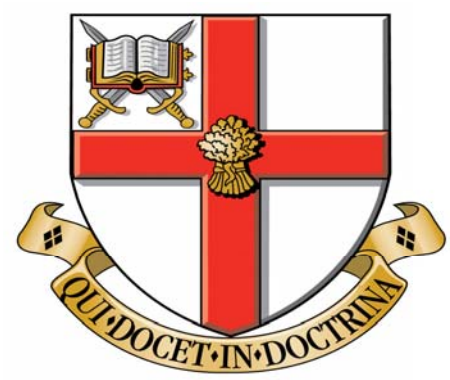
The role of the Chaplain in the strategic facilitation of multi-faith sacred space to alleviate the suffering associated with death and dying



University of Chester

Author(s): Giselle Rusted

Title: The role of the Chaplain in the strategic facilitation of multi-faith sacred space to alleviate the suffering associated with death and dying

Date: September 2014

Originally published as: University of Chester MA dissertation

The Role of the Chaplain in the Strategic Facilitation of Multi-Faith Sacred Space to Alleviate the Suffering Associated With Death and Dying

Dissertation submitted for the Degree of Master of Arts in the University of Chester in part fulfilment of the Modular Programme Faith and Public Policy

September, 2014

Table of contents

Abstract:

The aim of the research was to observe and scrutinise how chaplains go about facilitating a sacred space when requested, in the last days and hours of death. It sought to identify the context in which chaplains are compelled to facilitate religious and spiritual rituals and what perspectives participants have of chaplains when creating a sacred space within non-orthodox, clinical spaces. It also sought to understand the added value of chaplaincy in relation to high quatlity patient care and who was best placed to faciliate a sacred space at the point of death and dying.

The research used a cross sectional design study with purposive sampling and carried out ten one to one interviews with hospital staff, who had experienced chaplaincy. They were selected from different areas of the hospital. Additionally, the research used the participant observations of the researcher who is a chaplin. Using a thematic annalysis process to identify emerging themes, the research was able to achieve an indepth understanding of the contributions made by chaplains to patient and family experience, at the point of death and dying.

The research concluded that death is perceived as a significant rite of passage which requires marking; subject to a variety of expectations and that those best placed to deliver this service are chaplains, perceived as practioners in this field. The research indicated that chaplains care and are compassionate, courageous, competent and committed to providing high quality patient and family experience. Recommending that there should be greater collaboration between clinicians and chaplaincy because chaplains use their experience and knowledge when they are alongside patients and family, normalising death and contribute to a good death.

WORD COUNT**: 21,686**

Acknowledgments.

I would like to acknowledge the support and help of the following people who encouraged, sustained and helped me prior to and throughout my dissertation, ensuring that I completed this research. They are Elaine Graham, Chris Baker, Pam Moss and Martin Smith, in no particular order. I would also like to thank all those who cooperated and contributed so willingly to the research without which this thesis would not be possible including Judy Coombes who allowed me flexibility at work to achieve this. Finally, a very big thank you to my patient family, that is my husband Mike Rusted and two daughters Hannah and Charlotte Jones who without their patience, tolerance support and love I would not have been able to deliver this. You have me back now.

Critical Incident

> "My first task in approaching other people,
> Another culture,
> is to take off my shoes.
> For the place I am approaching is holy.
> Otherwise I find myself treading on another's dreams, their memories, and their stories.
> More serious still – I might forget
> That God was there…" (Franz, 2013).

Revd. Dr Kevin Franz, Head of Mental Healthcare Chaplaincy for the Greater Glasgow and Clyde Health Board Scotland, compares chaplaincy, to stepping into someone else's shoes. Providing the above quote from Esther de Waal, he attempts to catch the essence or mind-set of a chaplain. He uses interpathy, which means the land of unlikeness (Franz, 2013, p.75). Here the carer temporarily suspends their beliefs, attempting to genuinely enter into the experience of another. Sitting within an alien world, the chaplain looks around (Franz, 2013, p. 76). What is required is care, compassion, commitment, courage and competency, in relation to others. The chaplains' craft is more than technique, skill or intuition, going beyond the way we relate to individuals. It is about a whole way of being. It is a way of being human, of being religiously or spiritually alert (Franz, 2013, p.76). It is a way of sharing stories.

Michael Paterson understands the value and praxis of storytelling, demonstrating that chaplains themselves are bearers of stories that competently engage, motivate, inspire, support and challenge. It is a two way process (Paterson, 2013, p. 67). Paterson emphasises this pastoral task using four sketches taken from Sheila Cassidy's *Sharing the Darkness: The spirituality of Caring*. The first sketch depicts a doctor and a nurse in a clinical environment with a patient; sketch two portrays a chaplain, dog collar and stole with the same patient

sharing communion; the third sketch reveals the same doctor minus white coat and nurse but offers patient counselling. It concludes with patient and doctor within fluid and blurred boundaries revealing two people meeting in the raw vulnerability of literally naked humanity. Their roles no longer defining the relationship, words have dried up; "deep calls to deep' (Psalm 43) and both have nowhere to hide in their encounter (Paterson, 2013, p.67).

Appreciating further, what is undertaken by chaplains, this final example places you into the shoes of a sixteen year old who died of cancer. Her poem was found after her death;

> "Tonight as on other nights
> I walk alone
> Through the valley of fear
> O God I pray
> That you will hear me
> For only you alone know
> What is in my heart
> Lift me out of this valley of despair
> And set my soul free." (Cassidy, 1991, p.6)

Chapter One Introduction - The Structure of My Thesis

Human instinct attempts to make sense of the world around it, regardless of whether individuals have a faith or whether they have none. This search for meaning is particularly acute at the point of death or dying. It is here that there is a fundamental human requirement necessitating compassion and care because patients have no sense of control when faced with their own mortality. Chaplains, perceived as neutral, confidential and experienced are therefore requested to provide religious and spiritual sustenance, creatively in a clinical setting (Swift, 2009). This is challenging, demanding courage and compassion, intuitively and empathetically. There is also a requirement to think deeply about the way they convey spiritual and religious support for individuals, all of whom are unique (Swift, 2009).

Many challenges confront chaplaincy in a changing and diverse society, one that is multicultural, plural, with many engendering fluid and blurred boundaries (Reader & Baker, 2009). Here tensions are experienced between religion and secularism. This dissertation therefore seeks to unpack the arguments that have developed between religion and secularism, examining Steve Bruce's secularisation paradigm (2002) and the concept of the post-secular, arguing why religion and secularism must come to terms with each other and accept each other in the market place.

It then goes on to explore Heelas and Woodhead's 'subjectivisation thesis', examining the religious and spiritual motivations of individuals, acknowledging that individuals search for deeper meaning and greater spiritual engagement. It then examines, Victor Turner's concept

of liminality, relative to sacred space in the last days and hours of death and dying. It explains why spiritual and religious support is essential for family, friends and staff connected to the patient. It emphasises the transformation that takes place when individuals experience liminality as a space geographically, physically, religiously, secularly, spiritually and symbolically. It also examines Chris Swift's understanding of chaplaincy in the twenty first century and NHS (National Health Service), NICE (National Institute for Clinical Excellence) and WHO (World Health Organisations) protocols, highlighting the expectations and experiences of patients, family and staff in the last days and hours of death and dying. It explores good and bad practises of religious and spiritual care, explaining why chaplains, as healthcare professionals, are best placed to provide religious and spiritual support at the point of dying and death.

Demonstrated within this thesis are the results of research carried out through interviews and participant observation which reinforce the academics own insights. As a result of this enquiry, rich insights have been gained into the world view, experiences, challenges and validation of chaplains as they attempt to facilitate a sacred space, followed by a conclusion using the 6C's framework and further recommendations that need to be carried out.

1.1 The Post SecularDebate

The NHS is required by the Government to make savings of up to 20 billion pounds. In order to achieve this, the NHS is looking to change quickly by initially realising one off cuts totalling 520 million pounds (Telegraph, 2014). The National Secular Society (NSS) therefore argues that to reduce costs, and to benefit patient care, the NHS should not pay for

chaplaincy services. Secularists propose that the funds saved from cutting chaplaincy costs, could go towards paying for nursing and other medical costs. Consequently it campaigns for the separation of religion and state, promoting secularism as the best means to create a society in which people of all religions and none can live fairly and cohesively together (NSS, 2014). They argue that we now live in a secular society; therefore chaplains are not serving all patients equally. They claim that the present system is not fair, has no clinical benefit and should be paid for by the church (NSS, 2014).

A number of scholars have put forward secularisation theories, which the NSS uses to support their viewpoint. For example, Bruce, puts forward his secularisation paradigm (Bruce, 2005, p. 43), establishing that secularisation is a social condition born out of the declining importance of religion, leading to the deterioration of traditional religious practises. Secular institutions and the economy now fill this gap. Consequently individuals in society now behave differently, culturally and structurally (Bruce, 2005, p. 8). Bruce's paradigm consists of connected explanations concluding that modernization creates problems for religion (Bruce, 2005, p. 43).

He perceives modernisation as a multifaceted notion, comprised of the industrialisation of work, a shift from villages to towns and cities; the replacement of the small community by wider society. Consequently this led to the rise of individualism, the rise of egalitarianism and the rationalization both of thoughts and of social organisation. Religious authority decreased, with the progressive autonomisation of societal sectors undermining the domination of religious meaning and institutions (Bruce, 2005, p.2).

Bruce offers Brian Wilson's model to support his thinking. Wilson states, that traditional activities and functions have been secularised, allowing society's priorities over time to diminish in relation to supra-empirical concerns (such as religious belief). Technical methodologies therefore have displaced religious principles and undermined the religious consciousness: abandoning mythical, poetic and artistic interpretation for an empirical, rational, instrumental orientation toward nature (Bruce, 2005, p.7). .

Bruce concludes that the Protestant work ethic led to the unintended acceptance of capitalism through Calvin's justification of work. He argues that God favoured work, if it was conducted with integrity and honesty (Bruce, 2005, p.7). Furthermore Bruce suggests that structural and functional differentiation took place allowing industrialization and economic activity to displace the family as a production unit and social institution. This was replaced with work place expectations, where all are treated alike and equally, a rational, instrumental and pragmatic discipline, in contrast to the private sphere which is expressive, indulgent and emotional. Bruce also maintains that as religious power has dissolved there has been a shift with religious professionals being replaced by specialist professionals, acting within a secular framework (Bruce, 2005, p.8).

Additionally, Bruce perceives that there has been a transformation of social structures within society. Here new social roles and social mobility substitute what was once a feudal society, dictated by the status of individuals; where masters and servants knew their place. Bruce argues that pre the industrialisation society had fixed structures where church and monarchy had the power to manipulate society's relationship with God therefore individuals were subservient. These structures have now dissolved into a pick and mix, salvational system,

selected through the desires and motivations of individuals. Traditional integrated organic or communal conceptions of the moral and supernatural have become fragmented (Bruce, 2005, p. 11). Consequently individualism, a further bi-product, emerged from fragmentation and the opportunity for choice (Bruce, 2005, p. 11).

Bruce also maintains that the reformation of social structures resulted in social diversity, allowing for egalitarianism. Consequently there was structural differentiation and a climate of economic growth. Therefore, socialisation, once the core religious focus, has now been superseded by the presence of large scale industrial and commercial enterprises. Hence the effect of differentiation and socialisation is the predominant decline of moral and religious systems. This religious void has now been filled by competing secular conceptions continuing to assert their presence in the market place. Consequently, although religion for some people has retained subjective credibility; nevertheless it is losing its objective 'taken for grantedness' (Bruce, 2005, p.14).

Bruce further claims that the Reformation period permitted the spread of mass literacy, and therefore supplied a demand for acceptable resources which facilitated and allowed individuals direct access to God. Consequentially this enquiry and self-edification meant that inevitably laity became literate and self-educated. This led to greater rights in society, egalitarianism and liberal democracy being exercised. Change took place in the form of a new model of social organisation, replacing soul at the centre of reformed religion with the creation of sects and societies. Here likeminded people joined forces to pursue a common goal, creating increasing numbers of complex associations establishing a multifaceted differentiated society (Bruce, 2005, p. 15).

Core to Bruce's paradigm, which is picked up by The NSS, is the impact of diversity on society. Diversity is perceived as a central and key element to the development of a secular society. He perceives that diversity brings about acceptance of different and varying beliefs, providing harmony and tolerance of different faith beliefs. In contrast, theocracy has the ability to suppress minor faith and lacks tolerance. Consequently, society has become egalitarian, democratic and culturally diverse putting social harmony as a priority over the endorsement of religious orthodoxy (Bruce, 2005, p. 17). The different perspectives of diversity challenges peoples' religious beliefs which therefore brings into question core beliefs, that until that point would have been taken for granted, substantially undermining religion.

1.1.1 Bruce's Paradigm Challenged

Bruce's thesis, that religion will no longer continue to influence the public sphere, is contested by a number other academics, arguing for a new visibility of religion. Elaine Grahame supports this theory, providing Jose Casanova's theory. He argues that in the 1980s religion thrust itself into the public arena of moral and political contestation, seizing the attention and interest of the mass media, social scientists, professional politicians and the public at large (Graham, 2013, p.3). For example, he discerns the de-privatisation of religion due to the resistance of religious leaders who refuse to accept the marginalisation of religion. Therefore religion and politics becomes intertwined (Casanova, 2003).

