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Hospital-based spiritual care: what matters to patients?

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ABSTRACT

Demographic changes in Australia have led to an increase in both religious diversity and the number of people who do not nominate a faith affiliation at hospital admission. Models of chaplaincy have shifted from clerical and largely male to an increasingly skilled and diverse spiritual care workforce appointed directly by health services. This study uses survey and in-depth interview methods at an inner-city Australian hospital to examine patient preferences for hospital chaplaincy provided by faith communities, and the importance of faith affiliation compared to other spiritual care provider characteristics. Survey results indicate that of 110 respondents, a high proportion (74%) prefer spiritual care to be provided by a person of the same faith. However, when considered relative to other characteristics, faith affiliation was not as important as kindness, listening skills and a non-judgmental attitude. Our findings have implications for workforce planning and educating. Further research in different settings and with different populations will make the findings more generalizable.

KEYWORDS

Faith affiliation; hospital spiritual care; patient preference

Introduction

Recognizing the importance of chaplaincy services, the Victorian State Government, Australia agreed in the 1950s to provide fifty percent of total funding for the provision of chaplaincy in public hospitals to Victorian Christian Churches. Since the 2010s this funding has included a broader representation of faith communities (Holmes, 2019).

There have been many changes in society causing modifications in the delivery of spiritual care over the last six decades. First, there has been an increase in religious diversity and in numbers of people who do not nominate a faith affiliation as a result of the demographic changes in Australia (Australian Bureau of Statistics, 2016). Second, there are changes in understanding of spirituality and spiritual care in response to the expanding research and evidence on the positive contribution of spiritual care to patient

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outcomes (Fitchett, 2017; Flannelly et al., 2012; Jankowski, Handzo, & Flannelly, 2011). Finally, the models of chaplaincy have shifted from predominantly clerical (and male) providers of care appointed by a recognized church to an increasingly skilled spiritual care workforce appointed directly by health services (Rumbold, 2012; Timmins et al., 2018). This has led to increasing questions about the professional identity of spiritual care providers and the role of faith communities in providing spiritual care (Holmes, 2019; Nolan, 2021).

Currently in Victoria, fifteen faith communities receive State Government funding through the Spiritual Health Association (SHA) for the provision of spiritual care services to Victorian hospitals. While the faith communities of Victoria contribute to the spiritual care of people in hospital, there has been no evaluation of the benefits and outcomes of this model of service delivery in health care. The importance of a patient's faith affiliation and understanding of how their preferences for spiritual care contribute to health outcomes is not well understood. This research project will begin to address this gap by providing some of the evidence required to effectively evaluate the model and if necessary, to consider alternatives.

This study rests on the premise that spiritual care is an important aspect of a person's overall health and wellbeing, and the integration of spirituality into the biopsychosocial model of healthcare is a requirement of patient-centered care. In this study we employ the definition of spirituality that was agreed at the meeting between the George Washington Institute for Spirituality and Health and Caritas Internationalis with the Fetzer Institute in January 13–16, 2013, in Geneva, Switzerland:

Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices (Puchalski, Vitillo, Hull, & Reller, 2014)

Another important concept utilized in this study is *spiritual care* which is defined as:

Spiritual care is the provision of assessment, counselling, support and ritual in matters of a person's beliefs, traditions, values and practices enabling the person to access their own spiritual resources. (Spiritual Health Association, 2020)

A number of studies have investigated different ways of organizing spiritual care in hospital settings, in particular who should deliver it, identifying different approaches to the delivery of care (Anke I. Liefbroer, Ganzevoort, & Olsman, 2019).

Here, the focus is on patient preference. Glenister and Prewer (2017) examined what they called "patient choice" and classified these as: "(1) pastoral care by Royal Melbourne Hospital (RMH) staff, including an explicit religious or spiritual dimension; (2) pastoral care by RMH staff plus faith community involvement; (3) faith community involvement only; (4) pastoral care by RMH staff for emotional or personal needs only; (5) declined any pastoral care; and (6) other, including referral to other RMH services." Another study by Gardner, Tan, and Rumbold (2020) indicates that patients with and without a faith affiliation were satisfied with the care provided by the pastoral care team at a Catholic hospital. Therefore, religious affiliation alone does not determine patient preferences and requirements for spiritual care in hospital. In their study of specialist spiritual care for people with complex healthcare needs, Snowden et al. (2018) found that the most important aspect of chaplaincy care for patients in the UK and Australia

was “being able to talk about what is on my mind.” This was more important than being listened to, having faith/beliefs valued, or being understood.

