries of their religious
tradition in response to need. For example, a female Muslim volunteer reported that
she had visited male patients, one of whom was Muslim and one was Christian, in
response to specific needs (interview, female Muslim volunteer, Riverside,
21/12/2015). This approach to generic chaplaincy is *responsive* rather than *proactive*.

However, the tendency to prioritise religion-specific visiting was picked up by some
Christian chaplains as a limitation of their minority faith colleagues:

… the language we use is they look after their own, as do the
Catholics, whereas we Christians, t-the other ones [brief chuckle]
have a much wider remit... (interview, Christian chaplain,
Greenacre, 22/04/2016)

I think most Christian chaplains would see themselves as being there for everyone, whatever. I don't think that is true of faith chaplains, and that's probably because we only employ them for half a day so therefore there's not much chance to visit other people, but […] I think there would have to be a change in attitude, or change in beliefs within other faith groups so that they would see themselves as visiting anybody (interview, Anglican chaplain, Riverside, 05/11/2016).

In both cases, chaplains deployed an us-them dichotomy where the role of minority faith chaplains is constructed as parochial and exclusive, while the role of Christian chaplains is inclusive. Several chaplains recognised the constraints placed on minority faith chaplains by distribution of resources and hours. However, other reasons were given, including personality (interview, managing chaplain, Greenacre, 25/05/2016; interview, Catholic chaplain, Greenacre, 26/04/2016) and confidence with stepping outside the religious professional role (interview, Anglican chaplain, Greenacre, 28/04/2016). The Anglican chaplain at Riverside acknowledges the limited hours of his colleagues, but also suggests that this approach is *intrinsic* to the beliefs and practices of 'other' faith groups without qualification, even though all chaplains were mandated by the institution to operate in a religion-specific manner. Notably, Muslim, Baha'i, and Sikh volunteers had no issue with visiting 'generically', and chaplains and volunteers from a range of faith backgrounds across sites articulated *religious* justifications for engaging in generic visiting, or a general openness to visiting beyond their own faith group.

5.5.2.4 *Team Working and Strategising*

Team working may include attending team meetings and training events, making referrals, and co-ordinating volunteers. However, the level of team working among minority faith chaplains was variable. At Riverside and Greenacre, Anglican chaplains expressed annoyance at the lack of commitment of minority faith chaplains: 'it's been disappointing they haven't wanted to meet as a team' (interview, Anglican chaplain, Riverside, 05/11/2016). This implied that the disengagement was a matter of personal preference. Interestingly, the Jewish chaplain reported that he regularly attended the meetings (interview, Jewish chaplain, Riverside, 24/11/2015),

suggesting that he was aware that he *should* attend team meetings, but was unaware the meetings had stopped. Likewise, at Greenacre, two Anglican chaplains and a Catholic chaplain noted that minority faith involvement in team activities was non-committal, with the exception of the Sikh chaplain. One chaplain felt there was no redress for this, and reported that 'there is an element of a relaxed attitude towards the minority faiths' (interview, Anglican chaplain, Greenacre, 01/06/2016). This frustrated the chaplain 'because I respect them and I want us to be equal partners in what we're doing' (ibid.).

This lack of engagement extended to co-ordinating volunteers. At Greenacre and Riverside, Muslim, and Jewish volunteers expressed frustration with the lack of communication from their respective chaplains:

> I don't involve [the Jewish chaplain] [in co-ordinating the volunteers] because he's obviously not interested and I haven't…I'm afraid I haven't got time for people who are not interested! (interview, Jewish volunteer, Riverside, 16/12/2015)

> I've not seen much of him...I don't know whether it's good or bad but... I think sometimes I should be getting more support from him, which... I'm not (interview, Muslim volunteer, Greenacre, 18/04/2016).

Significantly, the volunteers who had limited contact with their respective chaplains were more likely to refer patients to an external community leader rather than the chaplain. Developing relationships with volunteers was vital for the recognition of the role minority faith chaplains as distinct from community-based faith leaders.

I suggest that two factors contribute to the disengagement of minority faiths from team working. Firstly, part-time (or less) chaplains especially have limited time and availability, especially if they have jobs elsewhere,[38] and may choose to prioritise

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[38] Especially evident when chaplains held other chaplaincy posts in secure settings which rendered them incommunicado while they worked in that setting (interview, Sikh chaplain, Greenacre, 26/05/2016; interview, Catholic chaplain, Greenacre, 16/05/2016).

patient visiting over against team meetings and debriefings. One Muslim chaplain was openly reluctant to attend team meetings because it interfered with visiting patients (interview, Muslim chaplain, Greenacre, 21/04/2016). At Stonehaven, the limited hours of the Sikh and Hindu chaplains were accounted for through ad hoc involvement in team meetings, although the relevance of the team meetings seemed to be decided by the managing chaplain. This availability is complicated by the impact of hours allocated on certain roles: full-time chaplains are more likely to engage in office-based work than their part-time colleagues, increasing their availability to other team members, especially to volunteers, for casual interactions that help develop the team ethos. Secondly, it was clear that some minority faith chaplains saw their role as being an individual religious functionary, rather than as part of a wider team: '…as far as my workload is concerned, I am the boss, I am the only person to refer to as well, I can't go and refer to somebody else' (interview, Hindu chaplain, Riverside, 08/12/2015). It is possible that the lack of communication between minority faith chaplains and chaplaincy colleagues highlights a key disjuncture between the role of chaplain and the role of religious leader in the community. The latter would not necessarily operate within the context of a 'team', and may not delegate roles in ways that are expected of chaplains.

5.5.3   Recognition by Chaplaincy Colleagues

The involvement of minority faith chaplains also depended on Christian colleagues recognising their distinct contribution. Recognition depends on the demarcation of role boundaries, where the need to refer minority faith chaplains for support is acknowledged. These role boundaries relate to the capacity of Christian chaplains or the patient's family to provide pastoral, spiritual, or religious care.

5.5.3.1   Beyond Familial Support

Several Christian chaplains assumed that families of minority faith patients are adequate providers of pastoral care for patients, rendering religious professionals unnecessary (fieldnotes, conversation with bank chaplain, Westview, 11/02/2016). This was shown by Anglican chaplains at Northbrook reporting that Sikh or Muslim patients were being attended to by their families and did not need follow up (fieldnotes, Northbrook, 02/11/2015). Some Christian chaplains suggested that

minority faith chaplains were not required for religion-specific activities, as these were tasks the family could perform:

> Christians and Hindus would on the whole want a priest to be with them if they're dying, in order to receive particular religious rituals that are important to Christian and Hindu people. Islam doesn't have that same need, imams sometimes are called because people are getting into a Western frame of mind, but it's not normal to call an imam in just because someone is dying. And Jewish...rabbi sometimes are called in for the prayers of forgiveness but the eldest son can do them, and so you don't necessarily need a rabbi to come and do them (interview, Anglican chaplain, Riverside, 05/11/2016).

However, female Muslim chaplains also noted that a chaplain or 'special person' does not necessarily need to be present for end of life situations (interview, female Muslim chaplain, Greenacre, 21/04/2016) and that their role is to enable families to manage those situations themselves (interview, female Muslim chaplain, Stonehaven, 01/08/2016). Notably, a Muslim chaplain at Greenacre reported that 'I do the same as a family would do' (interview, female Muslim chaplain, Greenacre, 21/04/2016). A Hindu volunteer also suggested that Hindu families are 'close-knit' and are always there to look after patient needs and therefore 'don't need the chaplaincy side' (interview, Hindu volunteer, Westview 16/02/2016).

In contrast, several minority faith chaplains suggested that the care they provide differs from familial care. Firstly, chaplains referred to their 'presence' and 'availability', with several chaplains noting that they are able to visit patients when family and friends are unable to (or, on rare occasions, choose not to). Secondly, chaplains suggested that patients valued being able talk with someone who was not family about deeply personal and sensitive issues. This was vital when families had broken down, most often indicated by female Muslim chaplains who supported patients who suffered from domestic abuse or marital breakups (fieldnotes, shadowing female Muslim chaplain, Greenacre, 07/04/2016; interview, female Muslim chaplain, Stonehaven, 25/07/2016) or patients struggling with alcoholism

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(interview, Sikh chaplain, Stonehaven, 02/08/2016). Thirdly, Muslim chaplaincy representatives suggested that they might be asked to provide the *adhan* because families are 'shy and don't know how' (interview, Muslim volunteer, Westview, 22/02/2016), or to give mixed-faith couples privacy (interview, Muslim chaplain, Stonehaven, 01/08/2016).

5.5.3.2   Substitutes for Religion-Specific Ritual

Occasionally, Christian chaplains may act as substitutes for their minority faith colleagues by engaging in inter-faith prayer. At Northbrook and Westview, the linguistic capital of Christian team members obviated the need to call in minority faith representatives. The backgrounds of these chaplains (from Pakistan and India respectively) provided them with the cultural capital to engage with the varied requirements of South Asian families:

> …he spoke to a Muslim family and tried to get hold of an imam for two hours. He could speak the language and understood the culture, so the family asked him to pray instead, so he prayed from a Christian understanding of forgiveness and reconciliation: 'they [Muslims] do not pray like this' (fieldnotes, conversation with Anglican chaplain, Northbrook, 19/11/2015).

> …according to the population base, Hindus are very minority here. So...I never have been to call anyone. Especially I am from India, they consider me so...no problem [laughs] I can talk in their own language and also... yeah, I manage it myself. If they need it I can...they never ask (interview, Free Church chaplain, Westview, 10/02/2016).

However, both chaplains utilised their linguistic capital to different ends. The Anglican chaplain at Northbrook offered a distinctly Christian prayer which accentuated difference (fieldnotes, Northbrook, 19/11/2015). Conversely, the Free Church chaplain appeared to engage in the neutralising techniques highlighted by Cadge and Sigalow (2013): 'I never mention the Christian words in [prayer] […] I'm saying like if it is a Muslim, I don't use the name of Jesus…' (interview Free Church chaplain, Westview, 10/02/2016). These chaplains perceived their cultural and

linguistic work to be sufficient for meeting the needs of the patients and families, leaving little room for a distinct role for a minority faith chaplaincy representative. These two approaches, accentuation and neutralisation, were also apparent among Christian chaplains providing inter-faith prayer to patients who did not share their linguistic or cultural background, although the extent to which they could do this for some families was limited due to language barriers. Inter-faith prayer was only mentioned once by a minority faith representative, in which a Sikh volunteer accentuated religious difference when praying with a Muslim couple (interview, Sikh volunteer, Greenacre, 28/04/2016).

At Greenacre and Stonehaven, it was standard practice for minority faith chaplains to deliver rituals specific to their own faith tradition, and minority faith chaplains were often the first point of contact. At Stonehaven, the administrator ensured referrals were passed onto the relevant chaplain, while at Greenacre, chaplains went to great lengths to ensure referrals were responded to by someone of the same faith (fieldnotes, Greenacre, 15/03/2016 and 16/03/2016).

5.5.3.3 Funeral Provision

There was still some evidence of Christian involvement in funeral provision for minority faith patients. The need to provide adult funerals for minority faith patients was exceptionally rare, as this is often arranged by the family or the community. However, a Free Church chaplain had reported that he oversaw two Hindu hospital funerals, providing the option for the family to call in a Hindu priest if they wished (interview, Free Church chaplain, Westview, 10/02/2016). The rationale for this was explained by the lead chaplain at Westview: 'with Hindu funerals a priest isn't required because the head of the family presides' (fieldnotes, conversation with lead chaplain, Westview, 24/02/2016). The lead chaplain at Northbrook reported that he had conducted a baby funeral for a Muslim family because the imam was 'not allowed' to take it (interview, lead chaplain, Northbrook, 17/12/2015). This question of whether 'stillborn babies [are] permitted to have the prayers and rituals associated with the dead' is a significant ethical issue (Gilliat-Ray *et al*. 2013: 90).[39] Notably,

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[39] Gilliat-Ray *et al*. note that the ritual recognition of non-viable foetuses is now 'common' in hospitals for non-Muslims; an Anglican chaplain reported that twenty years ago non-viable foetuses

the Christian and Muslim chaplains at Stonehaven presided over a joint trimonthly communal funeral service for non-viable foetuses and miscarried babies, demonstrating that it is permissible for imams or Muslim chaplains to offer ritual recognition of non-viable foetuses (fieldnotes, observation of trimonthly funeral, Stonehaven, 26/06/2016). In contrast, Christian chaplains (both Anglican and Free Church) at Greenacre and Christian chaplains at Riverside were the sole providers of 'multi-faith' baby funerals. Christian chaplains have moved into gaps for roles which minority religious leaders traditionally cannot or do not fulfil, although Muslim chaplains have begun to recognise the value of offering after-death rituals, such as *ghusl* (ritual washing) or funeral prayers for stillborn and miscarried babies, as a form of pastoral recognition (Gilliat-Ray *et al*. 2013: 130, see also Arshad, Horsfall, and Yasin 2004).

Orchard's concern about the 'appropriation of the role and responsibilities of other faiths by Christian denominations' (2001a: 16) appears to be well-founded. However, attempts made by Christian chaplains to practice rituals *specific* to minority faiths were rare. Only one Anglican chaplain at Westview Hospital expressed no qualms with performing end of life rituals for patients of different faiths as part of being a generic chaplain, but emphasised this was a last resort and that she would always try to bring in a relevant religious representative for ritual (interview, Anglican chaplain, Westview, 10/02/2016). Instead, religion-specific ritual was substituted with generic inter-faith prayer.

5.6   THE SOMATIC NORM

The concept of the 'somatic norm' (Puwar 2001) is useful for exploring differential levels of recognition for Christian and minority faith chaplains. For Puwar, the somatic norm refers to the 'corporeal imagination of power as naturalised in…white, male, upper/middle-class bodies' (2001: 652). Here, the somatic norm relates to the perceived normalcy of the Christian presence in chaplaincy among patients, visitors, and ward staff. Chaplaincy representatives noted that the assumption that chaplaincy is Christian was a common misconception among patients and staff.

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were cremated in hospital incinerators, suggesting that pastoral recognition of non-viable foetuses is a relatively recent development (fieldnotes, Riverside, 23/02/2017).

The somatic norm is most clearly evidenced in the wearing of the clerical collar by nearly all participating Christian chaplains (excepting the female Catholic chaplains at Northbrook and Greenacre and the lead chaplain at Northbrook). The non-religious pastoral carer spoke of the symbolic and embodied capital of Christian chaplains in contrast to her own lack of symbols:

> I don't have the uniform, so... […] this whole thing of something that's makes you recognisable, identifiable. I don't know that we can do it…that's centuries of stuff [short laugh] that mean those symbols are recognisable to them (interview, non-religious pastoral carer, Greenacre, 27/04/2016).

Furthermore, the somatic norm of the Christian chaplain was apparent in the misconceptions about minority faith or non-religious chaplaincy representatives. Buddhist and Baha'i chaplaincy volunteers were often asked which churches they attended when visiting patients generically (interview, Buddhist volunteer, Greenacre, 19/05/2016; interview, Baha'i volunteer, Greenacre, 09/05/2016; interview, Baha'i volunteer, Stonehaven, 16/08/2016). Minority faith patients appeared confused when minority faith chaplaincy representatives introduced themselves as a 'chaplain' or 'chaplaincy volunteer' due to the Christian connotations of the term. Interestingly, the non-religious pastoral carer recalled one instance when she was associated with Christianity by a visitor because she wore dark colours and her identification badge was 'ecclesiastical purple' (interview, non-religious pastoral carer, Greenacre, 27/04/2016). The somatic norm is not simply encompassed in the clerical collar, but also ethnic identity markers, 'ecclesiastical' symbols, and the connotations of the word 'chaplain'.

Chaplaincy representatives reported that staff occasionally might not recognise their roles as members of the chaplaincy team. Occasionally, chaplaincy representatives were mistaken for visitors and were informed by staff that it was not visiting hours (interview, Muslim chaplain, Riverside, 14/11/2015; interview, female Jewish volunteer, Riverside, 16/12/2015). A Hindu volunteer was once mistaken for a member of medical staff, although this — for obvious reasons — did not lead to

ward staff questioning his presence on the ward (fieldnotes, shadowing Hindu volunteer, Westview, 24/02/2016). This lack of familiarity with chaplaincy team members might be expected for chaplains and volunteers who visit irregularly and may not have a longstanding relationship with a particular ward. This links with another significant finding: the hours allocated to minority faith chaplaincy means that minority faith chaplaincy representatives' ability to be present and available on the wards is limited compared to their Christian colleagues. In this sense, the proactive, generic approach which emphasises presence and availability reinforces the somatic norm.

However, it was surprising when two female Muslim chaplains at Stonehaven highlighted occasions when ward staff had consistently failed to recognise them as staff members, despite their regular visits:

> I had a staff member, this is more than once, this happened
> different wards – "I'm sorry love, it's not visiting time." So it's
> really like, she's dressed a certain way, she's a visitor, and I mean,
> I'm not going to shout along a corridor 'cause I think this is
> patients and […] I'm walking and I'm still getting shouted at –
> "have you not heard, it's not visiting time" (interview, female
> Muslim chaplain, Stonehaven, 25/07/2016).

> … they don't recognise us, see us as professionals, they see us as
> family members…after a while it does get a bit annoying because
> you think "hang on, you can see who I am" and you...it's really
> surprising how some staff treat you… (interview, female Muslim
> chaplain, Stonehaven, 29/07/2016).

This misrecognition was observed first hand when a female Muslim chaplain was asked by a member of ward staff if she was there on a 'professional visit' (fieldnotes, shadowing female Muslim chaplain, Stonehaven, 27/06/2016). This suggested that the ward staff did not recognise her visiting role as chaplain to be 'professional' despite having seen the chaplain on previous occasions. In contrast to the hyper-visible identity markers that were particularly evident among male chaplains (Muslim, Hindu, and Jewish), female Muslim chaplains and volunteers were

rendered less distinctive and could easily be mistaken for visitors if their identification badges were not in plain sight. However, both Muslim chaplains compared staff attitudes to the Christian chaplain and suggested that this misrecognition was deliberate:

> You have to do a lot of work in terms of visiting and going out onto the wards and getting some sort of recognition, but…[the Christian chaplain] very, very quickly was accepted by lots of ward staff and even when there's staff members that he's made really good contacts with and he talks about them and then when I've gone onto the ward it's like "don't know who you are" (interview, female Muslim chaplain, Stonehaven, 25/07/2016).

5.6.1   Recognising the Somatic Norm

Several Christian chaplains reflected on the impact of their identity on the appropriateness of their encounters with minority faith patients and with staff. These chaplains highlighted concerns about their embodied presence as white Christians, and how these might manifest in a power disparity. Occasionally gender was also a factor in these reflections. An Anglican chaplain at Northbrook Hospital noted that asking a Sikh family about whether they needed a faith representative might be seen as condescending:

> That's where being a white woman can be quite difficult, because some of them think that I'm shaming them, you know, that they're not good enough, that they can do their own prayers thankyou and they can be quite cross with me (interview, Anglican chaplain, Northbrook, 07/12/2015).

Similarly, a Free Church chaplain at Greenacre expressed discomfort 'as a Christian man' with 'directing the behaviour of Muslim women' regarding the proper use of the prayer facilities (interview, Free Church chaplain, Greenacre, 11/05/2016). Christian chaplains at Greenacre felt it was the Muslim chaplains' responsibility to ensure Muslim users of the prayer facility were using the space appropriately. Significantly, the chaplain from Northbrook quoted above had no qualms with her role in facilitating prayer for various religious communities, which often involved

redirecting users of the main prayer room to alternative facilities (fieldnotes, observation of Sikh prayers, Northbrook, 30/11/2015).

The chaplains who acknowledged their somatic and embodied power were also more likely to emphasise the first point of contact with chaplaincy should be someone of a shared religious background, and to refer onto colleagues of different faiths where necessary:

> There's a lot to be said for chaplaincy that does meet people at the human level, that it's undeniable that... for some people at least...being able to meet people from their own faith with a shared cultural background and understanding...helps them to get to the heart of their needs lot more quickly and easily rather than have somebody like me thrashing about with...trying to be helpful (interview, Free Church chaplain, Greenacre, 11/05/2016)

This quote uncovers a key tension in spiritual assessment. The chaplain suggests that chaplains of a shared religious background are better able to understand and meet the religious or spiritual needs of patients. In contrast, the generic model of chaplaincy holds that chaplains who do not share the same faith background of the patient are equally capable of doing a spiritual assessment for those of a different religion to them. It is notable, however, that the generic model of chaplaincy is operationalised by Christian chaplains who, as the first point of contact for minority faith groups, are likely to reinforce the somatic norm. The was starkly evident at Northbrook: employing minority faith chaplains on bank, while offering remuneration, promoted an ad hoc way of working and relies on the judgement and mediation of the chaplain responding to a referral. If a chaplain from the 'core' team was able to deal with the referral themselves, an expense was saved from not calling in a bank chaplain. This is not simply a question of remuneration, but also of regular involvement in the chaplaincy team in order to challenge the somatic norm. Availability and presence on the wards are luxuries that cannot be afforded to volunteer, bank, sessional, or part-time chaplains.

5.6.2 The Institutional Somatic Norm

The findings show that Christian chaplains occupied committee roles by default. This suggests an implied legitimacy, neutrality, and objectivity and once more reinforces the somatic norm of chaplaincy (cf. Beckford and Gilliat 1996: 307). This finding challenges Bourdieu's failure to acknowledge the 'myth of professional objectivity in the field of religion' – instead chaplains appear to aspire to this myth of professional objectivity, even though 'the clergy cannot pretend to be impartial' (Verter 2003: 164). Minority faith chaplains who had institutional roles tended to be confined to Equality and Diversity committees, and their only role was to speak for their *own* religious or cultural communities. The ostensibly parochial concerns of minority faith groups are neatly confined to Equality and Diversity and cultural awareness, while Christian chaplains (often Anglican and Free Church) speak in a more universalistic tenor. This went unchallenged by the minority faith chaplains at Riverside and Greenacre, who seemed uninterested in participating in broader institutional roles. Notable exceptions included the Muslim chaplain at Greenacre attending the palliative care MDT and the extensive committee and MDT involvement of Muslim chaplains at Stonehaven.

Likewise, the involvement of minority faith chaplains in teaching was minimal, with Christian chaplains tending to offer 'generic' or mandatory training courses (interview, Anglican chaplain, Northbrook, 14/12/2015; interview, lead chaplain, Northbrook, 17/12/2015; interview, lead chaplain, Moorlands, 27/09/2016). At Riverside, the Anglican senior chaplain not only taught nursing staff about spiritual care for end of life patients, but also gave an overview of different religious traditions' approaches to end of life care (fieldnotes, observation of staff training, Riverside, 06/10/2015). The only exception was the delivery of cultural competency training by Muslim chaplains at Stonehaven, and the Muslim volunteers at Westview contributing to bereavement training for midwives (fieldnotes, observation of staff training, Westview, 14/01/2016). The involvement of Muslim chaplains in training cultivates both symbolic and social capital amongst staff (Gilliat-Ray *et al.* 2013: 125). The Muslim chaplains at Stonehaven were also working towards delivering a generic spiritual care training session (interview, managing chaplain, Stonehaven, 15/08/2016). Significantly, at Stonehaven, Sikh and Hindu chaplains were keen to

expand their roles to include teaching on religious and cultural awareness for their own faith groups, but not for more generic topics (interview, Hindu chaplain, Stonehaven, 29/07/2016; interview, Sikh chaplain, Stonehaven, 12/08/2016).

Institutional recognition is also apparent in the involvement of chaplaincy in staff induction and other Trust events, which helps increase the visibility and profile of the chaplaincy team. The managing chaplain at Stonehaven, for example, made sure that all team members were included at chaplaincy stalls at Trust events, although availability was more limited for minority faith colleagues. Sometimes the level of inclusion depended on factors beyond the control of the chaplaincy. Induction at Greenacre previously included all paid chaplains, yet this had to be cut back due to a reduction in the overall time allocated to induction (interview, Hindu chaplain, Greenacre, 25/04/2016). As time is reduced, so is the involvement of the minority faith personnel in high profile events.

While increasing institutional involvement of minority faith chaplains shows progress, Christian chaplains are still the institutional 'clearing house' for religion, showing the persistence of the Christian chaplain as the somatic norm. Yet where Muslim chaplains have developed enough symbolic and social capital, they have started to become the primary resource for minority issues in general. This points to the development of a new somatic norm: Muslim chaplains are becoming the go-to resource for questions about minority cultures, beliefs, and practices. This approach risks conflating Islamic issues with broader minority issues relating to culture (that is, providing the 'Asian' perspective). At Stonehaven, the growing recognition of Muslim chaplains as a resource about 'Asian' culture appears to arise from the perception that Muslim patients and families raise issues that require more management and negotiation (interview, stakeholder, Stonehaven, 27/07/2016). At the same time, the careful cultivation of a reputation of being pragmatic yet authoritative that has been recognised by stakeholders may lead to requests made to Muslim chaplains to investigate issues raised by other faiths, even at other Trusts (interview, stakeholder, Stonehaven, 20/07/2016). Muslim chaplains are the exception to the somatic norm of Christianity, but in the process become the somatic norm and locus for 'minority issues', where 'problematic' forms of religion and religious manifestation are managed and negotiated.

5.7   RATE OF EXCHANGE

Participation in national organisations constitutes a significant aspect of the recognition and the informal socialisation of chaplains. By building up networks (social capital) and a reputation within the field of chaplaincy (cultural capital), chaplains become socialised into a collegial identity, or 'community of practice' (Lave and Wenger 1991; Wenger 1998), beyond their immediate working environment. Recognition of these minority faith groups within the professional domain contributes to full participation. However, Christian and minority faith chaplains alike were disengaged from organisations such as the CHCC or UKBHC either due to lack of interest, time, or the fees associated with joining these bodies. For some minority faith chaplains, their disengagement with the CHCC arose from the perception that it is primarily a Christian organisation. One Muslim chaplain explicitly stated that 'the CHCC is very Christian' (fieldnotes, conversation with Muslim chaplain, Riverside, 07/10/2015), while other Muslim chaplains suggested that most of the knowledge base (journals and articles) and activities (training and conferences) of the CHCC focused on chaplaincy primarily from a Christian perspective rather than a multi-faith perspective (interview, female Muslim chaplain, Stonehaven, 29/07/2016; interview, managing chaplain, Stonehaven, 08/08/2016). Only one minority faith chaplain reported being registered with the UKBHC at the time of the study, although the non-religious pastoral carer at the same Trust also registered.

The attempts made by minority faith chaplains to transfer capital from the institutional domain to the professional domain constitute a significant stumbling block for minority faith chaplains. While it is possible that minority faith chaplains might reach relatively senior positions within their Trusts, this seniority may not be acknowledged or even visible in wider professional chaplaincy circles. Gilliat-Ray *et al*. note that 'the apparent absence of Muslims within formal academic and professional chaplaincy discourse contrasts very significantly with their increasing presence, seniority, agency and practical influence within public institutions on a day-to-day basis', attributing this to the lack of educational capital of Muslim 'alims to shape mainstream chaplaincy discourse and lack of religious capital among non-'alims to shape Muslim chaplaincy practice or policy (2013: 69).

This lack of capital should also be situated within a broader context which privileges certain modes of being a chaplain over others. A critical example of this was given by a minority faith chaplain:

> I applied for UKBHC membership and the question was raised, well one, what academic study have you actually done in chaplaincy and also we don't recognise this [endorsing body], who are they? I challenged it because from what I understand, UKBHC when it came into being, which is not that long ago, it grandfathered in all the existing chaplains, regardless of whether they had a degree in chaplaincy or a doctorate in chaplaincy so I think in my response I said to them, well if you're gonna fund me…a PhD in chaplaincy, I'll happily do it...but I've got these qualifications but also I've trained within [my faith] community, I've got this wealth of experience on being...community leadership within [my faith] community and part of [a national representative body], been involved in all sorts of initiatives...you know, if this doesn't make me qualified I'm not sure what actually does (interview, minority faith chaplain, 26/05/2016). [40]

Reference to a 'wealth of experience' in 'community leadership' and to training demonstrates this chaplain's embodied cultural capital. However, this embodied capital was not formalised as institutional cultural capital through the attainment of a chaplaincy-specific qualification, where embodied forms of knowledge are consolidated through accreditation. This chaplain's primary qualm appears to relate to unequal treatment, following the observation that existing (Christian) chaplains were 'grandfathered in' without the need to convert or exchange their embodied cultural capital. This suggests that different standards have been set for different faith representatives to be recognised within the chaplaincy profession. Likewise, a Sikh chaplain suggested that the UKBHC did not understand that 'demanding qualifications' is inappropriate 'when that's not how the faith community works' (fieldnotes, conversation Sikh chaplain, Greenacre, 08/04/2016). While Abrahamic

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[40] This chaplain's religious identity has not been disclosed to further mitigate the risk of identification.

faiths might have a standardised system of accredited seminary training for the formation of religious professionals (Nesbitt 2007: 297), such formalised accredited structures for 'qualifying' as a religious professional (indeed the very concept of a religious 'professional') rides roughshod over Sikh approaches to religious learning, but also risks undervaluing the contributions of chaplains who are not trained as religious professionals more widely.

Thus, social and embodied capital in the form of community activism and experience in chaplaincy did not fulfil the requirements of the national chaplaincy organisations. Consequently, the exchange rate for achieving recognition in his immediate networks of patients, staff, chaplaincy colleagues, and the broader Trust was lower than the exchange rate for being recognised by professional organisations. The rate of exchange between institutional recognition and professional recognition demonstrates a rift between the expectations of Trusts (including senior Trust staff) and the expectations of national chaplaincy bodies. Institutional recognition is a necessary but not sufficient condition for professional recognition.

5.7.1.1   *Alternative Avenues for Recognition*

The Muslim chaplains' network in northern England allows Muslim chaplains to develop a mutually supportive arena for developing the chaplaincy profession and enabling the consolidation of a knowledge base unique to them. The network offers an alternative space to organisations like the CHCC, and enables high-profile Muslim chaplains to build on their social and symbolic capital by becoming known authorities within the Muslim chaplaincy sphere. A Muslim chaplain in the north has acquired considerable symbolic capital *among* other Muslim chaplains nationally due to his authoritative expertise in *fiqh* (Islamic law), while a Muslim chaplain in the south has generated considerable social and symbolic capital due to his rapid and unprecedented rise to seniority within a chaplaincy Trust. Both of these chaplains were regularly cited as important authorities, role models, and sources of advice by Muslim chaplains across sites.

5.8   PARITY OF PARTICIPATION: SOME CONCLUSIONS

This chapter identified factors contributing to the integration of minority faith groups in chaplaincy with reference to distribution, recognition, and socialisation. I have shown that participatory parity is dependent both on accommodations made by 'incumbents' and adaptations made by 'newcomers'. Such accommodations include the decisions made by lead chaplains to create substantive posts for minority faith colleagues (based on the recognition of their unique contribution), involvement in team meetings, enabling equal access to resources, and the delegation of institutional roles to minority faith representatives. In exchange, minority faith chaplains were expected to adapt their roles, especially if they are religious professionals, to include a team-oriented, pastoral, patient-centred, and non-judgmental approach to chaplaincy, and may also be expected to provide a generic chaplaincy service to all patients.

At the same time, misrecognition (in the Bourdieuian sense) was evident in the pervasiveness of the somatic norm of chaplaincy as a Christian ministry. This was reinforced by the presence, availability, and visibility Christian chaplains on the ward compared to their minority faith colleagues, and reproduced by patients who occasionally mistook some minority faith chaplaincy representatives for Christians and staff who failed to recognise the role of Muslim chaplains.

At sites where multi-faith chaplaincy was well established (Riverside, Greenacre and Stonehaven), Christian chaplains appeared frustrated by a lack of team engagement and a perceived reluctance to engage in generic visiting from minority faith colleagues. Interestingly, complaints regarding the latter often came from Anglican chaplains, who have a long history of providing or facilitating care for all, whether in the parish or within the context of the hospital. In the 19th century, both Roman Catholic and Free Churches tended to 'visit their own parishioners' and were 'not usually in a position to minister to the entire hospital' (Beckford and Gilliat 1996: 226). Over time, Free Church chaplains have adopted the generic working practices of Anglican colleagues as a result of growing ecumenism and greater participatory parity. It is notable that at one site, Free Church chaplains had either promoted or been open to non-religious involvement and valued religion-specific care while also

offering generic support to patients (in contrast to two Anglican chaplains who had resisted non-religious involvement). I suggest this arose as a result of the history of incremental recognition Free Church chaplains in chaplaincy. Where Free Church chaplains made the comparison between the introduction of a non-religious post and the introduction of minority faith posts fifteen years prior, I suggest that Free Church chaplains also saw parallels between minority faith involvement and their own gradual recognition as equal partners in chaplaincy.

A significant issue arose when Christian chaplains took their localised experiences of multi-faith working and extrapolated this to minority faiths as a whole and made essentialised comments about entire faith groups (or 'minority faiths' as a single undifferentiated category), usually based on unmet expectations. This chapter demonstrates that minority faith involvement is significantly impacted by distribution of hours, the socialisation 'gap', and the terms by which minority faiths are welcomed into chaplaincy (where their distinctive contribution is primarily based on their religious functions or shared cultural attributes with patients). However, Christian chaplains occasionally suggested that the inability to adapt to the values of the institution and of chaplaincy was a result of there being no precedent for chaplaincy or pastoral care, or a lack of appropriate educational structures from within the faith community. On one occasion this was explicitly linked to the ability of religious leaders to engage in civic life generally and the NHS in particular (interview, lead chaplain, Northbrook, 17/12/2015). This misrecognition was applied to all faith groups with no regard for different understandings of religious leadership (as in Sikhism), the differing processes by which religious leaders are socialised (evident *within* Hinduism, let alone between religious groups), but also the differential pressures on faith communities to engage in public life (Birt 2006). Such misrecognition, arising out of local arrangements for multi-faith chaplaincy, ignored the willingness among minority faith volunteers – including Muslims, Sikhs, Baha'is and Buddhists – to routinely visit in a generic manner elsewhere, but also the openness of minority faith chaplains to engage in *responsive* generic visiting.

Minority faith chaplains were therefore expected to change their understandings and practices to fit in with 'institutionalised patterns of cultural value' (see Fraser 2003) concerning the provision of generic pastoral care and engagement as part of a wider

team. However, they were given few resources to do so (as they tended to learn 'on-the-job' and through informal training), both in terms of direct support from colleagues or financial support to engage in chaplaincy-specific training. I suggest that – given the intensity of the socialisation process for religious professionals (Berger and Luckmann 1967: 164-165) but also the limited contact with the institution arising from part-time (or less) hours – more formal processes of socialisation must be offered in order to ensure that minority faith chaplains are more familiar with the norms of working within chaplaincy, particularly around team working and understanding the norms of the institution. The pragmatic, non-judgmental approach appeared to be particularly evident among Muslim chaplaincy representatives who had completed the Markfield course and chaplains whose experience and community work grounded their chaplaincy role. No other religion-specific course of the same depth is currently available to other faith groups, and very little resource is available to fund opportunities for training and CPD.

At the same time, my analysis of the differential rate of exchange pointed towards a disparity in cultural value attributed by the chaplaincy profession (in providing generic pastoral care) and the cultural value attributed by the institution (for example, in providing religious expertise and the ability to negotiate complex religio-ethical issues, as in Stonehaven) to minority faith chaplains. I propose that chaplaincy should reconsider the patterns of cultural value that have become entrenched in the occupational domain which do not reflect the cultural value attributed to chaplaincy by the institution. This will be explored in further detail in the next chapter, especially in relation to the construction of chaplaincy.

6 Critical Dialogue

This chapter will engage in a critical dialogue between the findings and the chaplaincy literature. This will first be achieved with reference to Bourdieu's 'legitimate language' (1991b) to explain the varying levels of success of minority faith chaplains within the institutional and professional domains. Legitimate language is an apposite theoretical counterpoint given the emphasis in the chaplaincy literature on the importance of 'speaking the language' of the healthcare setting (Church of England 2010; Norwood 2006).

This first part of the chapter highlights the multiple uses of legitimate language within healthcare chaplaincy. In the same way that the role of the chaplain depends on institutional and professional recognition, legitimate language must also be deployed differentially in these domains. I will highlight how 'legitimate language' justifies varying levels of access accorded to minority faith groups across sites by reviewing the 'brokerage' model originally documented by Beckford and Gilliat (1996) and Orchard (2000). I will also explore legitimate language in relation to the need for minority faith chaplaincy representatives to demonstrate competence with switching registers when providing patient-centred care. The second part of the chapter will review the construction of chaplaincy in dialogue with key themes in the chaplaincy literature, including professionalisation, the distinctiveness of chaplaincy, marginality, and collegiality.

6.1 THE DISCURSIVE NEGOTIATION OF CHAPLAINCY: THE UTILITY OF BOURDIEU'S 'LEGITIMATE LANGUAGE'

Earlier chapters noted the growing requirement for chaplaincy to negotiate its place in a secular state-funded health service (Ballard 2010, Swift 2014). This negotiation is constructed discursively as chaplaincy interacts with the secular sacralities within

the NHS such as holistic care, patient-centred care, respect, dignity, equality and diversity, and cost-effectiveness (Swift 2013, Todd 2015b). Dominant discourses within chaplaincy have emerged from protracted engagement with these sacralities.

As analysis progressed, I associated the official discourses of the NHS and the chaplaincy profession with Bourdieu's 'legitimate language', also known as 'dominant', 'standardised', or 'normalised' language (Bourdieu 1991b: 46, 48). Legitimate language is considered to be a 'legitimate representation of the social world' which must be embedded in a legitimate context (Susen 2013: 209). A key aspect of legitimate language is the associated linguistic competence of actors or agents within particular social fields. Linguistic competence is a result of communicating in a 'relationally structured realm of asymmetrical socialisation' (Susen 2013: 209). Bourdieu dismisses 'the illusion of linguistic communism' (1992: 43) and instead argues that access to linguistic capital (competency) is distributed unequally within the social field (ibid.).

Legitimate language necessarily requires the devaluation of other uses of language and an 'instauration of a new hierarchy of linguistic usages' (Susen 2013: 209) that determines acceptable or appropriate language. Rey refers to the 'incursion of new forms of professionals and specialists into therapeutic and 'theological' or pastoral areas once monopolised by orthodox institutions' (2007: 65), which has a profound impact on the legitimacy of religious language in, for example, a healthcare setting. The changing role of the chaplain and the relationship between religion and health (Norwood 2006; Swift 2014) indicates how the use of religious language has become less 'acceptable' or 'legitimate' within an increasingly secular NHS, except when used in conjunction with the institutional legitimate language. Therefore, talk of providing religious care is only acceptable in the context of 'patient-centred care', 'equality' and 'human rights', while evangelism and mission threaten the institutional commitment to 'safeguarding' vulnerable people and 'patient autonomy' (DoH/Equality and Human Rights Group 2009: 22). Likewise, legitimate authority has transferred from the chaplain and religious authorities to the medical professional following a shift from long-term empathic care to short-term cure (Norwood 2006). As significant shifts in legitimate language radically reconfigure the role of religion within healthcare, chaplains must demonstrate linguistic competency in order to

negotiate and secure their place within a public healthcare setting (Bourdieu 1991b). Chaplains must be able to 'speak the language of the institution' (Aldridge 2006: 20; Church of England 2010: 32; Welford 2011: 104; Flatt 2015) in order to minimise their 'distance from the dominant structure' (Norwood 2006: 20).