The argument for a new visibility of religion in the market place is further reinforced and demonstrated by the activity of individuals pursuing meaning and purpose in the form of

increased religious dialogue: a causal impact of the 9/11 and 7/7 bombings (Habermas, 2010). Philosophers such as Jurgen Habermas, convinced that secularism had pushed religion and spirituality into the private sphere, changed their minds. As a result of Habermas' search for the creation and protection of an inclusive and robust public democratic space, he turned his attention to religion and its role. Consequently he came to understand that society must adapt to allow religion to play its fullest part (Beaumont & Baker, 2011, p.45); perceiving now, that religion and secularisation needed to co-exist and that both are intertwined (Habermas, 2010).

There is therefore, a changed perspective on secularism's relationship with society and rarely do scholars speak of the demise of religion (Reder & Schmidt, 2010, p. 2). Baker and Beaumont (2011, p.45), highlight Habermas' argument, which focuses on the role of religion, its contribution to society and obstacles in its way. Habermas claims that secularism is controlling and inequitable in its attitude to religion which is not experienced in the same way by secular institutions or organisations (Baker & Beaumont, 2011, p.45). On the one hand secularism seeks to protect the vulnerable such as women and children, perceived as dissenting and dysfunctional, for example in patriarchal dominated religions or cultures. However, there is a perceived burden on secularism to modernise consequently its controlling force damages religions cultural particularity, restricting the ability of religious citizens to genuinely partake in the public sphere (Baker & Beaumont, 2011, p.46).

This differentiation therefore is perceived as unacceptable and unsustainable. Habermas determines that one set of thinking, philosophies and belief from the secular should not influence and dominate another set of thinking, philosophies and beliefs: i.e. religion. Baker and Beaumont emphasise that Habermas now firmly believes there is a need for the secular

state to recognise the substantial contribution made to society by the lived reality of religious belief.

Moreover, Baker and Beaumont (2011, p.33) also raise awareness of Habermas' appeal for a post secular self-understanding of society in its entirety, where religion continues to exist vigorously alongside a secularising environment (Baker & Beaumont, 2011, p.33). In support of this, they focus on the impact of global migrations into the UK, with migrants bringing their own living and energetic faiths, refusing to be restricted to the private. These dynamic energies are processes of globalisation, publicly and privately, and assist in the stimulation and the re-emergence of religion in western urban life. Consequently they have an impact on the wider community and society (Baker & Beaumont, 2011, p.33).

1.2 The Spiritual Turn

Paul Heelas and Linda Woodhead add a different perspective to the secularisation and sacralisation debate, as a result of their examination of religious engagement in the UK and the USA. They try to ascertain whether religion is giving way to spirituality and the implications this may have for contemporary religion and its potential demise (Heelas & Woodhead, 2005, p. 77). They make their observations through the lens of religious and spiritual activity in Kendal in 2000, by observing religious church attendance compared to the participation of spiritual milieu, expressed as 'new age' alternative therapies, meditation, yoga, Tai chi, etc. (Heelas & Woodhead, 2005, p. 77). Identifying only small shifts in the religious landscape, consequently they put forward their subjectivation thesis; namely the 'the

subjective turn, identifying the co-existence of secularisation and sacralisation, with in the contemporary spiritual and religious market place' (Heelas & Woodhead, 2005, p. 77).

The subjectivisation thesis identifies the spiritual and religious motivations of lay individuals. Religion is defined as 'life as' which has always had spiritual elements and is distinctive from spirituality, namely 'subjective life', which has no religious elements. 'Life as' compels individuals to be influenced by external, traditional stereotypical expectations made on them by religious organisations, such as those through motherhood and marriage etc. Selfless sacrifices are made in contrast to that of their own desires and personal needs. They measured this against those who *turn away* from 'life as' and live in terms of internal or 'objective' roles, duties and obligations.

This turn towards life lived by reference to one's own subjective experiences, is called the 'subjective turn' (Heelas & Woodhead, 2005, p. 2). The 'subjective turn' is not to be confused with individualism because both 'life as' and 'subjective turn', look to a higher transcendent presence that is sacred in their search for meaning (Heelas & Woodhead, 2005, p.4). They perceive that a religion which tells individuals what to do, is out of tune with culture consequently society is gradually turning away from 'life as' and turning to the 'subjective turn'. This is because the subjective turn, connects them with the inner depths of one's unique life-in relation.

Moreover, the 'subjective turn', is also observed within the cultural canopy; for example in the education and the healthcare systems that seek to provide a greater sense of wellbeing within their organisations. Heelas and Woodhead (2005), reason that central to the fields of traditional religion and the spiritual milieu, there is significant spiritual growth where

mechanisms focus on and support the 'subjective turn'. Evidence of this shift, they claim, can also be found in the media, some religious traditions and the commercial world, which seeks to take advantage of this (Heelas & Woodhead, 2005).

These considerations and activities are also evident in health care settings, where nursing has turned to an understanding of the need for the delivery of spiritual wellbeing for patients and staff (Heelas and Woodhead, 2005, p. 80). Nurses are encouraged to ensure that patients receive a quality of life, in the form of complementary medicines, such as healing of feelings, perceiving that is contributes to making a difference, holistically. However, the subjectivisation thesis states that the desire of individuals for greater spiritual engagement competes between these two ways of relating, as individuals seek a deeper meaning for themselves in the cultural landscape (Heelas & Woodhead, 2005, p. 77).

1.3 Liminality

The concept of liminality, first developed by Arnold van Gennep, was advanced further by Victor Turner, an anthropologist, at the beginning of the twentieth century. Liminality is taken from the Latin which means threshold. It is the point at which change takes place from the present situation or context, to one of flux before becoming static again. Turner terms this as 'betwixt and between' (Miles-Watson, 2009, p161). This liminal state is a blurred period where people are neither in one state nor another state. Turner identifies the functional process of symbols and rituals, associated with rites of passage, such as birth, puberty, marriage and death as a place of liminality. For example, he provided an understanding of anti-structure which is the emergence of alternative responses made by individuals that are contrary to the expected norms of society. Furthermore, his study of primitive cultures

provides insights into modern secular society and the cultural processes. Miles-Watson argues that Turner provides clarity and deep anthropological insights rather than philosophical ones. Consequently it is a powerful tool for understanding the different divisible stages and transitions that are common to life (Miles-Watson, 2009, p161).

Turner identifies three stages of transition related to rituals and liminality. First there is separation, which is a moving away from physical, emotional or spiritual difference. This is in contrast to the norms of society and is therefore perceived as a threat to society. Secondly at the point of threshold or margin state, individuals pass through and disengage from the initial state. This is the actual liminal state. It is here that temporary communities are created as individuals who would not normally bond engage to form a transitory relationship (Miles-Watson, 2009, pg161). The final stage, aggregation takes place at the end of the changes where individuals move back into a static state. The implications for liminality within cultural norms and for those passing through this changed phase, produces exclusion from the norms, of where they move from and to. Whilst individuals travel through this transition stage, they are unable to participate in the norms of life (Turner, 1969).

1.3.1 Liminality, Chaplains and Rituals

Chaplains play a significant role within a hospital setting, especially for families, patients and staff, when they are summoned to a patient who is dying or who has died. The chaplain bestows religious, spiritual and emotional support through ritual processes. Turner's (1976) understanding of tribal societies determines "all life is pervaded by invisible influences" and

is wholly religious. Consequently rituals are an integral and pervasive part of their everyday life (Miles-Watson, 2009).

In contrast to this, modern society has attempted to locate religion separately from economic, political, domestic and recreational life (Deflem, 1991). Since the Reformation and through the process of institutionalisation and secularisation there have been moves to separate modern religion from culture. However Miles-Watson (2009, p. 169) argues that, it is now commonly assumed that the boundaries between the secular and the sacred in western society are becoming increasingly blurred. The chaplain therefore, is often summoned within in a multi-faith context to administer religious and spiritual rituals to multi-faith and none, within blurred boundaries, often at the point of threshold where patients, family and staff experience liminality.

1.3.2 Sacred Space and Liminality

Therefore it is at this point of threshold that chaplains facilitate a transition from a secular and utilitarian setting, to that of a spiritual and religious engagement. Patients and family consequently experience an awareness of God's presence or sense of spirituality. This is comparable to Turner's perception of the pilgrim where a blurring of the line between the modern rituals of today link back to ancient sacred texts. The living Holy Spirit or a sense of a higher and greater being is enabled by the multi-faith chaplain who facilitates the process of transition to a point of aggregation. The anxieties and grieving of the family are given solace, as they become aware of God's presence or experience something spiritual and it is here that they find support.

Clare McBeath suggests that the challenge in this liminal space and sacredness is to offer a place of sanctuary, a safe place in which people's experiences can be spoken of and valued (McBeath, 2009). It provides an opportunity within this safe zone, for the chaplain to pursue and engage with the realities of what has taken place. It is also a scary place where the existence of death is bravely reinforced by the chaplain. This rude reality helps the move to aggregation and they are changed. Turner therefore argues that what is offered, is a lowliness and sacredness of homogeneity, being similar or comparable to comradeship. The rite presents a moment in and out of time from secular to sacredness.

1.4 NHS Policies and Protocols

Statistics demonstrate that around a million people die in England each year and fifty eight per cent of deaths take place in NHS hospitals. Our understanding and ability to deal with death through positive strategies has been diminished due to the changes in society and as a result less people are dying at home. WHO also uphold that death in a hospital is a multifaceted and complex process, often in a clinical and sterile context, determining that there should be an established and explicit obligation for spiritual support for patients, their family and staff, from health care professionals. Consequently there is a crucial need for hospital staff and chaplains to provide high quality patient care for patients at the point of death and dying.

When individuals are prevented because of illness from practising their beliefs unaided, it is essential that the appropriate religious and spiritual support is provided (Swift, 2009). Individuals who are told that their condition is terminal, desire for a good death which

includes dignity, respect, pain free, familiar surroundings, to be with family and have a need for their own specific religious and spiritual expectations to be sustained. Moreover, as well as identifying that spirituality and religion is significantly important for patients faced with death, (Bussing & Koenig, 2010, p.19), it is also recognised that how the spirit is cared for, has a substantial impact on patients' and families' experiences (Swift, 2009).

The way we deal with death for patients and their families, is a mark of a decent and moral society (DOH, 2008, p. 19) and how a person died, remains in the memory of those who live on (Saunders, 2008, p.1). WHO therefore establishes that high quality care provided to patients and family is key to preventing many health issues; arguing, that it is especially important at the End of Life (ELO) where patients and family seek a need for meaning and purpose, forgiveness, reconciliation and affirmation of worth (WHO, 2014). Moreover, a lack of religious and spiritual provision, especially when requested, can have substantial consequences on healing; psychologically, existentially, emotionally and religiously (Bussing & Koening, 2010). Additionally, to ignore spiritual and religious needs when caring for the dying denies individuals dignity and fundamental rights (Bussing & Koenig, 2010, p. 25). It is therefore crucial that a sense of meaning and purpose for individuals is provided to assist their grieving.

Therefore robust palliative care and ELO care models are provided by NHS England, NHS Wales, and NHS Scotland. NICE understood that it is significantly important for the health and wellbeing of society (Living Matters Dying Matters, 2010; NICE, 2003, p.3). Additional pressures for the provision of high quality patient care has also been brought about by the Francis Report which highlights that the focus should be less on 'pathway' and more on high quality patient care (Bee Wee, 2013). Moreover, globally there is now a growing emphasis

on the need for spiritual care, where a holistic approach is required both as a philosophy and as a model of care (Hull, Staffordshire & Aberdeen University, 2010, p4).

The Francis Report was produced as a result of an enquiry to examine the failings of care at Mid Staffordshire hospital, scrutinising the leadership and culture. The main findings were summarised in a report, Patient Centred Leadership, highlighting three key lines of protection. This protection considered leadership's responsibility to create conducive conditions towards delivering consistently high standards of care that puts the patient first. It places an emphasis on corporate accountability to lead by example. Its focus is on high quality and safety of care, plus a guarantee to support and enable frontline staff in prioritising patients and their care. Furthermore it necessitates the development of leaders, at all levels with this emphasis to ensure the empowerment staff through adequate time and resources.

As a result of the Francis Report, Jane Cummings, England's Chief Nursing officer, introduced the Six C's strategy, a shared objective for all healthcare professionals. It concentrates on care, compassion, competence, communication, courage and commitment to ensure high patient care and includes a requirement from staff to appreciate themselves and the impact they have on those around them, facilitating greater understanding of how they are perceived and how they align with the values of the Trust (360 degree, 2014).

1.5 Why Chaplaincy?

Whilst there have been great efforts to introduce religious and spiritual support into the culture of NHS hospitals, nurses and clinicians are sometimes reluctant and struggle to

provide this themselves (Bussing & Koenig, 2010). Consequently there is a significant need for chaplains, as experienced healthcare professionals, to provide a lead, not only in supporting patients, family and staff but in the provision of leadership to other healthcare professionals who feel they are able to provide religious and spiritual care. Nursing staff and clinicians are afraid, unsure and inexperienced; consequently they struggle to achieve what is required.