The aim of this pilot study is to determine the perceived value of the hospital chaplaincy provided by faith communities. The study asks the question: what is the demand for faith specific spiritual care for patients with a designated faith affiliation?

There are two sub-questions:

- a. Do patients with a designated faith affiliation want someone from their own faith tradition to provide their spiritual care?
- b. How important is it, compared to other spiritual care provider characteristics that the care is provided by someone of the same faith affiliation?

Methods

Research design

The study was grounded in participatory research with a mixed methods design, including a short survey and semi-structured interviews with patients to better understand what matters to them regarding their spiritual care and the faith affiliation of spiritual care providers. Study methods were guided by a steering committee of researchers, and spiritual care managers from participating hospitals. This exploratory study is not intended to achieve saturation or designed to generalize findings across any population.

Setting

Five major hospitals agreed to participate in the study. Following an extended period of ethical review, the study team was able to collect data at only one site, the Royal Melbourne Hospital, before Covid-19 shut hospitals to external research projects and to date no other sites have reopened. Data presented here were collected in the hospital’s general medical, cardiology and nephrology wards, with the maternity and oncology wards excluded.

Research instruments

Data came from two sources: surveys and in-depth interviews. Surveys and interview guides were developed through a collaborative approach with members of the steering committee.

Eligibility Criteria

To be eligible to participate in this study, patients recruited met the following criteria:

- Have the capacity to consent for themselves.
- Were 18 years and over.
- Had nominated a faith affiliation on their intake form.

Patients who were admitted for day procedures and/or who were in maternity and oncology wards were not eligible.

Recruitment

The recruitment and data collection team consisted of hospital-based spiritual care volunteers and a member of the research team. The spiritual care coordinator worked with hospital volunteers to examine admission records and generate a list of patients who nominated a faith affiliation. Recruitment/data collection team members were given a list of patients and their faith affiliation, to approach within the hospital. When arriving on an indicated ward the volunteers first showed the list to the nurse in charge who then advised about competence to provide consent. Anyone who was deemed unable to provide consent for themselves was excluded.

The recruitment/data collection team approached eligible patients on the final list and provided them with a written Participant Explanatory Statement. Volunteers were trained to seek verbal consent for the short survey, and permission to be contacted for an in-depth interview at a later date.

Data collection

Survey data was collected by three spiritual care volunteers, who were provided with relevant information from the National Statement on Ethical Conduct and trained to administer a brief survey to the patients.

Pragmatic sampling was used to recruit interview participants. Survey participants were asked if they wanted to be contacted for an interview following their hospital stay. Semi-structured interviews were conducted by the researchers via telephone. The consent to participate in the interview was assumed based on their provision of contact details and reconfirmed prior to commencing the phone interviews.

The interviews were recorded. Each interview lasted up to 60 minutes in duration. The interviews explored patients' experience of spiritual care provided in hospital, and different qualities of spiritual caregivers that are most important to patients and in what way these characteristics matter to them.

Data management and analysis

The data were deidentified. Any names associated with data were then deleted/destroyed and not entered into the research database. Only names and contact numbers were collected for participants who wished to be contacted for individual in-depth interviews. Data was only shared through a password protected data sharing platform. Survey data were entered into Qualtrics and analyzed using simple descriptive statistics.

Interviews were professionally transcribed verbatim and de-identified. Data analysis was nonlinear and followed Braun and Clarke (2006) framework. We began with familiarization with the raw data. Immersion was followed by open coding and collating the data around a preliminary coding template, without trying to code into a pre-existing theoretical framework. We reflected on the initial coding template to identify and

Table 1. Faith affiliation of survey respondents (*n*-110).