I contend that the official normative discourses of the NHS and the chaplaincy profession are two different types of legitimate language operating in separate but related domains. While acknowledging the interplay between the institutional and professional domains, the legitimate language of chaplaincy is not simply determined by the legitimate language of the NHS. Institutional legitimate language is ossified within NHS policy and guidelines, while professional legitimate language is consolidated and reproduced through chaplaincy organisations and outputs (such as conferences, journals, standards and competencies, and the field of 'chaplaincy studies'). I distinguish between the 'working' linguistic competence chaplains may or may not demonstrate as they go about their everyday work (institutional linguistic competence), as opposed to the reflexive linguistic competence articulated in chaplaincy conferences and journals (professional linguistic competence). Linguistic competency is essential for chaplains to be recognised by other chaplains, particularly those who are the gatekeepers to professional accreditation. I explore the implications of the findings in relation to the capacity of minority faith chaplains to deploy legitimate language to progress (or not) within chaplaincy.

6.1.1 Limitations of Legitimate Language

Bourdieu's account of legitimate language has been criticised for overestimating the 'extent to which linguistic resources structure and determine largely complicit and unreflective agents' (Susen 2013: 223). However, Susen notes that 'relatively powerful actors may endorse patterns of action and reflection that challenge the legitimacy of their status quo' (2013: 225). The ambiguity of legitimate language allows chaplains to reinforce their position, but also has transformative empowering potential. This is apparent in the lobbying efforts made by lead/managing chaplains to involve minority faith groups in chaplaincy through deploying legitimate language. The multifunctionality of these linguistic resources (ibid.) is demonstrated in the deployment of legitimate tropes to justify two completely different ends, such

as the inclusion or exclusion of particular representatives from chaplaincy. Legitimate language is therefore interpreted, reinterpreted, and deployed in ways which can both uphold and transform the status quo.

6.2 LEGITIMATING ACCESS: BEYOND BROKERAGE

The findings indicate that brokerage is no longer the dominant mechanism for involving minority faith representatives within chaplaincy. The brokering relationship is no longer dependent on the Anglican chaplain mediating between patients, faith communities, faith representatives, and the hospital. Northbrook might be considered an exception. Establishment privilege continues to fragment, with the growing seniority of some Muslim chaplains contributing to 'breaking the Christian/Anglican monopoly' (Gilliat-Ray *et al*. 2013: 101). The position of broker or facilitator is no longer Anglican by necessity, but instead determined by seniority. These senior colleagues are far more likely to be Christian, but from a greater variety of denominations than was evident when Beckford and Gilliat (1996) and Orchard (2000) were writing.

These developments are a testament to the growing professionalisation of chaplaincy, where the prerequisite for upward mobility is no longer (necessarily) denomination, but skill, experience, and competence. In other words, career progression requires the deployment of symbolic, social, cultural (both embodied and objectified) and linguistic capital. However, capital is asymmetrically distributed in a way that continues to correspond with particular faith groups, especially the Church of England and Free Churches, but in some cases Muslim chaplains. Where Muslim chaplains have reached leadership positions, they too have become enablers for other minority faith colleagues by advocating for provision for minority faith patients, visitors, and staff. Notably, only a handful of Muslim chaplains have reached management positions in healthcare, but in prisons approximately 32% of managing chaplains are Muslim (Todd forthcoming: 8). The Theos chaplaincy report suggests that 'Muslim managing chaplains [in prisons] are now if anything over represented' but links this to 'fewer reported issues over multi-faith relations in chaplaincy teams' (Ryan 2015: 63).

Sessional and part-time chaplains are therefore dependent on full-time colleagues or the lead/managing chaplain to enable their work. The findings demonstrate that even at sites where minority faith chaplains were involved regularly, issues still arose around access, autonomy, and goodwill. Gatekeeping and facilitation are still evident, but justified through the deployment of legitimate language, rather than through the symbolic capital of the Anglican chaplain as an Establishment representative.

6.2.1   The Power of Personal Initiative

Beckford and Gilliat note that the levels of access afforded to minority faith communities in chaplaincy is 'more clearly a result of personal initiatives of individual chaplains rather than consequence of official policies' (1996: 508). The findings show this was still the case. At three sites (Westview, Greenacre and Stonehaven), lead/managing chaplains had made extensive efforts to diversify their volunteer bases, lobby for paid personnel, and to oversee the development of more appropriate prayer facilities. Occasionally, this may conflict with existing team members, especially when attempts are made to diversify the team: 'It came across as [the managing chaplain]'s thing, and not necessarily the Trust were pushing us to do it' (interview, Anglican chaplain, Greenacre, 01/06/2016).

While Beckford and Gilliat observed that minority faith chaplains are still 'not yet in a position where they can easily negotiate directly with hospital managers about…the material conditions in which they perform their roles' (1996: 356), it is clear that any attempts to increase hours, for example, need to be directed through lead chaplain rather than senior Trust stakeholders (e.g. the Deputy Chief Nurse). Such a dependence on the goodwill of the lead/managing chaplain will continue to impact on the career progression of minority faith chaplains. The mediating role of senior chaplains, who are still predominantly Christian, is still a core aspect of negotiating the degree of inclusion for minority faith groups.

6.2.2 Justifying Exclusion

Conversely, the approaches at Riverside, Northbrook, and Moorlands demonstrated a resistance to widening or developing participation in chaplaincy and even appeared to regress. At Northbrook and Moorlands, the lead chaplains appeared to be reluctant brokers who saw facilitating religion-specific care as a 'bottom line' (interview, lead chaplain, Northbrook, 17/12/2015; interview, lead chaplain, Moorlands, 27/09/2016). While approaches differed slightly, the implications apply to both teams. For example, Christian chaplains were the first point of contact for minority faith patients/families; Christian chaplains mediated between the patient/family and the religious representative; the criteria for calling in minority faith representatives were dependent on the individual chaplain's judgement (such as urgency, and whether or not the patient or family was practicing); face-to-face contact with minority faith representatives was minimal; and minority faith representatives were not involved in team meetings.

The primary difference between brokerage as outlined in Beckford and Gilliat (1996) and the model at Northbrook and Moorlands was that the chaplains in Beckford and Gilliat's study thought the model was the best approach to provide for needs in a multi-faith setting and were enthusiastic about promoting inclusion of minority faiths, despite significant flaws in the model (Beckford and Gilliat 1996: 256). In contrast, the brokerage model operationalised during the observations (although not explicitly referred to as such) seemed to arise out of a reluctance to develop a multi-faith chaplaincy team. Chaplains who are keen to promote multi-faith working have long since abandoned brokerage as a model and instead proactively created opportunities for regular substantive minority faith involvement in chaplaincy.

Lead/managing chaplains therefore have a considerable amount of power and agency to direct how far they diversify their teams (or not), and facilitate practice through institutional advocacy (for example, diet and prayer rooms), with few, if any, repercussions from the institution if diversification is resisted, stagnant, or reversed. However, I suggest gatekeeping strategies must be supported by deploying institutional legitimate language. A key example was the deployment of legitimate language in relation to the inclusion/exclusion of non-religious representatives at

Greenacre and Moorlands. Those resistant to non-religious involvement drew on the lack of patient 'need' and 'demand' and the lack of a 'distinctive' role for a non-religious representative (i.e. a service is already being offered to non-religious patients). In contrast, the managing chaplain at Greenacre recognised that framing his case as a matter of 'patient choice' was more convincing than an argument from 'equality', both of which constitute legitimate discourse in the NHS (interview, managing chaplain, Greenacre 25/05/2016). At Greenacre, comparisons were made between the reservations expressed in relation to minority faith and non-religious involvement in chaplaincy (interview, Muslim chaplain, Greenacre, 26/05/2016; interview, non-religious pastoral carer, Greenacre, 27/04/2016). Thus, chaplains can tactically deploy institutional discourses in ways which suit their own normative understandings of how chaplaincy should work.

6.2.3   Localised Legitimate Language

Chaplaincy teams develop their own understandings of legitimate language, derived from but not identical to the legitimate language of the institution, as mechanisms for gatekeeping entry into the team. This is most apparent in considerations of who should be involved in chaplaincy, especially in relation to the volunteer recruitment process and the collation of a community contacts list. The decision about which religious groups are involved in volunteering, where 'suitability' depends on an ability to provide patient-centred non-judgemental care, may have some input from other parties (that is, Voluntary Services representatives), but on the whole chaplains had considerable autonomy over decisions regarding suitability of prospective volunteers from a religious perspective.

At Westview, Greenacre, and Stonehaven, the religious (or non-religious) orientation of a prospective volunteer mattered less than whether they were patient-centred and non-proselytising (key aspects of the institutional legitimate language), which has led to the inclusion of Baha'is and Buddhists, even where it is not 'warranted' by demography, as well as non-religious volunteers. Some chaplaincy teams were not only welcoming when minority faith representatives approached them, but also proactively made efforts to engage with smaller local faith communities (Westview and Stonehaven).

Conversely, unsuitable candidates were largely portrayed as a liability through chaplains' deployment of discourses around 'safeguarding' and 'patient-centred care'. These encompassed concerns relating to proselytising and evangelism, although for the lead chaplain at Moorlands, the issue was prospective volunteers saying that 'they [are a] true member of their church and yet they've been...there's been a history to them' (interview, lead chaplain, Moorlands, 27/09/2016). Particular religious identities raised red flags for chaplains involved in recruiting, such as Jehovah's Witnesses and Seventh Day Adventists, as their agendas were perceived to be contrary to the ethos of chaplaincy (cf. Beckford and Gilliat 1996: 262). This was due to the perception among chaplains that these denominations were likely to proselytise and impose their own religious beliefs on patients.

The question of suitability varied between teams, and at times caused considerable disagreements within teams due to differing benchmarks in relation to acceptable attitudes and, in some cases, religious identities (including perceived attitudes of prospective volunteers that were based on chaplains' assumptions relating to a particular religious group). This was evident in the suspicion among Muslim chaplains at Stonehaven of the use of terms such as 'ministry' and 'mission' and 'Evangelical'/'evangelical' by prospective volunteers, which the Christian chaplain did not consider to be problematic:

> Some of the other chaplains have heard one of the applicants say a phrase or...the applicant has said a phrase which has been harmless and understandable to me but they've taken...put great store by the other chaplains and have considered the applicant unsuitable (interview, Christian chaplain, Stonehaven, 03/08/2016).

> ...[The prospective volunteer] was very adamant that it was like a ministry, they see it as ministry work um...so it's actually saying, no, you come with an open mind and you're dealing with people of different religions and different faiths and it's not about... providing ministry or evangelising faith, yeah, seems to

happen...noticed more with the Christian applicants (interview, female Muslim chaplain, Stonehaven, 29/07/2016).

The disagreements were grounded in the links made between 'mission' and 'evangelism' and proselytising or closed-mindedness. 'Ministry' was conflated with these two terms, when 'ministry' was often seen as unproblematic by other chaplains across sites. Likewise, the term 'evangelical'/ 'Evangelical' appeared to be conflated with evangelism or conversionist activism, but this overlooks other hallmarks of Evangelical identity, including activism for 'secular' causes (including, historically, public health and abolitionism), Biblicism (a particular regard for the Bible) and crucicentrism (emphasis on the sacrifice of Christ on the cross) (Bebbington 1989). Having an Evangelical identity was perceived to be inseparable from a proselytising agenda, although this was clearly not the case when interviewing an Evangelical volunteer at Westview who noted that 'this is not a place for a bully pulpit [...] in hospital I'm talking to people who are in pain, and they're feeling like prisoners of war because they've been here for three weeks [...] that's where you start out' (interview, Baptist volunteer, Westview, 25/02/2016). Evangelical identities are not necessarily incompatible with providing patient-centred care.

In contrast, the Anglican chaplain at Moorlands noted that the informal volunteer recruitment interview was more like a 'religious questionnaire' in order to 'find out whether someone really is an established person of faith coming from a particular angle' (interview, Anglican chaplain, Moorlands, 22/09/2016). More emphasis appeared to be placed on volunteers having a 'clear grasp of their own faith' which assured the lead chaplain that prospective volunteers have the skills necessary — compassion, sensitivity, and discernment — for chaplaincy work (interview, lead chaplain, Moorlands, 27/09/2016). In common with other sites, religious identity was used as a proxy for discerning suitability and skillset, although the Anglican chaplain felt volunteers that had been deemed suitable came from a 'narrow range…in terms of faith groups' (interview, Anglican chaplain, Moorlands, 22/09/2016). Ensuring volunteers had a strong religious identity was seen as necessary for 'safeguarding' patients (interview, lead chaplain, Moorlands, 22/09/2016).

6.2.4 Representative Legitimacy

Minority faith chaplains also made judgements about what constitutes representative legitimacy from their own faith perspective. An instructive example was the argument made by a Sikh chaplain to exclude a Sikh representative from a particular sectarian background:

> [It's] inappropriate for us to make a decision on who's right for what, because actually, someone from that particular school of thought may appreciate someone from that school of thought coming, but also recognising that there is a mainstream Sikh community which has many institutions, schools of thought within it, and...it's working towards that balance (interview, Sikh chaplain, Greenacre, 26/05/2016).

The discourse of belonging to a 'mainstream' community was deployed by several minority faith chaplains. The Hindu chaplain at Riverside often referred to his identity as a 'mainstream' Hindu ('*sanatana-dharma*'), in the context of defining himself as more open than representatives from particular sects, such as the Hare Krishnas (ISKCON) and Swaminarayan Hinduism (interview, Hindu chaplain, Riverside, 02/12/2015). This was confusing to the Anglican chaplain, who said, '[the Hindu chaplain] is not Krishna or Swaminarayan but I'm not quite sure what he is' (fieldnotes, Riverside, 03/11/2015). Similarly, a Muslim chaplain argued for the importance of knowing the 'fundamentals' of Islam: 'even with Sunni and Shi'ite, the core beliefs are the same' (fieldnotes, Stonehaven, 29/06/2016). This discourse justified their positions as suitable representatives of their faith communities and to assert that – because of their essential, fundamental understanding of the faith – they were well-positioned to meet the needs of all Sikh, Hindu, and Muslim patients respectively, regardless of the sect or school of thought. Interestingly, the Muslim chaplain appealed more to his knowledge and status as scholar, while the Sikh and Hindu chaplains referred more to their 'mainstream' identities.

In the case of the Sikh chaplain, the argument from representativeness was further buttressed by an appeal to 'safeguarding' and 'patient-centred care':

> If a person from this particular...tradition came to see a Sikh from
> the mainstream, they probably wouldn't appreciate it, so it's a...it's
> a two-way street. [It's] also making sure it doesn't...have a
> damaging impact on patients if they went to see the patient, or
> vice versa (interview, Sikh chaplain, Greenacre, 26/05/2016).

This appeal to institutional legitimate discourse caused a quandary for the managing chaplain, who expressed concerns about sectarian divisions justifying the exclusion of potential chaplaincy representatives:

> I haven't bottomed this one out...'cause I've spoke to [the Sikh
> chaplain] and I've left it to him […] if it was something like an
> analogous one where [he] was a High Church Anglican and he
> didn't like this person because they were an evangelical
> charismatic then that's....unless that impinges on the way they
> deliver the service, that's not an acceptable criteria to use
> (interview, managing chaplain, Greenacre, 25/05/2016).

The Sikh chaplain appears to suggest that the very identity of such a representative is a barrier to providing patient-centred care, while other chaplains often discuss patient-centredness in relation to how a chaplaincy representative engages with the patient. As observed earlier, in recruitment processes chaplains are beginning to consider patient-centredness as separate from the religious (or non-religious identity) of prospective volunteers, *except* when unorthodox, 'evangelical' or fringe identities are manifested. These identities are automatically considered to be inseparable from an outlook that is not patient-centred.

The managing chaplain at Greenacre also mentioned this in relation to the Hindu chaplain, who felt a prospective volunteer was unsuitable due to their caste, and argued such claims about suitability needed to correspond with the ethos of NHS:

> I wasn't happy with [the Hindu chaplain] saying no we can't have
> that person because they're not Brahmin caste, I would say we
> can have that person to be a volunteer...as long as they function
> within the boundaries of the religious teaching, so if within

Hinduism only a Brahmin priest can do certain stuff then I'm happy with that, because we do say that only an ordained Anglican can celebrate the communion, um...but we don't say only ordained Anglicans can be volunteers because there are other roles, so I...I do...have to watch that the decisions that the minority faith chaplains are making about who is suitable are not made for reasons that are not defensible for the NHS (interview, managing chaplain, Greenacre, 25/05/2016).

The difference in these two cases was that the Sikh chaplain was able to appeal to institutional legitimate language to justify the claims being made about the appropriateness of the community contact. In contrast, the Hindu chaplain appeared unable to frame a justification in terms of the legitimate language of the NHS. Ultimately, the legitimate language of equality deployed by the managing chaplain wins out against religious discourses used to justify the exclusion of particular groups without recourse to institutional legitimate language.

6.2.5   Community Contacts: A Distancing Strategy

All sites had contact lists for external minority faith representatives, including other Christian denominations such as Jehovah's Witnesses and Mormons. Calling on these contacts as required keeps 'problematic' religious groups at arm's length, while ensuring that appropriate representatives can be found in case of explicit need or demand. Numerically small minority faith groups (Baha'is and Buddhists) were given the freedom to visit all patients so long as their approach was patient-centred, but other minorities could only respond to particular requests and were automatically excluded from broader responsibilities based on assumptions made based on their religious identities. The use of the contact list as a distancing mechanism also applied to Muslims and non-religious representatives at Moorlands.

6.3   LEGITIMATE LANGUAGES: THE MULTIVALENCE OF LINGUISTIC COMPETENCY

Bourdieu's legitimate language can also refer to the appropriate deployment of language within a particular social field (1991b: 78). Actors change register through 'strategic modifications in discourse' in order for their exchanges to be contextually appropriate (Bourdieu 1991b: 78; see also Goffman on 'footing', 1981: 128). In a

medical setting, the 'legitimate' language deployed by authoritative professionals (clinicians, for example), is a formal clinical register in English. For chaplains, the only legitimate language in patient interaction is that which enables a patient-centred encounter, using linguistic forms understood by the patients. Chaplaincy representatives from all faiths referred to their role as a 'bridge' between patients and staff when patients did not understand information given by doctors. Chaplains must adapt to ensure the legitimacy of their role is recognised by patients and staff. The decisions chaplaincy representatives make about use of legitimate language range from whether to use English or 'community' languages, formal or informal registers, and the use of sacred language. The implications of 'community' language use among Christian chaplains at Northbrook and Westview have already been examined. Here I focus on language use by minority faith chaplains with patients and staff, and the potential institutional impact. The deployment and use of particular languages in patient encounter points to a particular location in the social field, and indicates the power relations between chaplains and patients.

Interestingly, for all the emphasis on 'translation' and 'language' in the chaplaincy literature (Woodward 1998; Macritchie 2001; Norwood 2006; Swinton and Mowat 2007; Church of England 2010; Kyriakides-Yeldham 2017) scarce attention has been paid to linguistic diversity among patients in a literal sense, except in Gilliat-Ray *et al*.'s study (2013: 88). This raises questions about how generic chaplaincy services can be provided if chaplains overlook basic language barriers and how chaplains spiritually can assess patients if they cannot speak the same language.

6.3.1 'Community' Languages

All Muslim, Hindu, and Sikh minority faith chaplaincy representatives were fluent in a number of South Asian vernacular languages, such as Urdu, Punjabi, and Gujarati, and visits to minority faith patients were often conducted in these languages. The use of community languages to engage in everyday conversation was recognised by the lead chaplain at Westview:

> Some of these people are quite isolated, because their English
> isn't, especially the older people who tend to be the people in the
> hospital, their English isn't always fantastic. And I've seen... that

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happening with [the Muslim volunteer], he's spoken to them in English and they've not really understood what he's...it's only really when he went into, I don't know what he...Bengali I think it was...that the man just came alive, he changed before our eyes […] So it's those sorts of situations which I think are really, really important, 'cause it's only by being able to talk to the people you can assess what their needs are (interview, lead chaplain, Westview, 18/02/2016).

For this lead chaplain, speaking the first language of patients not only helps isolated patients, but also assists with the assessment of the spiritual needs of the patient. This reflects Gilliat-Ray *et al*.'s observation that 'for some service users, being able to speak to someone who understands their language is vital to their sense of wellbeing' (2013: 88).

6.3.2   Language and Translation

Staff who overheard chaplaincy representatives engaging with patients in their first language often asked chaplaincy representatives to translate between them and patients. Staff valued the linguistic capital of minority faith chaplaincy representatives, demonstrated by frequent requests to translate for patients. Participants suggested that chaplains were often asked to translate because they are readily available and present on the wards and offered a 'quick fix' to a communication barrier (interview, Muslim volunteer, Stonehaven, 15/08/2016).

At Riverside, Westview, and Greenacre, some chaplaincy representatives appeared to have no problems with translating when requested, while others stated they would only translate for practical issues, rather than medical matters. The boundaries around translation appeared to be informal and determined by personal preference. Only one chaplain at Greenacre stated outright that he avoids translating as 'I don't wanna be seen as a translator' (interview, Muslim chaplain, Greenacre, 12/05/2016). In contrast, the chaplaincy team at Stonehaven prohibited all chaplains and volunteers from translating. The Sikh chaplain registered as a translator for the Trust, but distinguished this role from his chaplaincy work. This became a key way in which chaplaincy asserted its distinctiveness, and was framed in terms of liability

and Trust policy - chaplains were not insured to provide translation services (fieldnotes, Stonehaven, 29/06/2016). From the team's perspective, there was a mismatch between the staff recognition of chaplains and a legitimate role for chaplains to be undertaking. This has some broader implications in terms of maintaining the distinctiveness of chaplaincy over against interpreting departments and mitigates the risk of chaplaincy being seen primarily as an interpreting service. This reflects Gilliat-Ray *et al.*'s finding that chaplains 'tend to see translating as a vehicle for their work, and are cautious about letting it become one of the central reasons for their value in the institution' (2013: 89). However, chaplains at Stonehaven still had a role in translation, but in a broader sense of translating culture, evidenced by Muslim chaplains representing an 'Asian' perspective on committees and MDTs (interview, Muslim chaplain, Stonehaven, 08/08/2016). In this sense, the chaplains at Stonehaven emphasised their wider cultural capital rather than their linguistic capital.

For several chaplaincy representatives, their ability to speak multiple languages enables chaplains across faiths to be patient advocates and a 'bridge' between patients and staff. The ability to speak and translate languages connects to the ability to translate between cultural, religious, and institutional worldviews (Gilliat-Ray *et al*. 2013: 80). This includes advocating for patients on practical matters or grievances such as diet (fieldnotes, shadowing Jain volunteer, Greenacre, 08/04/2016), managing expectations of families navigating hospital bureaucracy following a bereavement (interview, male Muslim chaplain, Stonehaven, 15/08/2016; see also Gilliat-Ray *et al*. 2013: 58), consulting on issues such as cultural understandings of chronic pain (interview, male Muslim chaplain, Stonehaven, 15/08/2016), and empowering patients to ask questions about their treatment (interview, Sikh chaplain, Greenacre, 26/05/2016). This may also take place on a larger scale as chaplains engage proactively with dealing with serious 'management or operational failures' (Gilliat-Ray *et al*. 2013: 125), demonstrated by the involvement of a Muslim chaplain in investigating a formal complaint made to a neighbouring Trust by a Sikh family (interview, Muslim chaplain, Stonehaven, 15/08/2016).

6.3.3 Language and Authority

The use of religious, scriptural, or sacred language inscribes minority faith chaplains with authority. The use of sacred language that 'laypersons' may not understand maintains a 'strict control of the language…by religious authorities [and] safeguards the "magical", or perhaps better "transformative" power of that language' (Williams 2008: 125). In the context of chaplaincy, the deployment of 'sacred languages' offers comfort and reassurance and may have connotations of healing, but also reinforces the status and authority of religious professionals.

The authority of the chaplain is often asserted at the beginning of the encounter with the patient, with the use of faith-specific greetings with patients ('*salaam alaikum*', '*jay shri Krishna*'), combined with particular physical identity markers of the chaplain. The chaplain is therefore immediately recognisable as a religious figure. However, this also sets expectations about the tenor of the conversation and gives the encounter a religious footing: 'If you're not talking about religious, after we say 'jay shri Krishna' then all...automatically religious come between us' (interview, Hindu chaplain, Greenacre, 25/04/2016). Additionally, chaplains who were also religious professionals built on their religious and symbolic capital by introducing themselves to patients as 'imam' or 'pandit' or 'priest'. This 'code-switching' was necessary for patients to comprehend their role (see also Cadge and Sigalow 2013: 155-156), and set expectations about the nature and purpose of the visit, even though the role of chaplaincy is not directly comparable to the role of a religious professional. The authority of the chaplain might also be reinforced through the deployment of 'sacred' languages, such as Arabic or Sanskrit, for the purposes of ritual or praying with patients. A Hindu chaplain acknowledged that some patients might not understand Sanskrit, and compared it to Latin when explaining its significance (fieldnotes, Greenacre, 05/04/2016). The ability to pray in Arabic and recite healing verses from the Qur'an for Muslim chaplains is usually associated with religious scholars of both genders, who may be regarded as having more authority by patients (Gilliat-Ray *et al*. 2013: 83, 92).

It was also common for Muslim patients to intersperse their responses to Muslim chaplains with Arabic terms such as '*alhamdulillah*', '*mashallah*' or '*inshallah*',

even when talking about mundane everyday issues. While Williams suggests that 'religious adherents' use of sacred language is as part of their participation in the religious tradition to appropriate the transrational power that, it is believed, permeates the sacred language' (2008: 138), the quote below suggests that there are social reasons for this:

> …when I ask the question "hi how are you feeling today?" the automatic response is a religious response... and it will be "*alhamdullilah*, praise be to God...I'm- I'm much better, God is looking out for me" and that kind of thing. And you sometimes wonder what the understanding of that kind of response is, is it because they see you as a religious leader and therefore they have to give a religious answer...to match that, or is it the...the other bit where always be grateful to God, so therefore if they are being grateful for their health, they are bringing in the God element into it. So sometimes it becomes 100% religious talk […] [o]ther times it will be "yeah bro, yeah, I'm OK, I'm good" and… you just go on from there… (interview, male Muslim chaplain, Stonehaven, 15/08/2016).

These social reasons might result from the projection of authority onto the Muslim chaplain – where patients have certain expectations about how they should speak or behave when being visited by the 'imam' – or a broader understanding of Islamic etiquette which emphasises gratitude. Muslim chaplains are caught between emanated/projected authority and the patient-centred impulse of chaplaincy. The markers and language that render chaplains recognisable generate particular expectations among patients about the content of the conversation. The quote above demonstrates the adaptability of Muslim chaplains, especially in relation to the use of legitimate registers to fit patient expectation. The above quote demonstrates a growing reflexivity among Muslim chaplains of issues concerning power and authority in relation to patient care.

6.3.4   Conclusions

The ability to speak multiple languages often sets minority faith colleagues apart from their Christian colleagues (with two exceptions), and was useful for achieving recognition from patients and staff. In the same way that Christian chaplains are keen to distinguish their contribution to spiritual care from healthcare staff, Muslim chaplains at Stonehaven were keen to ensure that their contribution to holistic care did not risk being conflated with the interpreting department. For minority faith chaplains, translation was not only linguistic, but also related to communicating religious and cultural issues to the institution and vice versa. Translation, broadly conceptualised, is a significant element in empowering minority faith patients and families. Similarly, chaplains recognise the importance of changing linguistic registers in order to be patient-centred and offer an alternative to the legitimate language of the healthcare institution. This affirms the multivalence and situatedness of legitimate language, depending on who chaplains are engaging with at any given time.

6.4   CONSTRUCTING CHAPLAINCY

This section explores where minority faith involvement fits within the discursive construction of chaplaincy in the chaplaincy literature, with reference to 'official' discourse. The discourses examined are concerned with the professionalisation of chaplaincy and the trope of the 'multiply marginal' chaplain (Norwood 2006; Swift 2014), the distinctiveness of chaplaincy (Swinton and Mowat 2007), the tension between professionalisation and formation (Woodward 1998), and the collegiality of chaplaincy (Swift 2004: 184; De Vries *et al*. 2008: 26; Swift 2010: 203). This section will explore where the findings fit in relation to the legitimate language as articulated in the chaplaincy literature.

6.4.1   Reconsidering Marginality

The trope of the marginal chaplain is well-rehearsed in chaplaincy literature (Norwood 2006; Threlfall-Holmes and Newitt 2011; Swift 2014). The marginality discourse has arisen from the increasing requirement for chaplaincy to negotiate its position in the NHS (Ballard 2010; Orchard 2000; Norwood 2006; Swift 2014) and increasingly strained relationship between the Anglican chaplains and Church

hierarchies (Hancocks *et al*. 2008; Ballard 2010; Swift 2014). Consequently, chaplains are caught between being religious functionaries and healthcare professionals.

The marginality discourse is compounded by a perception that chaplaincy is under considerable pressure to subscribe and conform to the values of the NHS (Fraser 2010; Pattison 2015; Todd 2015b). Overemphasising external pressure risks presenting chaplains as quiescent and passive, rather than active everyday negotiators. As I have suggested, successful socialisation enables chaplains to tactically deploy institutional discourses around equality, patient-centred care (including patient choice), and cost-benefit to justify their position on a range of issues. The deployment of institutional discourses to support a particular view of chaplaincy was a tactic most commonly evident among Christian chaplains across sites and Muslim chaplains at Stonehaven.

The attempts of Muslim chaplains at other sites, as well as Jewish, Hindu, and Sikh chaplains across sites, to argue for increased hours lacked traction if such arguments were made without reference to the legitimate language of the institution. A key aspect of agency and autonomy is not just the concrete conditions of employment (hours allocated, working practices, etc.) but the ability of chaplains to appeal to the legitimate institutional language. However, linguistic competency and distribution are linked: hours allocated to minority faith chaplains may contribute to their continued socialisation in chaplaincy and therefore the ability to deploy institutional discourses. It is insufficient, for example, for a Hindu chaplain to suggest he can contribute to staff training on cultural competency (interview, Hindu chaplain, Stonehaven, 29/07/2016); he must also explain why this is important from the perspective of patient-centred care, and the resources this may save if a Trust can avoid a complaint or legal challenge, demonstrating cost-benefit. He must also explain why he is uniquely placed to provide this training. Likewise, requesting more hours solely for the purpose of engaging in more pastoral patient visiting (interview, Muslim chaplain, Riverside, 14/11/2015) often misses vital opportunities for chaplains to cultivate capital (social, cultural and linguistic) and increased influence through participation in institutional roles (see Gilliat-Ray *et al*. 2013: 125).

Minority faith chaplains with limited hours may require the assistance of their colleagues in order to translate their objectives into 'legitimate' language that the institution recognises. Senior chaplains are better placed to negotiate and lobby than their mostly sessional colleagues, necessitating facilitation (Beckford and Gilliat 1996; Orchard 2000). Despite claims from 'mainstream' chaplaincy discourse that chaplains in general are marginal within the institutional setting, chaplains clearly adapt to the institutional setting by adopting and deploying legitimate language. The ability to deploy legitimate language in order to support certain approaches to chaplaincy is evidence of the successful socialisation of chaplains. At the same time, legitimate language must be accompanied by appropriate forms of capital (such as the social capital generated through institutional roles). It is clear that the scope and opportunity for minority faith chaplaincy representatives to be socialised is far more limited than their Christian (and some Muslim) colleagues, which disproportionately disadvantages these representatives and prevents career progression. Without exposure to sufficient processes of socialisation, regular presence, and sustained institutional and professional engagement, minority faith chaplains are largely excluded from the mechanisms by which they can become fluent in the legitimate language that supports increased recognition.

The literature also refers to the marginality of chaplains in relation to their faith communities, especially Anglican chaplains and the Church of England. It is apparent that minority faith chaplains do not have similarly strained relationships with their faith communities, especially with earlier reference to the symbiotic relationship between the Hindu chaplain at Greenacre and the local Hindu community. For many minority faith chaplains who are also community-based religious professionals, there were still considerable overlaps between these roles. This reliance on community support is exacerbated by the allocation of part-time hours and the need to supplement income.

However, Gilliat-Ray *et al*. note that several Muslim chaplains expressed dissatisfaction with the terms and conditions of mosque-based jobs and were attracted to 'transparent employment policies and rights', 'comparatively generous remuneration', and opportunities for professional recognition offered by chaplaincy (2013: 53-55). The 'limitations placed upon [imams] while working in mosques'

(ibid.: 178) were also a significant push factor. Interestingly only one Muslim chaplain explained why he had chosen not to be a mosque-based imam:

> I was never into mosques…my vision, even when I was becoming an Islamic scholar, I always wanted to be a teacher [...] I couldn't see myself limiting, stopping at just a mosque. So I was never a mosque-based imam […] I think it was about spreading your wings, and that's what I like to do, rather than restrict myself (interview, Muslim chaplain, Stonehaven, 08/08/2016).

This perception also resonated with an Anglican chaplain's understanding of his chaplaincy role: 'I find it very freeing too…as a Christian priest who is...very liberal in my...religion... 'cause it...gives me the freedom to be me' (interview, Anglican chaplain, Greenacre, 28/04/2016). Chaplaincy was perceived to give more freedom as a career choice than community-based leadership. In a very limited sense, this Muslim chaplain may find some common ground with Anglican chaplains who find community-based work constrictive, although the reasons for this differ from their Anglican colleagues. Muslim chaplains do not constitute a counter-cultural minority within Islam (Hancocks *et al*. 2008, Swift 2014). However, it is clear that the experience of both Muslim and Anglican chaplains in public settings has helped to develop a sense of pragmatism and responsiveness to need that might not be reflected by their community-based colleagues (Ansari 2012; Swift 2014; for a comparison to Islamic social work, see Warden 2010).

Marginality as constructed by Christian chaplains is very different from the marginality and marginalisation experienced by minority faith chaplains. There are some parallels concerning the relationship with faith communities between Anglican and Muslim chaplains, but this was the exception rather than the rule, and most minority faith representatives had very strong connections with their faith communities. The marginalisation of minority faith chaplaincy representatives is exemplified by career stagnation, the deployment of an 'us-them' dichotomy by Christian chaplains in relation to minority faith representatives, and when working practices (inadvertently or otherwise) exclude minority faiths by restricting access to resources or reinforce the somatic norm. Nationally, as noted in the literature review,

the marginality of minority faith chaplains is especially pronounced in relation to the chaplaincy knowledge base and involvement in chaplaincy bodies (see also Gilliat-Ray *et al*. 2013: 69). The ability of influential Christian chaplains to ruminate on their marginal position in the NHS points to a comparatively comfortable position.

6.4.2   The Distinctiveness of Chaplaincy

The construction of a profession requires the demarcation of boundaries that differentiate chaplains from other potential providers of pastoral, religious, and spiritual care, including other healthcare professions, chaplaincy volunteers, community-based religious leaders, and family). De Vries *et al*. refer to the 'annexation' of territory where chaplains 'stake a claim' in the healthcare domain (2008: 24). Below I will examine the convergences and divergences between the construction of distinctiveness in the chaplaincy literature and by chaplains on the ground.

6.4.2.1   Distinguishing between Chaplains and Healthcare Professionals

When discussing their distinctive contribution, chaplains often referred to gaps in healthcare provision that they were able to fill (De Vries *et al*. 2008: 24). For chaplains across sites, this abandoned territory included the provision of spiritual care (as opposed the medical care provided by medical staff), which suggests that spiritual and medical/physical care are considered to be discrete domains. Most of the chaplains referring to this distinction were Christian, although a Jewish chaplain, Hindu volunteer, and Hindu chaplain also referred to providing spiritual care as a discrete aspect of care. An Anglican chaplain and a Hindu chaplain linked the provision of spiritual care directly to patient recovery, implicating the role of chaplaincy within the healing process. In contrast a Free Church chaplain acknowledged that staff may also provide spiritual care, but that chaplains could offer a resource for staff who did not have the time or experience, echoing the discourse of chaplain as resource on spiritual and religious issues in chaplaincy guidelines (SEHD 2002; Scottish Government Department of Health and Wellbeing 2008: 9; DoH 2003b; SYWDC 2003; NHS England 2015a: 7, 11). Significantly, both Baha'i volunteers interviewed were retired nurses, and did not explicitly identify holistic/spiritual care as unique to chaplaincy. Instead, what distinguished chaplaincy

representatives was having the time to provide such care. Chaplains and volunteers alike acknowledged that that chaplaincy representatives have the time to be present with and listen to patients. A Catholic chaplain at Greenacre and Hindu and Muslim volunteers at Stonehaven suggested that being a chaplaincy representative required a different skillset to medical staff, highlighting the rational 'instrumental' approach to medical care over against providing 'assurance', 'comfort' 'empathy', 'non-judgemental support', and 'human contact'; in short, the compassionate element of providing care.

Several chaplains also commented that a key aspect of this presence was that chaplaincy representatives are 'independent individuals away from the nurse's uniform, the doctor's stethoscope…' (interview, male Muslim chaplain, Stonehaven, 15/08/2016). When shadowing a Muslim volunteer at Westview, a patient expressed gratitude for the non-invasive and compassionate approach of the volunteers in contrast to the medical staff:

> The patient tells me having someone from the hospital to visit is nice – "staff come in poking you" [makes a poking gesture at his arm] "it's humanity isn't it?" (fieldnotes, shadowing Muslim volunteer, Westview, 25/01/2016).

The independence of chaplains was a helpful way of positioning chaplains as mediators between the patient and the institution, who can 'get the message through' or help put patients at ease (ibid.), especially on occasions where there might be tensions between patients/families and ward staff.

Some Christian chaplains expressed caution about overemphasising spiritual care when it was theoretically territory that other healthcare professionals could occupy. These chaplains argued that the specifically religious dimension distinguishes chaplaincy from other healthcare professionals and that ignoring the religious aspect of chaplaincy is counter-productive:

> Anybody can do spiritual care, but I don't think anybody can do religious care… My fear is that chaplaincy, if you really want to

know, I think chaplaincy is shooting itself in the foot (interview, Anglican chaplain, Northbrook, 07/12/2015).