In practical terms, at the coal face, and in competition with many complex and demanding priorities, spiritual care is not necessarily understood or seen as a priority. Consequently time is not made available in a highly governanced, tick box culture. This is also compounded by the greater pressures brought to bear on staff and services as financial reductions are implemented on staff resources. Where there are increased workloads on individuals making it harder for staff to provide spiritual and pastoral support (Smith, 2014).

The need for chaplains is acknowledged by the Theos Report (The Public Theology Think Tank, 2012). The report confirms that those with a faith or social networks within a faith setting, have better coping strategies and are able to deal better with illness. Theos also identifies that spiritual support helps patient's deal with the complexities of their illness and the uncertainties that they face, thus minimising their feelings of vulnerability. Furthermore, the research identifies the importance of the chaplain, as a health care professional, facilitating a spiritual and religious sacred space. It is the trust bestowed in that space that is fundamental.

Theos also acknowledges the lack of knowledge and confidence found in the faith and beliefs of nursing staff. Moreover it discovered that they are often too busy to expedite the level of

dialogue required to support patients. It also acknowledges that doctors tend to focus on the medical and technical, rather than the emotional and quality of life issues (Bussing & Koenig, 2010, p 18). The chaplain therefore is perceived as external or neutral to the clinicians and nurses. Moreover, evidence demonstrates that post death, family members will recall the small gestures of care and compassion. The offering of drinks or private space, empathy, compassion and honesty, balanced with hope which are all significantly important to their experience (Theos, 2012).

Furthermore, the report also provides important insights into patient experience of chaplains. They confirm that chaplains are able to share and empathise with their own religious and spiritual beliefs, acknowledging that there are a number of barriers, when speaking to other health care professionals. They distinguish between the chaplain's knowledge and experience and the inability, lack of confidence and limited experience of the nurses and clinicians in the facilitation of spirituality and religion. The need for religious and spiritual support therefore becomes more fundamental, when nurses and doctors fail to understand fully patient's beliefs. Even when nurses or clinicians become aware of these beliefs, they might not necessarily have the knowledge or experience robustly to discuss them further with the patient.

Additionally, the research reveals that patients struggling with chronic symptoms convey feelings of guilt, loss, sadness, anxiety, diminished self-esteem, loss of role function, communication problems with family and friends which bring about questions on the meaning of life and religious struggles (Bussing & Koenig, 2010, p 19). The research

concludes that spiritual support facilitated by a chaplain is a solution to sustaining good spiritual and religious care and helps sustain the trust of patients.

1.5.1 Chaplaincy

Swift argues that chaplains occupy an unusual and interesting place in British society providing deep insights and broad perspectives through engagement when facilitating the complexities of belief and spirituality, allowing a greater perception of what takes place at deeper levels (Swift, 2009, p. 91). Chaplaincy therefore lives in the territory of other disciplines (Swift, 2009) and is a prominent player in story telling which brings a semblance of meaning to those who experience immense personal pain and loss (Swift, 2009, p. 167). They are able to facilitate space, prayer; reflection and potential meaning in a utilitarian space creating new narratives which bring hope (Swift, 2009). Chaplains are seen and perceived as faith representatives in the field, who walk the space of the hospital. They are set apart from other staff in the hospital and are linked with what takes place in the community (Swift, 2009).

Therefore, chaplains, because of their experiences and insights in the field, are able to respond more effectively and confidently. What takes place in society and the local community, is presented within a hospital setting where the chaplain responds to fluid and shifting spaces, a hybrid space (Reader & Baker, 2009; Swift 2009). This necessitates a sensitive and intuitive response to be delivered compassionately and carefully due to different expectations religiously, spiritually and none. Their response mingles with the different values and expectations whether traditional, conservative, liberal or stereotypical of those

patients, family and staff that the chaplain encounters. Within this hybrid third space the chaplain attempts to navigate and facilitate a sacred space for the different desires, expectations, experiences and needs at any given moment. The negotiation is a complex challenge for the chaplain (Speck, 2004, p 22).

To create a sacred space within the clinical and utilitarian setting of a hospital, chaplains draw on their traditions and the past. They are connected historically to the hospital as the work house and many of the activities that they carry out are linked from the present to the past through liturgy, worship and prayers. Within a multi-faith chaplaincy, chaplains geographically sanction and authorise sacred space at various points internally in hospital spaces and externally at crematoriums and gravesides (Swift, 2009, p.161). The chaplain brings to the secular and clinical situation, religious and spiritual rituals as an aid to rites of passage in the form of symbolism, liturgy, their own persona interceding on behalf of God (Swift, 2009, p.162). They facilitate sacred space, mediating the liminal change that assists the transition for patients, family and staff in the last days and hours of death to multi-faith and none.

The chaplain, therefore, is considered a practitioner in the ritual processes that they provide, taking the lead for religious and spiritual solace at a time when individuals struggle with their own emotions and are at a point of crisis (Swift, 2009). It is the understanding of these fluid and shifting spaces, within the context of British culture, in the twenty first century, nationally and locally, that points to how, what, why and when there is a need for chaplains to facilitate religion and spirituality.

.

Chapter Two The Research Questions and Hypotheses

2.1 Plans, Strategies and Procedures

The aim of the research questions are to observe and scrutinise how chaplains go about facilitating a sacred space when they are requested to visit a patient in the last days and hours of death. It seeks to identify the context in which chaplains are compelled to facilitate religious and spiritual rituals and what perspectives participants have of chaplains when creating a sacred space within non-orthodox, clinical spaces, that also incorporate 'multifaith and none' (no faith) perspectives in a hospital. The interviews took place with hospital staff, who had had experiences of chaplaincy, and examined what they understood of the contribution made by chaplains to patient experience at the point of death and dying. As well as the data acquired from the interviews, the research was also able to use the particpant observations of the researcher who is a chaplin.

2.2 Research Methods

The research inquiry involved qualitative research using participation observation, leading to a case study with cross sectional design research. Due to the limited time and resources available, which involved one person interviewing and collating the data, no more than 10 people were interviewed. In order to collect the data required, a Purposive Sampling approach (Bryman, 2012) was applied. This allows the research to deliberately select specific

individuals for interview, who are known for their experience or precise viewpoint. This method therefore allows for a specific cross representation of society. The weakness in this method is that the reseacher in their selection may omit specific individuals who could have vital information to contribute (Gray, 2009, p. 152). Consequently, staff directly involved with patients and their families, at the ELO were selected for the purposes of this research.

The research invited other chaplains, patient liasion staff, managers, nursing staff and specialist nurses to participate from two hospitals UHSM and Jersey Hospital. The need to approach this specific group of people is because as a result of examining their experiences and views of chaplaincy; they validate realities of chaplains facilitating religious and spiritual care. By using this group of individuals, also, safeguards and supports the data ensuring that it is realistically linked to the theoretical literature supporting this thesis (Byaman, 2012).

The approach of the research questions was to prompt through thought-provoking questions, enabling participants to unpack their understanding of the research area. In the context of social studies research, it allows a greater in-depth research, through exploration and consideration of the social and human problems associated with death and dying when a sacred space is created. The interviews are deliberately unstructured and open-ended because, it has been demonstrated through previous research, that this is an effective way of generating an intensive detailed examination of participants beliefs and insights (Bryman, 2012). Open-ended and consequential questions are less categorical, and also provide deeper insights than quantitive research methods.

2.3 Demographics Table of Those Interviewed

PARTICIPANTS	AGE	SEX	DEPARTMENT	JOB TITLE	YEARS EXPERIENCE	RELIGIOUS & SPIRITUAL/ SPIRITUAL/NONE
10	24	F	Patient Liaison	Patients Experience Manager	20 years	Religious and Spiritual /Christian/ Methodist
11	62	M	Chaplaincy	Chaplain	5 years	Religious and Spiritual/Christian/ CofE
12	51	M	Macmillan	Macmillan Consultant Nurse	25 years	Religious and Spiritual/Christian Catholic with Methodist and Buddhist empathies
13	48	F	Cardiothoracic	Nurse	30 years	Atheist
14	35	F	Cardiothoracic	Practise Based Education Nurse	19 years	Spiritual/ brought up Catholic / struggles with belief
15	52	F	Jersey General Hospital	Staff Nurse	12	Spiritual CofE but not religious/ does not believe.
16	32	F	CTCCU Intensive Care	Sister	12 years	Not religious or spiritual / has empathy with spirituality/ Catholic up bringing
17	34	F	Corporate	Specialist Nurse – Vulnerable Adults	17 years	Spiritual / brought up as Catholic
18	24	M	CTCCU	Nurse	1 year	Spiritual not religious but has a belief in a greater power
19	46	F	Chaplaincy	Chaplain	6 months	Religious and Spiritual/ CofE

2.3.1 Demographics of Those Interviewed

The research sought out a good cross section of clinical staff to interview by drawing people from different areas of the hospital with representatives of different sexes, age groups, experiences, geographical areas and departments in the hospital. Consequently the data acquired provided balanced patterns of perceptions and a fair picture (Silverman, 2000, p.3).

The research interviewed ten health care professionals who had experienced chaplaincy at the point of death and dying from two hospitals. Sixty percent of those interviewed were female and forty percent were male. Thirty percent had no faith, thirty percent were spiritual and forty percent were religious and spiritual. Eighty percent were British white and twenty percent were Irish white, ranging from age twenty four to sixty two with a range of one years' experience through to twenty five years as Health Care Professionals.

2.4 Ethical Considerations

This research was agreed by the Chaplaincy Lead, the Cauldicott Guardian, Mandy Bailey, Director of Nursing and the University of Chester's Ethics Committee who provided written approval to go ahead with this research. From the outset and throughout, the research sought to clearly outline and demonstrate to participants, the methods to be used, the aims and how the data would be used and stored on completion (Creswell, 2009, p. 88). This included the significance of participants' contribution which provided them with a sense of ownership. Everything was carried out in an open and honest manner with no coercion (Creswell, 2009, p. 89) and consideration was taken throughout ensuring that no deception took place. The

overt observations that took place during this research, were only drawn from my experiences in the work place as chaplain at UHSM and not as the researcher and have been part of my professional development as a chaplain.

Consideration was also afforded for those who were thought to be vulnerable. Vulnerable participants are defined as “those who lack the ability to make personal life choices, to make decisions, to maintain independence and to self determine” (Laimputtang, 2007, p. 2). It was identified that none of the individuals, who participated in the research, fitted into the classic catergories of the vulnerable. For example, no one under 18 or in the upper age range. It was also agreed at the early outset of this research proposal, because of the sensitive nature of this reasearch, that it would be inappropriate to interview families connected with those who had died.

However, substantial care was given to staff who were interviewed. They were considered potentially vulnerable because the process of retelling their experiences and insights could provide painful triggers. Anyone invited to recall past events, which have not been postive, and whose private experiences are exposed to indepth investigations can be consequentially made vulnerable (Liamputtong, 2007, p.7). Additionally, whilst health care professionals aim to be objective, supportive and are fully trained to support patients, family and friends of those at the ELO, there is no guarantee that they will not be affected.

Therefore those interviewed were asked at the end of each session if the questions solicited had caused any problems. I had as a consideration, that if at any point I believed that the interview was not beneficial to the participant, I would close the interview down in a

constructive manner. One member of staff, interviewed was affected. The interview recalled very recents events, unknown to the researcher, concerning the death of a relative.

2.5 Consideration for Participants in the Research

Before the interviews commenced, a review of the information sheets was carried out and any concerns addressed before participants were asked to sign the consent form. Participants and researchers were made aware that they could withdraw at anytime throughout the research (Bell, 2005, p. 201). Participants were assured that withdrawal would not negatively impinge on them or their relationships within the organisation. If they wanted to withdraw it was made clear to them that any information they provided would be destroyed and data removed from the research. All participants were offered an opportunity to recieve results of the research (Bell, 2005, 49). All those interviewed were happy to participate and were willing participants. During one of the interviews a participant broke down as a result of the questioning touching painful memories. The interview was suspended, the dictation machine stopped and pastoral support was provided. The participant was given the choice of halting the interview but they insisted that they complete the interview. (Appendix: one and two)

2.6 Consent

A consent form and information sheet was provided outlining the aims of the project, the agreed boundaries and parameters of the research methods. Before signing participants were

asked to reflect back to the researcher what they had heard to ensure that they fully understood. The Consent process included a route for complaints or concerns. (Appendix: three).

2.7 Confidentiality and Annonymity

Confidentiality was applied throughout, in relation to the handling of material and distribution and communication to others. Participants were informed that the data would be stored securely with limited access and that it would be used solely by myself and my supervisor. Hard copies would be shredded and the computer data deleted after it had been stored on my laptop for ten years. They were informed that the data is password protected.

The research also sought to protect the identity of individuals observed at the point of dying and death, annoymising through the use of coding. The digital recording machine generated a number for each participant's conversation. Therefore the last two digits of that number were allocated to each participant as their identity. This provided anonymity but allowed the researcher to track conversations safely. This ensured that within the report, individuals are unable to identify themselves or patients. As an extra precaution, written permission from participants was sought at the point of consent, for use of data that could be potentially used elsewhere because it would have been too difficult to contact them or source who provided the information at a later stage (Cresswell, 2009, p.89). Participants aspirations would have been clearly noted but there were none. All participants were happy and enthusiastic to participate. None of those interviewed had any concerns about the data being used and

adopted in other projects. This was agreed and approved by the University of Chester's Ethics Committee.

