

A Standard for Research in Health Care Chaplaincy

Peter W Speck

Former Health Care Chaplain

Hon. Senior Research Fellow

King's College London

&

Visiting Fellow, Southampton University

Correspondence to: Revd. Prebendary Peter Speck

22 The Harrage, Romsey, SO51 8AE

Tel: 01794 516937

Pws7749@ntlworld.com

Abstract:

If we decide to spend a major part of our income on a particular item, such as a car, the chances are that we will spend time reviewing the market and assessing such factors as cost, reliability, suitability for the envisaged use and form of guarantee should anything go wrong with our new purchase. We might not use the term research to describe this activity but there is a sense in which we are testing the hypothesis that “there does exist the ideal car to match our needs and wishes”. Research need not be daunting once we are motivated.

Health care chaplains are strongly motivated to offer the best possible care, but are we sure that we are doing so? In this paper I review the need for chaplaincy to be aware of the growing amount of research evidence for the importance of spiritual care and belief in the provision of health care within the NHS. Much recent work has been undertaken by non-chaplains, or is unpublished. The paper, therefore, introduces a draft Standard for research proposing an incremental involvement ranging from developing awareness of the existing evidence to leading a research programme to advance the knowledge base.

Key Words:

Research, Evidence, Awareness, Involvement, Standard, Collaboration, Health-Care Chaplain

A standard for research in health care chaplaincy

Introduction	4
Implication for spiritual care providers	5
Awareness	5
Sifting the evidence	6
Where does one find the evidence?	7
Active involvement with research	9
Collaborate with existing research teams.....	9
Develop and take a lead in research projects	10
Conclusion	11
References.....	12
APPENDIX I	13
What do we mean by evidence?	13
APPENDIX II	15
Chaplaincy Research Standard Framework	15
<u>E3</u> Initiate and Contribute to Research	15
E3.1 Develop awareness, through critical exploration, of research themes and questions	
E3.2 Disseminate good practice and new research findings	
E3.3 Contribute through collaboration with other researchers in current research programmes	
E3.4 Take the lead in research projects through developing proposals, projects and programmes of research	

Introduction

Every patient who enters the UK health care system expects to be treated with dignity and respect, and to receive the best quality of care appropriate to their need (NHS Plan,2003). While this is true for the care given by doctors and nurses it is also true for the care provided by other professionals who meet the patient at various points in that person's illness journey. To ensure that the patient's expectation is met, in so far as it is realistic, all care-providers have established Standards for the service delivered by each professional group, which can be audited as part of a process of monitoring.

Health care chaplains established a set of National Occupational Standards (Sails et al,1993) which described the main aspects of their role and work. Various individual chaplains and representative groups then began to frame Quality Standards in order to audit the effectiveness with which they delivered their service. This was further strengthened by the incorporation of health care chaplaincy into the Governance framework of the NHS. However, the question arises as to what is the best quality of care? Is the care we offer today and different from that which we offered ten or twenty years ago. How do we know that our current practice is the most effective way of meeting the needs of the particular patient in front of us today? For example: in offering support to a family who have just experienced a sudden and tragic bereavement is our model of care based on earlier understandings of 'phases' and 'stages' (Parkes 1996 3rd ed., Kubler-Ross 1990) or are we aware of insights provided by the biographical approach (Walter 1999) or the Dual-Process model of Stroebe (1993). Research with bereaved people has led to major changes in how bereavement counsellors support

families. Have we evaluated this work and have we, or should we, change our pastoral practice?

The answer, within medical and nursing practice, is that all practice should be research-based and new research evaluated to see if changes in clinical practice are required. The past 10 years or more have seen a concerted effort to re-examine much of what was deemed 'good clinical practice' to see whether in fact was as good as previously believed. Evidence-based medicine and the National Institute for Clinical Excellence (NICE) are here to stay and are playing a crucial role in the re-appraisal of clinical practice in terms of both drugs and procedures. The recent issuing of the NICE guidance on supportive care within palliative care (NICE 2004) illustrates that all those involved in providing care (from whatever perspective) should do so on the basis of a recognised evidence base that protects the interests of the patient. Not all research findings are necessarily good and practitioners, individually and corporately, need to acquire the skills necessary to sift through the evidence offered before making radical changes.