Surprisingly, few minority faith chaplains explicitly referred to providing religious care or their religious identity as a distinguishing feature of the work of chaplain. It seemed as though for many minority faith chaplains the distinctiveness of the religious element of their care was taken-for-granted or implicit:

> [The Hindu chaplain] tries to lift the patient's mood and says "but in spite of infirmity you have a good spirit" and then says "I don't have any medical expertise, but I can offer chants or prayers if you like" (fieldnotes, shadowing Hindu chaplain, Riverside, 14/10/2015).

A lack of an explicit distinction between spiritual and religious care among most minority faith chaplaincy representatives highlights a significant limitation of the spirituality discourse deployed by Christian chaplains and in the chaplaincy literature. In order to suggest that religious care constitutes a discrete area of care separate from (but related to) spiritual care, there must be a bifurcation between religion and spirituality, which is not necessarily recognised by minority faith groups (Gilliat-Ray 2003). It was common for minority faith chaplaincy representatives to articulate an overlap between spirituality and theism, if not religion (and religious practices) more specifically. One Anglican chaplain even suggested that minority faith groups 'don't necessarily have the same distinction of spirituality as the Western world […] Their spirituality is so rooted in partly religion, but also their cultural heritage' (interview, lead chaplain, Northbrook, 17/12/2015). Yet the same chaplain continued to work with a generalised, universalistic, and differentiated understanding of spirituality that did not accommodate alternative understandings.

Minority faith chaplains at Greenacre and Stonehaven began to articulate understandings of spirituality as separate from religion. The Hindu and Sikh chaplains at Greenacre noted that those who are spiritual are not necessarily religious (interview, Hindu chaplain, Greenacre, 25/04/2016; interview, Sikh chaplain, Greenacre, 26/05/2016). The Sikh chaplain qualified his perspective by suggesting that 'the language to engage with the spiritual…[is] most developed within religious

traditions' and that spiritual needs are best met by someone of a shared religious background (interview, Sikh chaplain, Greenacre, 26/05/2016). This might counter arguments that Christian chaplains are able to meet 'generic' spiritual needs of patients from different faith groups. For a Muslim chaplain at Stonehaven, spirituality was not only separate from religion, but also universal: 'every human being has a spiritual need, but not every human being has a religious need' (interview, Muslim chaplain, Stonehaven, 15/08/2016).[41] In this sense, minority faith chaplains are beginning to adopt mainstream chaplaincy discourses about the generic, universal, and differentiated nature of spirituality, but may not necessarily make clear cut distinctions between providing spiritual and religious support. The next chapter will explore how far spiritual or religious support is distinguished from pastoral support.

6.4.2.2   *Distinguishing between Chaplains and Volunteers*

All paid chaplains, except two, argued that there was a difference between chaplains and volunteers. This boundary work was achieved with reference to role (division of labour), professionalism, working practices, and access. The work of the paid chaplains included sacrament/ritual, high intensity visits (end of life, emergencies), responding to on-call, providing funerals, administration, and the provision of spiritual support rather than just pastoral support. These roles were often linked to the authority of the chaplain. However, the volunteers that had some involvement in emergency call-outs and intense situations did not consider themselves to be distinct from chaplains. For Sikh chaplains, for example, the case for distinguishing between paid chaplains and volunteers was more difficult to articulate. The lack of a religious hierarchy meant that there was no substantial difference in the role of the Sikh chaplain at Greenacre and the volunteers who supported him:

> From a Sikh perspective, [there's no difference]. Because we
> don't have a concept of clergy. We don't have priests. So if any
> Sikh that is trained and able to lead a service or lead a prayer,

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[41] Hindu chaplains might refer to the universality of spirituality, but this was usually within an explicitly Hindu (dharmic) framework where the primary aim is to achieve union with God (interview, Hindu chaplain, Stonehaven, 09/08/2016).

they can do so. And so for me, that sense of being in a hierarchy

with the Sikh faith doesn't exist and therefore we are...equals in

that sense (interview, Sikh chaplain, Greenacre, 26/05/2016).

It was not uncommon for Sikh volunteers to refer to themselves as chaplains, despite some chaplains emphasising volunteers should not do this. Similarly, the female Muslim chaplain and a female Muslim volunteer at Greenacre did not see any difference between their roles. In both cases, the blurred boundaries arose from Sikh and Muslim volunteers providing emergency on-call cover.

6.4.2.3   *Distinguishing between Chaplains and Family Members*

Several sources note that pastoral care for some minority faith groups tends to be undertaken by family members (Welford 2011: 229; Eccles 2014: 5; Jhutti-Johal 2013: 265; Abu-Ras and Laird 2011: 51; Gilliat-Ray *et al*. 2013: 33). This assumption was shared by Christian chaplains, but also by some Muslim chaplains and one Hindu volunteer. However, minority faith chaplains most often cited the importance of presence, confidentiality, and being non-judgemental to distinguish themselves from family members. It was also clear that minority faith chaplains were increasingly requested to perform religious activities that might otherwise be undertaken by family members. The professionalisation of ritual will be explored in the next chapter.

6.4.2.4   *Distinguishing between Chaplains and Religious Leaders*

The distinction between minority faith chaplains and religious leaders is occasionally unclear, demonstrated most clearly by Hindu chaplains and Jewish chaplaincy representatives. While the literature explicitly discussing the relationship between chaplains and religious leaders is scant, these sources often make a hard and fast distinction between them (Carr 2001; Swinton and Mowat 2007; Swift 2013). Muslim and Sikh chaplains easily distinguished their role from community-based religious leaders, referring to their availability and providing non-judgemental patient-centred care. While a Sikh chaplain distinguished his role from a *gyani* (interview, Sikh chaplain, Greenacre, 26/05/2016), no direct comparison was drawn between the non-judgemental approach of the Muslim chaplains and the approach of mosque-based imams. In contrast, Warden found that Muslim social workers

explicitly distinguished themselves from mosque-based imams by using a non-judgemental approach as a marker of professionalism (2013: 93-94). A Muslim chaplain at Stonehaven also suggested that chaplains can mediate between different expectations and requirements and that knowledge/awareness of the healthcare environment can be helpful. The latter exemplifies Swift's suggestion that 'the location of the chaplain within the hospital—discharging a religious function with spiritual benefits—is essential' (2013: 256).

6.4.3 Bucking the Anti-Clerical Trend: Minority Faith Chaplains as 'Religious Experts'

The professionalisation of chaplaincy has been accompanied by a growing anti-clericalism, evident in Swift's critique (2014) of the conservatism in the Anglican hierarchy. Anti-orthodoxy has become the new orthodoxy within mainstream chaplaincy circles as 'up to half of the whole-time chaplains appear to have sought refuge in the NHS following experiences that have weakened their confidence in traditional religious leadership' (Swift 2014: 144). These tensions were evident in the fraught relationships between various bodies involved in chaplaincy, such as the HCC, the CHCC, the UKBHC, and the MFGHC (Church of England 2010; Swift 2014: 71-74). These tensions have contributed to a perception that professionalisation and 'formation' are mutually exclusive, with professionalisation requiring a shift away from a clerical identity (Woodward 1998: 47) by prioritising 'function at the expense of ontology' (Kyriakides-Yeldham 2017: 63). This distancing from clerical identity also appears to ground Swift's exposition of the chaplain as liberal practical theologian (2014). The chaplain's pragmatism strikes a balance between pastoral necessity and theological integrity, epitomised by the question of baptising a baby that has passed away (Swift 2014: 116-123). Orthodoxy embodied in religious leadership and pragmatism are treated as mutually exclusive.

This suspicion of religious leadership manifests in the relegation of religion-specific or religious care as a secondary or less desirable aspect of chaplaincy work on the grounds that religious care restricts the remit of chaplaincy to a narrow constituency (interview, lead chaplain, Northbrook, 17/12/2015; interview, Anglican chaplain, Greenacre, 22/04/2016). Some Anglican chaplains argued that religious leaders often

saw their role as educational rather than pastoral. Consequently, religious care/religion-specific visiting is presented as narrow, parochial, and exclusive, and linked to 'teaching', ritual or 'commanding behaviour' (Beckford and Gilliat 1996: 283) rather than non-judgemental pastoral support. This tension between religion-specific visiting and professionalisation can be seen in the expectation that chaplains will become increasingly generic as their seniority increases:

> I think as...minority faith chaplains get established and certainly
> if they move into full-time or leadership roles, they will perhaps
> start to behave more like...those established Christian chaplains
> by working more generically and being less focused on their own
> community (interview, managing chaplain, Greenacre,
> 25/05/2016).

Likewise, one Anglican chaplain questioned why minority faith chaplains should be paid at all if they 'visit their own' (interview, Anglican chaplain, Greenacre, 22/04/2016). A direct link is made between remuneration and adopting the generic approaches of Christian chaplains, creating a hierarchy of value which privileges generic over religion-specific approaches. This hierarchy of value, which determines hours and therefore involvement in wider roles (such as institutional involvement), treats 'religious care' as a bedside concern, where religious needs are narrowly interpreted as 'ceremonies, meditation, prayer, rites, sacraments and worship' (UKBHC 2009: 2-3), rather than having anything to contribute the workings of the wider hospital.

This attitude towards religion-specific care was reversed at Stonehaven, where the Muslim chaplains had created a niche for themselves as 'religious specialists' consulting on faith-specific issues on an institutional level, rather than simply at the bedside. Here, chaplains professionalised the religious aspect of chaplaincy work, while de-professionalising the generic aspect, which was primarily the domain of the volunteers. Notably, the chaplains at this Trust did engage in generic work, expressing an openness to speak with patients who signalled that they wished for a conversation, and through participation in institutional roles (such as involvement on

a dementia working group). However, stakeholders at Stonehaven reported that religious expertise was more meaningful to them:

> [The previous Free Church/Anglican chaplains] were happy with talking about spirituality, but actually when I was trying to say I just need somebody to come and talk about specific... you know... what is the Muslim view of death, what is...you know, why when we are saying the person's dying do they want to keep going, you know? (interview, stakeholder, Stonehaven, 06/07/2016)

The increasing recognition of the religious expertise offered by Muslim chaplains at Stonehaven demonstrates that the *symbolic* capital of Muslim chaplains is recognised not only by patients, but also by staff. Muslim chaplains were regularly called in for 'troubleshooting', liaising, and negotiating apparently intractable religious issues (Gilliat-Ray *et al*. 2013: 126), which requires chaplains to draw on their religious and institutional knowledge to arrive at a pragmatic response (interview, stakeholder, Stonehaven, 27/07/2016; Swift 2013: 256). The consultative role of Muslim chaplains at Stonehaven was exceptional, and was not replicated to the same extent among Muslim chaplains at other sites. Many ethical and religious issues raised at Stonehaven were not as pronounced at other sites, where involvement was often limited to bedside consultation on organ donation and switching off life support. Sikh chaplains also noted that their advice was occasionally sought in circumstances where the wearing of the Five Ks was problematic, such as the wearing of the *kirpan* (ceremonial dagger) during MRI scans, or how far wearing the *kara* (bracelet) was compatible with infection control policy, although these requests for advice appeared to be irregular. The next chapter will explore why a consultative role is developing particularly among Muslim chaplains.

Manifestations of religious authority are not mutually exclusive with offering patient-centred care. Patients regularly requested advice from Muslim and Sikh chaplains, but these chaplains emphasised that their support is non-judgemental, pastoral, and respectful of patient choice. Likewise, the provision of religious care in end of life situations may also have a pastoral element, as demonstrated by the Muslim volunteer deciding when to switch from reciting *Surah Yasin* (a verse

believed to have healing qualities) to the *shahadah* when supporting the parents of a dying child (interview, Muslim volunteer, Westview, 09/02/2016). The pragmatism required for pastoral care is not confined to liberal Anglican chaplains, but is operationalised by Muslim - and to a degree Sikh - chaplains who may retain a level of 'orthodoxy' while negotiating how religious belief and practice sits within a secular institutional setting. The ability to be pragmatic and adaptable does not require a disconnectedness from faith communities or a renunciation of 'orthodoxy', but instead the ability to re-cast and reconfigure authority in a context of non-judgemental patient-centred care. This can be linked to the concept of 'elastic orthodoxy', in which orthodox identities and beliefs can be tactically stretched and flexibly deployed for pragmatic ends (DeHanas 2012; see also Lindsay 2007; 82; Woodhead 2014). Muslim chaplains at Stonehaven in particular have successfully negotiated recognition within the immediate institution, but the reconfiguration of their roles where religious expertise is central is overlooked by the wider chaplaincy profession.

6.4.4 Chaplaincy as Collegial

Collegiality may refer to relationships with staff (Woodward 1998: 180), chaplains' collaborative working in ecumenical or multi-faith teams (Gilliat-Ray *et al*. 2013: 105-108), and the corporate identity of chaplaincy (Swift 2014). Arguably, the growing collegiality of chaplaincy could be linked to the anti-clericalism cited above: as the chaplain becomes increasingly distant from the parish priest, he or she develops a distinct professional identity as a member of healthcare staff. This is highlighted by Swift's assertion that for those who see chaplaincy as an expression of a church or faith community, chaplaincy possesses 'no collegial or corporate identity across religious divides' (Swift 2010: 203). The limitations of collegiality on a national level have already been discussed in the previous chapter.

The findings show that some minority faith chaplains do not necessarily engage in the collegial ethos that is now an assumed aspect of chaplaincy work. Ballard initially anticipated this problem when he stated that 'it is hard to see how realistically such diversity can be integrated into a really cohesive team' (2010: 200). Ballard suggests that diverse approaches to chaplaincy would cause problems for

team cohesion. The findings show that collegiality is most profoundly affected by different chaplains' self-understandings of their roles, but also working hours and differential levels of socialisation.

While Gilliat-Ray *et al*. have commented that some Muslim chaplains have 'clearly absorbed some prevalent ideas in medical health care regarding team-work… The justification that chaplains provided for "ringing round the scholars" seemed to mirror prevalent working practices and assumptions in the NHS' (2013: 61), it was unusual for chaplains to ask colleagues of different faiths for advice, partly because their visits tended to focus on patients of the same faith backgrounds. A key exception was the knowledge exchange at Westview. Additionally, Gilliat-Ray *et al*.'s observation that 'Christian-Muslim relations may be more fragile in parts of the NHS' (2013: 107) was apparent in the tensions between Christian and Muslim chaplains at Stonehaven, when a chaplain insinuated that the Muslim chaplain was an extremist (fieldnotes, Greenacre, 19/04/2016), and the critical attitude of a bank chaplain towards Muslim volunteers (fieldnotes, Westview, 21/01/2016 and 11/02/2016).

6.5   CONCLUSIONS

This chapter has explored the implications of the findings by drawing extensively on the literature. The findings were situated in dialogue with key themes in the chaplaincy literature, including brokerage and access for minority faith groups, the role of chaplain as translator, and the construction of chaplaincy as marginal, professional, and collegial. Bourdieu's concept of legitimate language illuminates the discussion, highlighting the importance of institutional and professional linguistic competence for chaplains' recognition. This use of legitimate language once more highlights differential access to capital among minority faith chaplains. Access has widened considerably since Orchard (2000) was writing, moving beyond Anglican monopoly towards a greater legitimacy afforded to other Christian denominations and Muslim chaplains. In this way, the professionalisation of chaplaincy - where denomination matters less than skillset and competence - has helped some Muslim chaplains, but hindered the remainder of minority faith chaplains.

7 Discussion

In this chapter, I will explore the ways in which the findings and analysis contribute to broader debates about religion in the public sphere in the UK. I will first explore the significance of chaplaincy in relation to developing knowledge regarding religious professionals, leaders, and specialists. Then I examine further the implications of considering chaplaincy as a public religion in a secular healthcare setting, focusing on especially on the regulation of religion.

7.1 DEVELOPING RELIGIOUS PROFESSIONS?

Gilliat-Ray (2008, 2010b) has discussed the implications of Muslim chaplaincy as a form of emergent religious professionalism, especially as the Muslim community in Britain has matured and developed (see also Gilliat-Ray *et al*. 2013). It is less clear how the concept of religious professions maps onto the involvement of other minority faith groups in healthcare chaplaincy. This difficulty can be accounted for by the dearth of sociological research on minority faith religious specialists (Hoge 2011), although there has been some literature on the changing role of the imam in the British context (Birt 2006; Gilliat-Ray 2010b). This dearth of literature is surprising, given that 'there is evidence to show that over time religious specialists serving diaspora communities are often influenced by the dominant professional roles of the religious majority' (2001a: 13,135). Such empirical research into British religious specialists, and the changing expectations of their communities concerning their role, is vital for understanding continuity and change among religious traditions in diasporic contexts.

Without a baseline knowledge of how religious professionalism in the British context is understood within different faith traditions, it is difficult to assess the development

of minority faith chaplaincy and the extent to which minority faith religious professionals have adapted their roles. This thesis partially addresses these issues when referring to participants' self-understanding, but has only been able to draw on literature concerning Muslim professional leadership. Likewise, it is difficult to establish how far chaplaincy is considered a legitimate and discrete avenue for religious professionalism within a particular faith tradition. The development of chaplaincy as a recognised 'religious profession' within a particular religious community depends primarily on the 'religions' interest in an internal division of labour' (Rüpke 1996: 241). It is clear that the work of minority faith chaplains is chipping away at the lack of awareness within faith communities about chaplaincy, but the idea of a religious leader offering pastoral, spiritual, and religious support in a secular setting is relatively recent to the religious division of labour for all of these groups.

I will discuss the potential implications of minority faith involvement in chaplaincy for the development of religious professions, drawing where possible on literature which discusses religious leadership. However, there is also some conceptual muddiness that needs to be addressed: the terms 'specialist' and 'professional' tend to be used interchangeably in the literature, but these terms should be considered separately. For example, being a religious specialist is a necessary but not sufficient condition for being a religious professional. Turner's anthropological account of religious specialists shows that only the 'institutional' priestly functionary might possess power derived from a 'body of codified and standardised ritual knowledge' while an 'inspirational' shamanic or prophetic functionary possesses power derived from a 'divine stroke' and personal communion with the divine (Turner 1968: 439). The institutional priestly functionary is more likely to qualify as a professional than their inspirational counterparts.[42] Gilliat-Ray argues that institutional religious specialists might be considered to be professionals on the grounds that they offer a 'non-standard product' (i.e. religion); they undertake tasks or services that cannot be exactly replicated; they require personal commitment and dedication; they have a broad knowledge of a specialised field; they aspire to personal development; they

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[42] Examples of 'inspirational' figures might include charismatic preachers or Sufi sheikhs, whose knowledge derives primarily from intense mystical experiences.

develop a hierarchy where role is determined by age, length of service and responsibilities; they must secure conformity and authority; and the remit of senior members covers a wide geographical area (Gilliat-Ray 2001a: 13,134). Religious professionals therefore are a specific form of religious specialist that are tied more to institutionalised rather than inspired authority. However, chaplaincy also provides fertile ground for exploring and widening conceptions of religious specialists, particularly with reference to 'lay' forms of chaplaincy emerging through the involvement of Sikh chaplains, female Muslim chaplains, and also female Catholic chaplains.

Christian chaplains may themselves dispute the term 'religious professional', especially when considerable efforts are being made to be recognised as secular 'healthcare professionals' (McCarthy 2010: 1; Swinton 2003; Kyriakides-Yeldham 2017: 28-29, 117-124). The preoccupation with spiritual care and generic chaplaincy exhibited by the chaplaincy literature and Christian chaplains on the ground demonstrates this enthusiasm for being recognised as a secular professional, but risks reducing the work of religious professionals to narrow understandings which assume religious care is limited to the provision of sacrament and ritual, prayer, and study of sacred texts (Welford 2011: 151), which can be conducted at the bedside. The ability of chaplains to distance themselves from being religious professionals maintains a sharp distinction between 'religious' and 'secular' that arises from a longstanding Westphalian understanding which erroneously assumes religious and secular realms and identities can be separated. This ignores the persistence of the somatic norm of the chaplain as an ordained member of the Christian church and institutional religious professional. It is hoped this examination of religious professionals will reveal the nuances behind the kind of care provided by minority faith chaplains and address the tendency to caricature religious care as a private bedside concern.

Consideration of religious professionals may benefit from discussion of the categories of specialist or leadership within different traditions. The primary religious functions of religious specialists across religious traditions include 'teaching, contemplation, transmission of scriptures, leadership, pastoral care or ritual' (Gilliat-Ray 2001a: 13,132), although this omits the 'legal' significance of religious specialists (that is, roles concerned with the clarification and application of

sharia or *halachah*, for example). Gilliat-Ray notes that there are four main categories of religious specialists in Islam: ritual, textual, scholarly/legal, and spiritual (2010b: 159). In the case of Muslim chaplaincy, the ritual and scholarly/legal aspects take precedence, with an especially prominent role in ethical decision-making, although Muslim chaplains are also developing a keen pastoral sense (Gilliat-Ray *et al*. 2013). In contrast, Hindu religious specialists in the UK tend to serve a ritual function. These specialists include pandits who perform regular *pūjā* (acts of ceremonial worship), *sandhus* (ascetics) trained by the Swaminarayan Hindu Mission in Gujarat who oversee temple worship (see also Williams 1998), and ISKCON-trained *pujāris* who are hired to perform life-cycle rites and fire offerings (Knott 2000: 94). The role of the rabbi or cantor in Judaism is largely centred on teaching and leading prayer, but may also be an arbiter on *halachic* issues. Gilliat-Ray notes that rabbis have expanded their primary role of teaching to include pastoral care; this may have been as a result of longstanding Jewish involvement in chaplaincy. Buddhist religious specialists tend to be associated with contemplative monastic functionaries (Gilliat-Ray 2001a: 13,133), but may also have a significant teaching role. In the Western context, Bluck suggests that 'British lay people may expect monastics to be teachers, priests, social workers, psychotherapists and personal meditation supervisors. In particular, they often expect teaching in return for supporting monastics' (2006: 43). Notably, the Buddhist volunteer interviewed also delivered Buddhist therapy as part of her community role (interview, Buddhist volunteer, Greenacre, 19/05/2016). There is no discrete literature concerned with Sikh leadership; any discussions of leadership are brief and tend to present *granthis* as 'custodians of the gurdwara' (Leaf 1996; Cole 2004: 13) whose role is 'purely functional' (Cole and Sambhi 1998: 65). Very little reference is made to the role of the *gyani* as mentioned by the Sikh chaplain at Greenacre (interview, Sikh chaplain, Greenacre, 26/05/2016). Cole and Sambhi note that 'a religion which has no ordained ministry or clergy has many strengths but it is the weaknesses which life in the Diaspora exposes, in particular lack of theological leadership' (1998: 199). Sikh chaplains may not have a 'theological' role, but may indicate potential for alternative forms of leadership to develop.

Minority faith chaplains appear to perform roles which fall into three main categories of religious specialism: ethico-legal, ritual, and pastoral. These dimensions shall be explored below.

7.1.1 The Professionalisation of Ritual: Exercising Ritual Control and Expanding the Ritual Specialist Role

A key finding was the expansion of the role of the Hindu and Muslim chaplains in the ritual domain beyond what might normally be expected for pandits and imams. It appears that patients and visitors are ceding ritual territory once occupied by the family to the male Hindu or Muslim chaplains as ritual specialists.

In continuity with the role of the pandit, it is unsurprising that Hindu chaplains tend to be primarily responsible for ritual. Only Hindu chaplains, as ritual specialists, have sufficient knowledge of ritual requirements and sacred language to perform particular rituals, both in an individualised or personal setting of the bedside, or the communal setting of regular prayers.[43] However, the number of call-outs for death rituals for the Hindu chaplain at Greenacre certainly marks a departure from Firth's observation that 'the rituals at the point of death do not require a pandit' and tend to be overseen by the family (1997: 70). Firth notes that occasionally in Britain 'older Hindus may be anxious about deaths during *pañcaka*[44] and may ask the pandit to perform the remedial rituals quietly, but to say nothing to the family to avoid great anxiety' (1997: 61), and that a *purohit* (priest) may be called to perform an act of penance. While an end of life situation for a Hindu patient was not directly observed, it appeared that emergency/urgent call-outs made to the Hindu chaplain included requests for end of life/death rituals. Notably, the Hindu chaplain reported that his role also included providing horoscopes for staff in addition to overseeing death rites and providing weekly prayers (*pūjā*). This reflects King's outline of the function of the Hindu priest which combines the roles of 'religious teacher (*ācārya*), domestic priest (*purohita*), temple priest (*pūjāri*), ritual specialist (*karmakaṇḍīn*), funeral priest (*mahāpatra*), astrologer (*jyotisi*) and possibly healer' (King 2008: 689, see also

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[43] This raises a larger question of how ritual performance differs in hospital spaces and temple or even domestic spaces, which cannot be examined further here.

[44] 'The five inauspicious days each lunar month' (Firth 1997: 79)

Baumann 2001: 69). In this sense, a continuity with the role of 'community' priest is implied in the role of the chaplain.

Muslim chaplaincy representatives also reported being requested to engage in ritual activities that could otherwise be performed by families, including the *adhan* for newborn babies (the Muslim chaplain at Stonehaven), advising on end of life practices (all Muslim chaplains at Stonehaven), or in some cases actually performing *tawba* and reciting the *shahadah* for end of life situations (one of the Muslim volunteers at Westview). Interestingly, when Muslim chaplains explained why they were called to assist with the *adhan* or end of life care, their explanation resonated with the experience of Catholic chaplains. Catholic chaplains at Greenacre, for example, reported that families make call-outs because they are unsure of the requirements for elderly relatives (interview, Catholic chaplain, Greenacre, 26/04/2016; interview, Catholic chaplain, Greenacre, 16/05/2016). Likewise, Muslim chaplaincy representatives suggested that families and patients lacked confidence to undertake the rituals themselves (interview, Muslim volunteer, Westview, 22/02//2016), wanted to make sure that what they were doing was correct (fieldnotes, Westview, 04/07/2016). Additionally, one Muslim chaplain suggested that for mixed faith couples, having somebody on-site to perform the *adhan* gives an additional element of privacy (interview, female Muslim chaplain, Stonehaven, 01/08/2016).

Rüpke highlights the ways in which religious specialists might exercise ritual control, including monopolisation, exemplification, and verification (1996: 247). In cases of monopolisation, only specialists have the appropriate competence to perform ritual, and thus the right to perform and modify ritual could be 'denied to non-specialists.' Where ritual specialists exemplify their ritual competence, there is some acknowledgement that rituals may be performed by non-specialists, but that specialists do so 'much more exactly and lavishly' (ibid.: 248) In other circumstances, anybody may perform the ritual, but its 'validity is permanently precarious by being subject to the specialists' potential veto' (ibid.). Without direct observation of Hindu and Muslim chaplains' performance of ritual, it is difficult to say whether their orientation to ritual is exemplary or verificatory. Muslim chaplains acknowledged that the performance of ritual was a matter of ensuring things were done 'correctly' in order to reassure the patient and visitors, or as a way of offering

privacy to the patients and family, instead of monopolising and closing off the performance of the ritual from non-specialists. However, Rüpke's account focuses primarily on the use of ritual for control, and fails to account for the *efficacy* of ritual, and the perceived increase of ritual efficacy as a result of being performed by a religious professional. The question of added efficacy might be seen, for example, in the request for the 'imam' (in this case, a male Muslim chaplaincy volunteer) to perform *tawba* on behalf of the patient (fieldnotes, Westview, 25/01/2016).

7.1.2 Ethico-Legal Specialists

Muslim chaplains appear to be distinguished from colleagues from other faiths primarily because of their extensive roles in negotiation and advocacy of religious practice within a healthcare setting. While Hindu and Sikh chaplains were also engaged in advocacy, this tended to take place through formal mechanisms such as equality and diversity leads/forums where they might lobby for issues such as diet or, in the case of Sikhs, the 5 Ks. Ad hoc 'troubleshooting' was unusual for Sikh and Hindu chaplains. These questions related to basic accommodations of religious needs, rather than the negotiation of individual, complex, contextually dependent ethical issues. In this sense, 'the complexity of Islamic law in some situations, especially around life and death, can offer Muslim chaplains a distinctive sphere of influence on staff that may not be so readily available to chaplains of other faiths' (Gilliat-Ray *et al*. 2013: 125).

Significant value is placed on Muslim chaplains as authoritative repositories of knowledge who can advise on, for example, bio-ethical or jurisprudential issues. As Gilliat-Ray has noted, 'Muslim chaplains themselves have to find ways of making the fulfilment of *sharia* possible within the frameworks and norms of a public institution, and this often requires an ability to make contextually appropriate, flexible and sometimes very rapid interpretations of Islamic legal principles' (2012: 117). Where Muslim chaplains have become involved in bio-ethical issues, there is a definite specialist professional role that is distinct from the imam, which may be considered as a discrete developing religious profession. It is significant, too, that chaplains across sites articulated similar bio-ethical rulings in what appears to be the development of a specialist body of knowledge, which is reproduced and reaffirmed

through the Muslim chaplains' network. Gilliat-Ray *et al.* note that Muslim chaplains argue that those with scholarly credentials are more able to 'recognise how and why different schools of thought might have varying approaches to religious matters. Some recognition of these differences enables chaplains to offer advice appropriate to the client's own school of thought' (2013: 59). However, the influence of the historic Deobandi school of thought in the theological education received by Muslim chaplains does open to question how far Muslim chaplains can account for a variety of schools of thought and law in the course of ethical decision-making (Gilliat-Ray *et al.* 2013: 62-63; see also Gilliat-Ray 2006). Even where rulings are said to be contextually dependent, these rulings are cross-checked and affirmed by religious authorities who are positioned within a particular theological and legal location within Islam. In this sense, Muslim chaplains set themselves apart from community-based imams (and from other national chaplaincy professional bodies such as the CHCC) by producing and reproducing their very own knowledge base and competencies, especially in relation to the negotiation of bio-medical ethics.

In theory, Jewish chaplains may face the same issues of interpreting *halachah* in a secular healthcare context, although no concrete examples of this were mentioned by Jewish chaplaincy representatives. Only brief mention was made of end of life issues – the Jewish chaplain interviewed stated that switching off life support in all contexts was unacceptable but provided no examples of having to negotiate or liaise with clinical staff on this matter (interview, Jewish chaplain, Riverside, 24/11/2015). It is difficult to tell whether this is due to a lack of demand on the part of Jewish patients, or whether their employment contracts (the two chaplaincy representatives were sessional and voluntary respectively) adversely impacted on patient, visitor, and staff recognition of the role and availability of Jewish chaplains who might function as ethico-legal specialists. At Riverside, the Jewish volunteers reported that they would seek *halachic* counsel from other rabbis rather than the chaplain, suggesting that there was no specialised role for Jewish chaplains distinguishable from any other rabbi. At the same time, these volunteers did not specify any concrete incidents when they needed to facilitate advice or guidance from a rabbi. Some literature on Jewish leadership supports the suggestion that Jewish patients are simply not expecting rabbinical input on ethical issues. Nesbitt cites Blohm's study of rabbis (2005), which found that there was a 'declining congregational interest in the rabbi making

halachic decisions or seeking the rabbi's advice on life decisions… [T]he rabbinical master role of teacher, as well as arbiter of religious law and tradition, has lost authority and prestige' (Nesbitt 2007: 311-312). This question cannot be resolved in this study, but could be addressed through a comprehensive study of Jewish chaplains, especially in London and Manchester.

7.1.2.1 Ethico-Legal Roles for Chaplains from the 'Dharmic' Religions?

As the study progressed, it became clear that biomedical ethics was an area that was more often engaged in by Muslim chaplains than colleagues of any other religion. The main exception to this rule may be Roman Catholic chaplains, although the breadth and depth of the biomedical issues explored by Muslim chaplains, especially at Stonehaven, far exceeded those reported by Roman Catholic chaplains. What, then, are the implications for minority faith chaplains from 'dharmic' religions: Buddhism, Hinduism, and Sikhism? Why is there less of a focus on the person of the chaplain as mediator in ethical disputes?

The findings demonstrated that boundaries between pandit and Hindu chaplain are far less clear than the boundaries between imam and Muslim chaplain, as their role as ritual specialists seems to take precedence over the negotiation of complex bio-medical issues. Only one Hindu chaplain reported that he was consulted about organ donation, but suggested his role was merely to inform the family that organ donation was permitted from a religious perspective, rather than to mediate between patients and staff (interview, Hindu chaplain, Riverside, 08/12/2015). Significantly, the only concrete example he gave took place at a different hospital and he was brought in effectively as an external consultant. During the observations, there was only one occasion when a Sikh chaplain was called out to provide advice on a bio-medical issue that was not related to the 5 Ks. In this instance a family was considering (and eventually opted for) the withdrawal of active life-supporting treatment (fieldnotes, Greenacre, 15/03/2016). However, the approach of the Sikh chaplain was less authoritative and more supportive, and he emphasised being non-judgemental over and above providing ethical directives (interview, Sikh chaplain, Greenacre, 26/05/2016). In this sense, the role of Sikh or even Hindu chaplains does not carry the same ethico-legal weight as a Muslim chaplain.

There are several possible reasons as to why bio-medical ethics is a more significant issue among Muslim chaplains than among chaplains of the 'dharmic' religions. Keown suggests that the relative lack of interest in ethics on the part of Buddhist teachers and scholars can first be attributed to the origins of Buddhism as a movement that was more focused on 'spiritual development rather than social reform' (1995: 8). Keown notes that 'there never developed in Buddhism a science of religious law of the kind found in Hinduism, Judaism, Islam and Christianity. In each of these traditions jurists and commentators have established codes and digests of laws in a systematic attempt to resolve conflicts between the daily life and the demands of sacred law' (1995: 9). Keown suggests that Buddhism - and, by association, Hinduism, Jainism, and Sikhism - may have little to say about bio-ethics as Indian culture has generally shown 'little interest in the subject as an independent philosophical discipline' (ibid.). Ethics pertaining to the 'dharmic' religions is concerned with a highly particularised and relational notion of duty in accordance with one's social positioning (*dharma*), instead of the universality and emphasis on individual responsibility and choice which grounds 'Western' ethics (ibid.). Interestingly, when the Sikh chaplain at Greenacre and Muslim chaplains at Stonehaven discussed their role in offering advice and guidance, they all referred to personal choice and responsibility, further evidence that chaplains are increasingly adopting individualistic, patient-centred approaches to care.

Apropos of Sikh ethical decision making, Bakshi suggests that Western bioethics is predominantly rights-based, whereas 'Sikh bioethics is primarily duty-based' (2008: 31). However, for both Bakshi and Jhutti-Johal, bioethical issues may become less of an issue as Sikhs become 'acculturated' to Western values: 'Sikhs born in Western countries accept Western ethical values in health care regarding issues such as abortion, organ donation and post mortems. Yet Sikh notions with respect to life and death may pose problems to recent immigrants, particularly older people, who apply the duty-based approach of their own tradition when considering treatment options' (Bakshi 2008: 32). Jhutti-Johal notes the two main issues centre on withdrawing treatment and the tension between family-centred decision making and patient autonomy (2013: 265-266). The outcomes of these decisions may depend on whether or not a Sikh is baptised and the level of acculturation into British society. Jhutti-

Johal also notes that, drawing on her fieldwork findings, most Sikhs are more concerned about efficacy of their treatment, rather than whether medication is animal or alcohol based, while baptised Sikhs may have a pragmatic approach which allows them to be 'prepared to break the requirements of baptism (*amrit*) if it improves their health. Many qualify this by saying that God will understand and that they would retake baptism once they are better' (2013: 267). This 'pragmatic' approach would therefore mitigate the need for a Sikh chaplain to mediate between patients/family and staff on biomedical issues.

7.1.3 Minority Faith Pastoral Carers?

Pattison (2000) notes that the nature and meaning of pastoral care is largely undefined by the literature on pastoral care, and suggests that the definition is taken for granted. Pastoral care can have both Christian and secular connotations. The use of the term by Sikh and Muslim chaplaincy representatives tends to link to listening, presence, confidentiality, and non-judgemental support, which suggests that the pastoral care that minority faith chaplains have in mind is 'shaped by liberal, individualistic counselling paradigms of care and communication' (Gilliat-Ray *et al*. 2013: 91; see also Pattison 2000). I suggest that for minority faith chaplains pastoral care is about an orientation towards the patient (or staff member) and a skillset, rather than a discrete bounded activity in itself, which is subsumed under a broader framework of providing religious or spiritual support. Minority faith chaplains clearly do engage in pastoral work, by providing comfort and reassurance to patients. There was some acknowledgement among chaplains that the ritual elements of the chaplaincy role can also have a pastoral orientation and impact, through the provision of ritual support to grieving families, such as choosing an appropriate time to switch from reciting *Surah Yasin* to the *shahadah* during an end of life scenario (interview, Muslim volunteer, Westview, 22/02/2016). Minority faith chaplains have therefore adapted their primary religious roles through adopting patient-centred pastoral approaches.

Some distinctions were made between 'pastoral care' and 'spiritual care' or 'religious care' which tended to reflect the difference between 'lay' and 'ordained' team members. This was especially apparent when Jewish and Jain volunteers

referred to their own roles in pastorally supporting patients, while chaplains may provide the 'spiritual' aspect (interview, Jewish volunteer, Riverside, 16/12/2015; interview, Jain volunteer, Greenacre, 25/04/2016). This was also true of the distinction between the male Muslim chaplain and female Muslim chaplains at Stonehaven. A difficulty arises when 'lay' chaplains, such as the Sikh and female Muslim chaplains, appeared not to differ in their roles from volunteers, especially in terms of providing pastoral care. At Stonehaven, other aspects were emphasised, including chaplains' roles as religious specialists, teachers or advisors, as well as their availability, the 'depth' of encounter and involvement in high intensity situations, such as end of life support. Thus, pastoral care in and of itself is not a sufficiently 'specialist' role for minority faith chaplaincy representatives, and may constitute a framework for providing spiritual and religious care for minority faith chaplains.

7.1.4 The Need for Outward Facing Leadership and the Exceptionalisation of Imams

Over the past five decades, significant changes have taken place in relation to the role of the imam, which have also contributed to the growing involvement of imams in chaplaincy. Gilliat-Ray notes that in the 1960s and 1970s, imams in British mosques were primarily foreign born and their roles were mostly mosque-centred, with 'little external profile or authority in wider society' (2010b: 163). These imams had limited English skills which restricted their engagement with civil society, including chaplaincy work. In the 1970s and 80s, it was common for visiting ministers in hospitals to be community leaders, well-meaning community members, or Muslim members of hospital staff, rather than the imam (Gilliat-Ray 2008: 146). At the beginning of the 21st century there were new and growing expectations for imams to be both pastorally competent and to be active community leaders with broader responsibilities such as 'bridging social capital' between Muslim communities and wider society (Gilliat-Ray 2010b: 168-169; Lewis 2006). Modood also refers to the British government's consideration of 'whether and how it needs to be involved in the training of imams' (2010: 8) as part of the efforts of the *Prevent*

agenda (Birt 2006).[45] As shown in the data, the majority of Muslim chaplains were first employed between 1999-2001, before any government initiative placed foreign-born ministers under the spotlight, and suggests that a good deal had already been achieved in terms of developing an outward-facing *'ulama* before concerted efforts were made by the Government to securitise imams. At the same time, demands from within suggest a growing role for mosques beyond places of prayer but as a place of guidance and support, as noted by a participant in Warden's study (2013: 174).