Chapter Three The Research Process

3.1 Thematic Analysis Process – Emerging Themes

A thematic analysis process was used because the method assists in distinguishing emerging themes, identifying, analysing and reporting patterns or themes (Braun & Clarke, 2006, p. 6; Fereday & Muir-Cochrane, 2006). Thematic analysis processes are useful because they provide an accessible and theoretically-flexible approach to annalysing qualitiative data (Braun & Clarke, 2006, p. 4). The method allows a methodical and detailed analysis with the use of coding, easily facilitating numerous and valid perspectives from the diverse experiences of each individual (Fereday & Muir-Cochrane, 2006). There are a number of different thematic analysis approaches, consequently there is no clear agreement about what it is or how you go about using it (Braun & Clarke, 2006, p. 6). For this reason my thematic model has been adapted and based on Jennifer Attride-Stirling's (2001) thematic networks, analytic tool for qualitive research (Attride-Stirling, 2001). The diagram below depict the assimilation of basic themes (red) into organising themes (green) which provide the emerging global theme (purple).

Attride-Stirling (2001), Braun and Clarke (2006) suggest that thematic analysis processes methods have not been well used or been a popular tool in the past. They argue that the process provides a deeper understanding of social phenomena and its dynamics (Attride-Stirling, 2001). Recognising the broader social context and acknowledging the ways in which individuals make sense of their experiences, meaning and reality (Braun & Clarke,

2006, p. 9). The coding captures the moment and theme allowing for deeper layers of consideration of the phenomenon (Fereday & Muir-Cochrane, 2006). Consequently this specific method was chosen because the theoretical framework and methods were suitable, for carefully dissecting each individuals' reality and percieving their experiences in finer detail. Thus developing a clear perception of the phenomenon in question (Braun & Clarke, 2006, p. 8; Fereday & Muir-Cochrane, 2006).

Furthermore, thematic networks are entwined with other common approaches, conceptual foundations and guiding principles such as grounded theory, frameworks and argumentation theory (Attride-Stirling, 2001, p. 387). It is what takes place when carrying out the thematic networks analysis process which is important because it seeks to highlight and draw out emerging themes from textual data and is elucidated by the use of a representational tool where the emerging themes are data driven (Attride-Stirling, 2001, p. 387; Fereday & Muir-Cochrane, 2006). It is not a new process but shares key features with hermenuetic analysis (Attride-Stirling, 2001, p. 388). The outcome of this analysis is to break up text facilitating the discovery of unequivocal rationalizations and their unspoken significance (Attride-Stirling, 2001, p. 388; Fereday & Muir-Cochrane, 2006). Moreover, the key to this is a requirement for the theme to be read within the context of other basic themes which combine to represent an organising theme. The thematic network is refined from the basic theme through the organising theme and consequently presents a global theme. It is the global theme which connects to the organising theme (Attride-Stirling, 2001, p. 389).

An example of how I deployed a spider diagram to highlight Attride-Stirling's use of thematic coding, with organising themes, basic themes and global themes.

3.2 Collection and Analysis of Data

The analysis of the process of interaction grounded in the views, beliefs and understandings of participants was recorded and their body language observed. As the interviews took place the data was collected and recorded in a methodical and consistent manner to enable uniform and comparative analysis (Creswell, 2009). The data was recorded and the interaction of participants during the discourse which took place, was observed, documented, analysed and compared with a view to understanding their perceptions of what takes place at the point of death and dying. The data was translated using connections and emerging themes. The process guaranteed that as the data emerged, it allowed the themed samples from different groups to secure similarities and differences (Creswell, 2009, 13).

3.3 Timescale

- January 22nd: Approval Received from Ethics Committee.
- March 12th: Interviews/Participant observations study/ case study
- April 7th Interviews ended
- May 5th: Data analysis completed and write report.

3.5 The Interview Questions

In order to generate data which would support the aims of the research, that is, it seeks to ascertain the way a chaplin facilitates a sacred space in the last days and hours of dying and death, six interview questions were devised and put to the particpants (Appendix Four).

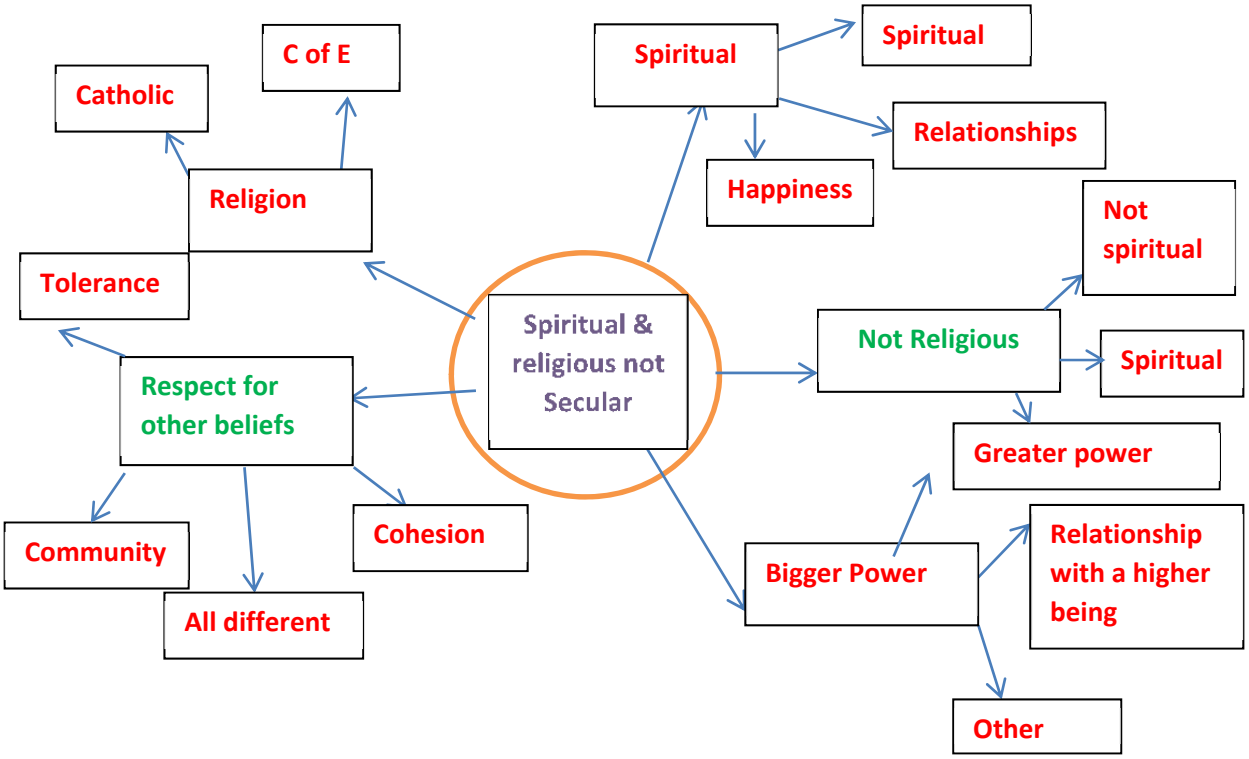
3.6 Pilot

For this research I carried out three pilot studies with a chaplain and two nurses to see how effective the questions were. There were only a few concerns and lessons to be learnt from the process. Significantly on the first pilot my batteries ran out on the digital dictation machine. Question one and question three had issues around they way participants percieved the unavailbility of a chaplain. My intention for this question was to find out how people would feel if chaplaincy was removed from the hospital. However, participants percieved the questions to mean, that they had called for a chaplain and one did not turn up. I decided to leave the question in as it was and provide further clarification after an intial response. This enabled me to understand the response from two angles. The outcome therefore was very affirming for chaplains, producing some strong emerging themes. Overall the questions provided diverse and interesting responses. Consequently, I was satisfied with the results produced by the questions which allowed interesting and valuable insights to be gained concurrently with reading the literature.

3.7 Interviews and Data Coding

I carried out the research over a one month period from the point of contacting people to set up interviews, them taking place and putting together the manuscripts. Most of the interviews were carried out one per day and typed up in the evening. This ensured that I could make any further notes such as observations around body language and things that were implicit from what individuals had communicated during the interview whilst it was live and fresh in my mind (Braun & Clarke, 2006, p. 15). All the interviews were recorded and typed up from a digital recording that I made during the interview.

3.1 Example of Spider Diagram with Emerging Themes



3.8 Basic Themes, Organising Themes and Global Emerging Themes

I am a methodical person by nature and consequently this strength was beneficial in facilitating robustly the scrutiny of the research data (Attride-Stirling, 2001, p.386). The data collected, was situated in boxed columns, with the basic themes on the left hand side. There was a two blank columns on the right hand side to write the organising themes (middle coloumn) and global emerging themes (right hand coloumn). Using my intial thoughts, gained whilst listening to the interviews and transcribing the interviews, I began to identify basic and organising themes which would in turn lead to the global themes. In order to find the basic and consequently the organising emerging themes, specific sentences and words were intially highlighted using different colours as part of the coding. The colour codes were associated for example with religious, spiritual, chaplain, sacred, impact etc. This produced the basic themes, which were implicit and explicit and were then written into the columns. Spider diagrams were also used to help link basic themes to organising themes allowing an understanding of what the global themes were (Attride-Stirling, 2001, p. 391).

Links were made from the basic themes to the organising themes. These were grouped into global themes Consequently, this method was able to highlight any commonalities and differences in the data. It enabled the text to be re-presented clearly, facilitating close attention to conceptual detail (Braun & Clarke, 2006, p. 15).

To assist with this process different colour codes were applied to the research for example, yellow was used for all language and words associated with the activities or the impact of

chaplains. Green highlighted all language and words associated with religious, spiritual, none religious or spiritual. Pink was used for language and actions associated with the perspectives of patients, family and staff and blue was used for emotions, significance and impact on those who came into contact with chaplains.

3.9 Emerging Global Themes

As a result of analysing the data, 16 organising themes emerged. These are listed below and the numbers are their codes.

1. Religious and Spiritual
2. Spiritual
3. Not Religious
4. Religion
5. Death and dying
6. Patients
7. Family
8. Staff
9. Sacred Space
10. Chaplaincy
11. Rituals
12. Practitioner
13. Emotions

14. Impact
15. Meaning
16. Significance

Chapter Four Data Analysis

4.1 Global Theme One Religion and Spirituality; Spirituality and No Religion or Spirituality. No Evidence of a Secular Landscape.

To gain a clear understanding and background to the focus of the research, the first aim was to acquire an understanding of a chaplain's worldview. Therefore participants were asked, "What is your understanding of the terms religious and spirituality?" The research question sought to demonstrate, through the experiences and opinions of the participants, a realistic understanding of the working environment of chaplains. It sought to achieve insights into the context of a sacred space and how this is facilitated by a chaplain, identifying the challenges that chaplains encounter when they support patients, family and staff.

As part of this initial query, it was also important to determine the participants' own individual religious and spiritual, or none at all, beliefs and viewpoints. Participants were then asked a second question, "Are you religious and spiritual? (Modified to Are you religious and Spiritual, Spiritual or none?)." The data obtained from these two key questions, therefore provided a benchmark. The data, therefore, is a key part of the research clearly establishing the insights of participants' and their perspectives, concepts, viewpoints and values in relation to religion and spirituality, spirituality or no beliefs. It also informs the research about the world views of patients, their family and staff who come into the hospital from not only the local community but nationally and internationally.

The first question provided a strong emerging basic theme and the consensus was that participants agreed that there is a difference between 'religious and spiritual' and 'spiritual'. They all perceived that people could either be religious and spiritual, just spiritual or neither (Code 1). Twenty percent of participants also recognised that "religious and spiritual could be entwined but separate (Code 1 & 2; Participants 15)." Additionally, there was confirmation from all participants that regardless of their own personal beliefs, they respected other people's beliefs and understanding including their cultural needs, especially at the point of death and dying (Code 5). The research also ascertained, through the conversations, that this tolerance had been reinforced in their training.

The second question, "Are you religious and spiritual, spiritual or none of these?" helped identify the world view of the participants. Although forty percent considered themselves not to be religious (Code 2), all but ten percent had been brought up within the context of a religious belief system (Code 5). Therefore amongst the participants, there were faith representatives from the Catholic, Methodist, Church of England and one person describing themselves as ecumenical (Code 5).

4.1.1 Spiritual Defined by Participants

Further basic themes became apparent as participants unpacked their own perceptions of how people could be 'spiritual but not religious (Code 2)'. This understanding is categorised in two specific areas. Firstly, fifty percent of participants define the meaning of spiritual, as a perception of "something greater than oneself," "a greater and bigger power than the

ordinary", "a higher being beyond human control but is not religious" (Code 2; Participants: 10, 12, 13, 14, 18).