Implication for spiritual care providers

The acceptance of spiritual and religious care as important factors in the provision of health care (NHS Chaplaincy 2003, SYWDC-Caring for the Spirit 2003) means that spiritual care providers also need to be aware of current research and able to evaluate the findings. Active involvement in research is not for all and the proposed Standard Framework (E3) recognises this fact. [see Appendix II]

Awareness

Against the background of evidence-based clinical practice health care managers will expect those employed to provide for the spiritual needs to be *aware* of the evidence

that has been gathered to date. Some of this work will be from outside the UK, notably from the USA, and therefore describing a different social and health care culture to our own. However, this work remains part of the wider evidence base even though perhaps not immediately applicable to our NHS setting. The American *Journal of Pastoral Care*, for example, contains a variety of peer reviewed research articles which examine many different pastoral situations and interventions, as well as evaluations of services. Some of these are very specific to the American setting, but others raise issues readily applicable to our own country (see Flannelly 2003). Much of the US literature examines the relationship between religious behaviour and a variety of measures of mortality and morbidity – focussing especially on mental health, end-of-life and various health profiles (Dein 1997, Speck 1998). Within the UK, research has developed into examining the possible relationship between belief (religious and/or spiritual) and a variety of health outcomes. (King et al 1999, Murray et al 2004, McIllmurray 2003) Some of this work has been undertaken by chaplains, but much of it has been by medical and nursing staff who have developed an interest in this aspect of care.

Sifting the evidence

‘All that glitters is not gold’ and spiritual care providers should be aware of this evidence and able to critically evaluate it. Where it seems to challenge current practice they should be able to decide whether the evidence is such as to merit a change in practice or a re-affirmation of current approaches. Reading papers in isolation is not always easy and it can be helpful if chaplains meet together at an agreed interval to review recent publications and evaluate their importance. People might take it in turn to read, present and critique a paper(s) or newly published book. In this way a growing number of chaplains will become aware of the research evidence and be able to cite it in meetings

or when preparing documents such as a Business Case to fund new initiatives. [There are various levels of evidence as referred to in Appendix 1].

This level of awareness would enable chaplains / teams to identify and explore research themes and develop questions, pertinent to the provision of spiritual care, for those more actively involved with research to explore further. This is the basis of : **E3.1** Develop awareness, through critical exploration, of research themes and questions

Where does one find the evidence?

If one looks at the Journals linked to health care chaplaincy there is clear evidence that many chaplains are seeking to improve the service they provide, to respond sensitively and appropriately to patient need, and to share that good practice with others. The many conferences convened by chaplaincy organisations over the years have had a strong educational and developmental aspect to them. Not all of the proceedings have appeared in print. Where they have they have tended to be published as reflective, case study, accounts which have enabled other practitioners to develop and re-shape their practice. These have sometimes been important milestones in spiritual care development, but not necessarily peer reviewed and reflective of a wide body of experience. Textbooks and chapters within textbooks have helped to shape pastoral practice since the mid-1960's. (eg. Cobb & Robshaw, 1998). However, with one or two exceptions, there have been few systematic research-based examinations of the role of health care chaplains which have been published and therefore able to be accessed and evaluated by others. There was a long gap between the study by Michael Wilson (1966) and those of Orchard (2001) and Wright (2003). The enrolment by chaplains for a variety of higher degrees has meant that some valuable studies have been undertaken but sadly not always subsequently published in peer reviewed journals. Several remain as

unpublished theses in University libraries and therefore not readily available to most working chaplains. I acknowledge that getting one's work published is a time consuming and daunting task. However, a scan of the key medical and nursing journals shows that the earlier antipathy to such topics has diminished and words such as religion and spirituality are much more common in the list of article 'key words'. Editors are more able to find referees who can judge the quality of papers submitted and so the opportunity exists if submitted work is tailored for the readership of the journal, conforms to the house style, and seems to take the knowledge and application of the subject further forward. This is the focus of section **E3.2** of the proposed Standard.

Dissemination of research findings and good practice can also be through participation in local and national professional meetings and conferences. Most major conferences, as part of their advanced publicity, put out a call for papers and abstracts. Specialities such as palliative care and care of the elderly are groups particularly interested in exploring the relevance of spirituality. This presents an opportunity for spiritual care providers to submit a short abstract of a particular aspect of care that they would be willing to present orally to a sub group at the conference or as a 'poster' at the meeting. The 'teaching media' department of a Trust will always help staff prepare their work for presentation as a poster for a conference, given sufficient notice. There is a charge for this service but this is usually not excessive. The same department can also help staff prepare overhead projector acetates for those who don't feel confident or wish to use a PowerPoint presentation via data projection.