Notably, both Jewish chaplaincy representatives identified with the ultra-orthodox Chabad Lubavitch sect, which has outward-facing outreach as a core part of its *raison d'être*. Chabad is distinct from other ultra-orthodox sects, which tend to be inward facing and have little to do with other Jewish denominations: 'Chabad has made a determined effort to work with non-orthodox Jews' (Kahn-Harris and Gidley 2010: 64). Thus, these rabbis emphasised the outward facing aspect of their roles and providing non-judgemental pastoral care and support to all Jews. The ultimate aim of this engagement may be 'to "convert" Jews to greater levels of observance – and ultimately to become part of the Chabad world – but they recognise that this is not a likely outcome for most Jews' (ibid.: 64). While this approach faced outwards from their immediate community, the level of engagement in civil society and public sphere is difficult to gauge without further research

Gilliat-Ray notes that the level of religious engineering taking place with regard to imams is not being undertaken in relation to other religious traditions (2010b: 175). For example, external pressures for Hindu communities to develop a more pastorally based outward-facing religious leadership role, which would assist with engagement in public institutions and taking up chaplaincy roles in particular, is much less pronounced. King suggests that some mandirs are beginning to show a preference for English-speaking priests and value the 'ability to nurture community projects and programmes', but that 'today it is still common in the UK and America for trained Brahmana priests to come from India with knowledge of Sanskritic mantras and

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[45] This strategy of regulating and promoting particular forms of religion in light of political violence is hardly new: Modood also refers to the historical efforts of the British government to work with Catholic and Protestant clerics to end the political violence in Northern Ireland (2010: 8).

experience of performing rituals in India' (King 2008: 689). There is scant empirical evidence concerning these trends, although the impact of this continued tendency for temples to 'import' pandits was demonstrated in the unsuccessful attempts of chaplaincy teams to recruit pandits from local temples. This reflects Birt's observation that Hindu ritual officiants have traditionally been brought in from abroad 'to oversee festivals' and have no 'pastoral function', the latter of which he suggests requires English language competence and other skills associated with 'integration' (2006: 695; see also Nye 1993: 170). Birt notes that Hindu and Sikh communities lobbied against Home Office rules that stated that 'imams and priests…should be able to show knowledge of and engagement with British civic life, including an understanding of other faiths; and a requirement for imams and priests to have professional qualifications' (Immigration and Nationality Directorate 2004, quoted in Birt 2006: 695). Imams in particular must demonstrate that they are not predisposed to 'radical "anti-West"' attitudes, which has led to more sustained engagement in public life and institutions. Diasporic religious communities are therefore subject to differential pressures in terms of adapting the roles of their religious leaders, specialists, and professionals.

7.1.5   Identifying the Gaps

Much attention has been paid to the development of religious leadership and professionalisation among Muslims, mostly with reference to chaplaincy, but also the changing role of the imam and the development of Islamic social care (Birt 2006; Gilliat-Ray 2008; Gilliat-Ray 2010b; Warden 2013; Gilliat-Ray *et al.* 2013). Some literature has also explored the changing roles and approaches of the rabbinate (Gilliat-Ray 2001a: 13, 135; Wigoder, Skolnick, and Himelstein 2002). However, literature in relation to both religious and community forms of leadership is broadly lacking in relation to the 'dharmic' religions. It is difficult to establish just yet how far chaplaincy constitutes a new distinct form of religious professionalism for minority faith groups, or whether chaplaincy is subsumed under the roles and priorities of extant religious leadership positions. It seems that Sikh chaplaincy has considerable potential for developing a well-recognised and discrete role as a religious profession, especially through ready adoption of non-judgemental patient-centred pastoral care approaches, although it becomes difficult to explain where the

Sikh volunteers' role ends and where the Sikh chaplain's role begins. The lack of research on leadership in minority religious groups has been noted by Nesbitt, and is especially pressing as these communities shift towards a 'congregational form in the wake of migration to a publicly diverse religious environment' (Nesbitt 2007: 315; see also Knott 1988; Hoge 2011). I have indicated ways in which chaplaincy helps consolidate new or extended roles and specialisms, but these are primarily grounded in the accounts of the participants, and require further research into contemporary religious leadership in the UK for further development.

7.2 CHAPLAINCY AS PUBLIC RELIGION: TENSIONS AND OPPORTUNITIES

Chaplaincy occupies the unique position of being the state-sanctioned manifestation of religion within the healthcare setting. The notion of chaplaincy constituting the public face of religion is outlined by Pattison (2015), who argues that chaplaincy becomes acceptable by reflecting public 'secular sacralities' and by adapting to the institutions in which they serve. As noted in the previous chapter, the involvement of chaplaincy in the NHS is contingent on chaplains successfully negotiating the legitimate language (or 'secular sacralities') of the host institution. I have established that official or mainstream chaplaincy discourse as highlighted in practitioner publications and national organisations as *one of many* possible ways which chaplaincy can align itself to the legitimate language of the institution. It has been assumed by Christian chaplains that such legitimate language necessitates the promotion of a generalised, universalistic spirituality discourse, while religious discourses (religion-specific/religious care) are simply incidental aspects of ensuring patient choice.

Alternative approaches to legitimate language among minority faith chaplains have been exemplified by the development of specialist roles at Stonehaven which re-conceptualise and broaden what it means to offer religious care. For example, the role of the Muslim chaplains in advising on access to pregnancy clinics during Ramadan (interview, male Muslim chaplain, Stonehaven, 08/08/2016) justifies religious care on the grounds that it addresses health inequalities. Likewise, the involvement of minority faith chaplains in translating, mediating, and advocating for patients – especially those for who do not speak English – is another way by which

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chaplains might address differential experiences of accessing and receiving care in general. Interestingly, the discourse of health inequalities is broadly absent from the chaplaincy literature, excepting the 2015 guidelines (NHS England 2015a). In the past decade, health science scholarship is beginning to acknowledge the relationship between religion, ethnicity, and health inequalities, as 'inequalities across religious groups were most apparent for Muslim and Sikh people, while inequalities within religious groups were most apparent for Caribbean people' (Karlsen and Nazroo 2009: 121; see also Laird *et al*. 2007). This is an area of healthcare provision where the chaplain's position as negotiator, mediator, and cultural ambassador (both for the NHS and for religious minorities) can be a real advantage, showing the relevance of religion-specific approaches and religious care in a secular healthcare setting. This demonstrates that religious care and modes of religious authority are acceptable within the context of the NHS so long as a connection with legitimate language is made. The promotion of spirituality, and reluctance to draw on religious discourse, reflects traditional liberal approaches to the public sphere which ban religious discourse and reasoning (Straumann 2008: 184), towards a Habermasian (2006) approach where religious discourse is permitted but must be articulated in ways which make sense to secular parties (expressed in terms of 'public reason' or 'generally accessible arguments').

7.2.1   Regulating Religion

Beckford and Richardson define 'regulation' as the 'process of directing or controlling things in accordance with rules' (2007: 397). They identify 'information gathering, standard setting and behaviour modification' as three aspects of this process (ibid.). Chaplaincy, with its outward orientation and public role, is therefore a rich site for exploring the questions of regulation and the ways in which 'religion is subject to attempts to control, canalise, categorise or certify its beliefs, expressions, practices and forms of organisation' (ibid.). Beckford and Richardson note that regulatory practices may favour religion over non-religion, or may advantage some religious groups and disadvantage others.

Different actors are involved in the regulation of religion in healthcare. On a national level, 'representative' religious bodies have begun to outline processes of

endorsement and training for the socialisation and regulation of suitable chaplaincy representatives, including volunteers. The findings show that the impact of this has been limited in relation to the recruitment of chaplaincy volunteers, as most endorsements for prospective volunteers are sought through local places of worship rather than through the national bodies. Centralised attempts to monopolise the regulation of chaplaincy volunteers appear to have been unsuccessful so far. These representative religious bodies have also attempted to provide religion-specific chaplaincy training in a bid to socialise chaplains, yet these attempts appear to lack recognition from 'general' chaplaincy bodies such as the UKBHC, as made clear in the experiences of the Sikh chaplain at Greenacre. As a registration body, the UKBHC serves a regulatory function by setting standards and assessing how far applicants for registration meet these standards. It is clear that there is a disconnect between the standards set by the religion-specific chaplaincy bodies and 'generic' national level bodies such as the UKBHC, which means that chaplains from particular faith groups are disadvantaged by the regulatory processes of the bodies that claim to be open to all.

On a local level, the findings show that so long as chaplaincies keep within the boundaries (or legitimate language) of the organisation in relation to religion, stakeholders appeared to be content for chaplaincy to be the primary regulators of manifested religion. This is particularly evident in relation to volunteer recruitment. At two sites (Riverside and Greenacre), the 'faith validation' or religious suitability of the prospective volunteer was primarily decided in interviews conducted by chaplaincy only, with one voluntary services manager noting that 'I leave it to the chaplaincy to make those decisions about that [community] standing' (interview, stakeholder, Greenacre, 11/05/2016). At two sites (Westview and Moorlands), volunteer managers reported that they may raise concerns regarding the candidates' religious background and intentions in subsequent interviews conducted by both chaplaincy and voluntary services, although only rare, highly specific examples were cited. The chaplaincy team at Stonehaven were self-regulated in their volunteer recruitment procedure, although disagreements arose when chaplains had mismatched understandings of the institution's legitimate language.

Likewise, chaplaincy-specific training was autonomously run by chaplaincy teams with little reference to voluntary services (although all volunteers attended mandatory training provided by voluntary services). The volunteer recruitment and training procedure is a prime example of the three aspects of the regulative process identified by Beckford and Richardson (2007): information is gathered about the religious background, identity and intentions of the volunteer in the chaplaincy interview, and standard setting and behaviour modification take place through the volunteer training and mentoring process. A prime example of behaviour modification can be seen here:

> Usually what we say in our prayer, we ask God's forgiveness
> first… this is the Muslim tradition, God forgive me, this is the
> first thing we say when we raise hand for prayer. [The honorary
> Anglican chaplain] advised me do not mention forgiveness in
> bedside because....the patient might think that because of his or
> her sin she or he being punished by God. Not good. OK, then, I
> understood that and after that I didn't mention (interview, Muslim
> volunteer, Westview, 09/02/2016).

Here a traditional practice of requesting God's forgiveness is identified as problematic by the mentoring chaplain, who provides guidance on how to provide patient-centred care for non-Muslim patients. This modification of behaviour was enacted in the context of on-the-job training of the volunteer who was shadowed by an Anglican chaplain.

Pattison's thesis that chaplaincy has become a new religion (2015) could theoretically be supported by an analysis of the volunteer recruitment and training processes in light of Beckford and Richardson's account of the self-regulation of religion. Chaplaincies, like religions, 'seek to control their practices and their practitioners' (Beckford and Richardson 2008: 398) through providing *constitutive rules* about the boundaries of chaplaincy and its foundations, understandings, and practices. The codification of constitutive rules and the development of centralised agencies has taken place at the national level, through the development of 'chaplaincy studies' (including a concern for the theology of chaplaincy),

chaplaincy-specific training courses, relevant guidelines, and codes of conduct. These developments are central to disseminating the legitimate language of chaplaincy. Admission into chaplaincy as a volunteer is dependent on the candidate displaying traits and values deemed suitable for the practice of chaplaincy, followed soon after by a period of training wherein volunteers are suitably socialised into chaplaincy and cross the boundary from outsider to insider (Beckford and Richardson 2007: 399). Once admission has been achieved, chaplaincies also apply *regulatory rules* which monitor and modify behaviour of their volunteers, usually through the ongoing delivery of training or the investigation of problematic volunteer behaviours. This was most apparent at Stonehaven when a volunteer was reported to be imposing prayer on patients (interview, female Muslim chaplain, Stonehaven, 01/08/2016). While chaplaincies are unable to keep their volunteers under constant surveillance, members of ward staff might also have a role in regulating manifestations of religion by reporting inappropriate behaviour to the chaplaincy team. This particular incident at Stonehaven set a process of investigation (including shadowing and interviewing) in train, and – if 're-training' is unsuccessful in prompting a modification of behaviour – could lead to a permanent expulsion from the chaplaincy team. Where this analogy may be less successful is when the disconnection between chaplaincy locally and nationally leads to local differences in its performance. This is particularly evident in the localised decision-making (and in some cases tensions) in relation to boundaries, working practices, and models of operating, but also when chaplains who do not fit the standards codified at a national level are allowed to continue to practice with minimal efforts to encourage conformity to these standards.

The overall framework for the regulation of religion in the NHS appears to be reasonably broad and laissez-faire, and chaplaincies often act as the primary mediators and negotiators of appropriate forms of religion in the healthcare setting. While the *Religion or Belief* guidelines (DoH/Equality and Human Rights Group 2009) do highlight some boundaries of acceptable manifestations of religion in the healthcare setting, it is often chaplains – both locally and nationally – who are at the forefront of these negotiations. McHale argues that the Human Rights Act 1998 has had minimal practical impact in relation to accommodating religious beliefs in healthcare settings (2013: 234). However, I suggest that while a handful of court

cases concerning religion or belief have achieved considerable media coverage,[46] these do not reflect the everyday negotiation processes that chaplains are involved in about how religion manifests in a secular healthcare setting. As Gilliat-Ray *et al*. argue, 'the incorporation of "religion" within equality and human rights legislation can present very particular challenges for public sector managers who may lack expertise in this area' (2013: 126). The appointment of Muslim chaplains can help facilitate and accommodate religious needs and expectations within the hospital through mediating issues themselves or training staff in cultural awareness and equality and diversity (Gilliat-Ray *et al*. 2013: 87).

Chaplaincy has also *anticipated* boundaries concerning the regulation of religion in healthcare. For example, despite boundaries around proselytising being codified in the *Religion or Belief* guidelines (DoH/Equality and Human Rights Group 2009), national chaplaincy bodies have long advocated restrictions on proselytising (Hospital Chaplaincies Council 1987: 55; Chaplaincy Education and Development Group 1993). [47] On the ground, the issue of proselytising has been addressed by chaplains placing considerable restrictions on those who wish to be part of the chaplaincy team (especially evident at Westview, Greenacre and Stonehaven) and blocking groups who have attempted to access hospitals to proselytise (fieldnotes, Riverside, 18/10/2015 and 23/10/2015). The question of regulation in relation to proselytising was particularly evident at Greenacre, Stonehaven, and Moorlands. At Greenacre, the managing chaplain had a significant role in regulating appropriate levels of access for Gideons representatives by removing 'privileged' access to patients and requesting that any Bibles should be sent to the chaplaincy for distribution (interview, stakeholder, Greenacre, 12/05/2016). Gideons representatives were allowed access at Stonehaven, but only able to visit wards under the

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[46] For example, Wasteney v. East London NHS Foundation Trust (Arlow 2016); Kuteh v. Dartford & Gravesham NHS Trust (Arlow 2018); and Chaplin v. Royal Devon & Exeter NHS Foundation Trust (Sandberg 2011: 113). There appears to be a shift from cases concerning conscious objection in the 1990s to cases concerning manifestation of religion, especially around evangelism, in the 21st century (McHale 2013).

[47] 'Individuals are protected from religious groups or individuals who seek to proselytise or impose their views on others or in any way minister inappropriately' (Chaplaincy Education and Development Group 1993, Element D1.2).

supervision of the Christian chaplain. In contrast, the approach of Moorlands was almost unregulated, with Gideons representatives regularly visiting patients under the umbrella (and therefore full endorsement) of the chaplaincy services.

Chaplaincy is subject to regulation nationally and locally, but it is apparent that regulation is most effective locally where chaplains are more familiar with the priorities and objectives of their Trusts. It is also clear that chaplaincies mostly self-regulate (Orchard 2000: 127; Pattison 2015: 24). The differing approaches to legitimate language show the ways in which chaplains might adapt to the immediate environment of their institution, while these approaches to chaplaincy are not necessarily recognised nationally.

7.2.2   Compartmentalising Religion

As part of the process of gatekeeping, chaplains make decisions about what forms and manifestations of religion are acceptable in the public sphere and which ones should remain private. This was usually achieved through controlling levels of access afforded to particular religious groups (through volunteer recruitment, or through developing a community contacts list), training volunteers who engage in generic visiting to set aside their religious identities, distinguishing between religious and spiritual care (and the roles associated with this distinction), and through involvement in institutional committees. Being the acceptable public face of religion not only applies to chaplains but also to chaplaincy volunteers engaged in regular ward visiting, who undergo rigorous vetting processes to ensure their outlook is consonant with the values chaplaincy teams hope to embody. In this sense, manifestations of religion are compartmentalised into what is acceptable/ unacceptable, with the less acceptable or unpredictable manifestations of religion being held at arm's length from the outward-facing provision of chaplaincy.

The representative of a religious community who is brought in simply to visit a specific patient at the bedside fulfils a private function: the local religious leader discharges their duty and leaves, and – as far as the hospital is concerned – occupies the same status as any other visitor. In contrast, the chaplain has access to most of the hospital and – in some cases – engages in institutional work, where the concomitant

visibility and profile of these roles embodies the publicly sanctioned presence of religion in the hospital. It is therefore imperative that chaplains must show a degree of linguistic competency in order to gain recognition and visibility within the institution. This was evidenced most clearly at Stonehaven, with chaplains of all faiths enjoying a degree of visibility and profile, although the carefully cultivated reputation of the Muslim chaplains as pragmatic religious specialists has led to the development of considerable symbolic and social capital that is recognised by the Trust.

Conversely, gatekeeping access to chaplaincy limits the capacity of particular faith groups to be enculturated in the legitimate language. Thus, for Northbrook and Moorlands, minority faith involvement in chaplaincy is on the whole private and minimally visible, with Christian chaplains constituting the public face of chaplaincy through their participation in Trust induction, committees, and events such as the Schwartz Round. At Northbrook, the expectation expressed by two of the Anglican chaplains that minority faiths should be conversant with providing context-specific generic spiritual care was undermined by the exclusion of minority faiths from regular involvement in the team (and therefore the mechanisms of learning and support requisite for developing a 'generic' approach). At Northbrook, and to a degree at Riverside and Greenacre, the hierarchy of value which subordinates religion-specific or religious care under generic care ensures that overtly religious aspects of chaplaincy remain primarily a bedside concern, while 'generic' chaplains are extensively involved in outward/public-facing institutional roles.

Swift, however, alludes to the disconnect in the meaningfulness of the public-private distinction from different religious perspectives:

> Several years ago I was speaking with a Muslim colleague about the circumstances in which a person might become exempt from fasting in Ramadan. When he explained that an illness caused this to happen I said: "So the physical takes precedence over the religious." He replied quickly, "No, the physical need becomes the greater religious priority." Around the world today, and taken over the course of Western history, it has been *normative to see*

> *religion as a whole-life commitment rather than a segregated activity* (2013: 257, emphasis added).

As noted in the previous chapter, such a separation between religion and the spiritual, as well as mundane everyday life, is unfamiliar to minority faith groups. Christian chaplains in the study also expressed concerns about whether their own outlook is treated as a 'whole-life commitment' or a 'segregated activity' (cf. Pattison 2013: 203); in short, the ability to or even desirability of compartmentalising religious identity in order to provide generic spiritual care to all. This debate was exemplified by an Anglican chaplain:

> When I first heard a certain person in this team going on and on about spirituality I started to feel as if… it was alright for him because he wasn't going to wear his dog collar so he wasn't really going to embrace his Christianity, so he could go mouthing off about spirituality […] I mean, sorry this probably is a bit tough, but I felt oh that's dead easy look [takes off clerical collar] I can walk around like this, going hey ho, we're all spiritual aren't we. I was a little bit cross with that (interview, Anglican chaplain, Northbrook Hospital, 07/12/2015).

In promoting generic chaplaincy over against a 'parochial' religion-specific approach, the assumption is made that generic chaplaincy offers a neutral, universal ground by which the needs of all patients, visitors, and staff are met. As soon as needs (whether pastoral or religious) are generalised and placed within this 'broader' framework of spiritual care, the argument is made that these needs can be met by any member of the chaplaincy team. When a solely generic model of chaplaincy is adopted, there is a risk that religion-specific commitments and needs are relegated as less important or set aside. At Northbrook, two of the Anglican chaplains only fulfilled specific religious requests if they were directly articulated and conveyed a sense of urgency by patients or family. This was also operationally the case at Moorlands, although the default appeared to be overtly Christian belief and practice, rather than a 'generic' understanding of spirituality. In these contexts, minority faith patients, visitors, and staff may be required readjust their needs and 'make do' with limited provisions available, relegating needs that might be disruptive to the work of

the hospital to a private concern that should be met by visitors (family or religious leaders), rather than worthy of being raised as a legitimate concern in a public setting. Here there was a very clear dichotomy between the acceptable public face of religion promoted by chaplaincy demonstrated by the ability of chaplains to access all wards and involvement in roles beyond patient visiting, and the private manifestations of minority religious need which are responded to on an ad hoc basis. Minority faith involvement in chaplaincy is visible only when chaplaincy teams decide their presence is required. In contexts where multi-faith teams were well-established, chaplains were willing to acknowledge the limitations of their own ability to accurately assess and meet the needs of minority faith patients. However, even in these cases, the role of minority faith representatives was mostly confined to bedside patient care.

It is significant that the majority of paid providers of generic spiritual support are Christian (usually Anglican or Free Church) chaplains. As highlighted throughout the findings chapters, the distribution of resources accords Christian chaplains the luxury of being 'present' and 'available' in ways that are not usually possible for minority faith chaplains. Regardless of the claims to provide general spiritual support, the relatively high visibility of Christian chaplains reinforces the somatic norm of chaplaincy as Christian, rather than 'generic' or 'multi-faith'. Many of the Christian chaplains who operated with this ostensibly universal 'generic' approach wore clerical collars as they did so. The contradiction of this was noted by a non-religious pastoral carer:

> Unless they are going to take off their religious dress, whatever that is, and I'd have trouble with that straight away, 'cause if...you should be proud of it, if that's what you've chosen as...it's your way of life. But you are then still approaching people from your religious perspective, regardless of how non-judgemental you can be and how much comfort you can give (interview, non-religious pastoral carer, Greenacre, 27/04/2016).

Notably, Swift criticises the alleged neutrality of the chaplain providing spiritual care and Orchard's call for chaplains to be 'empty-handed' (Swift 2004: 210-211).

Instead, he suggests that 'those who have dealings with patients come with their arms full. Arms full of professional discourse; full of technology and techniques; full of the unspoken signals of dress, titles and relationships' (ibid.). However, Swift suggests it is possible for chaplains' work to be 'disarmed' in order to 'to establish a unique kind of meeting between themselves and a patient which is not necessarily predicated on dominance' (ibid.). It is unclear why Swift thinks chaplains are uniquely placed to 'disarm', compartmentalise, and set aside their identities. Newitt suggests this 'disarming' can be achieved through chaplains developing critical self-awareness and reflexivity to mitigate the risk that 'co-narration becomes colonization' (2010: 13). Swift also appears to suggest that power relations in the encounter between chaplain and patient are merely a matter of chaplain demeanour rather than patient perception and response. The findings quite clearly demonstrated that the encounter between patient and chaplain is strongly influenced by the authority or status projected onto the chaplain by patients, regardless of the chaplains' attempts to distance themselves from this perception.

Newitt's observation that patient encounters are at risk of colonisation if the chaplain is not sufficiently reflexive is evidenced by the continuation of the somatic norm and the ways in which Christian chaplains mediate patient need in accordance with their own understandings. Christian chaplains may 'assess' patient needs to ascertain whether religion-specific support is required, but would inevitably do so from their own understanding of what religion-specific support and religious care entails. As evidenced by chaplains providing interfaith prayer, the performance and results can vary but one factor remains constant: the belief, on the part of the chaplain, that they are suited to meeting the specific needs of these patients. A generic understanding of spirituality can be used to justify the continued somatic norm by substituting specific ritual requirements for alternatives offered by Christian chaplains. The previous chapters have shown that in conjunction with raised awareness and visibility of minority faith chaplains, there appears to be a greater demand for religion-specific and religious care. Models of chaplaincy can therefore suppress or encourage demand for religious care.

Where the ad hoc involvement of minority faith chaplains might be referred to as *privatisation*, I suggest that chaplains who attempt to substitute the roles of minority

faith chaplains risk *colonising* religious care that is otherwise considered to be the domain of religious leaders (Newitt 2010). While this care is heralded as being 'neutral' and 'universalistic', the resultant power dynamics reveal a different picture, which bolsters the continued somatic norm of chaplaincy and hampers the work of minority faith chaplains.

7.3 CONCLUSIONS

This chapter has summarised the wider implications of the findings and analysis, focusing primarily on the evolution of new religious leadership, professional, and specialist roles among minority faith chaplains, and an exploration of the fundamental role of chaplaincy in gatekeeping and negotiating the nature, place, and role of religion in a secular healthcare setting. This chapter has shown that minority faith involvement in chaplaincy – both nationally and locally – is still couched in terms and attitudes that derive from Christian structures, understanding, and practice. This is equally evident in the consideration of chaplains as a new kind of 'religious professional' (and the potential difficulty Christian chaplains may have with this term) as well as considering the continued prominence of Christian chaplains in particular as an acceptable face of religion. Gilliat-Ray *et al*. rightly refer to a broken monopoly (2013: 101), although it is clear that the somatic norm is only seeing some hairline cracks and continues to persist in how chaplains are perceived by patients, staff, and stakeholders.

8 Conclusion

This thesis emerged from a concern to address the lack of literature regarding minority faith involvement in chaplaincy. While studies have previously explored the involvement of minority faith representatives in chaplaincy (Beckford and Gilliat 1996; Orchard 2000), significant changes have taken place since they were published, not least with the introduction of equality legislation, as well as the direct employment of minority faith representatives by the NHS (Gilliat-Ray 2008; Gilliat-Ray *et al*. 2013: 7-11). Gilliat-Ray *et al*. (2013) have provided a much-needed update on the state of play with Muslim chaplaincy, although these findings cannot be extrapolated to all minority faith groups, who have responded to calls for engagement in the public sphere in different ways, and whose understandings of religious leadership vary significantly. In the same way that the emphasis on the 'increasingly interdependent relationship' between Muslims and multiculturalism in Britain (Meer and Modood 2009: 481) obscures our understanding of relations between the state and other religious minorities (Singh 2005, Gidley and Kahn-Harris 2012), an account of Muslim chaplaincy cannot fully account for the differential experiences of chaplaincy for other minority faith communities.

In this conclusion, I bring together the findings and analysis from the previous chapters and discuss them in direct response to the research questions outlined in the methodology. Then I outline my contribution to knowledge, and close with an indication of possible future avenues for research.

8.1 GATHERING THE THREADS

8.1.1 How do NHS Trusts provide for the spiritual and religious needs of minority faith communities?

The findings demonstrate there is considerable variation in the ways in which the spiritual and religious needs of minority faith communities are met, although it is clear that chaplaincy has a major role in meeting these needs through the support provided by its personnel and through the maintenance of facilities for prayer, worship, and reflection. The findings reflect the ambiguity expressed in the literature in relation to the distinctive role of chaplaincy compared with other healthcare staff, although it is clear that the religious component of care in conjunction with the availability and time of the chaplains are major distinguishing features from the care that might be provided by other healthcare staff (Orchard 2000; Cobb 2004; Swinton and Mowat 2007; Orchard 2000; see also Cadge 2012).

The proliferation of working models for the inclusion of minority faith groups shows that some chaplaincies continue to be dependent on unremunerated labour in the form of community contacts or regular volunteers, while others have worked to develop a diverse remunerated chaplaincy team, although most minority faith chaplains were employed in a part-time capacity. The decision to recruit and remunerate minority faith chaplains (or not) appears to rest on demography (NHS England 2015a), the personal initiative of lead/managing chaplains, and the recognition that minority faith representatives have a distinctive contribution to make to the religious and spiritual care of patients. This recognition acknowledges that the role of minority faith chaplains cannot simply be undertaken by family (Welford 2011: 229; Eccles 2014: 5; Jhutti-Johal 2013: 265; Abu-Ras and Laird 2011: 51; Gilliat-Ray *et al*. 2013: 33) or by local faith community leaders. Instead, minority faith chaplains offer pastoral, non-judgemental, confidential, and patient-centred support which may not necessarily be offered by religious leaders or family, especially in relation to sensitive or taboo issues. One managing chaplain also commented that having an in-house chaplaincy team, rather than relying on external faith representatives, means that the care provided is 'reliable, high quality, and safe' (interview, managing chaplain, Greenacre, 25/05/2016). At the same time, the unique

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positioning of minority faith chaplains between hospital and faith community makes them ideal mediators and advocates both for the Trust and for patients and families (Swift 2013). As one stakeholder noted:

> It's their ability to understand and interpret religion in a very pragmatic way, and I think that is a key for a chaplain who works in health services, I'm not talking outside NHS, I think if you want to be NHS, you should be a person who understands the clinical challenges and can interpret faith and religion in a way that is conducive […] rather than saying, you know, this is the gospel, this is how we should go about it (interview, stakeholder, Stonehaven, 27/07/2016).

The marginality discourse, where chaplains occupy the interstices between hospital and faith community also applies to minority faith chaplains, but in very different ways. As shown in earlier chapters, minority faith chaplains are more firmly grounded in their faith communities, but also work at the fringes of the chaplaincy profession. This contrasts with Anglican (and some Free Church) chaplains, who appear to be content with distancing themselves from their churches. Interestingly, the pragmatism that Swift (2014) discusses seems to arise primarily from chaplains' disconnect with the church, rather than as a result of being immersed in the healthcare setting. This suggests that such a pragmatic approach can only be adopted once chaplains loosen the constraints of their faith communities. I suggest, however, that such pragmatism and a pastoral orientation can be developed while maintaining strong links with faith communities, especially evident among Muslim and Sikh chaplains.

While there was some evidence that the employment of minority faith chaplains resulted from factors external to the chaplaincy team (such as executive/ management decisions to make chaplaincy more multi-faith), it is clear that the decision to employ minority faith chaplains requires the support and lobbying of the lead/managing chaplain. This observation was made by Beckford and Gilliat (1996) and Orchard (2000), and demonstrates the continued influence of lead/managing chaplains in terms of developing their own teams. In this sense, the decision to

remunerate and to give regular hours legitimates the presence of other actors in the religious field. But at the same time, the decisions made by lead chaplains to include particular groups within chaplaincy may be perceived to contribute to their own prestige within the institutional or professional field (cf. Verter 2003: 166, see also Beckford and Gilliat 1996: 303), with one Anglican chaplain suggesting that the inclusion of a non-religious post was a 'political move' in the context of the broader national chaplaincy scene (interview, Anglican chaplain, Greenacre, 01/06/2016).

The findings highlighted the stagnation in career progress that most minority faith chaplains were experiencing. Some of the reasons for this become clear in the discussion of the question concerning integration below. However, the findings also suggest another form of stagnation: that the peak of the employment and recruitment of Hindu, Sikh, and Jewish chaplains is long past and took place within a short time period at the turn of the century. The recruitment of Muslim chaplains appeared to continue between 2003 and 2013 as the number of Muslim chaplains nearly doubled (Gilliat-Ray *et al*. 2013: 16). Few developments have been made since, with many chaplains occupying the same positions they occupied ten years ago. This stagnation suggests that with the recruitment of minority faith chaplains there is a sense of 'job done' amongst chaplaincy teams, and that no further steps need to be taken. But, as the findings have shown, it is possible for such progress to be reversed, either as a result of severe cuts made by the Trust (Stonehaven) or by a change of leadership (Northbrook, Moorlands). In contrast, there is a steadily increasing recruitment of non-religious representatives in the next wave of attempting to diversify chaplaincy services.

8.1.2 How do minority faith representatives/chaplains understand their role and work in a secular institution?

The findings in relation to this research question are best framed with reference to Orchard's distinction between 'transposing' and 'tailoring' roles from the faith community context to the healthcare context (2000: 92-93). It was rare for minority faith representatives to see their roles as directly transposed between community and hospital, and the only examples of this were apparent among Roman Catholic and Jewish chaplaincy representatives. However, any distinctions that were made by

chaplaincy representatives who were religious professionals were largely lost on patients of the same faith, as they tended to refer to themselves in terms of their titles as religious professionals (e.g. imam, rabbi, priest, pandit) which sets particular expectations about the nature and tone of the visit. In this sense, chaplains who were not religious professionals (that is, female Muslim chaplains and Sikh chaplains) had the advantage of being able to explain their roles in more flexible terms that frees them from the constraints of being associated with the authority of religious professionals. At the same time, these chaplains lacked the cultural and symbolic capital which enabled patients and families to trust in and recognise their colleagues with more ease.

Orchard links 'tailoring' with 'sponsor defined' understandings of chaplaincy as opposed to 'externally defined' transposed chaplaincy roles (Orchard 2000: 92-93). However, there was very little sense of 'sponsors' (i.e. hospital management) defining the role of minority faith chaplains or chaplaincy as a whole. This is particularly evident in the bare-bones mandatory training that chaplaincy is given by the institution, while many of the expectations of the chaplaincy role are articulated through a process of intra-departmental occupational socialisation. Orchard shows that sponsors had no clear-cut expectations for the role of chaplaincy, and chaplaincy was often left to its own devices (2000: 36, 127). This was reflected by the vagueness and ambiguity expressed by stakeholders in this study, especially among those who manage chaplaincy, about the role and effectiveness of chaplaincy. The primary exception to this was the growing recognition of Muslim chaplains at Stonehaven as repositories of knowledge about Islam, where stakeholders began to clearly express a demand for input from religious specialists through MDT and committee involvement. Thus, many chaplains receive little guidance about what the Trust expects from them (see also Pattison 2015), but may build up a portfolio and tailor their role over a period of time as staff begin to draw on chaplaincy for particular issues.

At the same time, it should not be surprising that religious leaders might apply some of their own understandings of religious leadership to the chaplaincy role. For example, religious specialists and leaders tend to work individually rather than collegially, which may explain why, for example, minority faith chaplains at

Riverside and Greenacre were less engaged with the team dynamic of chaplaincy. Likewise, few minority chaplains demonstrated an active engagement in CPD and professional development, or even participated in religion-specific chaplaincy courses. This may reflect attitudes to chaplaincy where one's status as a qualified religious professional was largely seen as a necessary *and* sufficient condition for being a chaplain. As Woodward noted, chaplains were 'present in the hospital by virtue of their ordination only – and because they have always been there' (1998: 262). Despite Autton's exhortation of 'formal and context-specific training' for chaplains (Autton 1968: 114-115), this did not fully materialise until 1998 with the introduction of a healthcare chaplaincy MA by a university department of healthcare studies (Swift 2014: 80) and specific guidance encouraging CPD (SYWDC 2003).

Ambiguity concerning the role of the chaplain might be attributed to the relatively unstandardised and informal approaches to the socialisation of minority faith chaplains. A significant proportion of minority faith chaplains had learnt 'on the job' by shadowing other chaplains. This was perceived to be adequate for continuing their role, and also adequate for them to teach other prospective and current chaplains for religion-specific courses (despite, in some cases, not undertaking the training themselves). In this sense there appeared to be a lack of access to and engagement with systematic and comprehensive training on the identity and role of chaplaincy, which can be attributed in part to limited distribution of resources.

All minority faith chaplains operated in a primarily religion-specific manner, while minority faith volunteers did a mixture of generic and religion-specific visiting, depending on the approach of the chaplaincy team. This religion-specific way of working is largely codified in chaplaincy guidelines which allocates hours in accordance with matching the faith of the patients (DoH 2003b; NHS England 2015a) and but also codified in the job descriptions for minority faith chaplains. This is not to say minority faith chaplains were not open to visiting patients of different faiths, but that this was not considered the main priority, even by senior or nearly full-time Muslim chaplains. For the chaplains who were not fortunate enough to have achieved senior positions, it was unsurprising that their visiting was primarily religion-specific because it was necessary for them to prioritise their workload as a result of limited working hours. Generic chaplaincy as enacted by minority faith

chaplains is incidental and responsive, while Christian chaplains operated with a proactive approach built on the facilitative aspects of brokerage, the bed-to-bed approach of traditional parish models, and the assumed public presence of Christianity.

8.1.3 To what extent are minority faith and non-religious belief groups integrated into chaplaincy teams and the wider chaplaincy profession?

The integration of minority faith groups into chaplaincy teams depends on achieving numerous forms of recognition. Here I will bring together discussion of the findings and analysis through the conceptual vantage points of the religious field, the exchange of capital, and the somatic norm.

8.1.3.1 The Religious Field

The inclusion of minority faith representatives in chaplaincy is dependent on the recognition of their legitimacy as actors in the religious field that chaplains occupy. This recognition is tripartite and includes acknowledging a) the capacity of minority faith groups to provide care, b) the need for minority faith chaplains to perform rituals specific to their faith traditions, and c) the limitations on the ability of Christian chaplains to provide care for different faith groups. Bourdieu's conception of the religious field provides a significant starting point but needs some rethinking. Bourdieu's religious field is the location of conflict between religious specialists who struggle to control access to 'the means of reproduction, and division of the goods of salvation' (Verter 2003: 155, citing Bourdieu 1987: 129; see also Bourdieu 1991a: 23). Reference to the 'goods of salvation' clearly points to a Christian, and in Bourdieu's case peculiarly Catholic, account of religious capital (Guest 2007: 188; McKinnon *et al*. 2011). Instead, I propose that the 'goods of salvation' are considered more broadly as 'symbolic goods' (Bourdieu 1993, cited in Verter 2003: 151, f.n. 2; see also Rey 2004) to account for the differential understandings of the role and function of religious specialists from minority faith traditions. Where Christian chaplains have routinely been able to offer 'symbolic goods' in place of minority faith representatives, such as inter-faith prayer in end of life situations or pastoral responses to bereavement, they maintain and exercise control of the religious field on the grounds that there is allegedly little or no 'demand' for the

specific symbolic goods offered by minority faith chaplains. This is particularly the case in relation to the provision of funerals for non-viable foetuses (whether miscarried, stillborn, or terminated) where religious traditions do not necessarily have the same religious capital or religious competencies (see Verter 2003: 157) to help make sense of perinatal grief. This appropriation of territory is not a direct appropriation of ritual competence, as may be the case in the American interfaith model (e.g. Lyndes *et al*. 2012: 81), but may instead draw on religious competence derived from the chaplain's own faith tradition, and potentially a degree of religious literacy in relation to the patient or family's faith tradition.