Secondly, forty percent of the participants understood 'spirituality only' as being expressed or sought creatively, focusing on their own happiness and well-being (Code 2: Participants: 12, 14, 17. 19). All participants recognised, that for individuals to be spiritual they are not part of anything organised or corporate but express their spirituality in an individual way. Spirituality, participants perceived, is something that is subjective and looks at achieving harmony, personal health and wellbeing (Code 2). Ninety percent of participants perceived that there are a variety of ways, for individuals, to express themselves, spiritually.

Participant 16 claimed that she is very "closed minded on religion and spirituality" but accepted and respected that it is a significant aspect of people's life and their wellbeing (Code 4). Participant 12 summarised some of the ways people expressed their spirituality including "nature, sport, music, art, religion" (Code 2). All participants perceived spirituality as something personal to each individual where they look for a sense of harmony and peace (Code 2). One participant, although clearly not religious, did not appear to have a strong sense or need to express themselves spiritually or religiously and consequently was not sure about religion and spirituality in other people's lives (Code 3; Participant 16).

4.1.2 Being Religious and Spiritual Rather Than Just Spiritual?

When it came to defining religious and spiritual, all participants' defined 'religious and spiritual people,' as individuals who engage with something that is 'organised and formal' ; 'Church going;' 'a form of control;' and 'where individuals have a faith in God and Jesus' (Code 5). Additionally, participants acknowledged that this is something that they were taught about and that faith is a tangible experience (Code 5; Participant 14, 16). Religious and spiritual people have a belief system, a formal way of worship which they practise, assisting them with their relationship with God (Code 5; Participants 10, 11, 12, 13, 14, 17, 19).

Furthermore, the data identified that it is this relationship and belief system which assists individuals, when it comes to questions and answers at the point of death and dying, postulating meaning concerning their life (Code 5; Participants 10, 11, 12, 14, 15, 17, 19). Consequently participants acknowledged that groups of individuals within the same belief system share a culture with others that has a specific set of expectations, rites and meaning at the point of death and dying (Code 4; Participants 10, 11, 12, 14, 15, 16, 17, 19). It was also recognised by all participants that those who had religious beliefs could also be spiritual (Code 1). Forty percent of participants acknowledged that they themselves are religious and spiritual.

4.1.3 The Religious and Spiritual Beliefs of the Participants

The second part of the question on religion and spirituality established the individual beliefs and viewpoints of participants. The data highlighted that sixty percent of participants identify themselves as not being religious (Code 3; Participants, 13, 14, 15, 16, 17, 18), consisting of twenty percent as being atheist (13, 16) and thirty percent were spiritual (i.e. has an understanding of a greater being) (Code 2 & 3; Participant: 14, 15, 17). One individual however who described themselves as being only spiritual seemed somewhat confused and unclear about their own spiritualty and religious expression. It was clear from the dialogue that on occasions when there was a crisis they used prayer and relied on the faith system they had grown up with (Code 1; Participant 14).

As a result of the discussions held, all participants concurred that everyone is different with distinct, individual needs and expectations. Consequently, it is a challenge for the chaplain to facilitate an appropriate sacred space for each individual. The data therefore highlights that we live in a world that is not secular but one where there are different faith expressions, individual ways of being religious and spiritual, or spiritual and there are those who have no faith at all. What is significant is that all these different perspectives are held by the participants, with different faiths, cultures and perspectives subsisting alongside each other acknowledging the existence of the other and even on occasions having dialogue with each other. There is acceptance and respect within the hospital.

4.2 Global Theme Two The facilitation of a Sacred Space

4.2.1 Chaplaincy

The first objective of the research was to establish the perceptions and understandings of religion and spirituality; spirituality or none (Code 1 & 2), in order to achieve an empathy with the context of a chaplain's worldview. The next part of the research was to acquire knowledge of what chaplains are, how they are perceived and what is delivered in a sacred space. Are chaplains qualified to be practitioners (Code 10)? One of the strongest and most significant organising themes which materialised throughout the interviews, and especially in response to question five and eight, was a passion and enthusiasm from all participants, and a keenness to share their deep respect for chaplaincy. All participants therefore are potent advocates for chaplaincy (Code 10).

Question five was "For those who request spiritual and religious support, and it is denied, what would be the impact on the quality of patient care at the point?" Additionally the last question "Do you have anything else to contribute?" These questions provided strong affirmation, that chaplaincy is a significantly important service within the hospital and is perceived as a "vital service" that needs to be available any time of the day or night. All participants recognised that a chaplain being available at any time was very important. This was because it provided them with total confidence that if they needed a chaplain, then one would be present as soon as possible (Code 10).

Participants also felt that they were dependant on the experience of the chaplains especially in the last days and hours of death (Code 10). Participant 10, highlighted that sometimes the lack of chaplaincy provision at the point of death and dying, is one of a list of complaints provided by a patient's family when they are not happy with treatment delivered. This participant summed these thoughts up by stating that "People need what chaplains deliver" (Code 12).

One of the common basic themes that emerged, was that seventy percent of participants recognised that chaplains acted as role models, leading by example, demonstrating how to treat staff and patients in the hospital (Code 10: Participant: 10, 11, 12, 14, 15, 16, 13). Participant observation analysis identified that the hospital is occupied by staff and patients who are made up of diverse, plural and multi-faith individuals (Appendix: 5). The chaplains are therefore perceived by participants to be neutral, objective and ecumenical in their attitude toward those they encounter (Code 10: Participants 10, 12, 13, 14, 15). Additionally, all participants recognised that chaplains supported patients, family and staff no matter whether they are religious and spiritual, spiritual or none (Code 10). Moreover, it was observed that chaplains at the South Manchester Hospital engage with everyone equally, fairly and compassionately regardless of their ethnicity, their culture or their sexuality and are viewed as a collaborative team (Participants: 12, 14, 15, 16, 17).

4.2.2 Sacred Space

Specific to the research question is the need to understand how chaplains facilitate sacred space. Sacred space in a hospital is not something that is fixed geographically. It is not something tangible but it is something that is virtual, a spiritual bubble, facilitated by the chaplain at any geographical point in the hospital. Therefore the research pursued an understanding of context and obligation, in establishing sacred space in a utilitarian and clinical environment. Participants observed that there are a number of challenges that a chaplain encounters when compelled to create a sacred space. Firstly, it is not always easy to perceive how religious and spiritual, spiritual or not, a patient may be, unless information is volunteered to them from family directly or via staff. This is because at a point of crisis, it is not always feasible to probe with questions due to the sensitive nature of the situation. There is always an opportunity for the chaplain, to ask members of staff, for further knowledge, but often they don't have substantive answers. At this point chaplains have limited knowledge to work on.

However, staff may also be present at the point a patient dies, as a result of longevity of stay and causal relationships built with staff and patients. Participant observation perceived and experienced occasions when more information is provided. Additionally, a relationship may also have been established between patient and chaplain, consequently challenging the chaplains own objective and neutral stance. Consequently there is an immediate requirement for chaplains to distance themselves from their own connections and emotions at the point of death and dying as they create a sacred space. Whilst this is not easily undertaken, there is an obligation for the chaplain to accomplish this for the sake of the family and patient. This is

because the chaplain is regarded as the “steady rock in the midst of chaos” (Code: 9; Participants 10).

Moreover it was identified that as a result of participant observation, sometimes more detailed information is provided. This can be varied, and may include requests that are part of the experiences, viewpoints, values and expectations of patients and families religious and spiritual world view. Ranging from those who are part of a large church community to those who do not worship much; very tenuous links with the church or a faith; or no links at all but they believe in God.

However, participant observations also highlighted that it is quite common for chaplains to receive minimal information, such as only the name of the patient, whether family and friends are present or not. They may also obtain a brief background and insight into the journey the patient and family have taken during their illness. Additionally, on occasions, a chaplain may be made aware of certain fractions in family relationships.

Therefore, participant observations acknowledges, that when a chaplain is requested to facilitate the last rite, the chaplain may only have a small window of information and consequently does not have deep insights into the religious and spiritual, spiritual or none of the patient or their family’s requirements. The chaplain, with this limited amount of knowledge, therefore needs to quickly secure the confidence of the patient and their family to create an appropriate sacred space.

Another common basic theme recognised at this point, identified through participant observations and participant interviews, was that a chaplain puts their own individual and personal beliefs to one side in order to meet the needs of the patients, enabling "the patient's and family's own spirituality to define the sacred space" (Code: 10; Participants: 10, 11, 12, 14, 15, 17, 19). Additionally seventy percent of participants recognised that every chaplain has a different style in the way they establish a sacred space or even how they engage with patients, therefore it is not 'one size fits all' (Code 11; Participants: 10, 11, 12, 13, 14, 15, 19).

4.2.3 Participant's Experiences of Religion and Spirituality

To achieve a greater understanding of sacred space and what chaplains deliver, participants were asked about their experiences on the ward and their consequent perspectives of spirituality and religion when it was delivered. Question three, was a catalyst for the largest area of discussion. For a number of participants this provided them with an opportunity to share their grief with another person. For others it was the first time they had been given the opportunity to express their thoughts and feelings (Code: 16; Participants: 10, 11, 12, 14, 15, 16 and 19). In this instance, as well as being the researcher, I was also perceived as the chaplain, someone neutral and confidential to talk to (Code 10).

Initially, fifty percent of participants responded immediately to question three, with their own personal experiences, of when a family member or friend had died (Participants: 14, 19, 11, 15, 10,). An additional twenty percent had experienced the death of a loved one but chose

not to discuss this. Whilst the research sought not to contact individuals who had lost relatives or friends, it was inevitable that some of the participants interviewed would have encountered death and dying personally at some point. The participants were all comfortable talking about their experiences and consequently their experiences provided valuable insights into the research that had not been anticipated which have allowed a greater understanding on this research to how a chaplain facilitates a sacred space.

A further prominent basic theme that emerged, was that participants powerfully identified that the 'religious authority' and the persona of a chaplain (Code 11: Participants: 10, 11, 12, 14, 15, 17, 19), contributes to sacred space, making it meaningful and substantial (Code 10: Participants: 10, 14, 11, 12, 15, 17, 19). Another important organising theme that emerged, came from thirty percent of participants (Participants: 13, 11, 12), who identified through their own experiences, that regardless of whether individuals were religious and spiritual, spiritual or not, that through the liturgy, prayers and symbolism, especially when they come to share the Lord's Prayer, everyone present was united (Code 11; Participants 10, 11, 12, 14, 15). Participants also acknowledged that how and what is delivered within a sacred space "brings individuals from a place of chaos to a place that is secure" (Participant 10), because all those present hear and listen to the same words at the same time. Consequently the sacred space generates a sense of order. This was also observed through my own participant observations. Furthermore, participants also recognised that as result of the unification, the mutual ritual affords something positive and affirmative to share afterwards.

Furthermore, thirty percent of participants acknowledge that as a result of the liturgy and prayers unifying all those present, individuals were supported, their own thinking challenged,

bringing them comfort and relief. Additionally, participant 10 cited occasions when individuals who were atheist or who had lost connections with their own religious beliefs, experienced a sacred space and had benefited. This was reinforced further by fifty percent of participants, who considered themselves as not religious, who have witnessed the substantial benefits that sacred space brings to patients and family (Code 11; Participants: 10, 14, 17, 15). None of the participants interviewed, had had an experience where a chaplain had not been present, when it had been requested for someone, in the last days and hours of death.

4.2.4 Rituals

Data generated from question Six identified rituals as another basic theme, emphasising the significance and importance of rituals, as part of a sacred space, for patients' and staff. It established that a number of rituals are carried out in a sacred space, and for those with religious beliefs this is expected and anticipated. For those who have no belief or who are just spiritual, although they have no specific expectations, they anticipate that something needs to take place which will mark this rite of passage in some way. Consequently, participants made it apparent that rituals were "needed", recognising that "it is very important" especially at the point where illness deteriorates. Participants established that a priest or chaplain is needed by family and patients, to perform rituals for the dying and the dead in the last days and hours, because patients and families, who are religious, have a set of expectations of what needs to take place. (Code 11; Participants 10, 11, 12, 14, 15, 17, 19)

Participants provided an understanding of the rituals required in a sacred space. These were communion, sacrament of the sick or prayers for the dying, symbolism in anointing and using the sign of the cross, laying on of hands, general prayers, as well as the use of familiar prayers, such as the Lord's Prayer and the Rosary, was acknowledged as appropriate (Code 12; Participants: 14,11,19,10, 15). All of these rituals contributed towards creating a sense of spirituality, and religious reflection at the point of dying and death, or afterwards, for patients and family (Code 1 & 2; Participants: 16, 12, 11, 19). Furthermore, it is also perceived by seventy percent of participants, that chaplains are able to deliver the "right prayer" or the "final prayer".

4.2.5 Practitioner

One of the theories that the research wanted to challenge, was whether the chaplains' delivery of a sacred space was specialised, or are staff capable of delivering religious and spiritual needs themselves. Therefore the participants were asked question Seven. The question sought to identify elements of a chaplains role that are or not feasible for staff to deliver. Also, how willing and comfortable are staff in dispensing religious and spiritual care, especially at the point of death and dying?