Faith affiliation comparison	Frequency	Percent	Royal Melbourne Hospital daily, 2019 (total: 661)
Other Christian	37	35.5	72 (10.9%)
Catholic	52	50.0	120 (18.2%)
Islam	5	4.8	20 (3.0%)
Orthodox	8	7.7	95 (14.4%)
Buddhist	1	1.0	10 (1.5%)
Total	103	100.0	

articulate commonly occurring themes. We adopted an inductive approach, where the initial themes were identified across the data set and were strongly linked to the data. Prevalence of themes were determined in terms of the convergence in the responses of informants to the interview questions. We developed a thematic map and refined it through repeated cycles of detailed examination of themes in relation to the coded data and the literature. The map reflected the importance of faith congruity between the patient and the person offering spiritual care, and the qualities of spiritual care providers that were most important to patients.

Ethics

Ethics and governance approval were obtained from Melbourne Health (2019.290). Reciprocal approval was received from La Trobe University.

Results

Surveys

Survey data were collected from 17 different wards over three days in December 2019. A total of 110 surveys were completed. Among 105 respondents who declared their gender, 48 (46%) were male, 57 (54%) were women. The average age was 68 (ranging from 20 to 103 years old).

All patients either spoke English or had relatives present who translated for researchers. [Table 1](#) illustrates the faith affiliation of survey respondents from a snapshot taken on one day in January 2019 of the RMH overall patient population.

Survey data, as shown in [Table 2](#), indicates that hospital recording of faith affiliation is over 90% accurate.

When asked if they preferred that spiritual care be provided by a person of the same faith, most participants considered it important. [Table 3](#) illustrates 74% of respondents indicated that having spiritual care provided by a person of the same faith is important and 26% indicated that it was not very important.

When considered relative to other characteristics, faith affiliation was not as important as kindness, listening skills and a non-judgmental attitude. Regardless of age, gender and faith affiliation, participants ranked “kindness” as the most important attribute that spiritual care workers should have, followed by “listening skills.” A “non-judgmental attitude” was ranked third and “same faith” was the least important across all categories. In the survey, the importance of faith affiliation was ranked against kindness, listening skills and a non-judgmental attitude. These attributes were derived from the literature

Table 2. Faith recording accuracy ($n = 109$).

	Frequency	Percent
Faith recording accuracy		
Yes	101	92.7
No	8	7.3

Table 3. Importance of faith congruity with spiritual care provider ($n = 95$).

	Frequency	Percent
Not important-less important	25	26.3
Important-most important	70	73.6

and discussion between steering committee participants. [Table 4](#) lists these four attributes according to the percentage of time each was ranked as the most important in the survey.

Interviews

Participants were recruited from survey respondents. Ten participants consented to be contacted for an interview. Six participants could not be contacted. Four participants, two men and two women, were interviewed by telephone by an experienced qualitative researcher. Interviews lasted between 10 and 55 minutes. Ages ranged from 55-77 years old. All participants were Anglo Saxon and Australian born.

The faith affiliation of each participant varied, but three were not currently affiliated with a faith community. One woman, Betty¹, was Anglican by background but currently only “occasionally” saw a Buddhist monk for support. One man, Keith, was “not a regular church goer” and had little to say about his faith affiliation. Vera, in contrast, gave up religion when two of her children died but was previously very engaged in organized religion, including Catholic, Church of England, Methodist, Presbyterian, and also played in the Salvation Army band. Finally, Stan was very active in the Uniting Church and his faith was an important part of his identity.

Participants were asked if it was important to them that their spiritual care was delivered by someone of the same faith. While noting they would prefer someone with the same faith background as their own, through discussion it became clear that it was not the most important factor. Betty mentioned that she would prefer Anglican because a shared faith is “something that you can resonate with and it’s more connecting.” However, she noted that Anglican was only part of her experiences growing up, but she is not currently involved in the Anglican community. While she sees a Buddhist monk these days, she noted that she was happy to see anyone but Catholic spiritual care workers. Stan spoke about his strong connection to his faith. He did not have a strong opinion about who should deliver spiritual care but did have thoughts about the kind of attributes a spiritual care worker should have.