This ability to substitute the symbolic goods of other faith traditions has been further supported in some quarters by pointing out the *lack* of symbolic goods (i.e. a tradition of pastoral care) in minority faith traditions, or the repositioning of symbolic goods within those particular traditions not as the domain of religious professionals but of 'lay' persons in the family or the community. The *potential* for minority faith groups to provide care is denied on grounds that are largely constructed by the dominant actors within the religious field. Such symbolic goods that could be provided by families tended to revolve around Hindu end of life rituals, Sikh end of life prayers, and Islamic birth and death rituals (calling the *adhan* into a newborn baby's ear, *tawba*, and reciting the *shahadah*). It is notable that these rituals are now increasingly considered to be the domain of Muslim, Sikh, and Hindu chaplaincy representatives where such provision is available (for example, Greenacre and Stonehaven) and there appears to be a growing demand amongst patients for provision of specific 'symbolic goods' by religious specialists from their own religious group.

Where minority faiths are involved in chaplaincy, this appears to be a result of Christian chaplains conferring legitimacy on their role in the religious field, demonstrated by the considerable role of senior chaplains in advocating for minority faith involvement. This legitimacy is not only conferred once, but is recognised on an ongoing basis: every referral made to a minority faith chaplain constitutes a recognition of their symbolic or religious capital, not only by fellow chaplains but also by members of staff and by patients. This symbolic or religious capital cannot be

substituted by other actors in the religious field and was recognised as such not only by patients, but also staff and chaplaincy colleagues.

8.1.3.2 Exchanging Capital

As we have seen above, conferring legitimacy within the religious field requires chaplains to recognise the symbolic and religious capital of minority faith representatives and their ability to provide a distinct form of religious care. This supports the case for the inclusion of religious professionals (that is Jewish, Hindu, and male Muslim chaplains), although this is slightly different for Sikh and female Muslim chaplains. Religious capital is not institutionalised in the same way, and their symbolic capital is qualitatively different from the authority vested in religious professionals. Chaplaincy therefore also draws on the social and embodied cultural capital of Sikh and female Muslim chaplains, which has contributed to the development of a pastoral sense that is non-judgemental and confidential.

While Hindu, Jewish, and male Muslim chaplains are inscribed with symbolic and religious capital that is instantly recognisable, Sikh and female Muslim chaplains needed to work harder among patients to be recognised. For Hindu, Jewish and male Muslim chaplains engaging patients, the exchange rate of their religious capital maintains parity when translating between a community and a healthcare setting and requires little explanation or justification. Parity may be possible for Sikh or female Muslim chaplains, but only as a result of being familiar to community members (that is, by virtue of their social capital) rather than being recognised by their status (symbolic capital). Over time, chaplains may develop symbolic capital throughout their communities as a result of their chaplaincy work, with many chaplains reporting that discharged patients expressed their appreciation for the chaplaincy support they received. The presence of minority faith chaplains on the wards and providing care to minority faith patients was vital for developing awareness and a reputation within the community, which would in turn generate more referrals.

Chaplains actively worked to generate social capital amongst ward staff through developing strong relationships and building rapport. Christian chaplains in particular spoke of the importance of maintaining a presence on the wards in order to

build relationships, and nearly all chaplaincy team members across sites made a point of introducing themselves on the wards. Increased presence on the wards heightened awareness of minority faith chaplaincy representatives and improved the mechanisms by which their services were sought. The development of social capital amongst staff was also achieved by offering staff support and therein creating stronger relationships with particular individuals who might open the door for future opportunities for role development. Providing this kind of staff support took place at any level in the institution, including estates staff, ward staff, departmental heads and executives (interview, female Muslim chaplain, Stonehaven, 28/07/2016; interview, Christian chaplain, Stonehaven, 18/07/2016). These future opportunities for role development may manifest in invitations to participate in MDTs and committees, to be visible at Trust-wide events and to provide teaching on the wards and to staff being trained. This raises the profile of chaplains – especially the case with Muslim chaplains at Stonehaven – which cultivates prestige and symbolic capital. This is particularly true of chaplains involved in troubleshooting for the Trust.

The successful cultivation of social and symbolic capital at an institutional level did not always translate to recognition within national chaplaincy organisations, signifying a disconnect in the rate of exchange required to accumulate capital in the institution and the rate of exchange required to be recognised by national chaplaincy bodies. Instead, Muslim chaplains have developed their own networks for developing their knowledge base and achieving recognition amongst themselves, with a handful of senior Muslim chaplains achieving considerable prominence. These chaplains, however, rarely receive recognition from wider chaplaincy organisations, which were still felt to promote specifically Christian approaches to chaplaincy. The experience of one minority faith chaplain attempting, and eventually succeeding, to join the UKBHC highlighted how the requirements for membership are underpinned by Christian understandings, especially with the preference for institutionalised capital (formalised theology and chaplaincy degrees) over against embodied and social capital (community experience and networks). Such an approach disadvantages Sikh and female Muslim chaplains in particular, whose community experience supports their chaplaincy role, but also potentially Hindu chaplains, whose routes to religious leadership vary considerably.

8.1.3.3   The Somatic Norm

Throughout the findings and analysis, it has become clear that the somatic norm (Puwar 2001) of chaplaincy as a mode of Christian ministry persists at all levels of the institution, from patients to stakeholders. Even at Stonehaven, where the somatic norm had fractured, female Muslim chaplains found they had more difficulty being recognised by ward staff than their Christian colleague.

The somatic norm is perpetuated through model of the 'available' and 'present' chaplain (Woodward 1998; Wright 2001; Swift 2004; Nolan 2011; Sullivan 2014; Cadge 2017: 4), usually associated with providing generic chaplaincy. Availability and presence were a theme discussed by many chaplains across faiths, but the ability to be available and present was of course dependent on the hours allocated to particular faiths. Christian chaplains (and Muslim chaplains at Stonehaven) were afforded the luxury of full-time or close to full-time hours and were therefore most likely to be available and present on the wards and to hold positions on institutional committees. When this is combined by the almost unanimous decision among Christian chaplains (across all cases) to wear the clerical collar, the first – or most common – point of contact that a number of patients and staff have is with a chaplain who is obviously Christian, reinforcing the somatic norm. This was most evident at Northbrook, where two of the chaplains wore clerical collars and were involved as first responders to referrals in the initial 'spiritual assessment' of minority faith patients. However, where teams emphasised that the first response to a referral should be a chaplain who matches the faith of the patient or family (such as Greenacre and Stonehaven) the link made between chaplaincy and the Christian somatic norm is broken.

8.1.3.4   Accommodation and Integration

Inclusion of minority faith groups in chaplaincy needs to acknowledge the ways in which chaplaincy practice must change to accommodate minority faith groups and the ways in which minority faith representatives may adapt to their new environment. Accommodations made by chaplaincy teams included the redistribution of hours and resources, such as access to patient information and office space. Given that most minority faith chaplains had access to these resources, the dependence of minority

faith chaplains on their Christian colleagues for access to patient information at Riverside was especially jarring. Further accommodations also included actively involving minority faith chaplains in the decision-making processes of the team, a reconfiguration of team meetings and how they are organised, but also reconsideration of how the team socialises and engages with one another on a personal level. This was most contentious at Greenacre, where Christian chaplains felt as though accommodations had been made, but that their minority faith colleagues, excepting the Sikh chaplain, were not engaging with the chaplaincy team.

Christian chaplains occasionally referred to the inability of minority faiths to adapt to working in the NHS more generally. This was linked to levels of commitment to the role (including attitudes towards team obligations) and the apparent inability or unwillingness to engage in generic visiting, on the grounds that chaplaincy should be able to offer support to 'all faiths and none'. In some cases, these unmet expectations were situated within broader attitudes regarding the competencies and capabilities of minority faith chaplains (lack of precedent, essentialised accounts of minority faiths groups not being able to adapt), while other chaplains were more likely to recognise the limitations of minority faith chaplains not being able to visit regularly, their limited hours, and also the need to prioritise their work, not just within the hospital but also externally. Yet many criticisms were not accompanied by a commitment to supporting minority faith chaplaincy representatives' professional development and few resources were made available for minority faith chaplaincy representatives to address these alleged deficiencies.

At the same time, minority faith chaplains and volunteers have clearly adapted to the working practices of the institution and the chaplaincy profession. It is clear that most minority faith chaplains distinguish between their roles as chaplains and as community-based faith leaders in order to provide pastoral, non-judgemental support. Minority faith volunteers, especially Muslim and Sikh volunteers, have easily taken to generic visiting. Minority faith chaplains generally expressed an openness to engaging with patients regardless of their religion or belief, but on a responsive rather than proactive basis.

8.2   CONTRIBUTION TO KNOWLEDGE

8.2.1   Contribution to Chaplaincy Studies

Throughout this thesis I have engaged with the nascent field of 'chaplaincy studies' and questioned some of the claims that are considered axiomatic within healthcare chaplaincy in particular. I have challenged the marginality discourse by repositioning the debate and focusing on minority faith groups and their experiences of providing pastoral, spiritual, and religious care. In the process, I have demonstrated that the marginality discourse (Woodward 1998; Swift 2014), in addition to accounts of 'external' pressures on chaplaincy (Woodward 1998; Fraser 2004; Pattison 2015), risks overlooking the agency of individual chaplains and the chaplaincy profession as a whole. At the same time, I have outlined the ways in which chaplaincy discourse, which is often reproduced by the field of chaplaincy studies, continues to be influenced by the assumptions of Christian chaplains which may alienate some minority faith chaplaincy representatives. I have shown the situatedness and particularity of the official chaplaincy discourse which is otherwise considered to 'generic' and universal. This builds on the observation made by Swift (2014) and Newitt (2010) that chaplains do not engage with patients 'empty handed', but should critically reflect on how their presence impacts their encounters. This also applies to the process of professional boundary construction. The findings may help shape the future trajectory of chaplaincy studies to be more sensitive towards these power dynamics, but also help chaplains acknowledge, in practice, their capabilities and capacities in shaping (as well as being shaped) by legitimate language, and the impact of this on their minority faith colleagues.

The findings show that there is a significant disconnect between the institutional expectations concerning chaplaincy and the discourses that are prevalent among Christian chaplains and national chaplaincy organisations. It is clear that chaplaincy is under considerable pressure to professionalise (Woodward 1998) and to comply with the secular sacralities of the host institution, including equality, diversity and human rights; cost-effectiveness; and compassion (Threlfall Holmes 2011b: 128; Todd 2015b). The response offered by chaplains creates 'institutionalised patterns of cultural value' (Fraser 2003) that privilege generic understandings of spirituality as

universal and inclusive, and subordinate religious/religion-specific approaches as parochial and exclusive. These responses are grounded not only in sociological accounts of declining religious authority, but also the suspicion with which some Anglican chaplains regard Establishment orthodoxy. I suggest this is one of many possible responses to the secular sacralities of the institution, and that the development of Muslim chaplaincy is providing other viable alternatives, including consideration of how chaplaincy may address hitherto neglected agendas, such as health inequalities. It was evident at Stonehaven that there is an appetite for publicly manifested religion, particularly where religion might be used as a resource in complex negotiations.

This thesis has therefore offered a double reconfiguration of chaplaincy discourse. I have interrogated the defining trope of the marginality of chaplaincy and highlighted the relative privilege of Christian chaplains in comparison to minority faith groups. I acknowledge that chaplaincy *as a profession* is characterised by a state of marginality as chaplains are caught between their faith community and the healthcare setting (Norwood 2006), but the way this marginality manifests differs considerably between religions. I suggest that while Christian chaplains are *marginal*, minority faith groups are at risk of being *marginalised* by significant barriers to participatory parity. At the same time, I have repositioned the response of chaplains to the external institutional pressures as one of many possible ways to configure the provision of pastoral, spiritual, and religious care in the NHS.

This thesis also makes several important practical contributions to the field. The mapping task that informed the criteria for case selection constitutes the first attempt not only to map paid chaplaincy provision but also volunteer base, community contacts, and prayer facilities. It is the first study since the introduction of formalised chaplaincy posts to include the perspectives of Baha'i, Buddhist, Hindu, Jewish, non-religious, and Sikh chaplaincy representatives. A wider range of voices have contributed to the study since the studies of Beckford and Gilliat (1996) and Orchard (2001), demonstrating the extent to which boundaries of inclusion and exclusion have shifted. The inclusion of volunteers distinguishes this study from other studies of healthcare chaplaincy, which tend to neglect these voices. I suggest this might be a result of the increasing emphasis on professionalisation and the

concern to justify the continued funding of chaplaincy. However, the inclusion of volunteers on the research agenda may actually contribute to the case for continued state funding.

While contributing to a developing account of socialisation among chaplains (Kyriakides-Yeldham 2017), I have also expanded on the use of Bourdieu's concepts of rate of exchange (Todd 2015a) and capital (Todd 2015a; Gilliat-Ray *et al*. 2015: 23) in the existing knowledge base.

8.2.2   Contribution to the Sociology of Religion

This thesis has made contributions to key themes within the sociology of religion, including a focus on how religion is constructed, the regulation of religion, and the public-private distinction. I have extended the evidence base for Pattison's claim that chaplaincy provides an 'acceptable face' of religion in the public sphere (Pattison 2015) by highlighting the multiple ways in which chaplaincy constitutes a gatekeeper of religion in the National Health Service. I have shown, with reference to Bourdieu's legitimate language, that chaplains are vital actors in the everyday negotiation of acceptable religious practice and the management of religious diversity in the context of healthcare provision. Legal cases may give some insight into how religion is managed in healthcare institutions (McHale 2013), although I suggest that chaplains are involved in every day micro-negotiations of acceptable and unacceptable religion.

This study of minority faith groups in chaplaincy has also contributed to a broader concern with examining religion as power (Woodhead 2011), especially when considering how power dynamics have changed since Beckford and Gilliat (1996) and Orchard (2000) were writing, not only between Christian chaplains and minority faith chaplains, but also ecumenically. It has become clear that current working practices in chaplaincy continue to contribute to the marginalisation of minority faith chaplains, especially in relation to access to mechanisms of socialisation (such as CPD and chaplaincy specific training). I have also drawn parallels between the gradual inclusion of non-Anglican denominations, minority faith groups, and non-religious involvement in chaplaincy.

This thesis also contributes insights into an area which is conspicuously underdeveloped in the sociology of religion; that is, the development of religious professions in the British context. Most of the information available to sociologists of religion at present focuses on a sociology of the clergy (Fichter 1961; Ranson, Bryman, and Hinings 1977; Russell 1980; Percy 2006), with particular interest devoted to women clergy (Davie 1994; Nesbitt 2007). Other accounts are highly generalised and abstract (Turner 1968; Vallier 1968; Gilliat-Ray 2001a; Nesbitt 2007). Only Gilliat-Ray (2010b) and Birt (2006) have begun to explore the unique manifestations and challenges of religious leadership among imams (and cursorily with reference to pandit*s* and *granthis* for Birt) within the British context specifically. My discussion of chaplains as religious professionals intends to stimulate interest in this area by exploring how chaplaincy provides a lens for examining change in leadership roles. Given the lack of empirical literature on this topic, my own discussion is informed primarily by participant perspectives and wider considerations about the different aspects of religious leadership, including ethics and ritual. It is hoped that successors to this study will begin to consider religious leadership as an area of interest in itself, rather than incidental to other research interests.

8.2.3 Participatory Parity as Critical Counterpoint

This thesis is the first to apply Fraser's concept of 'participatory parity' to chaplaincy studies in particular and the sociology of religion in general. Reference to 'participatory parity' enables a rich and multifaceted conceptual analysis which explores issues of recognition and distribution in relation to the involvement of minority faith groups in the public sphere generally. I suggested earlier that 'participatory parity' can be retrospectively applied to the work of Orchard (2000) and Beckford and Gilliat (1996) as a broader framework for understanding the dynamics of inclusion and exclusion at work in chaplaincy. However, the broader applications of Fraser's 'participatory parity' and 'perspectival dualism' could also assist with future studies of minority faith involvement in, for example, participative governance. Such a framework not only accounts for inter-faith inclusion/exclusion (such as the exclusion of Pagans from inter-faith bodies [Weller 2009: 77]) but also intra-faith inclusion/exclusion (such as the underrepresentation of women and young

people, or the exclusion of particular denominations or sects). In the context of chaplaincy, this may provide a helpful framework for examining the dynamics of inclusion and exclusion in national organisations, such as Network for Pastoral, Spiritual and Religious Care in Health (NPSRCH).

8.3 FUTURE RESEARCH

This research has identified significant gaps in relation to both chaplaincy studies and the sociology of religion. I encourage researchers involved in chaplaincy studies to consider researching the involvement of minority faith groups in healthcare chaplaincy as individual discrete groups; i.e. Hindu chaplaincy, Sikh chaplaincy, Buddhist chaplaincy, Jewish chaplaincy, and Baha'i chaplaincy. This thesis is unable to do full justice to the rich variety of understandings each faith community brings to chaplaincy. Such a focus in future research would allow for a more detailed account of how minority faith chaplaincy representatives understand and negotiate their role in light of their own faith perspective, the expectations of their communities, as well as the secular sacralities they must navigate (Todd 2015b). In particular, it would be instructive to find out why Jewish and Buddhist chaplains lag behind their American counterparts in terms of published outputs (Tabak 1997, 2010; Sheer 2008; Giles and Miller 2012). Likewise, rapid progress has been made with the development of the non-religious involvement in chaplaincy which requires further documentation and research, especially with the appointment of the first non-religious head of chaplaincy in March 2018.

I also encourage those involved in chaplaincy studies to carry out research with national level chaplaincy organisations and programmes. Orchard has noted previously that there is much knowledge that is spoken of but not consolidated in published literature (2001b:15). This is most evident, for example, in the development of religion-specific training courses, as well as the training course developed by the NPSRCH. The empirical healthcare chaplaincy literature has virtually nothing to say about the socialisation processes that both minority faith and Christian chaplains are subject to (except Kyriakides-Yeldham 2017). While this research has contributed an account of how volunteers are subject to increasingly formal socialisation processes, accounts of the training provided by institutions like

St Padarn's Cardiff Centre for Chaplaincy Studies and the Markfield Institute, as well as the much shorter-term NCHT and Sikh chaplaincy courses (see Appendix 2), would provide further vital insights into the ways in which (prospective) chaplains are prepared for their occupational and institutional role.

In the sociology of religion, there appears to be a significant lack of literature concerned with developing religious leadership within minority faith communities in a specifically British context and there is a significant degree of conceptual muddiness around the terms 'specialists', 'leaders' and 'professionals' that requires teasing out. This omission is strange considering the emphasis placed on showing the ways in which diaspora requires religious groups to adapt and change (Nesbitt 2007). Anthropologists of religion have often referred to 'institutional' religious leaders as preservers of tradition (Turner 1968), so how does this work when religious ideas and practices are introduced to a new context? What tensions and challenges present themselves for religious leaders and professionals in a diasporic context?
The findings have shown the ways in which religious leaders have adapted to new roles, despite the axiom that religious authorities reject or resist change. It is only fitting, therefore, that a whole new research agenda explores the ways in which diasporic religious leaderships develop and change within a British context.

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10 Appendices

10.1 OVERVIEW OF APPENDICES

Appendix 1: Related Acronyms and Organisations

A full list of organisations relevant to health care chaplaincy and their acronyms.

Appendix 2: Cardiff University School of History, Archaeology and Religion Research and Teaching Ethical Approval Form

The full University ethical approval form for the project.

Appendices 3 to 7: Project Documentation Submitted for Review by Research and Development Departments

These documents were used for the fieldwork at all sites, with some minor amendments made between each site. All of the documentation featured was approved by Research and Development and Information Governance offices at each site. The documentation submitted and used for Moorlands was more generalised in light of the expectation that there would be little or no engagement with minority faith groups. This includes a case study proposal, participant information sheet for chaplaincy team members and stakeholders, patient information letter, shadowing protocol, and written consent form for chaplaincy team members and stakeholders.

Appendices 8 to 11: Interview Tables and Schedules

The interview tables shows anonymised participants involved in the study with reference to their religious background (where applicable) and role in the chaplaincy team or the wider institution, the date and duration of the interview, and whether the interview transcript is full or abridged. The interview schedules include the questions for chaplaincy team members, stakeholders, and a one-off set of questions for representatives for an inter-faith forum local to Westview University Hospital. While site-specific questions have been included, questions tailored to specific participants have not.

Appendix 12: Sample Interview Transcript

A sample interview transcript for a Muslim chaplaincy representative, included with the permission of the participant. The transcript is redacted and the site is undisclosed to preserve anonymity.

Appendices 13 to 14: Coding Frameworks

Outlines of the coding frameworks used for NVivo. The first framework shows the codes developed alongside management and initial analysis of the dataset while the second framework shows how these nodes were arranged into much broader conceptual categories and themes.

Appendix 15: Application to the AHRC Skills Development Fund for NHS England Placement

The full funding proposal for the placement with NHS England to engage in knowledge exchange.

Appendix 16: Progress Report for NHS England

A progress report submitted to NHS England indicating preliminary findings from the fieldwork and support the case for a knowledge exchange placement.

10.2 Appendix 1: Related Organisations and Acronyms

CCCS – Cardiff Centre for Chaplaincy Studies, St Padarn's Institute

https://www.stpadarns.ac.uk/beginning-chaplaincy/ [Accessed: 23 August 2018]

https://www.stpadarns.ac.uk/mth-chaplaincy-studies/ [Accessed: 23 August 2018]

Chesed – formerly the Jewish Visitation Committee

https://www.theus.org.uk/article/about-us-chesed [Accessed: 29 July 2018]

CCHC – Churches Committee for Hospital Chaplaincy (no website)

CHCC – College of Healthcare Chaplains

https://www.healthcarechaplains.org/ [Accessed: 23 August 2018]

DoH – Department of Health (now Department of Health and Social Care)

https://www.gov.uk/government/organisations/department-of-health-and-social-care [Accessed: 23rd August 2018]

> Previously known as:
> **DHSS** – Department of Health and Social Security

ENHCC – European Network of Healthcare Chaplaincy

http://www.enhcc.eu/ [Accessed: 29 July 2018]

HCC – Hospital Chaplaincies Council (no website)

Humanists UK

https://humanism.org.uk/campaigns/human-rights-and-equality/chaplaincy-and-pastoral-support/ [Accessed: 25 September 2018]

> Previously known as:
> **BHA** – British Humanist Association (1967-2017)

MIHE – Markfield Institute for Higher Education

https://www.mihe.ac.uk/course/ma-muslim-chaplaincy [Accessed: 23 August 2018]

NAHAT – National Association for Health Authorities and Trusts (Now NHS Confederation)

https://www.nhsconfed.org/ [Accessed: 17 September 2018)

NCHT – National Council of Hindu Temples

http://www.nchtuk.org/index.php/extensions/s5-image-and-content-fader/healthcare-chaplaincy-project/47-static [Accessed: 23 August 2018]

NHSE – NHS England

https://www.england.nhs.uk/chaplaincy/ [Accessed: 23 August 2018]

NPSRCH – Network for Pastoral Spiritual and Religious Care in Health (2015-present)

http://hcfbg.org.uk/structure/ [Accessed: 23 August 2018]

> Previously known as:
> **HCFBG** – Healthcare Chaplaincy Faith and Belief Group (2013-2015)
> **MFGHC** – Multi-Faith Group for Healthcare Chaplaincy (2003-2013)

NSS – National Secular Society

https://www.secularism.org.uk/chaplaincy/ [Accessed: 25 September 2018]

Oxford Buddha Vihara

Hosted chaplaincy conference in 2014

http://www.oxfordbuddhavihara.org.uk/bhc.html [Accessed: 29 July 2018]

Sikh Chaplaincy UK

http://www.sikhchaplaincy.org.uk/ [Accessed: 29 July 2018]

SYWDC – South Yorkshire Workforce Development Confederation (now defunct)

The Buddhist Healthcare Chaplaincy Group

Buddhist Care Network

http://www.buddhistcarenetwork.org/ [Accessed: 29 July 2018]

UKBHC – UK Board for Healthcare Chaplaincy

http://www.ukbhc.org.uk/ [Accessed: 23 August 2018]

Previously known as: **CAAB** – Chaplaincy Academic and Accreditation Board (2005-2008)

Vanik Council UK

https://www.ncva.co.uk/jain-spiritual-care [Accessed: 23 August 2018]

**SCHOOL OF HISTORY, ARCHAEOLOGY AND RELIGION
RESEARCH AND TEACHING ETHICAL APPROVAL FORM**

To Be Submitted at least TWO WEEKS before a SREC meeting to: Annie Brown,
Co-School Manager, Room 4.56, School of History, Archaeology & Religion

Ext. 74252 (browna7@cardiff.ac.uk)

Principal Investigator / Supervisor	Professor Sophie Gilliat-Ray
Student Name & Number (if applicable)	Joanna Bryant, C1432685
Email Address	BryantJR@cardiff.ac.uk
Title of Project	Negotiated, Asserted or Assumed: The Status and Integration of Minority Faith Groups in Acute Healthcare Chaplaincy
Purpose of work proposed i.e. teaching, undergraduate project, postgraduate project, externally funded research, commercial research	Doctoral research
Other Collaborators	Revd Canon Dr Andrew Todd
Funding Body (if applicable)	AHRC
STUDENTS ONLY Has your supervisor both read *and* approved this form	YES ☒ NO ☐

Supervisor Signature	
	JGilliat-Ray (signature)

PLEASE REFER TO THE FOLLOWING BEFORE FILLING OUT THE REST OF YOUR APPLICATION:

1. The School Research Ethics webpage can be accessed via:

   http://www.cardiff.ac.uk/hisar/research/ethics/index.html

2. Information on data management, collecting personal data: data protection act requirements can be access via:
   http://www.cardiff.ac.uk/govrn/cocom/accinf/dataprotection/datap/data-protection-for-researchers.html

3. Information on Research Ethics can be accessed via the University's Research and Commercial Division web pages via the "Research Ethics" link on:
   https://www.cardiff.ac.uk/racdv/ethics/guidelines/index.html

4. Ensure attachment of the following with your application:

   a. **Full project proposal**

   b. **Participant information form and Consent form (if available)**

   c. **Copies of all relevant permissions (if applicable)**

   d. **Details concerning external funding (if applicable)**

Recruitment Procedures

		Yes	No	N/A
1	Does your project include children under 16 years of age?	☒	☐	☐
2	Does your project include people with learning or communication difficulties?	☒	☐	☐
3	Does your project include people in custody?	☐	☒	☐

4	Is your project likely to include people involved in illegal activities?	☐	☒	☐
5	Does your project involve people belonging to a vulnerable group, other than those listed above?	☒	☐	☐
6	Does your project include people who are, or are likely to become your clients or clients of the department in which you work?	☐	☒	☐
7	Does your project include people for whom English / Welsh is not their first language?	☒	☐	☐

PLEASE SEE ETHICAL ISSUES SECTION FOR

FURTHER CLARIFICATION AND DETAILS ON HOW POTENTIAL CONTACT WITH THESE GROUPS WILL BE MANAGED.

Consent Procedures (non-archaeological)

		Yes	No	N/A
8	Will you tell participants that their participation is voluntary?	☒	☐	☐
9	Will you obtain written consent for participation?	☒	☒	☐
10	If the research is observational, will you ask participants for their consent to being observed?	☒	☐	☐
11	Will you tell participants that they may withdraw from the research at any time and for any reasons?	☒	☐	☐
12	Will you give potential participants a significant period of time to consider participation?	☒	☐	☐

Possible Harm to Participants

		Yes	No	N/A
13	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort?	☐	☒	☐
14	Is there any realistic risk of any participants experiencing a detriment to their interests as a result of participation?	☐	☒	☐

| 15 | Please confirm that you have read and understood CU's Interim Guidance for Researchers Working with Children and Young People. (http://www.cardiff.ac.uk/sohcs/resources/Child%20Protection%20Procedures%20-%20Interim%20Gdnce%20-%20SEOs%20031209.pdf | ☒ | ☐ | ☐ |

If there are any risks to the participants you must explain in your proposal how you intend to minimise these risks. For further information regarding research ethics procedures and the University's health and safety policies please follow the link: (http://www.cf.ac.uk/osheu/index.html)

Data Protection

		Yes	No	N/A
15	Will any non-anonymised and/or personalised data be generated and/or stored?	☒	☐	☐
16	Will you have access to documents containing sensitive[48] data about living individuals?	☐	☒	☐
	If "Yes" will you gain the consent of the individuals concerned?	☐	☐	☒

Ancient Human Remains

		Yes	No	N/A
17	Have you secured the appropriate permission, if required, to excavate, export and/or sample any ancient human remains?	☐	☐	☒
18	If applicable, have you agreed any required reburial or repatriation of human remains after excavation and analysis?	☐	☐	☒

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[48] Sensitive data are *inter alia* data that relates to racial or ethnic origin, political opinions, religious beliefs, trade union membership, physical or mental health, sexual life, actual and alleged offences.

Permissions to Carry Out Fieldwork

		Yes	No	N/A
19	Have you secured the appropriate permission from the tenant and landowner?	☐	☐	☒
20	Does the research take place outside of the UK??	☐	☒	☐
	If "Yes" have you gained appropriate permissions?	☐	☐	☒
21	Does the area of research include any Scheduled Monuments?	☐	☒	☐
	If "Yes" have you gained permission from the appropriate authority?	☐	☐	☒
22	Is the area of research special environmental interest or value (e.g., is it an SSSI)?	☐	☐	☒
	If "Yes" have you gained permission from the appropriate authority?			
23	Have you contacted the local Site and Monuments Officer?	☐	☐	☒

Dissertation Summary (Students only)

Please provide further information on your overall dissertation proposal below (200-300 words only)

Healthcare chaplaincy has developed considerably over the past 25 years, particularly in relation to the development of multi-faith chaplaincy teams. This has followed acknowledgement by the NHS of the importance of meeting the spiritual and religious needs of patients, visitors and staff. Set against this background of rapid change, the researcher will examine the status and integration of minority faith groups in acute healthcare chaplaincies.

The fieldwork will involve a series of case studies across various NHS hospital sites in England and Wales, employing ethnographic and qualitative research methods to collect data. These methods include the observation of chaplains in their offices (1 week), the shadowing of minority faith chaplains/chaplaincy representatives (1 week), and semi structured interviews (2 weeks). A two-week contingency period following the official 4-week study will also enable the researcher to tie up loose ends, such as any remaining interviews, while allowing some additional time to write up fieldnotes and prepare for the next case study. In some case studies where minority faith representatives do not have regular patterns of working, the researcher intends to operate on an on-call basis, where she will shadow minority faith representatives as and when they are called in. The Cardiff and Vale University Health Board chaplaincy team has been approached for the pilot study.

The fieldwork will also include interviews with members of chaplaincy bodies who are not within the purview of the NHS and, if possible, observations of meetings at both local and national levels relating to healthcare chaplaincy.

Please explain how the identified ethical issues will be handled. It is your obligation to bring these and any other issues not covered on this form to the attention of the Committee (cont'd).

Informed consent will be requested from all participants prior to their taking part in the study. All participants will be given an information sheet explaining the project. Translations of the information sheet will be provided for patients, visitors and non-chaplaincy affiliated staff if requested. Written consent will be obtained from all national chaplaincy figures, chaplains themselves and chaplaincy team affiliates (such as chaplaincy volunteers and line managers) during the study. Permission to record interviews on an audio recording device will be requested at the beginning of each interview.

When shadowing chaplains, verbal consent to observe chaplain and patient/visitor/staff encounter will be requested after the chaplain provides a brief introduction to the researcher and to the research project. This is to ensure minimal interference to the encounter. If patients themselves are not in a position to give informed consent (i.e. are under 18 years of age, or otherwise vulnerable), then permission will be requested from family members if they are present. In some instances, the discretion of the researcher may be used to determine whether it is appropriate to observe such encounters, as situations may arise that are unexpected. The researcher will keep a record of verbal consent. If the patient does not permit the researcher to be present, the researcher will leave and meet the chaplain after the encounter. The researcher will always be accompanied by a member of the chaplaincy team when observing encounters with patients.

Confidentiality and Anonymity: While patients, visitors and non-chaplaincy staff will be involved in the study, it is emphasised that the primary focus is on members of the chaplaincy team. Therefore no personal data about the patient, visitor or member of staff will be noted or stored. As a consequence all notes relating to encounters with patients, visitors and members of staff will be anonymised from the outset. Patients will only be identifiable to the researcher by reference numbers that will be used to label the fieldnotes, which will include the date and the number of the encounter.

All notes relating to the observation of the chaplaincy team will contain identifiable data in the first instance, which will be then anonymised when the data is written up and stored digitally. Interviewees will be asked for their consent to be audio recorded using a dictation device. As with observations, data will initially be identifiable but anonymised during the transcription process.

Data Storage: The study will be located in several sites across England and Wales, rendering it difficult for the researcher to create or store data on a university network computer. Following discussions with the University Information Security Framework team, it has been agreed that notes can be written up on the researcher's MacBook Air due to the difficulty of accessing a university network computer during the fieldwork period. This laptop is currently password protected, and has an existing encryption feature, which will be enabled ahead of the fieldwork. Any passwords used will be in accordance with the university's password policy. Data will be backed up onto secure encrypted devices including an external hard drive (this will be linked to the laptop's 'Time Machine' feature that regularly backs up data). The researcher will also upload the notes onto the university network remotely via a secure Virtual Private Network connection.

Although interview recordings will be created on a digital audio recorder, the recording will be transferred to an encrypted device and removed from the dictaphone at the first opportunity.

During the study, research notes and transcripts will only be made accessible to the researcher, Jo Bryant, and her supervisors, Professor Sophie Gilliat-Ray and Revd Canon Dr Andrew Todd. At the end of the study, data will be stored on university systems/networks for up to 5 years following the end of the project, as per university data management and compliance guidelines. However anonymised data may be kept on personal encrypted devices indefinitely for reference by the researcher at a later date.

SHARE10/116

STATEMENT OF ETHICAL APPROVAL

This project has been considered using agreed School procedures and is now approved.

Signed_____ Print Name _____ Date 10 . iii . 15 .
(Chair, School Ethics Committee)

Signed_____ Print Name J. Chevorx Date 10.3.15
(Second Confirmation)

v1.2, 28/01/2016

Negotiated, Asserted or Assumed? The Status and Integration of Minority Faith Groups in Acute Healthcare Chaplaincy – Case Study Proposal

Rationale

Chaplaincy provides a significant lens for examining the role of religion in public life and institutions. In recent years, healthcare chaplaincy has been brought to public attention following campaigns by the National Secular Society (NSS) to revoke its public funding on the grounds that such provision is discriminatory. However, while the chaplaincy literature has responded to this challenge, neither the NSS campaign nor research into the field of chaplaincy (with very few exceptions) account for the role of minority faith groups generally in acute healthcare chaplaincy.

'Multi-faith chaplaincy' has grown considerably over the past 25 years, following recognition that religious diversity constitutes an important element of the British socio-cultural setting. However, 'multi-faith' has been interpreted variously across chaplaincy teams, with Trusts and Health Boards responding in different ways to the requirement to provide for the spiritual and religious needs of minority faith communities. This project aims to undertake case studies in order to ascertain the various ways in which chaplaincy teams have adapted to the diverse religious context of the UK.

Aims of the Study

While it is understood that chaplaincies centre primarily on the work of paid chaplains who visit wards regularly, this study also recognises the role of faith representatives who are involved in chaplaincy teams in a sessional or voluntary capacity. More specifically the project is concerned with:

- Undertaking a set of localised comparative case studies of chaplaincy teams in acute hospitals across a sample of NHS Trusts and Health Boards, focusing specifically on issues relating to minority faith groups

- Raising the profile of minority faith groups in healthcare chaplaincy and examining the ways in which spiritual care is provided for minority faith communities by NHS Trusts
- Addressing gaps in chaplaincy literature by producing an account of the extent to which minority faith chaplaincy representatives are integrated into chaplaincy teams and the NHS
- Contributing a non-practitioner's account to an academic body of knowledge which is primarily informed by chaplaincy practitioners

Key Questions

- In what ways has religious and spiritual care provision in chaplaincies developed since the 1991 Patients Charter?[49]
- How do NHS trusts provide for the spiritual and religious needs of minority faith communities?
- How do minority faith representatives/chaplains understand their role and work in a secular institution?
- To what extent are minority faith groups integrated into chaplaincy teams? In what capacities are they employed and in what ways does this affect their work?
- In what ways and to what extent are chaplaincies operating as 'multi-faith' teams? What are the implications of the 'generic chaplaincy' model?

The Study Team

Jo Bryant is an Arts and Humanities Research Council funded PhD student in the Department of Religious and Theological Studies at Cardiff University. She is supervised by Professor Sophie Gilliat-Ray and Rev Canon Dr Andrew Todd. This study falls within the remit of the Cardiff Centre for Chaplaincy Studies based at St Michael's Theological College, and the Centre for Study of Islam in the UK at Cardiff University. She has worked previously in chaplaincy research with Professor Stephen Pattison from the University of Birmingham and Rev Dr Christopher Swift at Leeds Teaching Hospitals NHS Trust.

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[49] The first political recognition of religious diversity among staff, patients and visitors in the NHS

The Fieldwork

The overall project includes a series of case studies of hospital chaplaincy teams across England and Wales using ethnographic techniques, where the student becomes immersed in the study setting through observational means. It is proposed that a case study takes place at **[REDACTED].**

It is proposed that this study is treated as a service evaluation, as its primary aim is to evaluate the extent to which healthcare chaplaincy can be said to be 'multi-faith', the extent to which minority faith representatives are integrated within chaplaincy teams, and the degree to which this is recognised by the host institution and their faith communities. A possible outcome of the service evaluation is that a report on the chaplaincy team is provided for the Trust.

Additionally, the fieldwork will include interviews and observations with national representatives and organisations external to the NHS in order to obtain a broader picture of healthcare chaplaincy. University ethical approval has been obtained for this component of the fieldwork, as it falls outside the remit of NHS ethical review.

The Case Study

Prior to the formal case study at each site, the student will be introduced to the chaplaincy team members and will present the proposed study so that the team is fully aware of what is taking place. It is proposed that a week is spent in each of the chaplaincy offices (= total 2 weeks), followed by 2 - 3 weeks of shadowing and 2 - 3 weeks set aside for conducting interviews (see below). The student may also request to see documentation relating to multi-faith dimensions of chaplaincy work during this period.