A number of basic themes emerged. Firstly, an initial response from all participants where sixty percent recognised it as feasible (Code 12; Participants: 10, 11, 12, 14, 17, 18), and forty percent adamant that it was not realistic (Code 2; Participants 10, 11, 12, 14). However,

forty percent identified that some staff already delivered religious and spiritual care (Code 12; Participants: 13, 15, 16, 19).

For those who believed that staff could deliver, they established that they had witnessed staff providing religious and spiritual care. They were therefore confident in staff provision, perceiving that what was being delivered as empathy, support and listening. It was here that participants shared their own stories of staff carrying out spiritual and religious rituals. For example post death, when they were preparing bodies for the morgue they laid flowers, crosses and shells etc. on the person or the pillow (Code 2; Participants 10, 11, 12).

Participant observations also acknowledged that there is a perception that these spiritual and religious symbols represent a mark of dignity and respect for a person who has died. This practice, it was explained, is one that is passed on from nurse to nurse at the point of training on the ward. Participant observations also highlighted the unspoken and spoken understanding of many encounters experienced by nurses, of the presence of something spiritual at the point of death (Code 2; Participant: 10, 14).

However, for those who did not believe it was feasible, for staff to deliver religion and spirituality, they felt very uncomfortable and concerned about the impact on patients if they got this wrong. This understanding was supported by forty percent of participants (Code: 1 Participants: 13, 14, 15, 18). There were a numbers of factors put forward by these participants. For example, participants felt strongly that “due to the excessive workloads placed on staff there would not be time to provide patients with this level of support because of their time constraints and other priorities” (Participants 10, 11, 13, 15, 16, 19).

Additionally they perceived that because they were so busy, they might not appreciate or see the needs of the patient (Participants: 11, 13, 15, 16, 17). They recognised through their experience on the ward that there are too many other priorities, which are compliance and governance led, which take priority (Code 10).

However, some participant observations acknowledge that in some cases of emergency, specific staff are able to perform the roles of a chaplain. For example, in the case of dying babies maternity staff are able to provide emergency baptisms, including naming and blessings for still births. Chaplains are still seen as experienced and appropriate, consequently at the South Manchester Hospital midwives will call upon the chaplain to provide these rites of passage. Therefore the common consensus is that it would be preferable to call a chaplain who is outside the patients' present experiences and perceived as 'the professional'.

A secondary organising theme raised, was that staff may not feel qualified enough and consequently they would not be confident in what they were providing (Participant 10, 14). Participant 19 identified that for staff "their medical position would be compromised, perceiving that the delivery of religious support was beyond their remit." Additionally, it was perceived that this is outside their professional training; it is not expected from them and is not part of their job description. Moreover, there are the expectations of patient and family to be considered which staff may not be able to fulfil or confidently deliver (Code 1 & 2; Participants 10, 15, 16, 17, 18, 19).

A further compelling basic theme that emerged, was the lack of confidence felt by staff, especially those who are not religious or do not have a sense of spirituality. There was also some hesitancy here, from those staff who felt it was feasible. The main concern focused on the deeper levels of support that patients required. Participants were uncomfortable about being asked to provide answers to existential questions, perceived as too personal, forcing them out of their professional relationships. They felt they would only be able to draw on their 'own small world views' which could be inappropriate.

Furthermore, it was felt that there needed to be some clear boundaries and also a consistency of service (Participants: 10, 11, 13, 15, 19). There would be issues around expectations from patients and staff if the delivery of service was not consistent. "I am not sure that this would be consistent across the board, because of the level of empowerment, which needs to be enforced" (Code 1 & 2; Participant 14). "Especially if it was not clear which members of staff were confident and capable of providing this. It would depend on each person's confidence and whether they believed in prayer" (Code 13). Whilst Participant 11 identified that there is a training requirement to help staff deliver religious and spiritual support, it was evident that even if staff were given this, they would still not feel comfortable delivering religious and spiritual support (Code 1 & 2; Participants: 13, 15, 16 18). There is however, value for patients, if staff were to have training because this would assist and help them to identify when a patient needed this type of support and how to go about asking the right questions ensuring that their needs are met.

Furthermore, participant 10 acknowledged, "I think a major part of a healthcare professional's role, is listening and supporting" (Code 10). "I think that listening is such an

important part of our role, we can facilitate it, create a quite space for family, this is achievable" (Code 13). The emerging theme was that the chaplain was the practitioner and that whilst there was a common understanding, that at a certain level, staff can deliver to patients some of the compassionate and pastoral needs, they need to be supported by chaplains. (Code 12) What emerged was that whilst it was recognized that this was feasible, "some families might feel that it is insufficient, perceiving that every individual is different and unique with different spiritual and religious needs" (Code 10; Participant: 10, 13, 14, 17).

All those interviewed felt very strongly about the availability of chaplains within a healthcare setting, especially, as part of a collaborative effort alongside nurses and clinicians. Participants identified that there is a need for patients to have access to sacred space, provided by someone who knows what they are doing and is experienced. Participants believed that patients should receive what chaplain' provided, as well as the medical treatment they receive (Code: 1, 2 &12; participant 15, 11). One participant perceived that "religious and spiritual support is as important as medication." "This is God at work and it enables people to be closer to God especially in the last days of dying and death."

Consequently the organising theme that emerged here, identified the chaplain as the practitioner. Furthermore the dialogue also considered what a chaplain achieved in a sacred space. Eighty percent of participants ascertain that as a practitioner, chaplains facilitate spiritual support to multi faith and none in a sensitive, gentle and calming manner (Participants: 14, 19, 11,12,10,17, 15, 16). Moreover, sixty percent of participants perceived that chaplains enable a sacred space, conveying a sense of holiness and peace (Participants: 14, 19, 11, 12, 10, 17), which they understood as spiritual. Thirty percent experienced this as

a profound moment (Participants: 14, 10, 12). Furthermore, all participants recognised, that as a resource, chaplains are perceived to have the requisite gifts and skills to create a sacred space that are not possessed by others in the hospital (Code 11).

4.3 Global Theme Three Religion and Spirituality for Patients, Family and Staff at the Point of Death and Dying

5.3.1 Death and Dying

So far the research data has provided us with insights into religion and spirituality; spirituality and none concluding that there is great awareness that religions and spirituality are important for multi-faith and none and we are not therefore living in a secular world. The research goes on to help us understand the worldview of chaplains and how they facilitate a sacred space in a utilitarian landscape.

The research data subsequently sought an understanding of how patients respond when faced with their own mortality. Moreover it identified the place of the chaplain at this point, providing valuable insights and experiences of family, friends and staff. As a result of examining the context of death and dying, the research was also able to gain significant insights into how and why there is a need for chaplains to facilitate a sacred space. This section of the data analysis therefore, initially provides an understanding of what takes place

when patients and family are faced with death and then goes on to look at the impact of religion and spirituality for family, patients and staff.

One of the basic themes that emerged from the data was the experiences and responses of family, patients and staff at the point that a patient is informed that they are going to die. Therefore the first part of this section provides an analysis of death and dying before going on to look at the place of the chaplain within this, from the perspective of the family, patients and staff including their needs. To set the context for this, therefore, an understanding of where the patient sits is established.

Participant observations confirmed that at the point that patients come into hospital, they and their family and friends enter a state of liminality, perceiving hospital as alien, unfamiliar and frightening. They discover themselves located in a space contrary to expected norms of society, outside the norms of their everyday experience. Consequently, they lose control to institutional structures and processes of the medical world. Participant observations identify that many patients come in to hospital for treatment and go home after the clinical intervention has had positive effects, subsequently leaving a state of liminality, returning to the norms of everyday living. However, for some, where the clinical intervention that they sought does not make a difference, patients are then faced with their own mortality. Therefore, they are in a state of shock or denial depending on how they are able to comprehend and process the information that they are given. This state of liminality is what chaplains encounter when they are requested.

To achieve a greater understanding of the state of liminality the data sought to look at the reactions to death and dying. One of the basic themes linked to death and dying was fear. Participants identified that patients are frightened about whether they are going to be able to deal with death (Participant 12). They worry about what will happen to those they leave behind which leads to anxiety and panic (Participants 10, 11, 14, 19). One of the participants highlighted, "There is one thing you can't do in life and that is you cannot opt out of death."

Additionally, death is not something we plan for and we have no idea when that moment might be. Participants indicated that, patients faced with their own mortality (Code 5), "are afraid of the unknown especially in a hospital environment which they do not understand and had no control over; there is a certain amount of angst" (Code: 15; Participant: 19). Other concerns that patients experience include a sense of not wanting to die, not being ready to die (Code: 5; Participant 11) and being angry and struggling whilst coming to terms with their own mortality (Code 5; Participant: 15, 12 14). Alternatively, some patients can be very resigned about their fate and submit to what is going to take place (Participants 11, 12 16, 19).

4.3.2 A Need for Religion and Spirituality at the Point of Death and Dying.

Participant 12, however, highlighted that whilst patients might be frightened, eventually they are able to find their own personal resources to draw on thus enabling them to cope. Contrary to the experiences of other participants, Participant 12 believed that those who were religious

were more likely to be scared of death than those who are not religious. Perceiving that non-religious people look upon death as a release from the pain they are encountering considering death "like going to sleep. They have no other expectations (Participant 12). "Conversely, however, sixty percent of participants identified that people are individual and regardless of whether they are religious or not they are frightened of dying, need support and gain benefits from sacred space. They identified that those who are religious and request a chaplain have the maximum benefit (Participants: 10, 11, 13, 14, 15, 17).

Furthermore, participants established that "When patients come into hospital and they are told that they are going to die, they do reflect on religion and spirituality" (Code: 1 & 2), in relation to their lives including patients who are not religious (Code: 3; Participants: 10, 11, 12, 14, 16, 17, 19). It was made clear that patients have a desire and need to talk about God; "they want to know whether they are good or bad" (Participant: 16). Sometimes they recognise and face the consequences of their actions in the past, and suddenly panic and realise they are not immortal. "I have had lots of conversations with patients about God and their mortality, lots of spiritual conversations. When faced with death, all patients think about their own spirituality and death" (Participant: 14).

Therefore, if access to a chaplain is not made available, the person will still die, but the lack of spiritual and religious provision, will hinder and exacerbate the journey they are on. "From a medical perspective this is very bad" (Participant 11). This understanding was further supported by participant 16, who although unsure about their own religion and spirituality, indicated that if patients "wanted it, then it is important", reflecting "I have to respect their

religious and spiritual needs and I understand that it is important for them. I also see the benefits and understand the difference it makes."

4.3.3 Making Death More Manageable

Consequently, it was identified, that if chaplains are not available for patients "it would be very difficult because staff would not be able to provide what patients needed when they were dying" and the creation of a sacred space. Participants indicated that it is paramount that a chaplain is available (Code 10, 11, 12, 14, 15, 16), recognising that the chaplain's interaction with the patient and families is pivotal in enabling acceptance, making death more manageable (Participants: 10, 11, 14, 15, 17).

Having pursued an understanding of death and dying for patients, families and staff, another important part of the research was to understand the significance of chaplaincy for families, patients and staff at the point of death and dying. Consequently, the next three sections examine the responses to question Five and Six. The analysis looks at these three areas together alongside these two questions because the conversation from both sections crossed over feeding into each other.

4.3.4 Family

A strong organising theme that became evident, as a result of the discussions that took place with participants, is that although chaplains are called out to patients, patients are not the primary beneficiary of a sacred space generated by the chaplain. It is the patient's family and friends, and on occasion's staff, who gain the most from the presence of a chaplain and what they deliver. Additionally, the majority of participants acknowledged that often a request for a chaplain comes from the family on behalf of the patient rather than the patient. The motivations behind this request is because often families worry considerably about what will happen to their loved one when they die and the formulation of a sacred space alleviates their concerns (Participants: 10, 11, 12, 14, 15, 17, 19).

4.3.5 Expectations from the Family

Expectations, in relation to the needs of patients and family, was a further emerging basic theme that occurred on a number of occasions throughout the research. At the point of death there are a number of expectations because death is perceived as a significant milestone for everyone (Code: 5; Participant 10). Participants acknowledged that expectations can vary from a large amount of knowledge; to just knowing that something should occur. Participants also pointed to the fact, that families have a set of religious and spiritual expectations, when it comes to marking this rite of passage (Code: 8; Participants: 11, 12, 14). These expectations can range from different and sometimes complex expectations to simple or hardly any expectation.

Participants recognised that this was because each patient has individual and different needs for a sacred space, due to the fact that each faith or denomination anticipates different necessities prior, during and after death. Additionally, for some there will be a sense of urgency for a chaplain to be present before, during or after the passing of a patient to create the appropriate sacred space (Code: 9; Participants: 10, 14, 19, 11, 18, 17, 15). This is because for those who are religious there is a need to tie up loose ends, a need for forgiveness, for prayers and to be anointed (Code: 11; Participant 10, 11, 14, 15, 17, 19). Participant 16 perceived that the chaplain also helps facilitate relationships between family and patients when there are family issues or bonds are not strong.

Moreover, for those whose relationship with God is tenuous, the chaplain is recognised by the family as "someone who has a living relationship, who can mediate on their behalf" (Participants: 12, 15, 16) and can say "the right words at the right time." "The rituals, therefore, need to take place, even though they might not know what needs to happen. This is because they are relying on the chaplain to do it for them" (Code 9 & 10; Participants 11).