Attributes which participants repeatedly identified as important for spiritual care workers included: Truthful, genuine, supportive, understanding, and empathetic. Participants noted wanting to talk with “someone that has been through a similar

Table 4. Frequency of attribute being ranked most important ($n = 97$).

	Frequency	Percent
Kindness	45	46.4
Listening	20	35.1
Non-judgmental	19	19.6
Same faith	13	13.4

experience” (Betty). “Empathy and understanding” are qualities that participants wanted their spiritual care workers to have. Betty said it was important that person has the ability to put themselves “in someone else’s shoes...rather than just offering you token words.”

Vera expanded on empathy by adding that it was important that the spiritual carer has “a sense of where the person is. If the person doesn’t want to talk, well don’t push them. Just spend a bit of time with them and hold their hand.”

Also important for Stan was the idea that a spiritual care provider would come prepared. He said, “In other words being prepared to talk about... spiritual [things]... Not necessarily reading... the Bible or something like that... Maybe dropping off weekly little discussion points.”

Vera described a very positive experience with a spiritual care worker who was “natural” with her. She described her as

open and honest with me and she asked me questions that I would never answer to anybody, not even my family. She had me that relaxed that I could answer questions I don’t speak to my family about.... she put me at ease, she was really nice. And she was very caring when she was talking to me.

She also valued the ability to mix-up the conversation. She says it is “very important to have a good time... and a bit of serious talk and light talk. It’s not all heavy.”

Participants also described what they did *not* like spiritual care workers to do. Stan said, he doesn’t like “patter”.

One of the things that I feel fairly strongly about, is that they don’t come in and minister to me as if they know, and they’ve got patter. That they want to do this, they want to do that. And then they say, “Oh well I’m busy, I’ve got to leave now” I’ve come across that a couple of times.

Vera described how she does not like carers to be pushy. “I told her I wasn’t religious, but we still had quite a good chat. She was a very interesting lady, she wasn’t pushy, she was nice and so I said, ‘Yes, I’ll talk to you’... It doesn’t matter who I speak to. I mean I’m quite happy to speak to somebody.”

Finally, for Vera, whose two children died and was no longer religious, she did not want spiritual carers to talk about religion. “And as soon as they started talking about religion, I just had to turn them off. I just couldn’t talk to them about it, about religion. I’d try and answer honestly, but deep down I’m still not religious, but to each his own.” Vera recalled a good experience with a spiritual carer to further her thoughts about not talking about religion, she said:

We didn’t talk a lot about religion, but we talked about a lot of things and that’s something you need to do when you’re in hospitals. Talk about anything but medical or

religion. When you've had religion rammed down your throat like I did [previously] that really made me so angry.

Overall, participants understood spiritual care to involve a connection. One good experience was described as an opportunity to "open up". Vera said:

I opened up to her, as I've spoken to you, you're the only second person I've ever opened up to, in this line of conversation. And I just feel that they need to be natural, open, honest, and introduce themselves first of all and smile when introducing themselves because she was fantastic.

She went on, "She completely relaxed me and that's something I can't do very often. I don't relax very much."

Stan explained his vision of spiritual care as "It's almost like meeting the stranger, as Christ did in a number of those excerpts. Walking on the way, meeting, stopping, having a chat. Doing whatever, and then pushing on."

Discussion

This study uses survey and in-depth interview methods at an inner-city Australian hospital to examine patient preferences for hospital chaplaincy provided by faith communities, as perceived by patients and the perceived importance of faith affiliation compared to other spiritual care provider characteristics.

Half of this study sample identified as Catholic (50%), and the second largest group were Other Christians (35.9%). This is in contrast with the 2016 Australian census which found that 22.6% of the population identified as Catholic and Christians correspond to 65.4% of the population (Australian Bureau of Statistics, 2016). For the age group over 65 years old, census data indicates an overwhelming affiliation with Christianity (70.3%) (Australian Bureau of Statistics, 2016).