This study will utilise the following data collection methods:

- **Participant observation** – this will include being present in chaplaincy offices and facilities to observe general comings and goings of members of the chaplaincy team, as well as their interactions with one another. This will also, if the team is willing, include observations of team meetings and wider chaplaincy involvement in the Trust. These observations will take place during normal chaplaincy office hours, in order for the student to build relationships with the team.
- **Shadowing** – this will involve following minority faith chaplains and chaplaincy representatives in their daily work around the hospital. This includes observing scenarios involving patients and staff, however the main focus will be on the chaplaincy team member and the encounters

they have, rather than on the particulars of patients, visitors or staff members. As far as possible, the identity of the student will be made clear to all those who are being observed.

- **Semi-structured interviews** – all members of the chaplaincy team, including those who do not necessarily visit the hospital regularly, will be invited for interview in order to follow up on observations. These will take place during the last two weeks of the study in order to follow up on observations, and will last approximately 45 minutes to an hour. While the focus is on minority faith chaplains/volunteers, the student will also be interviewing Christian chaplains, and also hopes to interview managers and other staff stakeholders who work with or alongside chaplaincy.

An additional contingency period of two weeks will be factored in at the end of the study, which will primarily be used for write-up and analysis but also to enable the student to be available to the teams in an on-call capacity or to schedule further interviews.

The overall fieldwork, comprising a series of case studies, is planned to take place between 1st October 2015 and 1st November 2016. This particular study is planned to take place sometime between May and August 2016.

Recruitment

Chaplains and chaplaincy team affiliates (volunteers, line managers and stakeholders) of all faiths will be recruited into the fieldwork, subject to their consent to participate. While the study is primarily concerned with minority faith groups, it also aims to explore the perspectives of all team members. Therefore these participants will be selected by virtue of their role in the NHS. If possible, managers and stakeholders in roles that relate to chaplaincy will be asked to participate in the study.

As part of the shadowing component of the study, encounters with patients, staff and visitors will be observed. However, it is not possible to say which patients, staff or visitors will be involved, or quantify a sample in advance. It is possible that persons under the age of 18, vulnerable persons or persons unable to give informed consent may be observed or encountered, although these groups will not be actively sought after in the study. The student will be accompanied by a member of the chaplaincy team when coming into contact with these groups. The study is unlikely to impact on patient vulnerability. The ethical implications will be discussed below.

It is emphasised that chaplains and chaplaincy team affiliates are considered to be active primary participants in the case study. Conversely patients, visitors and other staff members are considered to be secondary participants, insofar as they are not the primary focus of the observations. The case study will not be affected by the identifiable details of a particular patient, visitor or non-chaplaincy affiliated member of staff.

Informed Consent

All chaplaincy team members and affiliates will be asked for written informed consent and given a participant information sheet. Permission to record interviews on an audio recording device will be requested at the beginning of each interview.

Patients will be asked for verbal informed consent in order to allow the encounter to proceed with minimal interference. If patients themselves are not in a position to give informed consent (i.e. are under 18 years of age, or otherwise vulnerable), then permission will be requested from family members if they are present. In some instances, the discretion of the student may determine whether it is appropriate to observe such encounters, as unexpected situations may arise. The student will always be accompanied by a chaplain when observing encounters with patients.

Records will be kept in all instances of verbal consent. It is intended that the chaplain will briefly introduce the patient to the student and the project. Patients will be given a letter with basic information about the study. Observations of encounters will be recorded as written fieldnotes only. If the patient does not permit the student to be present, the student will leave and meet the chaplain after the encounter.

All participants have the right to:

- Completely withdraw from the study until the end of the fieldwork period (September 2016). This is primarily because removing data regarding a particular participant becomes more difficult when fieldnotes have been anonymised.
- Partially withdraw some information from the study while remaining a participant in the study
- Refuse to answer a question
- View interview transcripts in order to make comments or clarify points, but not to alter the substance of the data

Confidentiality and Privacy

All interviews will be conducted in private settings, preferably in meeting rooms or offices available. All contributors and participants in the study will be anonymised when fieldnotes and transcripts are written up.

It is the student's responsibility to ensure that data remains confidential provided that the information given is directly relevant to the project. Full confidentiality cannot be guaranteed in the event of information being disclosed which has legal or ethical ramifications beyond the remit of the project. Participants will be notified of this in the participant information sheet.

Patients, staff and visitors who are observed during the shadowing period will automatically be anonymised in fieldnotes. The student will not ask for or write down identifiable personal details relating to the patient, staff member or visitor, and will instead be able to identify the encounter by assigning a unique reference number to the encounter in the fieldnotes.

Data Storage

The study will be located in several sites across England and Wales, thus rendering it difficult to create or store data on a university network computer. Following discussions with Cardiff University's Information Security Framework team, it has been agreed that fieldnotes can be written up and stored on an encrypted and password protected MacBook Air. The laptop has an encryption function that will be enabled ahead of the fieldwork, and passwords will comply with university requirements.

Data will be stored on an encrypted memory stick and/or external hard drive as a backup, and will also be uploaded onto the University network remotely, using a secure Virtual Private Network connection. Data will also be stored on Microsoft OneDrive for business (secure password protected cloud storage licensed to Cardiff university).

With permission, interviews will be audio recorded and temporarily stored on a digital audio recorder. At the first opportunity the recording will be transferred to an encrypted device and removed from the dictaphone. Subsequent transcriptions will be anonymised.

During the study, field notes and transcripts will only be made accessible to the student, Jo Bryant, and her supervisors, Professor Sophie Gilliat-Ray and Rev Canon Dr Andrew Todd.

Data will be stored by Cardiff University for up to 5 years following the end of the project, as per university data management and compliance guidelines. However anonymised data may be kept on personal encrypted devices indefinitely for reference by the student at a later date.

Channels of Feedback for Patients, Visitors and Non-Chaplaincy Staff

The student is aware that she may witness moments of distress and sensitivity during the course of observations. If patients, visitors or staff are unhappy with the study, they can withdraw immediately, or contact the chaplaincy team, who can feed back to the student.

Possible Outcomes

The study will primarily result in a doctoral thesis, which will be available to the public in electronic form at the end of the project. The student will also produce articles for academic/professional journals and present the findings at conferences, provide feedback to the chaplaincy team and the Trust. There is further scope for providing guidance and recommendations for Trusts based on the findings of the study.

If a report is produced for the Trust, it may be difficult to keep chaplaincy team members and affiliates anonymised. However, it will be more difficult to identify participants in any external outputs (thesis, articles, conference papers), particularly as comparisons will be made with other anonymised sites.

Supporting documents to be submitted for ethical approval

- Written consent form
- Participant information sheet
  - Information letter (for patients, visitors and non-chaplaincy staff)
  - Participant information sheet for chaplaincy and chaplaincy-affiliated staff

v3.8, 10/06/2016

The Status and Integration of Minority Faith Groups in Acute

Healthcare Chaplaincy

Participant Information Sheet for Chaplaincy Team Members and Stakeholders

Rationale

Chaplaincy provides an illuminating case study for examining the role of religion in public life and institutions. Healthcare chaplaincy in particular has developed considerably over the past 25 years, especially in relation to the development of multi-faith chaplaincy teams. This has followed acknowledgement by the NHS of the importance of meeting the spiritual and religious needs of patients, visitors and staff. Set against this background of rapid change, the status and integration of minority faith groups in acute healthcare chaplaincies will be examined through a series of case studies at hospital sites across England.

Aims of the Study

While it is understood that chaplaincies centre primarily on the work of paid chaplains who visit wards regularly, this study also recognises the role of faith representatives who are involved in chaplaincy teams in a sessional or voluntary capacity. The project broadly is concerned with:

- Raising the profile of minority faith groups in healthcare chaplaincy and examining the ways in which spiritual care is provided for minority faith communities by NHS Trusts
- Addressing gaps in chaplaincy literature by exploring the role and integration of these groups in healthcare chaplaincy
- Contributing a non-practitioner's account to an academic body of knowledge which is primarily informed by chaplaincy practitioners

Key Questions

Following these broad aims, the study intends to answer the following questions:
- In what ways has multi-faith chaplaincy developed in the past 25 years?
- How do NHS trusts provide for the spiritual and religious needs of minority faith communities?
- How do minority faith representatives/chaplains understand their role and work in a secular institution?
- To what extent are minority faith groups integrated into chaplaincy teams?
- In what ways and to what extent are chaplaincies operating as 'multi-faith' teams? How does the 'generic chaplaincy' model impact on the development of multi-faith chaplaincy?

The Study Team

Jo Bryant is an Arts and Humanities Research Council funded PhD student at Cardiff University, supervised by Professor Sophie Gilliat-Ray and Revd. Canon Dr Andrew Todd.

The Fieldwork

The fieldwork primarily consists of a series of case studies in Trusts across England. This fieldwork will include observations, shadowing and interviews. The fieldwork will also include meeting with national chaplaincy/religious organisations and interviewing key representatives and members of these groups.

What is involved in participation?

This case study will last approximately 8-10 weeks and will include observations, shadowing and interviews. There will be two-week contingency period at the end of the formal case study that will enable the student to address any remaining loose ends.

During the observation and shadowing stages, the student will observe the comings and goings in the chaplaincy offices and shadow minority faith chaplaincy representatives. When shadowing chaplaincy team members, chaplains and chaplaincy representatives will need to briefly introduce the student and the project to patients, visitors and staff they encounter. All participants can request that observations are stopped at any point.

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Chaplaincy team members and stakeholders in chaplaincy will also be asked to take part in an interview that will last approximately 45 minutes to an hour. Permission to audio record the interview will be requested at the beginning of the interview.

If you decide to participate, you will be asked to sign a written consent form that ensures you understand the implications of the study. Patients, visitors and staff will be asked for verbal consent to be observed and given a basic information letter. If patients cannot give verbal consent, the family will be asked if present. You will be able to withdraw during the fieldwork period until around December 2016 (you will be updated with a more specific date, and notified when this deadline is approaching). If you decide you no longer wish to participate, any data collected will not be kept or used without your explicit permission.

If the encounters with patients or staff are of a sensitive nature, you can request that the student discontinues her observations and meets with you after the encounter has taken place.

Will my data be stored securely?

Digital fieldnotes and transcripts will be created and saved on a password protected and encrypted laptop. The notes will then be uploaded onto the Cardiff University network remotely and saved on Microsoft OneDrive for Business (secure cloud storage licensed to Cardiff University). Both the university network and cloud storage are password protected. All electronic copies of notes and transcriptions will be saved onto an encrypted external hard drive as backup. The notes and transcriptions may be referred to or quoted in the final written thesis or other outputs (such as reports and articles). Anonymised data will be stored securely on university networks for up to five years following the end of the project, and may be kept indefinitely on personal encrypted devices belonging to the student. Audio recordings from interviews will be made on an encrypted audio recorder and stored on encrypted devices and networks.

Is my information confidential?

Full confidentiality cannot be guaranteed if information is given which has legal or ethical consequences beyond the remit of the project. When fieldnotes and interview transcripts are written up, all participants will be anonymised. You may be quoted in the report to the Trust and in other outputs. Patients, staff and visitors will not be asked for personal information.

Giving Feedback

If you have any comments about the way the study is being conducted, please do not hesitate to let your team leader, the student or her supervisors know. The transcript from your interview will be sent to you so you can review and feedback on (but not substantially amend) the contents. The student will also present the findings to the chaplaincy team after the study is complete in order to obtain feedback from the team as a whole.

Possible Outcomes

The study will primarily result in a doctoral thesis, which will be available to the public in electronic form at the end of the project. The student will also produce a report for the Trust, as well as articles for academic/professional journals and conference papers.

If a report is produced for the Trust, it may be difficult to keep participants anonymous. However, it will be more difficult to identify participants in any external outputs (thesis, articles, conference papers), particularly as comparisons will be made with other anonymised sites.

How do I send feedback about the project?

Chaplains and staff members will be able to contact me via my email address: BryantJR@cardiff.ac.uk. You can also contact my supervisors, Professor Sophie Gilliat-Ray (Gilliat-RayS@cardiff.ac.uk) and Revd Canon Dr Andrew Todd (andrew.todd@stmichaels.ac.uk) if you have any feedback or questions.

The first patient information letter was used for Westview, Greenacre and Stonehaven. The second letter included a consent form in accordance with the requirements of the R&D department at Riverside. At Riverside, written consent from patients was a condition of obtaining access. The Research and Development department also added the Trust logo to the letter, which has been removed from the copy below.

v1.3, 10/06/2016

Dear Patient,

This letter provides information about a study currently taking place at [Trust name]. I am a student at the Department of Religious and Theological Studies at Cardiff University conducting a study on minority faith groups in hospital chaplaincy. As part of this study, I will be doing observations and interviews to find out how minority faith groups are involved in chaplaincy.

These observations involve following chaplaincy representatives in their work around the hospital. This includes meetings and conversations with patients and visitors. You will be told about the study and asked for permission to be observed.

If you do not wish to be observed, please tell us and I will leave and continue observations after the meeting has finished. If you agree to be observed, I will not request or write down personal details. However I will make notes on the meeting, which will then be typed up and stored securely. If you give permission to be observed, but change your mind during the encounter, please let us know.

The overall findings will be written up in a doctoral thesis and as journal articles, but also may be used to inform future NHS guidelines and policy about chaplaincy. In the short term, a report on the chaplaincy service will be produced for the Trust. You will not be identifiable in these outcomes.

If you would like to provide feedback about being observed, you can contact the hospital chaplaincy team who will pass on any comments, or you can contact me at BryantJR@cardiff.ac.uk.

Many thanks and best wishes,

Jo Bryant
PhD student
Department of Religious and Theological Studies
School of History, Archaeology and Religion
Cardiff University

Dear Patient,

This letter provides information about a study taking place at [Trust name]. I am a doctoral student at the Department of Religious and Theological Studies at Cardiff University conducting a study on minority faith groups in acute hospital chaplaincy. As part of this study, I will be doing observations and interviews to find out how far minority faith groups are involved in chaplaincy.

These observations involve following chaplaincy representatives from minority faith groups in their work around the hospital, including meetings and conversations with patients and visitors. You will be told about the study and asked for consent to be observed.

If you do not wish to be observed, please tell us and I will leave and continue observations after the meeting has finished. If you agree to be observed, I will not request or write down personal details. However I will make notes on the meeting, which will then be typed up and stored securely. If you agree to be observed, but change your mind during the encounter, please let us know.

The overall findings will be written up in a doctoral thesis and as journal articles but also may be used to inform future NHS guidelines and policy about chaplaincy. You will not be identifiable in these outcomes.

If you would like to provide feedback about being observed, you can contact the chaplaincy team who will pass on any comments, or you can contact me at BryantJR@cardiff.ac.uk.

Many thanks and best wishes,

Jo Bryant

PhD student

Department of Religious and Theological Studies

School of History, Archaeology and Religion

Cardiff University

……………………………………………………………………………………………
…

<table>
<tr><td></td><td>Please
initial</td></tr>
<tr><td>I agree to be observed and understand that notes will be made during the observations.</td><td>☐</td></tr>
<tr><td>I understand that all information collection will be anonymous and I will not be identified at any point</td><td>☐</td></tr>
</table>

Client Signature……………………………………………………………….

      Date………………………….

Researcher signature …………………………………………………

      Date…………………………...

v1.6, 10/06/2016

The Status and Integration of Minority Faith Groups in Acute Healthcare Chaplaincy

Protocol for Shadowing Chaplaincy Team Members

As part of this service evaluation, I intend to shadow chaplaincy team members from minority faith groups in order to see how team members go about their everyday work, how people respond to team members, and to get an idea of what is involved in the chaplaincy role. This sheet supplements the original Participant Information Sheet and is intended to clarify that, by coming to shadow your work, I am asking for your consent as follows:

- I would like to observe your work, accompanying you as you go about your ordinary tasks.

- You can ask me not to accompany you at any time, particularly if there is a sensitive situation where you or another person may feel uncomfortable.

- Any patients or other individuals we meet during the day should be introduced to me. You will need to briefly explain why I am with you, and ask patients whether or not they agree to being observed. Please make sure that all patients are given the patient information letter and have given verbal consent for me observe. If patients do not want me to observe, I will leave the room and meet with you afterwards.

- I will not record details of any conversations, encounters or exchanges if you or other people concerned explicitly ask me not to do so.

- I will not record encounters on an electronic recording device or verbatim, but I will be writing notes as I go for my own reference. If you find this intrusive, you can ask me to stop.

- If anything I do is intrusive or inhibiting, you can ask me to stop doing it.

- I do not require you to dedicate time specifically to speak with me or to do anything different to your normal work. However, it would be helpful if we could talk at the beginning and end of the observations so we are clear about what is going to happen, what has happened and to reflect on the day.

- If an encounter or exchange has taken place in a different language, I would like to set aside some time afterwards for you to summarise the conversation, if possible.

- The notes will be written up and stored securely, as mentioned in the Participant Information Sheet. These notes will be anonymised.

- You will not be directly quoted in the project report and any other outcomes without your explicit consent. Any quotes will remain anonymised.

v1.4, 10/06/2016

Consent Form

Please ensure you have read and familiarised yourself with the Participant Information Sheet before you complete this consent form. Before giving consent, it is important that you know what the study is about and understand the implications of taking part. If you have any further questions, please feel free to ask at any time during the study. Thankyou for agreeing to participate in this study

I have read and fully understand the participant information sheet ☐

I have received satisfactory answers to any questions I have about the study ☐

I understand that participation is voluntary and that I am able to withdraw during the course of the study without having to provide a reason ☐

I understand the terms of confidentiality as detailed in the participant information sheet ☐

I understand that anonymised data will be kept on secure university storage for up to 5 years after the end of the study for the purposes of further research, and may be made accessible to other academic researchers. I ☐

understand that the researcher may keep data indefinitely on personal encrypted devices.

I understand that any information I give will be anonymised and may be quoted in the final thesis, publications, or other outputs relating to the study ☐

I give my permission be recorded using audio equipment (if you do not wish to be recorded, alternative arrangements can be made) ☐

I give my full consent to participate in the project ☐

Participant signature:

Date:

Researcher signature:

Date:

10.9.1 Riverside

Code	Post/Role	Date of interview	Duration	Transcript Type
Interview A	Christian volunteer	03/11/2015	00:20:16	Full
Interview B	Muslim chaplain	04/11/2015; 14/11/2015	01:11:01	Full
Interview C	CofE chaplain (acting lead)	05/11/2016	01:42:33	Full
Interview D	Deputy Chief Nurse	09/11/2015; 03/12/2015	00:32:36	Full
Interview E	PALS officer	10/11/2015	00:23:54	Full
Interview F	Hindu volunteer	10/11/2015	00:23:11	Full
Interview G	Christian volunteer	12/11/2015	00:22:10	Full
Interview H	Jewish chaplain	24/11/2015	01:13:33	Full
Interview I	Hindu chaplain	02/12/2015; 08/12/2015	02:10:00	Full
Interview J	Jewish volunteer	02/12/2015	01:14:00	Abridged
Interview K	Equality and Diversity lead	04/12/2015	00:44:34	Abridged
Interview L	Roman Catholic chaplain	08/12/2015	01:14:00	Full
Interview M	Christian volunteer	09/12/2015	00:12:00	Full
Interview N	Palliative Care Consultant	10/12/2015	00:15:05	Full

Interview O	Roman Catholic volunteer	16/12/2015	00:33:13	Abridged
Interview P	Jewish volunteer	16/12/2015	00:57:48	Full
Interview Q	Muslim volunteer	21/12/2015	01:13:42	Full
			14:43:36	

10.9.2 Northbrook

Code	Post/Role	Date of interview	Duration	Transcript Type
Interview A	CofE chaplain	30/12/2015	01:06:22	Full
Interview B	CofE chaplain	07/12/2015; 14/12/2015	02:33:00	Abridged
Interview C	Sikh volunteer	10/12/2015	00:42:45	Full
Interview D	Equality and Diversity lead	16/12/2015	00:49:34	Full
Interview E	Roman Catholic chaplain	17/12/2015	00:46:06	Full
Interview F	CofE chaplain (lead chaplain)	17/12/2015	01:08:46	Full
			07:06:33	

10.9.3 Westview

Code	Post/Role	Date of interview	Duration	Transcript Type
Interview A	Free Church chaplain (bank)	01/02/2016	00:52:49	Full (Transcript Withdrawn)
Interview B	Voluntary services	02/02/2016	00:46:26	Full
Interview C	CofE chaplain (bank)	02/02/2016	00:59:01	Full
Interview D	CofE chaplain (honorary)	03/02/2016; 10/02/2016	00:50:41	Full
Interview E	Urology Consultants	03/02/2016	00:49:01	Full
Interview F	CofE volunteer	08/02/2016	00:29:27	Full
Interview G	Muslim volunteer	09/02/2016; 22/02/2016	03:31:44	Full
Interview H	Administrator	09/02/2016	01:01:30	Full
Interview I	Free Church chaplain	10/02/2016	00:41:39	Full
Interview J	Muslim volunteer	11/02/2016; 25/02/2016	00:55:48	Full
Interview K	Deputy Chief Nurse	11/02/2016	00:28:08	Full
Interview L	Bereavement Midwife	15/02/2016	00:46:48	Full
Interview M	Christian volunteer	16/02/2016	00:26:37	Full
Interview N	Hindu volunteer	16/02/2016	00:46:45	Full
Interview O	Inter-faith forum representative	17/02/2016	00:56:34	Abridged

Interview P	Inter-faith forum representative	17/02/2016	00:36:03	Abridged
Interview Q	CofE chaplain (lead chaplain)	18/02/2016	03:55:56	Full
Interview R	Roman Catholic chaplain	19/02/2016	00:48:49	Full
Interview S	Bereavement Support Officer	19/02/2016	00:31:59	Full
Interview T	Christian volunteer	25/02/2016	00:38:54	Full
Interview U	Patient Experience Officer	26/02/2016	00:18:53	Full
Interview V	Non-Religious volunteer	17/02/2016	Not recorded	Not recorded; abridged, rough notes only
			21:13:32	

10.9.4 Greenacre

Code	Post/Role	Date of interview	Duration	Transcript Type
Interview A	Muslim volunteer	18/04/2016; 20/04/2016	02:45:56	Full
Interview B	Muslim chaplain	21/04/2016	01:51:07	Full
Interview C	Anglican chaplain	22/04/2016	01:57:45	Full
Interview D	Jain volunteer	25/04/2016	01:10:53	Full
Interview E	Hindu chaplain	25/04/2016	01:58:05	Full
Interview F	Roman Catholic chaplain	26/04/2016	02:03:54	Full
Interview G	Free Church chaplain	27/04/2016; 11/05/2016; 18/05/2016	02:25:05	Full
Interview H	Non-Religious Pastoral Carer	27/04/2016	02:05:42	Full
Interview I	Sikh volunteer	28/04/2016	01:52:23	Full
Interview J	Anglican chaplain	28/04/2016	01:48:57	Full
Interview K	Baha'i volunteer	09/05/2016	00:45:08	Full
Interview L	Voluntary Services Manager	11/05/2016	01:40:00	Abridged
Interview M	Muslim chaplain	12/05/2016; 26/05/2016	01:14:21	Full
Interview N	Equality Lead	12/05/2016	01:07:50	Abridged

Interview O	Jewish volunteer	15/05/2016	00:43:01	Full
Interview P	Roman Catholic chaplain	16/05/2016; 17/05/2016	02:24:50	Full
Interview Q	Patient and Public Involvement Manager	17/05/2016; 27/05/2016	02:00:26	Abridged
Interview R	Assistant Chief Nurse	18/05/2016	00:38:32	Abridged
Interview S	Buddhist volunteer	19/05/2016	00:59:00	Full
Interview T	Muslim volunteer	24/05/2016	00:57:26	Full
Interview U	Chaplaincy Manager	25/05/2016	01:14:59	Full
Interview V	Sikh chaplain	26/05/2016	02:18:52	Full
Interview W	Sikh volunteer	01/06/2016	00:58:59	Full
Interview X	Anglican chaplain	01/06/2016	01:58:26	Full
			39:01:37	

10.9.5 Stonehaven

Code	Post/Role	Date of interview	Duration	Transcript Type
Interview A	ICU Nurse	06/07/2016	00:54:21	Abridged
Interview B	Muslim volunteer	15/07/2016	00:32:07	Full
Interview C	Palliative Care Team	18/07/2016	00:38:13	Full
Interview D	Christian (Anglican/ Free Church) chaplain	18/07/2016; 03/08/2016	02:25:44	Full
Interview E	Palliative Nurse Specialist	20/07/2016	01:05:00	Full
Interview F	Equality and Diversity lead	20/07/2016	00:55:42	Full
Interview G	Muslim chaplain	25/07/2016; 28/07/2016	03:12:09	Full
Interview H	Head of Midwifery	27/07/2016	00:45:04	Full
Interview I	Neonatal Consultant	27/07/2016	00:54:29	Full
Interview J	Muslim chaplain	29/07/2016; 01/08/2016	04:38:12	Full
Interview K	Hindu chaplain	29/07/2016; 09/08/2016	03:32:54	Full
Interview L	Ethnic minority Community Liaison	01/08/2016	01:06:12	Full

Interview M	Sikh chaplain	02/08/2016; 12/08/2016	02:30:23	Full
Interview N	Assistant Chief Nurse	04/08/2016	00:54:39	Full
Interview O	PALS/ Bereavement officer	05/08/2016	00:51:08	Full
Interview P	Managing chaplain	08/08/2016; 15/08/2016; 19/08/2016	04:31:42	Full
Interview Q	Voluntary Services Manager	08/08/2016	00:28:22	Full
Interview R	Muslim volunteer	11/08/2016	00:37:36	Full
Interview S	Muslim volunteer	15/08/2016	00:39:10	Full
Interview T	Administrator	16/08/2016	01:47:04	Full
Interview U	Baha'i volunteer	16/08/2016	00:51:28	Full
Interview V	Hindu volunteer	16/08/2016	00:45:37	Full
Interview W	Muslim volunteer	17/08/2016	00:57:33	Full
Interview X	Non-Religious volunteer	17/08/2016	00:33:56	Full
			36:08:45	

10.9.6 Moorlands

There is missing data for the duration of the recording for the interview with the Anglican chaplain as the audio recording was corrupted. Approximately one hour's worth of interview was recovered from the interview.

Code	Post/Role	Date of interview	Duration	Transcript Type
Interview A	Voluntary Services Manager	12/09/2016	00:32:22	Full
Interview B	Anglican volunteer	14/09/2016	00:26:10	Full
Interview C	United Reform Church volunteer	14/09/2016	01:17:04	Full
Interview D	Business Manager	15/09/2016	00:22:41	Full
Interview E	Roman Catholic chaplain	15/09/2016	01:08:14	Full (Transcript Withdrawn)
Interview F	Anglican volunteer	19/09/2016	00:21:15	Full
Interview G	Christian volunteer	21/09/2016	00:31:16	Full
Interview H	Anglican chaplain	22/09/2016; 23/09/2016		Full
Interview I	Bereavement Officer	23/09/2016	00:20:39	Full
Interview J	Chief Executive	26/09/2016	00:32:27	Full
Interview K	Lead chaplain (Free Church)	27/09/2016	01:34:53	Full
Interview L	Roman Catholic chaplain	27/09/2016	00:19:30	Full

Interview M	Equality and Diversity lead	27/09/2016	00:30:48	Full
			07:57:19	

Most questions below were asked of chaplaincy team members, unless otherwise marked with the following codes:

V = volunteer (all faiths)
MFV = minority faith volunteer
MFC = minority faith chaplain
LC – lead chaplain

Phrasing may be altered to render the questions more appropriate to the participant being interviewed. Questions specific to particular participants have not been included in this general interview schedule.

1. Background
   1.1. How did you first hear about chaplaincy? What motivated you to become involved?
   1.2. How did you get involved?
   1.3. How long have you been a chaplain/chaplaincy volunteer?
   1.4. What was involved in the application process?
      1.4.1. Were you required to provide references?
      1.4.2. What kind of references were requested?
   1.5. What were your expectations/first impressions when you first got involved in chaplaincy?
   1.6. Did you do any training when you started out in chaplaincy? What did that involve?
      1.6.1. What was involved in the volunteer training course?
      1.6.2. Who did you shadow when you were trained?
      1.6.3. Has anybody shadowed you for their training?
      1.6.4. If you were shadowing or being shadowed by a team member of a different faith, can you reflect on your experience of that?
   1.7. Have you received any further training after your initial training?
   1.8. Have you received any chaplaincy-specific training external to the Trust? *(e.g. St Michael's, Markfield, Guys and St Thomas)*
   1.9. Do you have a role in your faith community? What is involved in that?
   1.10.   Do you have any other chaplaincy roles?
   1.11.   Is there a difference between being a visiting community leader [imam/rabbi/priest] and a chaplain?
   1.12.   Do you have any prior experience of multi-faith working? What was involved in that?
   1.13.   What do you do outside chaplaincy? If retired, what was your previous occupation? Has this experience helped in your chaplaincy work?

1.14. What do you know about the beginnings of multi-faith working in this chaplaincy team? **[LC]**

1.15. Do you need to be a scholar or religious leader to be a chaplain?

1.16. What changes have taken place in the chaplaincy team in your time here?

1.17. **[For those with counselling skills/qualifications]** How does chaplaincy differ from counselling/psychotherapy?

2. Role

2.1. What is involved in your role as chaplain/chaplaincy volunteer?

2.2. Are you available for on-call? Are you paid for on-call? **[CC, MFC]**

2.3. How often are you approached to translate for staff or patients?

2.4. What is your role beyond patient visiting? *(e.g. staff support, advocacy, consultation, publicising chaplaincy)*

2.5. Do you have a role in recruiting volunteers? **[LC, CC, MFC]**

2.6. Do you have a role in mentoring, training, or co-ordinating volunteers? *(same faith, mixed faith?)* **[LC, CC, MFC]**

2.7. Do you engage in any institutional roles? *(e.g. Trust induction, MDTs, committees, teaching)*

2.8. In what circumstances do you provide hospital funerals? **[CC and occasionally MFC]**

2.9. Are you involved in organising festivals, celebrations, or regular prayers?

2.10. Have you been approached about participating in the Sikh Day of Prayer? **[LC]**

2.11. Do staff understand your role?

2.12. Do patients understand your role?

2.13. Does your community understand your role? **[V, MFC]**

2.14. What is the difference between paid and voluntary chaplaincy team members? What benefits are there to having paid minority faith team members?

2.15. What are the primary barriers and challenges from fulfilling your chaplaincy role?

2.16. What was your most challenging encounter?

2.17. What was your most challenging encounter with someone of a different faith (if any)?

2.18. What was your most memorable encounter?

2.19. How would you expand or develop your role? **[MFV, MFC]**

2.20. Who have you asked about extending your hours? **[MFV, MFC]**

2.21. Is there a system by which cover is provided if you are unavailable?

2.22. Do you do any community follow up/visits to discharged patients?

2.23. Does the role of Christian chaplains differ from the role of minority faith chaplains? If so, how?

3. Working Practices
    3.1. Do you have access to patient information? How accurate is patient information? *(ask lead chaplains about whether there is specific Caldecott Guardian interpretation)*
        3.1.1. Have you identified patients of the same faith that weren't on your list?
        3.1.2. How do you identify these patients? *(e.g. asking ward staff, checking patient information boards on the ward)*
    3.2. How do you prioritise your workload? Which wards do you prioritise?
    3.3. Do you primarily visit patients of different faiths or do you see everybody? Did you *expect* your role to be religion-specific or generic?
        3.3.1. *[If engaged in faith-specific visiting only]* Have you ever visited a patient from a different faith?
        3.3.2. *[If visiting is list-based]* Do you visit patients who are not on your patient list?
        3.3.3. Have you ever had any mixed-faith encounters? *(e.g. patients with families or partners of a faith different to theirs)*
        3.3.4. Have you ever visited patients of the opposite sex? **[mostly applicable to Muslim chaplains and volunteers]**
    3.4. Can/should minority faith chaplains work generically? **[CC]**
    3.5. Should chaplaincy demonstrate its impact? Why or why not? **[LC, CC, MFC]**
    3.6. How would you describe your relationship with staff? Are ward staff co-operative?
    3.7. How do you introduce yourself to patients? *(chaplain, rabbi, priest, imam, pandit?)*
    3.8. What boundaries are there to your role? Is there anything you can't or should not do or any wards you can't access?
        3.8.1. Do you pray with patients? Do you wait for patients ask for prayer or do you offer it? How do you pray – by the bedside, or in your personal practice?
    3.9. How often do you refer patients to other chaplains/chaplaincy volunteers?
    3.10.   What are the advantages and disadvantages to wearing the clerical collar? Why have you chosen [not] to wear it? **[CC]**
    3.11.   What mechanisms for auditing and record keeping are in place?
    3.12.   Which departments do you have the most contact with?

4. Recruitment Practices and Community Links **[mostly LC]**
    4.1. When did the team develop a multi-faith approach?
    4.2. How were chaplains recruited/selected?
    4.3. How are volunteers recruited?
        4.3.1. Have there been any disagreements with other parties (e.g. chaplaincy colleagues or voluntary services) involved in recruitment regarding suitability of volunteers?

4.3.2.　How were these resolved?
4.4. Is there a list of community contacts that you can call in?
4.4.1.　How do you select/recruit/approach community contacts for the list?
4.4.2.　How often do you call somebody in from the external contact list?
4.4.3.　How often do you update your community contact list?
4.4.4.　What is the procedure for calling in an external contact?
4.5. What is involved in volunteer training courses? **[LC, CC, MFC]**

5. Team Relationships
5.1. How much contact do you have with the chaplaincy manager/lead chaplain?
5.2. How much contact do you have with the (other) minority faith chaplains?
5.3. How would you describe your relationships with your colleagues? *(paid chaplains, volunteers of the same faith, volunteers of a different faith)*
5.4. Have you attended any social events with the chaplaincy team?
5.5. Are you involved in team meetings? How often do they take place?
5.6. Is there opportunity for you to debrief? How and when?
5.7. Do you feel supported by the chaplaincy team? How do they support you?
5.8. Have you asked chaplaincy colleagues for advice? What kind of issues have you asked about?
5.9. How much contact do you have with your line manager (e.g. Deputy Chief Nurse)? **[LC]**
5.10.　　How has the team been affected by changes in leadership (if at all)?
5.11.　　How has the team changed since you joined as lead/managing chaplain? What changes have you made? **[LC]**
5.12.　　**[If applicable]** Why is humour and banter important among chaplaincy colleagues? Is there anybody you feel more or less comfortable having a joke with?
5.13.　　Does the team do annual appraisals?

6. Prayer facilities
6.1. What are your thoughts on the prayer facilities provided by the chaplaincy?
6.2. Do you have a role in monitoring the prayer facilities?
6.2.1.　Do you monitor literature left in the prayer facilities? What do you look out for? What counts as 'inappropriate' literature?
6.3. Have there been any disputes or tensions about the use of the facilities by people of different faiths? How have these been resolved?
6.4. Do you have a mentor/supervisor/community member who supports you in your role? **[MFC]**
6.5. Do you know any other chaplains [from your faith background]? Where are they based and how do you know them? [MFV, MFC]

6.6. Have you requested advice from other chaplains external to this Trust?

6.7. What other resources do you draw on to support your work? **[MFV, MFC]**

6.8. Which sources do you draw upon for ethical rulings? **[MFV, MFC – especially for Jewish and Muslim representatives]**

6.9. What links have you made with local faith communities? How often do you consult with them? **[LC]**

7. General questions

7.1. What is chaplaincy?

7.2. What are the precedents for chaplaincy in your faith tradition? **[MFV, MFC]**

7.3. What is generic chaplaincy?

7.3.1. Is generic chaplaincy an appropriate model for meeting needs of a diverse population?

7.4. What is spirituality?

7.5. What traits and skills are important for being a chaplain/chaplaincy volunteer?

7.6. What are your views on the involvement of non-religious representatives in chaplaincy?

8. National picture **[MFC and CC only]**

8.1. Are you aware of any chaplaincy organisations or national level bodies? *(e.g. CHCC, HCFBG, UKBHC)*

8.2. Are you involved in teaching/delivery of chaplaincy courses? *(e.g. Markfield, NCHT course, Sikh chaplaincy UK, universities)*

8.3. What is your relationship to general national representative bodies for your religion? *(e.g. Muslim Council of Britain, National Council of Hindu Temples, the Hindu Forum of Britain, the United Synagogue/Board of Deputies)*

8.4. Are you involved in any of these organisations? If not, why not?

8.5. Are you aware of any chaplaincy guidelines? Which ones?

10.10.1 Site Specific Questions

Riverside

1. Multi-Faith User Group (MFUG)
    1.1. Are you involved in the MFUG? [MFV, MFC]
    1.2. How did the MFUG start up? What did it intend to do?
    1.3. Have you engaged with in consultations with local faith groups *outside* the MFUG?
    1.4. How did you get representatives from local faith groups involved?
    1.5. What issues have been raised by the MFUG?
    1.6. What has been achieved? What has been less successful?
2. Facilities for Prayer and Worship
    2.1. What are the limitations of using the chapel for worship? **[Hindu chaplain]**
    2.2. Do there need to be facilities to enable Jewish practice (e.g. Shabbat Room)? **[Jewish chaplains and volunteers]**
3. Team Relationships
    3.1. How are decisions made in the team? **[CC]**
    3.2. Should the Muslim, Jewish and Hindu chaplains be involved in decision-making about the team? **[CC]**
    3.3. What do you know about the working practices of the team at the sister site? **[CC, MFC]**

Northbrook

1. Working Practices
    1.1. How do you know when a chaplain/community contact should be called in for a patient? What are the criteria for making a call-out?
    1.2. What do you know about the working practices of the team at the sister site? [CC]

Westview

1. How did the relationship with [the local inter-faith forum] come about?
2. Leadership
    2.1. What changes have taken place since the lead chaplain came into post?
    2.2. The lead chaplain has been building a business case for a substantive Muslim post. What do you think the impact will be?
3. Facilities for Prayer
    3.1. In what ways has the chapel space been misused?
    3.2. How long was the chapel used for Muslim prayer? When did this change?
4. What is the purpose of the faith stats?

Greenacre

1. Working practices
    1.1. What are the stickers in the patient notes for? When was that introduced? **[CC, MFC]**
    1.2. How did the spiritual care liaison[50] programme start? How are you involved? **[CC, MFC]**
    1.3. There has been some resistance among volunteers about the new volunteer uniform; how did that come about and what were the objections?
    1.4. The team has quite a few meetings for team members; which ones do you attend and which ones are you encouraged to attend?
2. Team Relationships
    2.1. Were you consulted about the spiritual care policy?
    2.2. Were you consulted about the development of the new multi-faith prayer facilities?
    2.3. Team members reported some resistance the introduction of the non-religious pastoral care role; what were the objections to it?
    2.4. Some team members have expressed concerns about the level of engagement of minority faith chaplains, what are your thoughts? **[CC, MFC]**

Stonehaven

1. Role and Remit
    1.1. How did the trimonthly burial service come about?
    1.2. Why are chaplains not permitted to translate for patients or staff?
    1.3. How has your role changed and how do you see it developing? **[Muslim chaplains]**
    1.4. How often do you attend funerals of patients who died in hospital? **[Muslim chaplains]**

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[50] Rephrased to preserve anonymity

2. Team Relationships

    2.1. The team engage in a lot of banter – why is humour and banter important? Has anyone overstepped boundaries for appropriate humour? Who do you feel comfortable or uncomfortable joking around with?