Additionally, participants also recognised that there is a lack of provision in the secular world, and insufficient language to fill the gaps needed at the point of death and dying. Participant 10, explained "supporting death with secular language is different from secular marriages and naming and blessings (baptism), where there is time to consider and create non-religious alternatives, because of the abruptness and context of death, individuals are unable and do not have the time to seek out alternatives before, during or after death

(Participant 10, 19). Added to this, participants identified that society has lost its coping strategies at the point of death and dying and therefore does not know how to embrace death and dying emotionally and practically (Participants: 10, 11, 15, 16, 19). Therefore, there will always be a tension between the expectations of those with a faith and what they need; and , those with no particular faith and those who are not bothered (Participants: 10, 11, 14, 19).

Moreover, one of the participants identified that often "the family want people who are not clinical or medical" (Code: 10; Participant 12). This is hugely important because they want people who understand people (Code: 10; Participant 12). The presence of a chaplain allows them to talk confidentially to someone they perceive as neutral, objective and will not have an impact on the treatment of their loved one or themselves (Code: 10; Participants: 10, 11, 12, 15, 17, 19). "This is about human things, so we need people who understand human things other than technical things." "If a chaplain is not present this would mean something is missing" (Code: 10; Participant 14). Therefore when families experience what a chaplain delivers in a sacred space and they feel that they have done the right things for the person they love, it allows them to grieve properly and is part of the 'closure' they need (Code: 10; Participants 14, 11, 19, 13). This is because of the positive experiences acquired before and after the patient dies through the facilitation of a sacred space assisting their loved one from this world to the next (Code: 10; Participant 12).

4.3.7 Patients

Whilst it has been identified that the chaplain is called primarily by the family for the patient and is benefited mostly by the family themselves, there are also the needs of the patient to

consider. However, a common basic theme was that participants felt that often patients are too poorly to understand what is taking place within the sacred space. This could be for a variety of reasons, including; that they are often too focused on their illness and how it is affecting them, such as being uncomfortable, in pain or they have difficulty breathing. Additionally the patient will also be worried about what will happen to their loved ones when they die and any unfinished business they may have, especially if their imminent death has only recently been communicated to them (Participants: 10, 11, 12, 14, 15, 16, 17, 19).

However, a further basic theme identified by participants, was that for those patients who are able to benefit from the visit of a chaplain, spiritual care for patients was important. This is because "The chaplain is able to prepare the patient and family for death in a controlled manner" (Participants 16). Eighty percent of participants established that for many patients who face their own mortality, especially those who are given the opportunity to come to terms with their own death, this is important. Participants believed that it allowed patients to feel more in control practically and spiritually. They are able to put their house in order and find peace with God, perceiving chaplains as holy, spiritual, a listening ear, a mentor, confidential, and neutral (Participants: 10, 11, 12, 14). The chaplain therefore, is someone who normalises death and therefore is prepared to attempt to answer essential life and death questions (Participants: 10, 11, 12, 14, 15, 16, 17, 16, 17). All participants identified the chaplain as private and neutral, disconnected from those providing their treatment which was beneficial to patients.

Additionally, for those patients who request and are conscious enough to value a chaplain, forty percent of participants recognised that for patients and family, the chaplain is someone who suffers alongside the patient, assisting them along the final part of their life (Participants: 11, 19, 12, 15). Seventy percent of participants acknowledged that the religious and spiritual needs delivered to patients by the chaplains are perceived as significantly important, especially to those who are orthodox when there is a sense of urgency around the 'Sacrament of Sick', prayers for the dying or the last rites (Participants: 10, 11, 12, 14, 16, 17, 19).

For some patients, therefore there is an urgent need to receive forgiveness, through the prayers and liturgy, within a sacred space created by the chaplain or priest (Participants: 10, 14, 19, 11, 17). "A chaplain is able to facilitate a sacred space, mediating forgiveness, individuals have an opportunity to confess their sins, be absolved, come to terms with their life and gain a sense of completeness" (Code: chaplain; Participant 10). Additionally, all participants identified that for many patients who are afraid of dying, the sacred space achieves an air of acceptance and calmness consequently helping them accept and face their own mortality (Participants: 10, 11, 14, 15, 17, 19). "Some still show signs of anger but it is a calm anger."

Therefore, for patients, regardless of whether they are aware of a chaplain being present because they are too ill or worried the presence of a chaplain is an important part of nursing care. (Code: chaplain; Participant 14). "For someone who is denied religious and spiritual support, it would be an act of omission and neglect on behalf of the health professional." (Code: 10; Participant 14).

4.3.8 Staff

As well as family and patients gaining from the presence of a chaplain, an additional organising theme emerged, identifying that for staff, participants perceived a need for chaplains on the ward. The data indicated that chaplains are valued by staff. Participants also recognised that for staff the availability of a chaplain is a "key factor" (Participants 10), specifically when staff are out of their depth, when engaging with those facing death and dying. Participant 16, explained that nurses or clinicians are perceived by the patient to be clinically intrusive to their personal space, making constant medical demands upon them to assist them back to full health or through death. The presence of a chaplain sets clear boundaries and understandings about what is being delivered, especially when a patient is very poorly and confused. This allows "the patient to know what to expect and why they are there" (Code: 10; Participant 16).

4.3.8 Demystifying

A further basic theme identified by participants was the chaplain's formation of a sacred space, using rituals, perceived by participants as not only meeting a response to patients' needs but is also often the catalyst for patients who have questions that need to be answered. Participants, therefore, recognised that staff perceived the chaplain as someone who has the gifts, skills and experience to respond to questions that maybe staff do not have the aptitude, time or space to convey sensitively and appropriately (Participants: 12, 14, 16, 17, 15, 19, 11). Participants also alluded to the fact that by attempting to answer the

questions themselves or being seen to provide religious and spiritual support, they could get this delicate task wrong and thus inadvertently cause offence, damage and pain to patients and their families (Code: 1, 2 &10; Participants: 14, 16,15). Participants therefore understood the chaplain as a fellow professional who demystifies and elucidates the final journey being embarked upon.

4 3.9 Doing the Job Properly

Another compelling emerging basic theme came from the responses to Question Six. This question provided insights about how staff felt about their need to call a chaplain. Primarily the staff believed that they were fulfilling their job role because it was part of the family care plan for the patient. Participants highlighted that for staff there was a requirement that a patient's religious and spiritual need should be determined as part of the Care for the Dying protocols in the hospital (previously known as the Liverpool Pathway). The process seeks out the religious and spiritual needs of the patient at point of entry to the hospital. Participants explained that there is a significant need for staff to revisit this part of the process on behalf of the patient at the point of death and dying. Those who took this initiative felt that they were expediting not only the patient's wishes but supporting the family by providing this.

Moreover, it was also identified that because patients are asked this information when they first enter the hospital even though they are not understood to be seriously ill, they do not always see the significance of the question which may be pertinent to them later when their

illness becomes terminal. Staff, therefore take the initiative to revisit this sensitively and are often able to support patients more effectively in their religious and spiritual needs (Participants: 10, 14, 15, 17). Participants therefore perceived this to be best practice (Participants: 10, 14, 11, 19, 15, 12).

Moreover a concluding basic theme was that staff understood that by requesting a chaplain it demonstrated a holistic and collaborative approach. Staff consciously safeguarded for "the best possible death within the context of what was taking place for the patient, their family and friends." Participant, 16 said, "I pride myself in making dying as good as possible. We see death as black; it is part of life and it can be done so well. We need to get to a point where it we can make it as good as possible. We have the resources available at hand" (Code 1, 2 & 5; Participant 16). Additionally, participants also recognised that for staff it means that they are able to safeguard the dignity and respect of the patient and their family's wishes. Participants believed that for staff this means that what they deliver is patient and family focused and therefore provides high quality patient care "This is best practice."

4.3.10 Taking The Pressure Off

A final emerging theme is the awareness that once a chaplain is present and the patient is handed over, it makes it easier for the staff and more manageable (Code: 10; Participants 10, 11, 12, 19).

Participants reported that chaplains are a distinctive resource, relied upon by staff (Participants: 10, 11, 12, 13, 14, 15, 16, 17, 19). As a resource they are particularly significant when there is a crisis point for the family. At the point of death and dying, emotions run high and there is a need for rituals and a sacred space to be generated for the patient and their families. Participant 16 identified that for staff, "The ability to call on a chaplain eases the pressures encountered, allowing them time to get on with the clinical demands of the patient" (Participants: 11, 12, 13, 14, 15, 17). It is less stressful because they are confident that the family are being supported in the right way (Code: 10; Participant 10, 14, 11, 13, 17, 16, 18, 19). This collaborative effort therefore contributes holistically to a better death for patients and family. Consequently, staff are more confident in what is taking place because they understand the integrity, motivations and compassion that chaplains offer and they perceive them as capable, supporting the patient's needs more explicitly (10, 11, 12, 14, 16, 19).

This support does not only apply to patients in the hospital. Participant 13 highlighted that whenever there are deaths of staff either suddenly, through illness or through accident or suicide. "Chaplains have always been there holding it together, found the right words, space and time to support those staff who are affected. The chapel is a place of focus where people go."

4.4 Global Theme Four Why Only Hospital Chaplains Can Facilitate a Sacred Space.

The research ultimately engages with the milieu of death and dying, consequently the data provides a number of organising themes which distinguish the “emotions” from the “impact” that chaplains have at the point of death. Other organising themes that were extricated are the “meaning” and “significance” of chaplaincy at this point for patients when a chaplain is present. These organising themes related to anyone who had come into contact with dying patients, either through their job roles or have a relationship with the patient describing their experiences.

4.4.1 Emotions

This thesis has already identified through the research the different emotions which are experienced by patients when faced with their own mortality, identifying that it is very important to provide a good death which includes positive experiences. Negative experiences can have an undesirable lasting effect on individuals and consequently the bereavement process can be delayed and prolonged more than it should be. Therefore what takes place at this point is very important.

The data has also established that families and patients can be extremely anxious leading up to death. However participants distinguished that when rituals are delivered by a chaplain in a sacred space there is a significant outcome for patients and families which is beneficial

(Code 5; Participants 10, 11, 12, 13, 14, 15, 16). The outcome of chaplains facilitating a sacred space for patients and especially family is a sense of calmness and peace. Participants also recognised that staff put great value in what the chaplains facilitated because they have witnessed that the family felt more comfortable and less perturbed about what was taking place, thus alleviating the family's fear (Participants: 10, 11, 12, 14, 15, 19).

4.4.2 Impact

A significant organising theme was the impact chaplains had at the point of death. It was identified by seventy percent of participants that chaplains, through their experiences and encounters across the hospital, feel comfortable talking about death and dying, therefore making it easier for patients and their family to have sensitive discussions (10, 11, 12, 14, 19). As a result of the conversations that took place, participants recognised that as well as the impact that the language of the liturgy has, in a sacred space, for patients, family and staff, chaplains provide an affirmation of beliefs, thoughts and understanding of relationships with God and a confirmation of God's presence and His plan for individuals. This is significant as it helps patients and family with their sense of identity and self-worth.

Participants also perceived that as well as creating a safe space to talk for patients and families, chaplains walk alongside them, providing a listening ear, answering questions, and providing compassion and support. This also has a substantial impact on the grieving process, allowing the family to constructively move forward (Code: 16 & 5; Participants: 19, 10, 11, 12, 14, 15, 17). Regardless of a families' or patients' religious and spiritual identity,

there is a significant impact on them, when the chaplain facilitates a sacred space. This impact is felt as a sense of relief, minimising the fear that families experience about what will take place. They feel comforted and feel much better (Participants: 10, 11, 13, 14, 15, 16, 19). Additionally, there are also patients who do not consider requesting a chaplain but on suggestion from staff, they access these rituals, although they have no expectations. There is however, a perception of an overall benefit to their wellbeing (Code 11; Participants 10, 11, 13, 14, 15, 16, 17, 18, 19). Participant observations also confirmed that when patients are at a point of crisis, it does not matter whether patients, family or staff are religious and spiritual, spiritual or not, the provision of rituals in a sacred space is a positive experience and significant.

4.4.3 Meaning

The provision of meaning was an emerging theme where participants identified that a need for sacred space is important because chaplains absolve them from the things the patients feels they have done wrong and consequently they believe would get in the way of what happens to them when they die. Furthermore, participants recognised that family members felt guilty if they had not been able to support the patient's wishes. Therefore, family and friends of the patient are sometimes highly motivated and sometimes have a specific set of expectations in relation to the protocols that need to be set in place. These expectations are born through their own religious and spiritual practices or own viewpoint to try to ensure "the right thing" is achieved on behalf of their family member. Additionally, participants observed that some patients struggle and become quite anxious as they near death becoming distraught especially if they are concerned for their loved ones whom they are leaving (Code

5 & 12; Participant 10, 11, 14, 16, 17,) therefore it is essential that they have access to a chaplain and their expectations are met.