One of the reasons for a reluctance to engage with empirical research and the scientific study of spiritual care and its efficacy may relate to a perception that the work (and especially the effectiveness) of a health care chaplain is not measurable. In addition it

can seem too intrusive to explore the intimacy of the pastoral encounter. Most spiritual care providers work in a private one-to-one relationship with little or no observation of what they do and say. This is similar to the relationship between client and counsellor / therapist. However, therapists now recognise the need to find ways of demonstrating and evaluating the effectiveness of the various approaches and theoretical understandings which they represent. As mentioned earlier in this paper, active involvement in research may not be for everyone but a review of the journals shows that, with a very few exceptions, much of the current work seems to be undertaken by doctors and nurses without the involvement of health care chaplains. There is a great need for collaborative, multi-professional approaches to such studies which is the focus of **E3.3 and E3.4**

Active involvement with research

Collaborate with existing research teams

For some individuals and health care chaplaincy teams there will be a desire to become more involved in the research process. The strategy proposed in *Caring for the Spirit* envisages a clear research arm to the future development of the service. This might cause a degree of anxiety amongst some and excitement in others. It is a difficult task for a lone individual or a team working within a Trust in isolation to develop a research programme. Apart from the skills required to frame research questions, write proposals, apply for ethical approval via COREC [research ethics committee approval] and comply with research governance within the trust, there is the major issue of funding. However, there will be a large number of people within each NHS Trust who will already be active researchers. The Research and Development directorate (R&D) and the local research ethics committee (LREC) may be able to help in identifying research teams that chaplaincy might approach to explore the possibility of collaborative working. Knowledge

of the research evidence, as discussed above, will help chaplains to demonstrate the possibilities for exploring spiritual belief as a factor which might be contributing to some of the outcomes more medically-focussed studies may be studying. For example, a team exploring the factors affecting the ability of patients to cope with a diagnosis of chronic illness, such as disseminated sclerosis, may be willing to include a measure of belief alongside the other measures they are proposing to use – for very little extra cost. If this level of co-operation is possible the chaplain/team can begin to acquire the skills to develop a study and analyse the data and results.

Not all chaplains will have had the opportunity to acquire research skills as part of a higher degree course. Many Trusts and medical schools run courses for researchers and students on research methodology, as well as more specialist courses on the use of computer statistical packages (eg SPSS www.spss.com) or databases for the management of journal and other references (eg Reference Manager www.refman.com). For internal staff this course may be free or at very reduced cost. The R&D directorate or medical school will have details. The various representative bodies for health care chaplains may also have short course available to assist those wishing to explore research further.

Develop and take a lead in research projects

There may come a time when some chaplains feel ready to take the lead in the formulation of specific areas of study, to frame the research questions, seek funding and undertake the management of a particular project or projects. This might include the recruitment of a research assistant or establishing a clear link into an academic department within a university.

The studies undertaken may be local to the Trust or, through collaboration with other chaplains, across several Trust sites. The existing networks which exist within health-care chaplaincy would lend themselves quite naturally to such multi-centre studies. A very positive aspect of this would be the possibility of recruiting much larger numbers of participants into a study, a greater chance of achieving statistically significant results, and a more rapid development of a robust evidence base for the importance of spiritual care within the UK NHS and a greater understanding of the most effective ways of providing that care for patients and staff.

Conclusion

Health care chaplains have a significant profile at present within the NHS but if they are to maintain and build on that they need to develop the confidence to examine and demonstrate the effectiveness of what they provide for patients and staff. To achieve this they will need to, at least, be critically aware of the evidence that exists now, and support colleagues who wish to further develop a research interest through various degrees of involvement. This is important now and will be increasingly important if health care chaplaincy is to remain a key aspect of our health care system in future years. For this reason the Standard E3 is offered as a suitable way forward.