3. Prejudice and Racism

    3.1. Can you give examples of staff treating you differently to your Christian colleague? **[Muslim chaplains]**

    3.2. Some colleagues have reported being on the receiving end of racist attitudes from staff and patients, has that happened to you? Can you give any examples? **[Muslim chaplains]**

4. What prompted the review of chaplaincy in 2012?

5. Why is it important to have separate Sikh and Hindu chaplaincy posts? What was involved in making the case to introduce the posts and subsequently increase the hours? What has been the impact?

Moorlands

1. What is the difference between volunteers, honorary chaplains, and paid chaplains?

2. How often do you come across patients from different faiths?

3. Have you ever called in a minority faith representative? Under what circumstances do you make a referral?

4. What is the purpose of the morning prayer meetings?

1. Background
    1.1. What is your role in the Trust? How long have you been in post?
    1.2. What is your relationship to the chaplaincy team?
        1.2.1. How does chaplaincy relate to your department?
        1.2.2. Where does chaplaincy sit in the Trust structure **[chaplaincy line managers]**
    1.3. When did you first hear about chaplaincy?
        1.3.1. Did you know about chaplaincy before you started working with chaplaincy?
        1.3.2. Has your understanding changed since then?
    1.4. Have you worked with chaplaincies at different Trusts? How does your experience of working with each team compare?

2. Understandings and Awareness of Chaplaincy
    2.1. What is chaplaincy?
    2.2. What is the role of chaplaincy?
        2.2.1. Does chaplaincy have a role beyond patient visiting?
    2.3. What is the role of the volunteers? What is the difference between the volunteers and the paid chaplains?
    2.4. How does chaplaincy contribute to the institution? What is its significance?
    2.5. What is spirituality?
    2.6. What does chaplaincy/spiritual care offer or contribute to the NHS and to the Trust?
    2.7. How does chaplaincy help the Trust meet its objectives (if at all)?
    2.8. Are you aware of any chaplaincy-specific organisations or guidelines?

3. Contact with chaplaincy
    3.1. Have you met all members of the chaplaincy team?
    3.2. Which chaplaincy team member do you have the most contact with?
    3.3. How often do you see the chaplaincy team/particular members of the chaplaincy team?
    3.4. Do you work alongside chaplaincy in the Trust? What kind of things do work together on? *(e.g. sit on the same committees)*
    3.5. Are you aware of the celebrations organised by chaplaincy? What does this include?
    3.6. How often do you call upon the chaplaincy team? Which chaplains are you most likely to work with?
    3.7. Have you asked chaplaincy to advise on or mediate for an equality issue?
    3.8. Have you personally made use of the chaplaincy team?

4. Assessing chaplaincy
    4.1. What accountability mechanisms are in place for the chaplaincy?
        4.1.1. How do/would you assess the effectiveness of chaplaincy?
        4.1.2. What metrics would you use to assess the impact of chaplaincy?
        4.1.3. Have patients, visitors or staff fed back to you about the chaplaincy? What kind of feedback have you received?
    4.2. What could chaplaincy develop or improve?
    4.3. What does chaplaincy do well? How do you know chaplaincy is doing a good job?
    4.4. How, if at all, has chaplaincy evolved or changed in the time that you've been here? What, if any, has been the impact of the change of leadership of the chaplaincy? **[asked at Westview, Stonehaven and Moorlands]**
    4.5. Are the facilities for prayer and worship adequate? What needs to be improved or developed?

5. **Volunteer base (voluntary services managers only)**
    5.1. How far do you have a say in which volunteers are selected for chaplaincy?
    5.2. What do you look for when recruiting volunteers?
    5.3. On what grounds would you find a prospective volunteer unsuitable? How often have you found prospective volunteers to be unsuitable?
    5.4. Have there been any disagreements between you and chaplaincy about suitability of volunteers?
    5.5. Do you have any input for the training of chaplaincy volunteers?
    5.6. What is the proportion of chaplaincy volunteers compared to other volunteers? What is the relative turnover of different volunteer groups?
    5.7. How do chaplaincy volunteers differ from other hospital volunteers?
    5.8. Are chaplaincy volunteers primarily accountable to you or to the chaplaincy?
    5.9. What can and can't volunteers do according to Trust policy? What are the boundaries for being a volunteer?

10.12 APPENDIX 11: INTERVIEW QUESTIONS FOR INTER-FAITH FORUM

       STAKEHOLDERS

Used only at Westview.

1. Background
   1.1. What is your role in the inter-faith forum?
   1.2. What is your role in your faith community?
   1.3. Do you just connect with places of worship or with other community organisations? Do you have links with other inter-faith groups?
   1.4. How did you first hear about chaplaincy?
2. Collaboration with chaplaincy
   2.1. How did the collaboration come about? How long ago?
   2.2. What were the aims and objectives of working together?
   2.3. Has the change in the leadership of the chaplaincy team impacted on the nature of the collaboration? How?
   2.4. What was the rationale for working alongside chaplaincy?
   2.5. Whose idea was it to do the tour of local places of worship for the chaplaincy team? What was the feedback?
   2.6. How might engagement/collaboration be developed further?
   2.7. What can chaplaincy do to develop or improve?
   2.8. The lead chaplain is putting together a case for a paid Muslim post – what do you think will be the impact?
3. Understandings
   3.1. What is chaplaincy?
   3.2. How can hospitals best provide for spiritual needs of people from various faith groups? How can chaplaincy best provide for spiritual/religious needs of patients?
   3.3. What are your thoughts on the current prayer facilities? What might be a desirable design? (prompt: generic or multi-faith?)

Speaker	Transcript
Researcher	Can you tell me first how you got involved in the chaplaincy?
Interviewee U	Um [the female Muslim chaplain] introduced it to me...I used to...I asked her about how... what her job involves and that and I really admired that she would take out time of the week and...I wanted to do something like that, just visit sick patients in hospital so she introduced me to the voluntary side of things and how to get on board.
Researcher	What is it about visiting the sick that appealed to you?
Interviewee U	Urm...what I find now since I've started is that sometimes...they make you feel...although you come in with the intention of trying to make them a bit better, trying to make them feel a bit lighter, you leave...you tend to leave the hospital with them making you feel better. Because sometimes we have like low days obviously as well and...it's...just a realisation that no matter what you're going through in life, there's always people worse off and just that appreciation that you know you have your health.
Researcher	And how is it you know [the female Muslim chaplain]?
Interviewee U	Family friends.
Researcher	How long have you been involved in the chaplaincy for?
Interviewee U	Well I think I'm in my fourth year now.
Researcher	[section redacted]
Interviewee U	[section redacted]
Researcher	What were your expectations when you first came into the role?
Interviewee U	Er...I didn't have any expectations really, for me it was just... I just landed the role of voluntary chaplain when I specifically wanted to be in the chaplaincy sector of voluntary services. Erm, I had no expectations, it was just I didn't want to disappoint patients. Yeah. My whole aim is to visit a patient and to leave them in a slightly more cheerful mood than when I first started visiting them.
Researcher	I know it was four years ago, but what can you tell me about the recruitment and application process to become a volunteer?
Interviewee U	Yeah we get interviewed, certain forms we have to fill in, and get interviewed by...I was interviewed by [the lead chaplain] and a

	member of the voluntary services, and then I had to be member of the Trust for three months I think before I could actively start volunteering and then also before that there was induction days that we had to attend, what to do...the dos and don'ts of what to do on the ward and...how to deal with patients' requests and that...if they surpass our expertise so yeah.
Researcher	Did you receive any specific mentoring or training specific to chaplaincy?
Interviewee U	Yes, [the female Muslim chaplain]...was my mentor for the first few visits that I did. When she was happy with the way I was visiting those patients, that's when I started doing it on my own really.
Researcher	Have you received any other training in relation to chaplaincy?
Interviewee U	No. Haven't had any. I do...I do studies privately so I don't know if that... it's got nothing to do with the hospital but I'm doing a course in Islamic studies as well, which helps my chaplaincy.
Researcher	[Where do you study?]
Interviewee U	[...] it's privately, it's er... based at the [school name] in [location]
Researcher	Does it help with your understanding of chaplaincy?
Interviewee U	I actually started chaplaincy before I started the course, but since I started the course, it helps me to appreciate it a lot more, um the benefits for myself as well as for the others whilst doing the chaplaincy so yeah. It's opened my eyes to a lot more, mm.
Researcher	Why did you do the course and what did you expect out of it?
Interviewee U	Um I wanted a deeper understanding in my own religion, yes..er... I wanted to...my aim is to be able to...I read the Qur'an now, my aim is to be able to read and understand it as well, so that's the reason for me doing the course.
Researcher	Do you have any roles here in the Muslim community in [location]?
Interviewee U	No
Researcher	Before starting working in the team, did you have any prior experience of working in a multi-faith setting?
Interviewee U	Erm...worked in schools before, voluntary again, primary schools was my...where my children were, yeah, that's about it. Mainly been a full-time mum [laugh]

Researcher	You've mentioned that you were specifically interested in healthcare chaplaincy and visiting patients, are you aware of any other forms of chaplaincy?
Interviewee U	Yeah, the prison area...um...mental health, schools...schools is something I would like to go into I think.
Researcher	And have you heard of any Muslim involvement in chaplaincy in schools at all?
Interviewee U	No, and sadly...there's not a requirement like...in my own children's school they do have a chaplain but it's a Christian based chaplain um and I feel that they don't see the need to have a Muslim chaplain although it's predominantly Muslim now, that school. Would be nice to have one.
Researcher	The only context where I've heard schools having a chaplain is a Church of England school...
Interviewee U	No, it's a local school [names school]
Researcher	And do you know anybody who works in these other sectors of chaplaincy?
Interviewee U	I recently met one, at the training day that we had two weeks ago, [name] […]
Researcher	What does your role as a chaplaincy volunteer involve?
Interviewee U	Talking to patients, um generally, general social talk about family, friends, what they do in their life, um...what they're feeling, how they're feeling that day, um...spiritual care, sometimes they want you to pray for them, sometimes they just want you to be quiet, and just like quiet company. Sometimes they just...yeah, praying for them. And sometimes they just wanna have a chat and offload, it's just they've got a lot of problems mentally and family problems and whatever and they just need somebody to listen, to um... we just sit and we listen to what they have to say.
Researcher	With the more spiritual things, do patients request prayer or do you offer it?
Interviewee U	I offer it, but er...more than not, I offer it. There's been one or two instances where they've requested, yeah. And I've been one or two cases where the patient is not responsive at all so I just go and pray, yeah.

Researcher	Have you ever prayed for patients outside the hospital, is that something that you do?
Interviewee U	Yes I do, yeah, mainly with family and friends, when they're ill... to visit them...or maybe close to dying as well, and also after death, we generally, we do pray by our dead, so...something that we do.
Researcher	And what is your understanding of the purpose of prayer in these situations?
Interviewee U	Prayer... [sighs] brings God's assistance, we believe, it...it lightens the burden that the patient is feeling, I believe at that time as well. I've been in cases where...particular woman I can...she...I taught her a few verses from the Qur'an and she prayed it and she said "I already feel lighter praying it." It spiritually uplifts them as well, I believe it [inaudible] a lot of their issues as well. It takes their mind of as well sometimes. It takes their mind off what happening around them and it makes time pass, 'cause sometimes sitting in the hospital can be very lonely, especially if you're not understanding what's...TV is playing but it's not in your language or...you can't read the books that are available. So it's something for them to focus on.
Researcher	When we were out shadowing today I noticed you didn't pray with anybody, is it rare to pray with people?
Interviewee U	To be honest I only pray if they...if I offer it and they say yes, or if they ask me to. I don't generally like...I do my silent prayers for them, but I don't generally like to force it on them, um...because sometimes patients think if you're praying it's like last rites...they're not going to come out of it and I don't want to worry them in that way and yeah and I offer it to them if they...that's why when I introduce myself and services I say I can pray for you if you want, giving them the opportunity to then ask, to say you know pray for me or can you pray something. Only sometimes have they asked, have they replied to say pray something, and that's when I would pray. Or if a patient is in like intensive care where they're not responsive, I would just pray anyway.
Researcher	[…]
Interviewee U	[…]

Researcher	[You also do general ward visiting] Why were you interested in doing that?
Interviewee U	Um because I wanted to...reach out to the wider community, not only to the Muslim patients. 'Cause I think as a role, chaplain...when you say chaplain, people generally think religious, something to do with religion and...from what I've learnt coming here, it's not only that role that you play, sometimes you just a friendly ear to people and that's what I wanted to be to the wider community and...I feel like when I'm walking on a ward and I'm just going to see the one person and there's...I know there's other people on that ward that would like a little chat and...I've not been able to sit by them and introduce myself to them, I just go and say hi, are you OK because I've been limited to just sticking to the Muslim female patients and I wanted to broaden my horizon and also broaden their horizons to say you know, I'm dressed like this but that doesn't mean I'm just about one thing. I'm human as well [laughs]
Researcher	You mentioned that earlier, that people do seem to make assumptions based on what you're dressed...could you reflect on how people have responded?
Interviewee U	It's...it's been very diverse. I've had lovely ladies giving me a bright smile, saying "how are you dear?" 'cause I've been waiting to see a patient and, you know, they want to chat and...we'll get talking about it and then you know eventually little comments like "so this thing that you wear, this what do you call it a headscarf?" and "why do you wear that?" and "why do some women cover their faces?" and "you know, some women wear it so beautifully" and "I like how you've worn it, so why do some ladies think they need to cover everything up?" You know, it's...they have a lot of questions and I think that's also my reason for wanting to talk to non-Muslim members as well, being able to explain my faith not...preaching to them, but they might have questions about my faith that I could answer, you know.
Researcher	Is it appropriate to call that da'wah or is that too strong a word to use?
Interviewee U	I wouldn't say da'wah because I'm......oh...da'wah is too... [clicks tongue] I think... to preach...to explain... I think so, maybe in a way

	it is. Because I'm ex-...without er...physically talking to them about Islam, I'm explaining...why I do certain things or why I wear certain things...so yes. Enlightenment, which could be da'wah, yeah.
Researcher	How often have you been out to visit generally?
Interviewee U	Oh, quite often.
Researcher	How does that compare to visiting just the female Muslim patients? Is there any difference?
Interviewee U	Er...there's a lot of similarities, for sure, um...but whereas with the Muslim patients I will talk about, I will mention God and ask them to remember me in their prayers...I've asked non-Muslims to remember me in their prayers as well, but er...I don't...I'm not very spiritual with the non-Muslim patients. But sometimes they...if it's a Catholic, they'll openly...they like to talk...and if it's a religious person they'll talk about...as Catholics this is what we do and then I'll pick up the similarities 'cause we do have similarities just to show them that in many ways we're very similar. Not to scare them off really, that's my point [laughs]
Researcher	And have you visited male non-Muslim patients at all? Do you prefer to stick to female patients?
Interviewee U	Erm...I have not visited, no, no. I'm a shy person generally so... for me to come out of my zone and... [inaudible] I love it, but it's work for me, so I...I hope to get there eventually, with a bit more confidence. Yeah.
Researcher	Would there be any problems in terms of your faith with visiting non-Muslim male patients? Is it more a personal thing?
Interviewee U	There's a bit of faith in it as well, but personally I have [visited] non-Muslim male patients, but because they've been friends of mine in the past, not as a chaplain, privately, I would definitely like to visit like elderly male patients, that would be some...something I'd like to do. The younger males I don't know, I don't think I would be comfortable with that, I don't know. Mmm.
Researcher	Do you think there's a difference between your role and [the female Muslim chaplain]'s role?
Interviewee U	No.
Researcher	So the paid chaplains […] do similar things to what you do?
Interviewee U	Yeah.

Researcher	Are there any limitations or boundaries of what you can do in your role?
Interviewee U	As a volunteer chaplain?
Researcher	Mm.
Interviewee U	Erm... no, not really.
Researcher	And I'm told a couple of times you've responded to call-outs […]. How often has that happened?
Interviewee U	It's happened a couple of times, er... And...one time mainly I remember it was for a young girl who just suddenly passed away, you know, was called out, and [the female Muslim chaplain] wasn't available...um.. [inaudible] It was a shock, it was a shock for me as well, [redacted: young girl brought in who suddenly fell critically ill] and I was called on, and that was the first time I was actually on-call as well, because they requested the female Muslim chaplain although [the male Muslim chaplain] would have been available.
Researcher	Could you reflect more on what happened? How did you feel about it?
Interviewee U	I was actually here doing my rounds when I got the call and I...I switched the phone off a few times before I interrupted the patient and said "I'm so sorry, let me just answer this", 'cause on my phone it's rung unknown so I didn't even know it was the hospital switchboard calling. And then it was [Site A] switchboard calling to say we've had a...she's critical, at that time she was critical […] and family's requesting a Muslim chaplain, so I got there as quick as I can but um...by the time I got there she had just passed away...um, now...at [Site A] they...the deaths that happen, they have a relatives' room, bit like the quiet room, um...so at the...at that time I didn't go where the girl was, where she had passed away, but was really with the family, extended family because in that little room she had her parents and her siblings were there and I didn't feel it was my right to be there, unless they requested it. And they were aware that I was...because family member made them aware of it but erm.. I...I decided I would only go in if they needed me and they didn't ask for me, so I was in the other room, in the visitor's room with the extended family and her sister...her brother was there as well. So I was pretty much there the whole day, only when now they wanted

	to take her down to the mortuary um...did the parents then leave her and that's when I met them and had a chat with them […] so I had a quick word with the mum and she asked me to stay and see her...the girl's mum. Um...until the nurses actually came, because the nurses didn't want to take her away whilst the parents were still there so I stayed with her until nurses came and then did whatever they needed to do, take out the cannulas and all of that, prepare her for the mortuary. And they were appreciative of that. I got a call from [a chaplain] as well, but it was...it stayed with me a few days, it did...er...it was the first time I think I had come across death in my role as a chaplain. I've seen death before naturally in my family and that, but...having the role of the chaplain, and at the same time I was very much aware of whether I was overstepping my boundaries. I wasn't sure what the boundaries were, was quite blurry at that time, you know? And I'm not a person to step on people's feet so...hover round in the background unless...until you ask for me. Um...but yeah, it was an experience.
Researcher	When [one of the chaplains] called you up, was that a kind of debriefing?
Interviewee U	Debriefing and also to say that if you need to chat, you know we're here and also that we... I think he got feedback from [Site A] to say I did a really good job, not that I was waiting for that, but I was just there as support so... I'm glad...I'm glad they appreciated it. It was nice to have that feedback. I was still...after I got home that day, and it was a long day, um...I was unsure whether I'd fulfilled my role as a chaplain, as I should. So it was nice to get that bit of feedback.
Researcher	Why did you think you hadn't fulfilled the role?
Interviewee U	I think that's me as a person...and you know, you have to tell me whether I'm doing OK or not, I'm very unsure of myself and er...again, like, I don't like to offend people or...not to do something as the role specifies. Chaplain is not...I can't even say it's a role, it's just...did I do what I needed to be there, was I doing what I was called to do? That's what I needed to know and 'cause I had not had experience in that area at all and I think I did.
Researcher	And you mentioned it was quite difficult and a bit of a shock, how did you deal with that to support the family?

Interviewee U	Yeah, it was a shock. Um...again I go back on my religious beliefs, um... in...God...there's an explanation, in religion there's an explanation, everything that God does...and I had to deep...dig into my knowledge to be able to give support and strength to the family so you're saying things like, you know, "God loved her. God takes those he loves first. And there was something definite she was doing right for God to want to have taken her." She didn't suffer, it was literally minutes, you know, that she went in, um... just...giving them support, that she...she went in her grandmother's lap, hopefully she prayed what she needed to pray, you know, she was a good girl, she was a good person, so just giving them support, helping them...at that time it's everything...you need to say things and do things that makes them strong, makes them feel, you know, slightly positive, give them hope, you know things like "you're gonna see her again, this is not the end."
Researcher	You said you have that religious knowledge, where did you learn these things?
Interviewee U	I've grown up...growing up, I've grown up in quite a religious environment, my..,er...religion's been a very important part of my life, from young so I attended the traditional madrassas as well growing up, so knowledge from that, and then my own self-study over the years, er... I myself went through, you know, I find when you go through hard times in life and we all do, I mean, few years ago 2008 we had a sudden death in my immediate family […] that was a very dark time for all of us and...er...I reconnected with God and it...it explains a lot, you know? Especially when you lean back in your religion and you search for answers within your faith, you find them... er....rather than just not knowing, that not knowing kills you half the time, so it's being able to share what I learnt with other people, little stories like, you know, the angels are taking her soul up right now to heaven to meet God and then she'll be meeting members of the family that have passed on so she's with family, don't think she's alone, she's not on this journey alone, she's with somebody. You know and because of her belief she's gonna be in paradise, you know? Her beliefs will...because there's nothing to worry about, she wasn't a girl who went astray or who was on drugs

	or anything, she was a good girl. There's no reason for you to be worried, but naturally as parents as the nature of things go you never, you never dream that your child will go before you.
Researcher	You've mentioned religious knowledge and you also give out the prayer books with the ayas in them, are there are any other resources from Islamic tradition that you draw on either to support yourself or to support patients?
Interviewee U	Erm...I listen to lectures a lot, I ask advice from scholars er...I read other books as well, stories of the...our pious predecessors. Yeah.
Researcher	Are there any particular scholars you draw on?
Interviewee U	Um...I don't know if you've heard of Mufti Menk.
Researcher	I haven't.
Interviewee U	He's on YouTube if you want...he's a family friend as well and um... Nouman Ali Khan, he's another one, he's on YouTube, they have their lectures and specifically based on...death, or the sick, or family or whatever.
Researcher	And in a couple of instances this morning you were speaking in different languages, which languages do you speak?
Interviewee U	I speak Urdu, Kutchi, I understand Gujarati but I'm not very well speaking it, um... and English.
Researcher	Have you been asked to translate by staff at all?
Interviewee U	Yes, a few times that happens.
Researcher	Has that ever been for medical stuff or just general...?
Interviewee U	Medical stuff, mainly...drugs, yeah. They're taking enough drugs, sometimes patients don't want to take a drug, and they've asked me to explain this is why they have to. Or if they're in pain, sometimes patients asking me to tell the nurse that they're in pain 'cause they can't translate, um...so yeah, it's just telling the nurse that she's in pain. Nurse will say "well we've given her the medicine but we can't give her any more until certain time after, so..." Yeah.
Researcher	Do you do any work with staff, do you build a relationship with staff at all or is mostly patient centred?
Interviewee U	Mainly patient centred.
Researcher	Do patients, staff and visitors understand your role?

Interviewee U	Patients, a lot of the time don't understand the role. Sometimes [laughs] the elderly...one certain old lady, she would... "oh OK, so can you get me a cup of tea please? I want something to read, can you go get me something from downstairs to read?" or "can you go and get me a packet of crisps?" I'm like, no, that's not my role. I don't...I can sit here and talk to you, that's about all I can do. Um, there's been a...once or twice, I've been tempted on the stroke ward to feed um because patients trying to feed themselves were missing their mouth completely. Quite a mess and nobody was around to help her. Er...I was reminded very nicely that...that's not in my role as the chaplain, obviously, I'm not trained to feed someone...I guess it's instinct. Just to want to help somebody.
Researcher	So you did help out but you were told...
Interviewee U	Er, no...I asked and that's when I was reminded. Yeah.
Researcher	You mentioned patients from Asian backgrounds might find it difficult to open up, how do you work with that?
Interviewee U	You sit and you talk to them, then I would just like...if they're very quiet and giving you the one answer, because they're not sure what you're doing there and sometimes they think...that if I tell them something that they're gonna go and report it somewhere and that's what their main fear is so you just try and sit and you talk and get them comfortable and I like to talk about family, you know, children, how many children are there, how many grandchildren do they have, what do they do when they're not in hospital, just get them talking and then some will talk and some will remain quiet and so you know you're not gonna get through to them and some will open up and they will have a lot to say. You know, I...I'll explain to them, to say, whatever you saying is between you and I unless you want me to go and tell somebody. There was a lady that we visited was um...at home, she has...her husband had alienated her from her whole family, complete and utter dominance, didn't want anything to do...didn't want her to have anything to do with her family so when she was in hospital it was her only chance to meet her outside her family, so she would want messages passed on. Now I'm not in that... I can't pass the messages on, but then um...she found somebody eventually who could...sending a phone message or

	something to family members, so she was telling me that this only time her sister could come and visit because he wouldn't...they're not welcome to my house. And er...it's...but... I couldn't do anything with that, it worried me...it worried me to say people are still living like that but er...my job was at that...my job was just to visit her and that was done. I couldn't go and... I didn't know who to go to and I don't think I had her permission. She was just telling me what her situation was. She didn't...she was too scared of her husband to be able to make a report about it.
Researcher	So there are boundaries about what you can do when visiting patients and what you can do with them in their community setting as well.
Interviewee U	Yeah. Well, I...I advised this lady there are groups, there is numbers you can call, groups you can speak to, you don't have to carry on living like this, she would be scared of even...even if you met her sister on the street, she would be scared of talking to her and yet they lived not far apart because of what the husband would do, um...but I said you can talk anonymously, nobody has to know names and that. But...it's within the culture to stay quiet and tolerate it. And this was lady in her sixties, fifties or sixties, she just...she's spent life like that. So I think the best thing you can do is just go and talk to them, just try and take their mind off stuff like that. Hmm.
Researcher	It seemed this morning that the first patient you saw was somebody you already knew?
Interviewee U	Yes, [name], yes. She's been in and out quite a lot, and erm...we've grown to be friends now and she's...she's a young girl, in her mid-late 20s and erm... I admire her, I admire for her for strength, I admire her for her mental strength as well, 'cause I've seen [her] a lot, I've seen her at times...times, like today she was quite chirpy and healthy and quite positive but I've seen her in a lot of pain and just about giving her, just about, you know, saying things that I know she would regret later, but really in a lot of pain. Just, I don't know, got close to her like that and it's... there's certain relationships that we build so she...few months ago she just gave me her number because I said, you can talk to me whenever, it doesn't have to be...I come in once a week so it's...sometimes I'm not there when you

	really need somebody to talk to, so...and I felt she's comfortable talking to me so we exchanged numbers and that, but she hasn't text me even once [laughs] Yeah, so she's a lovely girl. A lovely girl, and again these are the kind of people that make you realise your problems are minor, minor...not even existent when you see people like this, they've got so much going on in their life and they can still smile in the morning.
Researcher	So you haven't met people on the wards who you already known but you've developed relationships over time?
Interviewee U	No, not really, no, no. I've met family friends that are people that I've already known but I've not developed relationship from the ward.
Researcher	[redacted]
Interviewee U	[redacted]
Researcher	Do you normally not expect to go to maternity and places like that?
Interviewee U	Yeah, I used to when I first started to be honest, I used to go to maternity because I love babies [laughs] I would love to go and visit them, then [one of the chaplains] was telling me, generally we don't do maternity unless they ask for it, because it's a case of coming in, having baby and leaving. And normally they're having...they've got family with them, so...which is true, they're not in for many days, and I...in the past when I've been...you either the visit, they've got their husbands with them, or their partners, or their family and...their focus is on baby so they don't need somebody to come [laughs] sort of have a casual chat, unless they ask for it. There have been occasions where I've gone, 'cause I've seen on the list that the lady has been in for 10 or 12 days, so...just to see that they're OK.
Researcher	And moving onto your interactions with the team, who would you say you see most in the team?
Interviewee U	[The Anglican chaplain] and [the lead chaplain] and [the Catholic chaplain], and [the Christian volunteer], tend to miss [the Christian volunteer] now because I come in later but yeah, those are the people I mainly see, and [another volunteer].
Researcher	And you were at the last team meeting, do you attend those meetings regularly? Do you think they're important?
Interviewee U	Yes, yes.

Researcher	How often do you have contact with [the Muslim chaplains and volunteers], how much contact do you have with them?
Interviewee U	With [the female Muslim chaplain] we generally hook up maybe once a month...once every two months and she'll come with me on the visits […]
Researcher	Have you ever met or had any conversations with...?
Interviewee U	I've never met [the male Muslim chaplain], I've met [another Muslim volunteer] at meetings but our days different so we don't meet. I've met him at the meetings but I've never met [the male Muslim chaplain] [laugh]
Researcher	In the four years you've been here!
Interviewee U	Yeah, it's funny I've not met him, because I've...he doesn't come to our meetings and obviously I don't go to their meetings.
Researcher	Is there a particular reason why you go on the wards with [the female Muslim chaplain]? Is it so she can see how you're getting on...?
Interviewee U	I think it's a bit of both, um... I don't know, she'll ring me up, she'll say "shall we do a visit together next Tuesday or tomorrow?" or whatever, and I'll say yeah, OK. So maybe it's a way of keeping me...making sure I'm still on...doing what I need to be doing and nothing else and um...yeah. Sometimes it's like er...I'd like to go to [Site B] and so I need to go with her, I can't...I can do [Site B] on my own but not [Site A] because I've been assigned to [Site C] and [Site B], but mainly here, so if I was to go to [Site A] I'd need to do it with [the female Muslim chaplain].
Researcher	OK, because you're not officially assigned...
Interviewee U	I'm not officially, no.
Researcher	Do you feel supported by the team?
Interviewee U	Yes.
Researcher	Especially after that call-out with [the lead chaplain] calling up.
Interviewee U	Yeah, yeah. [Two chaplains followed up] … yeah got a call from him too, I think he was on-call chaplain for that day. [the lead chaplain] was away, [the lead chaplain] called me the next day. It was very nice actually, it was really nice, I'm glad they called.

Researcher	You mentioned in the two or three days afterwards you found it quite difficult, did you actually kind of debrief with them?
Interviewee U	I did, I came in the following Tuesday and I...had a word with [one of the chaplains]. In the meeting I think we debriefed, we just um...again I wanted assurance and he gave me that assurance so...I was fine. And from the very beginning [one of the chaplains] told me you've got to learn, when you walk out the hospital, you leave whatever you've experienced here, you leave whatever you see here and don't take it with you so I've tried to do that and...but...that was an occasion where I couldn't. It went home with me.
Researcher	Do you have a mentor or anybody you go to specifically for spiritual guidance?
Interviewee U	Um, since I've started the course yes, I do have my teacher who's a scholar, quite...quite intellectually capable and um... speak to my mum, without me mentioning names, I speak to my mum! She's the one who makes me feel better. Yeah.
Researcher	Are there any particular issues you've brought up with your mentors?
Interviewee U	Um.... no, I've had issues but I would...I generally go to...if it's not spiritual, I go, I see [the lead chaplain]. Or [the Anglican chaplain], [the Anglican chaplain] is very good, he's very easy to speak to, um like sometimes I'll get from patients they don't want to talk, so how do you deal with that, what's the nice way of ending that meeting. Yeah. So if I have queries like that, dealing with patients and patient matters, I like to go to [the lead chaplain] directly, and if [the lead chaplain]'s not there, to [the Anglican chaplain]. So I would say they're my mentors as well.
Researcher	Have you made any referrals to...I know you haven't met [the male Muslim chaplain], but any to him or to [the female Muslim chaplain] at all?
Interviewee U	Yes, I've mentioned to [the female Muslim chaplain] like if I visit a patient and I think they needed a visit, then [the female Muslim chaplain]'s normally in on a Thursday, I'll just mention to see this person, as I think either they're not gonna be lasting too long, or it just...might be nice for them to have another visit
Researcher	Have you made referrals to any other faith chaplains at all?

Interviewee U	Um I think once I visited a Christian member, so I did...I spoke to [the lead chaplain] about it, yeah.
Researcher	And that was from your general ward visiting?
Interviewee U	Yeah.
Researcher	And you said earlier you were aware of chaplains involved in other sectors, do you receive any support or advice from these chaplains at all, do you have much contact with them?
Interviewee U	No, I have no contact with them.
Researcher	And to ask a really obvious question, what is chaplaincy?
Interviewee U	For me? Chaplaincy's about visiting the patients...or being making yourself available for people to come to you with their concerns, with...a religious side to it, depending on your faith. Yeah.
Researcher	Where does that fit in a healthcare context, why is that important?
Interviewee U	Because health and religion are connected, and it's when people are sick and low that they tend to turn to religion more, and spiritual faith, 'cause that's when the questions start arising, "is there a God? Where is he? Why am I feeling like this if he loves me?" Things like that.
Researcher	Have you ever heard of the phrase generic chaplaincy at all?
Interviewee U	No.
Researcher	You don't need to have! Just asking. In terms of a bigger picture, are you aware of any organisations relating to chaplaincy or who work alongside chaplaincy at all?
Interviewee U	No [I'm just aware of one chaplaincy course] which I was very interested in, many years ago, but I didn't manage to get onto the course. I was having my family at that time, so I needed to be at home with my young children. But it's something I would have loved to do....maybe one day.
Researcher	So it's something you'd consider doing in the future?
Interviewee U	Yeah, I would, maybe after I finish with my diploma, go on to do something like that.
Researcher	[redacted]
Interviewee U	[redacted]
Researcher	Was that before you got involved with volunteering here then?
Interviewee U	Yes. It was many years before.

Researcher	What do you think are the challenges and opportunities for being a Muslim volunteer?
Interviewee U	The challenges, um...my dress, the fact that I wear a headscarf, um... non-Muslims are sometimes a bit, you know, they're unsure I think. And sometimes especially with things that are going on in the media and how media portrays things, you do get the negative vibes from them […] Um, advantages I'd say on the Muslim side...um... the female patients that I go to visit they feel an affinity, they connect, seeing me dressed the way I am, feel like I'm one of theirs, mmm, it helps them to open up a little bit. So...yeah.
Researcher	You talked earlier about meeting the spiritual needs of patients, what does spiritual mean, what is spirituality?
Interviewee U	Helping them to connect with Allah, helping them to connect with God, um teaching them prayers, little things that they can do...to feel that connection, so that... regardless of...life of death...their connection with God is strong, so whether they're here to stay or whether they're not gonna be here long, um...I'd like to think they're going to meet Lord with er...in a good way. Mm.
Researcher	And earlier you mentioned [a chaplain] giving you feedback about your call-out, have you received any other feedback about the work you do at all?
Interviewee U	No.
Researcher	What are the qualities you think are important for being a chaplain/chaplaincy volunteer?
Interviewee U	You have to have a lot of patience, sympathetic, you need to be able to be a good listener [long pause] and um...sometimes you need to be able to take rejection well, um... patience I think.
Researcher	[redacted]
Interviewee U	[redacted]
Researcher	And what are the precedents are there for chaplaincy or patient visiting in Islamic tradition?
Interviewee U	There's...um...patient visiting, it's part of religion actually, it's a lot of rewards for the person who visits and for the patient itself, but yes it's...it's um...it holds a lot of reward, as a Muslim, for someone who visits the sick. It's er...in Islam, it's as if you're sitting in the gardens of paradise um...so Islam...um what's the word... Islam

	wants you to do it, it's...yeah, something you should do, it's in all that you take. And um...for generally, for everybody, you don't have to be a scholar, you don't have to be a learned person, just if you know that somebody's unwell um...and also don't...your visits shouldn't be too long. Short, simple visits. Just so the person knows that somebody's thinking of them, praying for them.
Researcher	[redacted]
Interviewee U	[redacted]
Researcher	Great, well that's all the questions I had, for you, but if you have any comments you can say something now or I can get in touch. I think that's it.
Interviewee U	I love every minute of it. When I come in. And to be honest sometimes I... I don't feel like coming in, there's days of, oh my God, I've got so much to do today, but when I'm here I'm glad I made the effort. I mean, because again it reminds me there's people in much worse off conditions. There was a lady I met, she was like half dying but she was still smiling, and she was...you know, the glass was half full rather than half empty. And it just...blows me away, every time to think wow, you know? Appreciate what you have. And yeah, it's taught me a lot, it's taught me patience, I wasn't a very patient person, I...just taught me patience. So, yeah, so...like I tell [the lead chaplain] always, I benefit just as much as I'm hoping the other patient does.
Researcher	Sorry, two more questions for you, is that alright? You've mentioned earlier there have been a couple of times when you...literally come in and just spoken to two patients because they've taken that much of your time, I mean, I guess that's....that's because it goes beyond just social chit chat, there's deeper stuff you're talking about. What kind of things do those more substantial conversations...?
Interviewee U	Coming to mind now it was [patient mentioned earlier] one time. The first that we had today. She was in so much, she was having chest pains, back was sore, she was being dialysed all at the same time and I thought OK, this...she's touch and go right now, and she mentally, she's normally strong, but this day she was just giving up and her...she was saying "why? Why is God doing this to me? I'm a

good person, I pray, I do all of this and I'm constantly doing it, and when I don't see, when I'm getting worse, why is he doing?" So I felt that day it was my responsibility to sit here as a person of faith, to try and get her out of that mode of thinking why and get her into the mode of thinking to say no, there's a reason behind it and...whatever the reason, turn to God even more, er...follow your faith even more, be strong in your faith even more because God's listening, God's there, he can see everything you're going through, and there's a reason why you're going through that, he's...there's a reason why he's putting you through that, but there's blessing in illness as well and look to that, look to the positives, even though you're so low, look to the positives. But it was a long visit that day for me because...I was hitting a brick wall at times, no matter how much I was talking, it was... and I don't blame her at all, I mean, she was at a point where she was hitting a brick wall, whatever she tried...she was trying to get on with life, she had accepted the fact that she was a kidney patient on dialysis for the rest of her life or whatever, waiting for a kidney, and...all these other health issues started coming up and she just wanted to live life, she just wanted to finish studies and love like a normal...you know, this started off in her teens, now she's in her twenties. She just wanted to live her teens and twenties and... like she sees other people around her doing. So...er...I sat with her for a while and in that time nurses came and sedated her little bit and gave her of paracetamol, well, strong painkillers and she settled down but...she was still weak mentally. But...I...I...sat with her as long as I could. I don't know how long I would have had to have sit if I didn't change her mind that day, but just to remind her again that God is loving, God is loving, God is there and he's listening and this is the time wen you really need to search your soul and beg....beg for help, because only he can help. Hmm, that's all...that day I think I spent over an hour with her, and the nurses coming in and out so I would step out while they saw to her and go back in again. But I didn't feel I wanted to leave her so I'd rather, with a patient like that, I'd rather spend my time with them than to go visit another patient. Yeah.

Researcher	Great, I think that's all we have time for anyway, we'll stop there, thankyou.