Our findings suggest that a high proportion (74%) of respondents, all of whom recorded a faith affiliation on admission to hospital, prefer spiritual care to be provided by a person of the same faith. Glenister and Prewer (2017) study found that "of the 77% of patients who identified with a particular religion, 29% requested attention from a representative from their own faith tradition." (p. 628). More than 40% of these patients required a hospital-based specialist faith chaplain. However, in the present study when patients were further asked what qualities matter most to them in their spiritual carer, faith affiliation was the least important. Qualitative results, though limited, point to similar findings. One patient first stated that affiliation mattered, then through discussion it became clear that characteristics such as empathy and listening skills were more important and it was less important to receive care by a certain faith. This finding is aligned with the result from a recent study by Liefbroer and Nagel (2021, p. 366) which found that faith affiliation is not "significantly" important for how the client understands the relationship, "i.e. as spiritual guide, counselor, or companion". However, they also found that the activities undertaken during the conversation do not make a difference to this understanding, such as listening, speaking, praying, or performing rituals. While our study does not specifically examine how the relationship is understood, our qualitative findings indicate that patients may have preferences to the kinds of conversations that take place.

Our limited qualitative data begins to tease out qualities that patients do not like from spiritual care providers, such as pushiness. Also important was that spiritual care providers found the right balance between talking about “heavy” topics, like medicine and religion, and lighter topics. One study found similar results with end-of-life patients and carers finding proselytization and “prescriptive approaches to spiritual care” to be “insensitive and inappropriate” (Selman, Young, Vermandere, Stirling, & Leget, 2014).

The survey results provide further evidence about what attributes of spiritual care providers hospital patients think are most important. Like other studies have found, patients interviewed here expressed the importance of empathy, being listened to and being met where they are, or as one study called it, “being treated as a person” (Gardner et al., 2020). That study also found that patients valued leaflets distributed by the spiritual care team, as suggested by one participant in the qualitative component in our study (Gardner et al., 2020). One large qualitative focus group study conducted across nine countries also found that “human connection” was a “prerequisite to providing effective spiritual care” (Selman et al., 2014). Interpersonal factors that were considered important were consistent with the findings of this study, such as openness, genuineness, and empathy. Our study adds to the research by providing further evidence to confirm the qualities that matter most to patients.

One study examined what aspects of the spiritual care relationship were most important for patients in Scotland and Australia and found that what patients felt was most important was “being able to talk about what is on my mind” (Snowden et al., 2018). This was found to be more important than being listened to, having your faith/beliefs valued or being understood. These results reflect our qualitative findings in which participants described needing to feel at ease in order to talk.

Other studies have identified the demand for spiritual care in hospital and found that patients who are older and more religious are more likely to request spiritual care than those who are younger and less religious (Fitchett, Meyer, & Burton, 2000). The study also found that patients without a reported faith affiliation are not less likely to request spiritual care than those who identify as religious. While all participants in this study identified a faith affiliation at hospital intake, they were not all currently practicing. Although our sample size is too small to be definitive, our qualitative data hints that patients may welcome spiritual care even if they do not identify as feeling connected to a faith community. These nuances of faith affiliation hint at the complexity of spiritual care provision. Just knowing the faith affiliation of patients does not provide sufficient information to draw conclusions about patients’ spiritual needs or preference for spiritual care.

Conclusions & Limitations

This study was intended to be set in five large hospitals across Melbourne. Given the setback of Covid-19 only one-fifth of the data was collected. Other sites have either received approval or it is pending, and further data collection can take place in the future once restrictions are eased.

Therefore, given the small sample size of the qualitative data, the findings offer insight into what is important in the delivery of spiritual care in one site. Findings

indicate that patients believe faith affiliation of the spiritual care team is important but not as important as other attributes such as kindness, listening skills and a non-judgmental attitude. These findings have implications for workforce planning and educating and they should be validated across all sites before recommendations are made.

This study sample was not random nor is it a representative sample of faith affiliation across Victoria or Australia. The survey sample was pragmatic and consisted of available patients on the days the surveys were collected by Spiritual Care volunteers who received brief training in data collection. Future research in this area should more carefully sample participants to ensure results can provide evidence across faith affiliation, age groups, cultural groups, gender, and other patient characteristics.

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Note

1. All names are pseudonyms.

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