References

- Cobb M., Robshaw V. 1998. *The Spiritual Challenge of Health Care*. London: Churchill-Livingstone.
- Dein S., Stygall J., 1997. Does being Religious help or hinder coping with chronic illness? A critical review. *Palliative Medicine*. **11**, 291-299.
- Department of Health, 2003. *NHS Chaplaincy: Meeting the Religious and Spiritual needs of Patients and Staff*. London: DoH
- Department of Health, 2003. *The NHS Plan*. London: DoH
- Flannely K.J., Weaver A.J., Handzo G.F., 2003. A Three-Year Study of Chaplains; Professional Activities at Memorial Sloan-Kettering Cancer Center in New York City. *Psycho-Oncology*. **12**, 760-768
- King M., Speck P., Thomas A., 1999. The effect of spiritual beliefs on outcome from illness. *Social Science and Medicine*, **48**, 1291-1299.
- Kubler-Ross E., 1990. *On Death and Dying*. London: Routledge.
- National Institute for Clinical Excellence, 2004. *Guidance on Cancer Services: Improving Supportive and Palliative Care for Adults with Cancer*. London: NICE.
- Orchard H., 2000. *Hospital Chaplaincy: Modern, Dependable?* Sheffield: Lincoln Theological Institute
- Parkes C.M., 1996. *Bereavement – Studies of Grief in Adult Life*. 3rd ed. Harmondsworth: Penguin.
- Sails A. et al., 1993. *Health Care Chaplaincy Standards (doc2110193)*. Bristol: NHS Training Directorate.
- South Yorkshire Workforce Development Confederation, 2003. *Caring for the Spirit*. Sheffield: SYWDC.
- Speck P., 1998. Spiritual issues in palliative care. In: Doyle D., Hanks G., MacDonald M (eds) *The Oxford Textbook of Palliative Medicine*. Oxford: OUP
- Stroebe M.S., Stroebe W., Hansson R.O. 1993. *Handbook of Bereavement: Theory, research and intervention*. Cambridge: Cambridge University Press.
- Walter T., 1999. *On Bereavement: The Culture of Grief*. Buckingham: OUP.
- Wilson M., 1966. *The Hospital: A Place of Truth*. Birmingham: Birmingham University.
- Wright M., 2001. Chaplaincy in hospice and hospital: findings from a survey in England and Wales. *Palliative Medicine*. **15**, 229-242.

APPENDIX I

What do we mean by evidence?

1. Evidence base practice = dynamic process.

Need to base practice on evidence therefore:

- Decide what do we want to find evidence about
- Access the evidence
- Appraise the evidence
- Use best available evidence
- Evaluate impact of the evidence.

2. Why is evidence important

- Demonstrate effectiveness
- Improve care
- Identify key skills
- Solve problems
- Identify needs
- Provide rationale for practice
- Enhance professional status
- Show employers / faith bodies importance of use of evidence

3. Where to find the evidence

A range of techniques can be used to access the breadth of evidence that informs practice.

- **Evidence from research:**
Search and review literature, original papers, narrative and systematic plus cited references in the work of others etc.
- **Evidence based on experiences**
Reflect on practice, articulate these reflections and share with others
Published abstracts from conferences etc
- **Evidence based of theory not necessarily research-based.**
Published and unpublished literature, plus facilitated discussion with others. Theses in University libraries.

- **Evidence gathered from clients/ patients and/or their carers.**
Look for experiential writings, audit data, satisfaction levels, complaints etc
- **Evidence passed on by role models / experts**
Policy directives, observation, consultancy panels. “Delphi” surveys (several rounds of information collecting and analysis to reach a consensus). Focus groups etc.
- **Evidence passed on through policy directives**
Clinical guidelines (eg. NICE), published standards, internet searches.

5. Questions for Health-Care Chaplaincy:

- What evidence is there for the structure, role and efficacy of health care chaplaincy? What can we offer to the DoH or to NICE or CHAI that what we do is worthwhile, cost effective, and worth further investment? Is it different for:
 - the mental health sector
 - the acute sector
 - the palliative care & hospice setting
- How can more chaplains be encouraged to write about good practice, submit abstracts to conferences, present posters etc. (see J.Pastoral Care; Contact; Scottish Chaplaincy Journal, Health Service Journal etc)
- What are the key areas where we need to undertake research?
- What are some of the key research questions?

Peter Speck: June 2004
pws7749@ntlworld.com

Chaplaincy Research Standard Framework

This standard is a development from earlier work drafted by Speck, Cobb and Fraser as part of the research development work for *Caring for the Spirit*. The final version of this standard was included on the website on 28th February 2005.