Parent Node	Child Node	Sub Node	Sources	References
Access [Chaplaincy Team]			179	790
	Facilitation		91	243
Accessing Chaplaincy and Facilities			103	224
Authority and Leadership			105	330
	Inadequacies of Medicine		16	20
	Knowledge		45	90
	Primacy of Medicine		18	26
Availability			222	841
Background			191	2196
	Community Role, Standing and Involvement		110	414
	Endorsement		45	107
	Experience		106	359
	Getting Involved		75	179
	Hearing about Chaplaincy		41	68
	Motivation		82	195
	Previous Occupations		79	194
	Skills		44	89
	Time in Chaplaincy		67	103
	Training and Education		90	379
	Vocation		20	33
Barriers, Challenges and Limitations			175	898
	Awareness		109	388
		Religious Literacy	83	265
	Discomfort		13	31
	Misunderstandings and Misconceptions		80	176
	Negative Attitudes and Responses		67	123
		Racism	16	22

Boundaries			213	1662
	Imposition		55	85
	Outreach, Proselytising and Evangelism		61	110
Chaplaincy Impact			136	480
	Appreciation, Recognition and Being Valued		105	276
	Feedback		69	155
Chaplaincy Role and Remit			278	10593
	Accompanied or Joint Visits		13	50
	Admin		89	199
	Advising Patients and Family		69	148
	Bereavement		89	222
	Chance Encounter		38	60
	Co-ordinating and Mentoring Volunteers		116	381
	Community Follow Up		50	114
	End of Life, Death and Dying		156	531
	Ethical Issues		65	221
	Expanding Role		35	119
	Family Support		80	195
	Follow Up		114	281
	Funerals		94	336
	Honorary Chaplain		10	14
	Institutional Role		117	390
	Listening		57	134
	Mediation, Accommodation and Advocacy		89	217
	Translation and Interpretation		41	136
	Memorials and other services		10	14

	Minority Faith Chaplain Remit		15	51
	Monitoring Facilities		53	168
	Pastoral Care		60	147
	Patient Facing		199	2875
		Already Knows Patients	45	113
		Chaplains' Assumptions about Patients	8	12
		Chat	77	285
		Declining Visits	37	59
		Encouragement	15	28
		Explaining Chaplaincy Provision	42	84
		Explaining Role	43	115
		Medical Interruptions and Interventions	29	47
		Medical, Health and Hospital Talk	37	233
		Non-Verbal Communication - Patients	6	12
		Patient and Visitor Response	83	320
		Patient Cues	45	90
		Patient Distress	24	46
		Patient Unavailable	58	181
		Religious Talk	86	256
		Touch, Posture and Gesture	67	282
	Practical Support		46	121
	Prayer, Meditation and Chanting		148	696
	Referrals and Call-Outs		206	1084
		Community Referrals	11	19

	Religious Care		106	255
		Celebrations and Festivals	86	310
		Regular Services and Prayers	118	337
		Sacrament and Ritual	99	259
		Blessing	26	52
	Research Involvement		19	27
	Signposting		63	101
	Specialisms		25	73
	Staff Support		73	146
	Teaching, Explaining, Consulting		88	350
	Training Provided or Facilitated by Chaplaincy		100	332
		Volunteer Training	142	553
	Volunteer Remit		92	245
Commitment			33	48
Commonality			33	46
	Humanity		46	66
Communication and Interaction			245	2065
	Debriefing and Handover		127	301
	Informal Interaction		53	119
	Meetings		137	491
Community Understandings			25	59
Counselling			20	56
Culture			109	278
	Distinction between Religion and Culture		14	26
Defining and Understanding Chaplaincy			103	234
	Contribution to Healthcare		99	326
		Healing and Recovery	26	37
		Holistic Care	34	49
		Mitigating Isolation	27	46
		Reassurance and Comfort	63	127

	Distinctiveness of Chaplaincy		70	104
Desirable Chaplains' Traits or Qualities			130	504
	Empathy		19	21
	Non-Judgemental		46	84
	Open, Pragmatic and Adaptable		84	197
	Sensitivity and Discernment		49	140
Distinction between Paid and Voluntary			85	211
Events			44	124
Evolution and Change			42	121
Expectation, Demand, or Need			209	1076
	Diet		27	48
External Connections			177	1106
	Community Links		125	592
	External Support		36	96
	Networks		69	212
	Other Chaplaincies or Trusts		56	103
Family and Personal Support Networks			84	187
Funding and Resource [outside NHS]			41	89
	Donations		17	22
Gender			106	274
Goodwill			33	63
Humour			117	378
Identity			170	760
	Authenticity and Integrity		23	47
	Chaplaincy as Ministry		12	22
	Denominational and Sectarian		123	376
	Ethnicity		35	48

Inclusivity			41	102
Institution			251	2402
	Choice		31	60
	Confidentiality and Privacy		128	312
	Dignity		29	50
	Equality and Diversity		60	218
	Evidence		9	17
	Finance and Budget		96	205
	Infection Control		95	271
	Informed Consent or Permission		34	55
	Mandatory Training		62	114
	Patient Experience		12	19
	Patient-Centred Care		68	166
	Quality of Care		5	11
	Risk		38	59
	Safeguarding		50	83
	Stakeholders		152	586
Interfaith Encounter			112	356
Introductions on the wards			50	230
Job Satisfaction			30	38
Language			146	684
	Greeting		29	90
	Nomenclature		147	437
Learning			58	150
	Learning about Different Faiths		22	53
	Learning on the Job		35	55
		Finding Way around Hospital	22	30
		Shadowing	7	13

Material Culture			159	596
	Handling Scriptures		6	11
Models of Operating			184	1216
	Generic		131	548
	Mixed model		10	14
	Proactive		27	51
	Reactive		46	68
	Religion-specific		100	246
	Specialist [Religious]		15	23
	Spiritual Assessment		22	37
	Spiritual Care		68	160
Narrative and Story			49	126
	Challenging and Memorable Moments		49	140
	Complex Cases		11	16
	Mixed-Faith Encounter		15	47
National Context			49	122
	Legislative Framework		17	41
National Picture			161	1185
	Chaplaincy Organisations		70	460
	Comparing Trusts		32	60
	Key People		22	65
	National Guidelines		76	196
	Other Chaplaincy Sectors		53	131
	Other National Organisations		55	185
Non-Religious involvement			71	213
Other Roles			76	231
	Personal Visit		16	45

Personal Practice			47	107
Personality			46	95
Personnel			85	283
Politics and Current Affairs			23	53
Practicalities and Logistics			220	1432
	Hours Allocated		76	240
	Patient Information		150	625
	Remuneration		56	151
	Time		130	352
Precedent			53	131
Presence			67	122
Professionalisation			146	741
	Accountability		48	89
	Career Progression		21	46
	Chaplaincy-Specific Qualifications and Training		71	257
	CPD		63	189
	Reflective Practice		26	44
	Research Awareness		9	14
	Skills, Knowledge, Experience		11	23
Recruitment of Chaplains			39	142
	Job Description		16	30
Relationship with Staff			181	906
	Staff Attitudes		12	23
Representation			45	98
Resources			132	513
	Technology		67	163
Respect			39	90
Responsibility			28	47
Site Context			99	196
	Demographic		72	125
Spaces			193	998
	Facilities for Prayer, Worship and Reflection		179	895
		Etiquette	58	116
	Office Space		49	77

Spirituality			98	243
Team Ethos			257	2954
	Managerial and leadership		96	408
	Strategy and Decision Making		65	210
	Supervision and Appraisal		40	107
	Team Leader Influence		101	314
	Team Relationships		237	1796
	Advice and Consultation		55	214
	Support		98	273
Tensions and Conflicts			92	334
Theology			99	220
Visibility			198	766
	Identification		74	137
Volunteer Base			153	657
	Terminating Volunteering		9	25
	Volunteer Recruitment		99	343
		Unsuitable Applicants	23	53
Working Practices			246	2632
	Auditing and Record-Keeping		163	523
	Chaplaincy Documents		22	32
	Cover		91	210
	Coverage		121	352
		Cross-Site Working	82	214
	Identifying and Locating Patients		71	238
	Local strategy, guidelines, and SOPs		79	186
	Patient List		135	420
	Prioritising Workload		77	187

10.15 APPENDIX 14: NVIVO ANALYTICAL FRAMEWORK

Parent Node	Child Node	Sub-node	Sources	References
Capital			242	3204
	Authority and Leadership		105	329
	Inadequacies of Medicine		16	20
	Knowledge		46	90
	Primacy of Medicine		18	26
	Chaplaincy Impact		136	480
		Appreciation, Recognition and Being Valued	105	276
		Feedback	69	155
	Community Understandings		24	58
	Recognition		218	1431
	Community Role, Standing and		110	414

	Involvement			
	Endorsement		45	107
	Relationship with Staff		180	901
	Staff Attitudes		12	23
	Relationship with Staff		180	901
	Staff Attitudes		12	23
Distribution			269	3130
	Distinction between Paid and Voluntary		85	211
	Finance and Budget		96	205
	Personnel		85	283
	Practicalities and Logistics		220	1432
	Hours Allocated		76	240
	Patient		150	625

	Information			
	Remuneration		56	151
	Time		130	352
	Spaces		193	998
		Facilities for Prayer, Worship and Reflection	179	895
		Etiquette	58	116
		Office Space	49	77
Power			174	599
	Access		161	493
	Facilitation		90	241
	Brokerage		3	4
	Gatekeeper		58	93
Socialisation			194	1731
	Experience		106	359
	Learning		58	150

		Learning about Different Faiths	22	53
		Learning on the Job	35	55
		Finding Way around Hospital	22	30
		Shadowing	7	13
	Previous Occupations		79	194
	Skills		44	89
	Training and Education		90	379
	Volunteer Training		142	553
Somatic Norm			260	2165
	Availability		221	835
	Awareness		109	388
	Religious Literacy		83	265

	Misunderstandings and Misconceptions	372	80	176
	Visibility		198	766
	Identification		74	137

Application for AHRC Student Development Fund

Name of Student:	Jo Bryant
Home institution:	Cardiff University
Type of activity:	Placement (external partner)

SECTIONS A – C TO BE COMPLETED BY THE STUDENT

A.   Applicant statement

Please describe the activity you wish to undertake below, ensuring you have read and adhered to the requirements of this section, as outlined in the accompanying guidance and notes:

Applicant's Statement (placements)
During the first year of the doctorate, contact was established with the Patient Experience lead at NHS England. The Patient Experience brief includes the provision of chaplaincy services. The lead, Catherine Thompson, expressed an interest in the research and suggested that further possible outputs might include models of best practice based on the findings. However, in order to produce outputs that are workable for NHS England, I propose working alongside the Patient Experience team by doing a knowledge exchange placement. This

proposal has been agreed to in principle by Catherine Thompson, and I have received confirmation by the DTP that this placement is feasible.

This knowledge exchange placement would include attendance at meetings regarding the strategic development of healthcare chaplaincy, familiarisation with the Patient Experience department and its resources, and establishing its links with relevant departments (such as Equality and Diversity) and/or important figures relating to chaplaincy. It is proposed that the placement takes place over 6 months, on a part-time basis, as chaplaincy is only one aspect of the Patient Experience portfolio. Therefore, 0.5 WTE hours will be allocated to the placement, and 0.5 WTE hours will be allocated to the doctorate.

This placement would provide an invaluable opportunity to maximise impact of research findings by working strategically at a national level, which may lead to the development of further guidelines and strategies.

Applicant's Statement (skills development)
The placement with NHS England will develop all three subdomains of RDF Domain D (Engagement, Influence and Impact). The placement will involve becoming part of the Patient Experience Division and working collaboratively and collegially with the division (domain D1). During this placement, I will also be working towards producing guidelines, strategies and/or models of best practice for NHS chaplaincy (domain D2). This may also include provision of training (domain D3). This will also develop domain B3, by exploring possible career options outside academia, but also B2, in order to establish an appropriate balance between placement and PhD.

Applicant's Statement (Practical Arrangements)
Due to the researcher's teaching commitments, it will not be possible to commence the placement until June 2017. The placement would therefore finish in December 2017 and require a 3-month extension of the studentship up to this point.

While NHS England has been supportive of the placement, it has been stressed that this will be dependent on a funding bid they have submitted for the chaplaincy programme. The outcome will be made clear around December 2016.

NHS England has offices based in Leeds and London. During the placement, it is expected that the researcher will be based in Leeds, as rental costs will be lower. This will mean regular trips to London in order to attend meetings or meet with representatives from the sister office. The researcher is also familiar with Leeds and able to access the resources and existing high profile chaplaincy contacts there.

B.   BREAKDOWN OF COSTS

Please provide a full break-down of the costs you are applying for an award to meet, ensuring you have read and adhered to the requirements of this section, as outlined in the accompanying guidance and notes.

Travel Costs:

These are projected costs and there are no specific dates in the diary for these trips. It is expected that one trip will need to be made to London per fortnight at most (roughly 15 trips expected) and that one trip between Leeds and Cardiff will be made every other month for supervisions.

Dates		Point of departure	Destination (City and Country)	Cost (£)
From	To			
TBC	TBC	Leeds	London	£106.65 (off-peak rtn – may be able to get cheaper singles) x 15 potential trips = £1,599.75

TBC	TBC	Leeds	Cardiff	£66.25 (anytime rtn – may be able to get cheaper singles) x 3 = £198.75

Add additional rows as necessary

Accommodation Costs:

Dates		Number of nights	Cost per night	Total Cost (£)
From	To			

Other Costs:

Dates		Details of cost	Cost (£)
From	To		
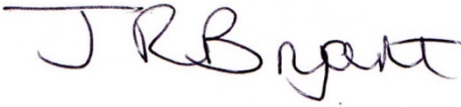
Add additional rows as necessary

Grand total	£1798.50 (+ normal stipend for 6 months between June and December 2017)

C. SIGNATURE

I confirm that I have read the accompanying Notes of Guidance and I will undertake to inform the SWW DTP Hub if the activity is cancelled or the length of an activity is reduced. In the event of the activity being cancelled or reduced, I understand that I will be required to refund any money that has been overpaid.

Name of Student:	Jo Bryant

Student signature *(by typing your name you are providing your electronic signature):*	![signature] J R Bryant
Date:	14th November 2016

D.   SUPPORTING CASE (TO BE COMPLETED BY THE SUPERVISOR)

Supervisor's supporting statement

Please state the purpose of the activity and explain how it is essential to the student's research or will contribute to their career development - please ensure you have read and adhered to the requirements of this section, as outlined in the accompanying guidance and notes:

The knowledge-exchange placement proposed here would significantly benefit Jo's career development. While it would give her experience of other career opportunities than those in the academic world, the main benefit would be to enhance Jo's competence in the engagement, influence and impact dimensions of academic research. The outputs proposed, which would set out good practice in involvement of minority faiths in public healthcare chaplaincy, would be significantly
enabled by a placement with NHS England. This organisation is a public policy body currently working, inter alia, with the significance of the public equality duty for the commissioning and delivery of healthcare (including healthcare chaplaincy). A particular aspect of NHS England's work is the reduction of health inequalities. This is, therefore an ideal context for Jo to explore how her research might generate outputs in terms of policy, examples of good practice and related training that would have the potential to improve the experience of members of minority faiths in the healthcare setting. At the same time, working within such a policy environment would also enhance the analysis of Jo's data and the critical dialogue between that analysis and the wider field.

I fully support the application and would commend this placement as having the potential to significantly enhance the PhD and Jo's future career.

Name of supervisor:	The Rev Dr Andrew Todd
Signature *(by typing your name you are providing your electronic signature):*	Andrew Todd
Date:	4th November 2016

A Study on the Integration of Minority Faith Groups in Acute Healthcare Chaplaincy

A Progress Report for NHS England

October 2016

Jo Bryant

PhD Candidate

Department of Religious and Theological Studies

School of History, Archaeology and Religion

Cardiff University

CONTENTS

Introduction

This study is a doctoral research project based in the Department of Religious and Theological Studies at Cardiff University, with links to the Centre for the Study of Islam in the UK and the Cardiff Centre for Chaplaincy Studies. This project is funded by the AHRC (Arts and Humanities Research Council) and supervised by Professor Sophie Gilliat-Ray, Revd. Dr Andrew Todd, and Dr Mansur Ali.

This project aims to:

- Examine the ways in which spiritual and religious care is provided for minority faith communities by NHS Trusts.
- Raise the profile of minority faith groups in healthcare chaplaincy.
- Address gaps in chaplaincy literature by exploring the role and integration of these groups in healthcare chaplaincy.
- Contribute a non-practitioner's account to an academic body of knowledge which is primarily informed by chaplaincy practitioners.

This report will outline the research project, the progress made so far, and present a proposal for working alongside NHS England for a knowledge exchange placement.

Study Design

This project is a two-tier empirical study of healthcare chaplaincy. The first tier has involved interviewing high profile chaplaincy representatives and observations of events or meetings hosted by chaplaincy organisations.

The second tier has involved undertaking five case studies chaplaincy teams in Trusts across England. These case studies included observations of the chaplaincy offices, shadowing minority faith representatives, and interviews with chaplaincy team members and staff stakeholders.

Overview of Progress So Far

During the first year of the project, a literature review was conducted in order to examine the current knowledge base regarding chaplaincy, including primary and secondary sources about chaplaincy in the UK and the US.[51] A basic database of chaplaincy provision in England and Wales was created in order to obtain a birds-eye view of the provision being made and lay the groundwork for selecting cases. The project design was finalised and approved by a departmental ethical review committee and access was negotiated to the case study sites. Contact was established with core chaplaincy organisations and representatives and interviews were conducted.

The entirety of the second year was devoted to data collection at the 5 case study sites, which included observations, shadowing, interviews and collation of written documents relating to working practices of the team.

The third year (2016-2017) will be dedicated to organising and analysing the data collected, writing up reports for the Trusts and working towards completing the thesis.

Limitations of the Study

The study was unable to obtain patient perspectives on chaplaincy as the main focus was on chaplaincy teams and their representatives. Due to the detail and depth of data from each case study, it would be difficult to make comments about chaplaincy in general at this stage.

Selection Criteria

The database compiled in the first year was used to assist with case selection. The chaplaincy teams were primarily chosen due to their service models and how these may or may not reflect the local demography that each hospital or Trust serves. It was intended that chaplaincy teams

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[51] The primary sources include chaplaincy guidelines, standards and policies produced by the NHS and chaplaincy organisations.

serving particularly diverse areas, or areas with high proportions of particular religious minorities (such as Hindus or Sikhs), would be examined, while also cross-referencing with the service models, i.e. whether chaplaincy team members of minority faith groups were involved in a full-time, part-time, honorary, bank, sessional or voluntary capacity.

Access

The researcher gained access to numerous Trusts by proposing to conduct a service evaluation of the chaplaincy team at each Trust. This meant that the researcher liaised with each Trust individually, each with different requirements for access. This included obtaining a research passport and/or honorary contract and, in one case, registering on a clinical audit database.

Service evaluations at five Trusts were completed as of Friday 30th September 2016. The locations of sites will not be disclosed in the interest of confidentiality.

A further four Trusts were approached unsuccessfully prior to the start of the fieldwork. The reasons for this were varied, including a perceived clash with an internal audit being conducted by the chaplaincy team, changes in personnel, staff shortages, and feasibility of compliance with R&D requirements particular to one site.

Summary of Findings

While the data is yet to be analysed, some preliminary statements can be made about the findings so far:

- Vastly different service models were in operation between Trusts and even *within* Trusts, from models which are dependent on volunteers to do the bulk of the patient visiting to different degrees of paid chaplaincy (i.e. bank, part-time, sessional/SLA).

- Most minority faith chaplains have very little autonomy in comparison to their Christian counterparts, with the exception of one Trust whose Muslim chaplains work independently. Autonomy appears to increase with an increase in the number of contracted hours.

- Team leaders have a significant impact on the degree of multi-faith involvement within a team, although this can also be determined by broader institutional factors such as budgeting.

- Teams have different standards, expectations, boundaries, and remits for their volunteers.

- Teams have different approaches to routine patient visiting, which can be referral-based, list-based, or bed-to-bed. The first two approaches are reactive and the third approach is proactive.

- At present, due to limited hours and the need for focused patient visiting, minority faith representatives tend to do referral- or list-based visiting. There was some evidence that minority faiths would like to and do operate generically (often associated with proactive visiting).

- There is evidence that minority faith chaplains and chaplaincy team representatives are taking on institutional roles within chaplaincy (such as contributions to MDTs, providing advice on equality and diversity issues, etc.), although this varies between teams.

- Patient lists are particularly problematic due to varying levels of accuracy when recording patient data and levels of access to

patient information for chaplains. Possible factors affecting the level of access to patient information include the Caldicott interpretation at the Trust or the implementation of new patient information systems.

- The involvement of the British Humanist Association in chaplaincy has been broadly contested, with chaplaincy teams often disagreeing about whether or not to involve non-religious pastoral carers in chaplaincy.

- Minority faith groups have a limited role in the strategic development of chaplaincy at a national level, as well as the research agenda for chaplaincy.

Fieldwork with Chaplaincy Organisations

During the first year of the project, links were established or followed up with core chaplaincy organisations and bodies, including the College of Healthcare Chaplains, the Healthcare Chaplaincy Faith and Belief Group, Sikh Chaplaincy UK, the National Spiritual Assembly of the Baha'i faith, representatives from the British Humanist Association, and Church House (formerly the Hospital Chaplaincies Council). So far the researcher has undertaken 5 interviews with representatives from these groups.

The following events were attended:

- Norman Autton Annual Lecture - 21st October 2014
- Cardiff Centre for Chaplaincy Studies Day Conference – 27th November 2014
- HCFBG annual meeting – 24th March 2015
- Chaplaincy: A Very Modern Ministry report launch and conference (hosted by Theos) – 15th March 2015
- CHCC annual conference – 10th September 2015
- Chaplaincy in Action Conference – 9th-10th June 2016

The researcher is still to establish or follow up connections with the UK Board of Healthcare Chaplaincy, the Chaplaincy Leadership Forum, the new Head of Pastoral Support at the BHA, Chesed, the Buddhist Healthcare Chaplaincy Group, and the National Council of Hindu Temples.

The Case Studies

The bulk of the data collection for the project began on 5th October 2015 and was completed on 30th September 2016. The data collected includes fieldnotes from observations and shadowing, 105 interviews with chaplaincy team members and stakeholders,[52] photographs of the chaplaincy offices and facilities for prayer and worship, and documentation requested from the chaplaincy teams regarding working practices, recording visits, auditing, and locally determined guidance/strategies. Since the data has been collected, I have maintained contact with chaplaincy teams, who have kept me updated on changes in personnel. Therefore it must be noted that the findings presented below provide a snapshot of a chaplaincy team at a particular point in time, that there have been changes to the teams and how they work since the data was collected.

Pilot Study (October – December 2015)

The pilot study was conducted with two chaplaincy teams who cover one of the most diverse areas in the UK, with significant populations of Muslims, Hindus and Sikhs, as well as a sizeable minority of Jews.

Due to a recent merger, two chaplaincy teams served one Trust, with completely different models of working:

> Site A operates with a **reactive religion-specific ("traditional") model** – chaplains are employed to see patients of their own faith, and only deviate from a patient list when a patient explicitly shows interest or when referred to a patient by a member of staff. This team included a full-time Anglican chaplain, a full-time Catholic

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[52] This included 'substantive' interviews which will be analysed in detail, and 'contextual' interviews in order to find out more about the working practices of each chaplaincy team.

chaplain, sessional Muslim, Hindu, and Jewish chaplains, and a team of volunteers.

Site B operates with a **proactive generic model** – chaplains visit bed-to-bed, with a predominantly Anglican team calling in minority faith chaplains on the bank system as and when they are needed. Regular Sikh volunteers also visited patients identified by Anglican chaplains from their generic rounds.

These models of working are a result of disparate interpretations of the Caldicott guidelines that were still in place at each hospital at the time of the study. For site (a), the interpretation allowed the chaplaincy to print off patient lists for each faith, but not to go bed-to-bed on the grounds of patient privacy. For site (b), the interpretation did not allow any access to patient data but instead allowed chaplains to go bed-to-bed to generate referrals for follow-up visits.

Site A

Site A has a full-time Anglican chaplain and a full-time Catholic chaplain, as well as sessional Muslim, Jewish and Hindu chaplains who visit patients on their patient lists. In theory, these sessional chaplains provide a contact point for volunteers of their respective faiths. In practice, there is little communication between the sessional chaplains and their volunteers due to visiting on different days of the week (with the exception of the Hindu chaplain). Minimal communication between the Anglican chaplain and Anglican volunteers and volunteers from Protestant backgrounds was also apparent. Conversely, the Catholic volunteers met weekly in the Catholic chaplains' office to collect patient lists and debrief. They conclude their visit with Mass in the chapel. There was also little communication between the sessional chaplains and the full-time chaplains, as they worked from different chaplaincy offices, and any communication tended to be informal and ad hoc.

The sessional chaplains do not have access to their own computers, despite having NHS email addresses, and are dependent on the full-time

Catholic chaplain to print out patient lists. If neither of the full-time chaplains are available, the sessional chaplains are unable to do their visits.

The primary role for the sessional chaplains appears to be visiting patients, although the Hindu chaplain is active in organising regular Hindu prayer meetings and annual Diwali celebrations. The Jewish chaplain distributed Hanukkah gifts to Jewish patients, although its occurrence in this case appeared to be the first time this has happened. The Muslim chaplain meets with staff and provides support with the organisation of Friday prayers, although does not attend the prayers himself. All of the chaplains are also involved in a multi-faith user group, which meets to discuss religion-specific issues arising in patient care. A primary outcome has been the compilation of an annual multi-faith calendar.

This team used to have regular team meetings, but these stopped soon after the previous team leader retired. A team leader has yet to be formally appointed. Most decisions are made between the Anglican and Catholic chaplain on an informal and ad hoc basis. There is no current spiritual care or chaplaincy policy.

Site B

Site B, at the time of data collection, had two full-time Anglican chaplains, a part-time Anglican chaplain and a part-time Catholic chaplain. Since the case finished, one of the full-time Anglican chaplains and the part-time Catholic chaplain have left the team. The team had a clear procedure for calling in minority faith bank and voluntary team members as and when they are required. However, in the past 3 years, according to the team call-out book, there have been only 34 call outs for Hindu, Muslim, Sikh and Jewish bank staff/volunteers combined. These call outs may be the result of a ward referral, or a chaplain picking up on a need during their generic visits. The findings suggest that the grounds on which chaplains call in bank chaplains and volunteers are arbitrary and that patients are not empowered to request faith specific support from the Trust. According

to one full-time Anglican, the provision for Muslims used to be "tighter" than it is now and there's "no multi-faith clarity" within the team. The team relies on the goodwill of two Sikh volunteers to provide regular visiting services to Sikh patients. These Sikh volunteers also co-ordinate the monthly Sikh prayers, and one of the Anglican chaplains ensures that the space is monitored and set aside for their use.

The team at Site B also provide chaplaincy services at a neighbouring Trust. At this Trust, there is a regular Buddhist volunteer who visits generically, as well as regular Christian visitors, including a Ukrainian Orthodox volunteer. Muslim, Sikh, Hindu and Jewish chaplains operate on a bank/honorary basis. The chaplaincy team were more involved with teaching at this site, particularly in relation to spirituality and the 'softer' aspects of patient care, such as breaking bad news.

The Christian chaplains have regular team meetings, although bank and honorary chaplains do not attend due to issues of availability. While there is no spiritual care strategy specifically for this Trust, the team work with the strategy they use for providing services to the other Trust.

Case Study 2 (January – February 2016)

This case was located in an area with a sizeable Muslim demographic, which has seen recent tensions between the Muslim population and far-right political groups. The team has one full-time Anglican lead chaplain, who is supported by a part-time Free Church chaplain (0.6WTE), several bank chaplains from various denominations, a part-time Roman Catholic chaplain, and a strong volunteer base. Both the Hindu and Muslim services are provided by volunteers from the respective faith groups.

Provision for Muslim patients and staff is entirely voluntary, although the team leader has made numerous attempts to submit a business case for the Trust to employ a part-time Muslim chaplain. While the Trust appears to have been receptive, funding for this post is yet to materialise. Two of the three Muslim volunteers are well trained, having completed courses in Muslim chaplaincy at the Markfield Institute of Higher Education, while the

other has experience of working within prison chaplaincy. One of the Muslim volunteers also assists the team leader with the provision of training in relation to baby deaths for midwifery staff, and does this in a voluntary capacity. The team leader also has a very good relationship with prominent Muslim staff who organise the Friday prayers, especially after he negotiated the provision of a designated prayer space.

The bank, part-time and voluntary team members do the majority of the patient visiting, mostly on a **proactive** basis. The team leader co-ordinates volunteers and has a significant role in bereavement and provision of funerals. The Catholic chaplain primarily visits Catholic patients. While most of the volunteers work on a **generic** basis, the Catholic, Methodist, Muslim and Hindu volunteers are given patient lists to guide their visits. However, when the Muslim volunteers were shadowed, they seemed to be comfortable operating generically. The team leader expressed a concern that the Trust was too reliant on the goodwill of volunteers and that it may not always been possible to make consistent provision.

The chaplaincy does have access to patient information, but volunteers rely on paid team members to print off patient lists if they do faith-specific visiting.

Team meetings are attended by paid (including bank) chaplains only. There is no current spiritual care or chaplaincy policy.

Case Study 3 (March – May 2016)

This case study took place in a location with significant Hindu and Sikh populations, as well as a sizeable Muslim community. The chaplaincy team is split across three sites, and has a full-time Free Church chaplaincy manager, a full-time Anglican chaplain, two Anglican chaplains and a Free Church chaplain who are nearly full-time,[53] a part-time Catholic chaplain, and part-time Muslim (male and female), Sikh and Hindu chaplains. They have also recently recruited a non-religious pastoral carer to join the team.

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[53] Their hours equate to approximately 0.9WTE each.

The inclusion of the non-religious pastoral carer was a source of considerable disagreement within the team, from across several faiths. The team is supported by volunteers from different faiths. Provision for Buddhist and Jewish patients is made by volunteers.

The Christian chaplains share the on-call rota, which is paid, while any call-outs for the Hindu, Sikh and Muslim chaplains are recompensed with time off in lieu. This was often seen by the minority faith chaplains as a disadvantage as this interfered with their weekly visiting.

The team produces monthly multi-faith calendars that are sent to all wards and displayed in the prayer rooms, as well as Spiritual Care Bulletins, which are distributed to chaplaincy volunteers and hospital staff. They are developing a Spiritual Care Link programme where ward staff facilitate connections between wards and the chaplaincy team in order to help raise awareness and encourage referrals.

All chaplains and volunteers have access to patient information, although the degree of access varies. For example, all paid chaplains are able to make and access private notes about patient encounters, while volunteers do not. All chaplains have access to computers, although on a busy in the office day this may be difficult.

It is standard practice for the Free Church and Anglican chaplains to visit wards **generically** (at one of the sites the wards are divided up among the chaplains), while the **Muslim, Sikh, Hindu and Catholic chaplains visit reactively**, using patient lists and referrals to guide their visits. The Hindu chaplain organises and leads weekly Hindu prayers at each site, while Sikh volunteers organise the yearly commemoration of Guru Nanak's birthday. The Muslim, Sikh and Hindu chaplains are part of the Trust's Equality Advisory Group. The Muslim chaplain also sits on an end of life MDT meeting at one of the sites.

The team have regular team meetings, both general and site-specific, as well as meetings with volunteers. These team meetings are open to all chaplaincy team members. However, the Christian chaplains also meet

separately to discuss on-call and other strategic issues arising. At the time of observation, the team were having a spiritual care policy ratified by a Trust committee.

Case Study 4 (June – August 2016)

This fourth case study was situated in a location with a large Muslim population, and with a chaplaincy team that has the highest number of WTE hours dedicated to Muslim posts. The Trust is spread over two sites, although most of the chaplains are based at the primary site for the Trust. There is a full-time male Muslim chaplain, two part-time female Muslim chaplains, a full-time Christian chaplain, a part-time Hindu chaplain, a part-time Sikh chaplain, and a strong regular volunteer base, including a volunteer of no faith. Previously, the Hindu chaplain used to act as a voluntary "faith visitor" for both Hindu and Sikh patients. The team also includes an administrator, who co-ordinates volunteers and manages referrals for the chaplains. A paid on-call service is provided by the Muslim and Christian chaplains on rotation.

While there was a degree of reluctance from other chaplaincy teams about working in maternity and paediatrics, the two female Muslim chaplains and several female Muslim volunteers have a strong presence in these areas and visit these wards generically. Otherwise, the Muslim chaplains tend to visit on a faith-specific basis, although they appeared not to be dependent on lists and received a steady flow of referrals. The Christian chaplain appears to operate on a more proactive generic bed-to-bed basis. The Hindu and Sikh chaplains work from a patient list. Volunteers are generally encouraged to visit generically on allocated wards. The Muslim and Christian chaplains both have wider institutional roles, sitting on committees and delivering training to their volunteers and to wards, with particular emphasis on cultural competence and literacy.

This chaplaincy is the only team studied where the Muslim chaplain leads daily prayers in the prayer facilities. A significant amount of time is

dedicated to monitoring and maintaining the newly opened Muslim prayer facilities in the main hospital.

The team has a spiritual care/chaplaincy policy, which is due for update soon. The team has regular team meetings which all paid chaplains are invited to, although the Hindu and Sikh chaplains are usually advised as to which meetings are directly relevant for them due to their limited hours and availability.

Case Study 5 (September 2016)

The fifth case study differs from other cases and was selected on the grounds that it would provide a meaningful contrast with the cases previously examined. This case was based in a rural area, with limited ethnic diversity, and 62.3% of its population identifying as Christian and 28.9% identifying as non-religious in the 2011 census. Despite the demographic of the local population, this particular hospital has a diverse staff with a significant minority of Muslim personnel.

The team has three paid members, including the Free Church lead chaplain, a full-time Anglican chaplain, and an administrator. The team also has Catholic chaplains from the local parish employed through a Service Level Agreement to provide care to Catholic patients for up to 6 hours a week. This includes regular routine visits of Catholic patients as well as on-call. The paid chaplains are also supported by a team of honorary chaplains from various denominations. It is only possible to be an honorary chaplain if you are a minister from a local church and therefore able to provide communion to patients. The team also has a large volunteer base from a variety of denominations, who visit allocated wards generically. These visits generate follow-up referrals and also requests to attend chapel on Sundays.

The chaplaincy has a list of faith contacts who they can call in if the need arises, although this rarely happens. The team appeared to have good relationships with the Muslim doctors, who use the multi-faith prayer room for daily prayer and the main chapel for their Friday prayers. The

chaplaincy has worked with Muslim doctors to deliver training on end of life care for Muslim patients to volunteers, and to raise money for the crisis in Syria.

The hospital had recently changed its patient information system, which meant the access to patient information was very limited. This has been a cause of concern for Catholic personnel, who had been dependent on patient lists. The Catholic chaplains now rely on external referrals and self-referrals from parishioners.

Some interviewees at this site expressed dissatisfaction with the level of the multi-faith work and engagement in the team. One stakeholder suggested that, even if the demographics diversified, the team leader would be reluctant to change the *modus operandi* of the team to reflect such changes. Some concerns were raised about the intentions behind the chaplaincy work, and it was observed the boundaries regarding volunteers offering prayer were more lax in comparison to other sites. The contrasting approaches of this team are best highlighted by the unsupervised weekly visits of Gideon's representatives to the hospital, while the presence of Gideon's representatives has been a source of controversy elsewhere.

At present the team have regular meetings, but do not have a spiritual care policy or strategy. The team leader is currently undertaking research on an integrated care plan for chaplaincy provision.

The Next Steps

The fieldwork component of the study has been completed and the researcher will focus on the transcription of interview recordings until the end of the year. A report for the first case is currently being written and will be sent to the Trust soon.

In the new year, the data will be organised, analysed and written up as a doctoral thesis. Reports for each Trust will also be produced. The researcher will also return to links that have not already been established or followed up (see **Fieldwork with Chaplaincy Organisations** section above).

Proposal for Future Work with NHS England

Following conversations with representatives from NHS England, there has been some interest in this project, particularly in the possibility of converting the findings into some models of best practice.

The AHRC (Arts and Humanities Research Council) provides doctoral researchers with the opportunity to undertake a placement with an external partner with financial assistance from the Skills Development Fund. This placement allows researchers to pause their PhD but continue to receive their stipend in order to work with external organisations to develop skills in research dissemination, knowledge exchange, collaboration, and public engagement.

Following the expression of interest from NHS England, it is proposed that the researcher works with NHS England to establish how best to produce outputs that are useful to the organisation. The researcher will be better able to produce outputs by working alongside NHS England to ascertain a) the resources allocated to chaplaincy oversight, b) the aims and objectives relating to healthcare chaplaincy, and c) what connections already exist with faith communities and chaplaincy organisations.

Following discussions with Catherine Thompson at the annual chaplaincy conference at York St John, it was established that such a placement could only take place on a part-time basis, as chaplaincy is a small part of the Patient Experience brief. It is proposed that the researcher splits her time so she is working approximately 0.5WTE (2.5 days a week) with NHS England, and matched by the same on the doctoral research, for up to 6 months. It is recommended that this is treated flexibly, in accordance with when chaplaincy meetings take place, and that a weekly timesheet is put in place to ensure that appropriate hours are being dedicated.

Due to the researcher's teaching commitments, it is suggested that the placement begins June 2017 and ends December 2017. It is proposed that the researcher is based in Leeds, as she already has significant connections with both the university and with Chris Swift, who is a key figure in the chaplaincy scene. The researcher is willing to travel to London as and when necessary, and the research council have indicated they would be willing to cover the travel costs.

Subject to the agreement of Catherine Thompson and other relevant personnel at NHS England, an application will be made to the AHRC's Skills Development Fund for continued funding to make a knowledge exchange placement possible. The AHRC have so far said that travel expenses can also be covered for the placement. The next deadline for the AHRC Skills Development Fund application is on **14th November 2016** and the outcome should be announced around January 2017.

Concluding Summary

This report has been produced following the successful completion of five case studies with NHS chaplaincy teams. Extensive links have been fostered with chaplaincy organisations and chaplaincy teams on the ground in order to carry out a comprehensive study of the integration of minority faiths in healthcare chaplaincy. The findings demonstrate the complexity of the working practices of chaplaincy teams, and that chaplaincy team leaders and the Trusts they work within have a significant influence on how far chaplaincy is multi-faith, the autonomy of minority faith representatives, and the role and remit of chaplaincy in the hospitals they serve. It is hoped that the findings and their analysis will be of assistance to chaplains and NHS England. It has been proposed that a knowledge exchange placement will maximise the impact of these findings and help contribute to the further strategic development of chaplaincy.