E3 Initiate and Contribute to Research

E3.1 Develop awareness, through critical exploration, of research themes and questions

E3.2 Disseminate good practice and new research findings

E3.3 Contribute through collaboration with other researchers in current research programmes

E3.4 Take the lead in research projects through developing proposals, projects and programmes of research

E3.1 Develop awareness, through critical exploration, of research themes and questions

Health Care Chaplaincy Standards

E3 INITIATE AND CONTRIBUTE TO RESEARCH

Performance Criteria:

- a. Research issues arising from practice and the health and social care context are discussed and debated among colleagues.
- b. Comprehensive and critical reviews of research literature are undertaken around identified themes and subjects.
- c. Results of existing research are examined in the context of health care chaplaincy.
- d. Opportunities to attend and to participate in relevant research forums and conferences are identified and resources secured.
- e. Emerging research questions and themes are consistent with the aims of the chaplaincy service.
- f. Research questions and themes are prioritised according to their clinical relevance and the strategy of the chaplaincy service, and the objectives of the NHS.

E3.1 Develop awareness, through critical exploration, of research themes and questions

Range:

Literature: Academic peer-reviewed journals.

Subjects: Sociology, Psychology, Healthcare, Medicine, Psychiatry, Theology, Pastoral Care, Research Methods, Counselling, Ethics.

Practice: Pastoral Care, Formal Counselling, Therapy

Underpinning Knowledge:

- a. Range of recent literature.
- b. Literature search methods and resources.
- c. Research activities of the health care and associated academic communities.
- d. Critical reading and understanding of research papers.
- e. Aims of the chaplaincy service.

E3.2 Disseminate good practice and new research findings

Performance Criteria:

- a. Good practice for spiritual care is identified within health and social care context
- b. Opportunities to present experience and examples of good practice are identified and resources secured to enable attendance at meetings, conferences, research forums.
- c. Opportunities are sought to publish examples of good practice and new research findings in peer reviewed journals, textbooks and other appropriate periodicals
- d. Opportunities are sought to publish good practice and research findings in popular media outlets.

E3.2 Disseminate good practice and new research findings

Range:

Publications: Academic peer-reviewed journals
Academic text book publishers
The media services

Subjects: Pastoral care and specific situations and patient groups.
Research methodology and approaches
Counselling, ethics, theology
Religious / spiritual needs and multi-faith dialogue

Practice: Provision of spiritual care, pastoral counselling, within a multi-faith setting

Underpinning Knowledge:

- a. How to write a paper for a peer-reviewed journal
- b. How to write a paper for a non-academic journal / magazine
- c. How to prepare an abstract for a seminar, conference or forum
- d. Presentation skills to facilitate preparation and presentation of research findings via a poster or oral presentation
- e. Knowledge of the media

E3.3 Contribute through collaboration with other research teams in current research programme.

Performance Criteria:

- a. Opportunities are identified to collaborate with research active colleagues.
- b. Research proposals are submitted to, and approved by, relevant research ethics committees
- c. Resources required to undertake specific research projects are identified and obtained, in collaboration with associated researchers.
- d. Research projects are undertaken and monitored within a recognised research governance framework

Range:

Existence of other researchers within organisation

Underpinning Knowledge:

- a. Research Governance.
- b. Research Ethics.
- c. Knowledge of established research teams and programmes within Trust or other appropriate institution

E3.4 Take lead in research projects through developing proposals, projects and programmes of research

Performance Criteria:

- a. Research issues are refined and focused into specific research questions.
- b. Potential research methods are identified and assessed for their applicability, reliability and validity in relation to the research question.
- c. Specialist advice and opinion is sought where necessary on statistics, research design and ethics.
- d. Full research proposals are developed and written in a recognised format.
- e. Research proposals are discussed and evaluated in relevant forums in the health care community.
- f. Funding is sought to support the research programme
- g. Possible recruitment of staff with specific research focus and skills. E.g. research assistant

E3.4 Take lead in research projects through developing proposals, projects and programmes of research

Range:

Dedicated time to undertake research activity

Subject areas for research as detailed in 3.1

Practice: Results applicable to provision of spiritual/ religious care and development of role for spiritual care provision to those of any or no faith perspective.

Underpinning Knowledge:

- a. Knowledge of research methodology, writing of proposals, ethical protocols and analysis of results.
- b. Data analysis and statistical advice available within Trust, medical school or linked University
- c. Methods of applying for and securing funding for projects or research programme from Research Funding bodies.
- d. Research Governance and Research Ethics Committees
- e. Knowledge of local and national research needs within health care chaplaincy