Therefore, because all these factors can contribute to patients' fear at the point of death sometimes, the intensity of the patient's fear renders them speechless or unable to express their feelings. Participants therefore identified that for family and friends, the liturgy within a sacred space provides meaning and expression, imparting a sense of hope and reassurance. Consequently the chaplain speaks the thoughts and feelings of all those around, calming the patient, "making them less scared or anxious" subsequently making them peaceful, less afraid and reducing the pain they experience (Participants: 10, 11, 12, 14 , 17, 19).

4.4.4 Significance

Participants perceive therefore that for many people, whether they are religious and spiritual; spiritual or not, what chaplains deliver at this point of a person's narrative, is significant because this rite of passage has been marked. This is extremely important to all those individuals involved (Participants: 10, 11, 12, 14, 17, 19). Therefore, for all patients, religious and spiritual or not, chaplains bring about a sense of meaning in the last days and hours of death because for patients who are dying "all boundaries, all values shift, move and change and therefore the patients' place in the world changes" (Code 11). It is because of these changing and shifting boundaries that "patients need some reassurance, some affirmation about themselves. Consequently they need some values reinstating for themselves."

As a result, this conveys massive comfort, with seventy percent of participants recognising that through the language expressed in a sacred space, family, friends and staff receive reassurance that the patient is going to a better place and therefore there is a sense of completion because they have accomplished the right circumstances for their family member.

Additionally, participants comprehended that a chaplain provides a sensitive, safe environment allowing “an opportunity to say farewell” and affords a “proper sending off.’ Finally, all participants believe that the sacred space created by the persona and presence of the chaplain, whether it is religious and spiritual, spiritual or not spiritual, is significantly important to all those present but significantly the family. They feel reassured and comforted; the traumatic impact is reduced for them.

By accomplishing this, fifty percent of participants concur that the facilitation of sacred space by chaplains, compassionately, brings a sense of reality and focus to what is taking place (10, 11, 12, 14, 17). Therefore all participants experience the presence of the chaplain, and the rituals provided in a sacred space, as being positive because meaning is brought to a place that is desolate and frightening. The chaplain’s creation of a sacred space normalises what is taking place.

Chapter Five Conclusion and Research Findings

5.1 Summary

The research set out to understand how a chaplain strategically facilitates a sacred space at the point of death and dying to alleviate suffering. Whilst there has been a reasonable amount of research demonstrating the significance of religious and spiritual care for patients, very little research has been conducted at this stage. Some healthcare professionals and management do not always fully appreciate the added value and substantial benefits for patients and family when a chaplain contributes to end of life care. Additionally, often chaplains themselves, do not acknowledge the sizeable contribution they, as health professionals make. Moreover, the research challenges the mis-conceptions of secular groups who percieve the financial costs of chaplaincy as unnecessary and are constantly challenging the need and benefit of chaplains (Swift, 2006). It is for this reason that I decided to enquire into how, why and what a chaplain facilitates at the point of death and dying.

The research, sought to understand the voices of other academics in this area, ascertaining that through scientific measurement there is a rejection of a purely materialistic or positivist view of the world, in favour of religion and spiritual petitions. It identified the arguments between religion and secularism concluding that one must accept the other and that society needs both to be balanced and equitable. Through Heelas and Woodhead's research there is also the acknowledgement of the co-existence of secularisation and sacralisation reinforcing the needs for individuals religious and spiritual needs to be supported.

The literature further describes a co-existing society in tension between secular activities and the growing endeavours of religion and spirituality. Society therefore is now perceived as post secular. There has always been and continues to be a sense of spirituality and religiosity which is growing, contrary to alternative arguments that are put forward by academics such as Bruce (2005). It is within this context that chaplaincy encounters and experiences blurred boundaries and expectations, when strategically facilitating a sacred space.

Additionally, patients and family find themselves in a state of liminality. Here a transition from one state to another takes place, separation from the everyday norms of life and integration into a clinical setting. Another way of being, which is temporary and transitional. Individuals acknowledging the authority and persona, of the chaplain are positively supported. It is at the point of threshold, that chaplains mediate on behalf of family and patients, employing sacred words, symbols and texts to mark this final rite of passage. They are able to meet the expectations, beliefs or ideas of patients and their families. This has a meaningful impact on their wellbeing and happiness, emotionally and psychologically. As a concequence of the Francis report, there is a growing interest in a need for high quality patient care including the dying and bereaved. There is now a focus on the six C's which are care, compassion, competance, communication, courage and commitment, as hospitals seek to provide better patient care for patients. Therefore, it is within these shifting and blurred but contested boundaries, that it becomes increasingly apparent that religious ideals and practices are still important when we consider how we run public services and the public space that needs to be created. One that is holistic, balanced, ethical and non-material.

5.2 Research Findings

The research produced prolific amounts of data, generating diverse and different insights into what takes place at the point of death and dying. It took into account the perceptions of those who were not religious or spiritual, as well as those who considered themselves religious and spiritual. Consequently, establishing that many staff and patients are religious and spiritual, spiritual or none and that every individual is unique in their religiosity or spirituality or both. Regardless of whether individuals are religious and spiritual, spiritual or none, it identified that that many individuals have some form of understanding or relationship with God, a greater being or a need to express themselves spiritually, at the point of death and dying. Furthermore, death is perceived as a significant rite of passage which requires marking, subject to expectations. The insights gained therefore provide the backdrop for a chaplain's world view, shaping their roles.

Additionally, the majority of the research took place within a culture that was utilitarian and clinical, serving a diverse and plural population with a variety of religious and spiritual beliefs and in some cases none. At the South Manchester Hospital there are nine, multi-faith chaplains male and female, all representing different faith traditions, who provide a multi-faith and none service. This can be anything from a chat, to something more deep and meaningful.

Finally, any evidence of a secular world view was hard to find. Participants, who were atheist or no faith, placed a substantial emphasis on the importance of religion and spirituality for individuals whose expectations needed supporting by chaplaincy. The research provided

a wider picture of society, supporting arguments for a post secular world where faith has a voice. Moreover, there is a need to support the religious and spiritual needs of those from a multi-faith and plural community.

5.3 Significance of the Findings

The 6C's framework is a tool used to summarise the research findings and can also provide an awareness and appreciation of chaplaincy and the impact on those around them including chaplaincy's contribution and primary focus on patient and family care. It establishes that chaplain's care; are compassionate, listen carefully to patients needs and courageously mediate on behalf of patients. Chaplains are committed to meeting expectations and needs, especially when it comes to facilitating a sacred space at the point of death and dying.

5.3.1 Care

Chaplains consistently deliver high quality care to patients and families especially those who are vulnerable. They are pastorally focused, offering a listening ear, religious and spiritual support; consequently they are in a position of trust which enables them to develop relationships quickly. Staff therefore, have great confidence in requesting a chaplain for patients and their families at the point of death and dying having witnessed firsthand the benefits patients gain. The care provided is particularly important when they were at a loss to know what to do during a point of crisis with patients and family. They know a chaplain is available 24/7 and perceive this as putting the patient and family first by meeting their needs.

Clinical staff also perceive, that chaplains are able to spend quality time with patients and family at a time when they have more pressing priorities. They have confidence knowing that when the chaplain arrives, there is a sense of relief for staff enabling them to focus on other priorities, confident that the chaplain will provide the appropriate support.

5.3.2 Compassion

The delivery of care by chaplains is facilitated compassionately through the relationships they develop which are based on empathy, kindness, respect and dignity. This is demonstrated through the actions of the chaplain as they suffer alongside patients and family offering solidarity within a sacred space. Here, chaplains perform rituals knowing that they assist in normalising death because the rituals consist of familiar words of affirmation and symbolism.

Individuals associate chaplains and their rituals, with their own religious tradition or cultural expectations. Consequently the creation of a sacred space, removes heightened hysteria in the form of a distraction, providing a different perspective. At the same time chaplains bestow confirmation of the inevitable, acceptance and closure, enabling patients and family to face mortality. Addtionally, the language of rituals unites patients and family in their own expectations, providing them with a positive focus point, that they are able to share later. Moreover what chaplains deliver is driven by the needs of individuals, because chaplains put aside their own religious beliefs in order effectively to provide the appropriate support. The

aspirations of individuals shape the sacred space and subsequently they receive a sense of completeness. Even those without a faith find support in what chaplains provide.

5.3.3 Competance

The research strongly identified that many health care professionals had complete confidence in chaplains, as competent, knowledgeable, healthcare workers. So much so that when it came to providing religious and spiritual care to patients, they felt that chaplains were the most appropriate and qualified person who could consistently provide high standards of care.

A significant part of facilitating a sacred space was the authority and persona of the Chaplain. Patients, family and staff, acknowledge that the presence of a chaplain, 'sanctified' the sacred space, associating the chaplain with their own belief system. Furthermore, staff perceive chaplains as knowledgeable and experienced practitioners with specific skills, gifts, experiences and insights. They are also understood as neutral and objective; and outside the clinical protocols and processes that patients experienced. Consequently, the use of chaplains set clear boundaries, supporting and meeting expectations.

Staff also indicated that they confidently request a chaplain because as health care professionals, they sought to deliver best practice, perceiving chaplains as collaborative in their endeavours. When it came to meeting the needs and expectations of patients and family, the chaplain reliably contributes to the best possible death. Consequently the provision of this final gift for patients and family by staff means that they know that they

have met their needs and expectations and have done their job well. This is additionally important because staff feel they are able to expedite the 'Care for the Dying' protocols and in doing so; they are fully compliant and have delivered high quality care.

Additionally, some participants felt that they could provide religious and spiritual support because they felt it was part of their vocation and they had their own religious and spiritual experience. However they also, revealed that what they could provide was only at a limited level and within specific conditions. Consequently, considerable concern was expressed by healthcare professionals, worried that they might 'get it wrong', cause offence and fail to deliver adequately. There were strong feelings that at a deeper and more individual level, staff were not competent, or that the same level of service could not be delivered consistently across the hospital. There was also some uncertainty as to whether health care professionals could deliver religious and spiritual care, even if they had had training. Moreover, it was clearly conveyed that this was beyond their job description and professional remit, compromising their own professional clinical role.

5.3.4 Communication

A core part of a chaplains role is listening. They listen to the stories of the patients, families and the staff. Individuals have confidence in chaplains because they are perceived as neutral and objective; separate from the clinical care that is being delivered. This enables them to discuss the treatment they are receiving, or their own personal concerns allowing individuals to discern and make decisions about their own needs which they share with chaplains. As a result of extablishing a positive relationship with the patient, they are sometimes able to

intercede on behalf of patients or family, voicing the thoughts and feelings of patients and families especially when they struggle for words. Chaplains therefore are objective mediators and ethical, moral observers, who look for 'fair play' and equity functioning outside the normal processes of the hospital.

As well as patients and family, staff also avail themselves of the chaplains' listening ear. Consequently they are more effective in their role in the work place and morale is higher. One atheist participant felt very strongly, that there should be more chaplains available in the hospital, especially for staff explaining that they were not supported sufficiently enough.

5.3.5 Courage

Chaplains face many challenges, the largest of which is being fully understood by some health care professionals. Sometimes when they are requested by family and patients and have the full cooperation of staff, there can be tensions between what they need to facilitate and the priorities of staff. Summoned to the bedside of a dying patient, A & E or theatre, chaplains courageously encounter the challenges of the utilitarian and clinical environment which can be noisy and chaotic. A hospital does not stop when someone dies. Chaplains often have to intuitively discern the needs of patients and their families. Therefore, they boldly and courageously strategically facilitate a sacred space which is far removed from a church or a chapel setting.

Chaplains are requested to attend patients across all areas of the hospital including A & E and theatres, building a wide range of relationships in multi-disciplinary areas. This allows them to gain a large number of insights into many clinical areas of the hospital; providing a greater overview of what takes place in the hospital, discerning good or poor practices where they are compelled to inform others of patients at risk.

Additionally, chaplains, courageously embrace uniqueness and differences without judgement, are tolerant and deliver to all equally. They provide culturally appropriate services in a sensitive manner. Taking courage, they intuitively and strategically facilitate a sacred space with minimal knowledge, in order to meet the expectations of patients and their family: courageously and compassionately, offering bespoke rituals, within blurred and contested boundaries. They are further challenged, when offered knowledge of individuals religious and spiritual beliefs, attempting to postulate a space that has deep meaning and significance, outside their own traditions and belief.

5.3.6 Commitment

A Chaplain's commitment is to the patients, family and staff in a multi-faith and none capacity. They are committed to seeking out and supporting the most vulnerable in the hospital, especially at times when staff are under extreme pressure. Their commitment is to minimise the trauma patients, family and staff experience consequently limiting any emotional and psychological impact. Their role in the hospital is to be one human being alongside another, outside clinical intrusion. Chaplains are committed to be consistent, self-evaluating and self-reflecting to ensure that they can deliver this specialised service.

5.4 Unexpected Outcomes

There were a number of unexpected outcomes from the research which was not provided by other research. Primarily the significance of chaplains being present, having a lasting and important impact for families and patients. It was also apparent from the majority of those interviewed that the chaplaincy team at the South Manchester Hospital set an exemplary model to others on how all individuals needed to be treated. The chaplains prided themselves in maintaining this philosophy which had been established historically by Revd. John Perryman, now retired, but was Lead Chaplain for twenty four years.

Moreover, it was evident that because society has lost its coping strategies when it comes to death and dying, chaplaincy filled this gap, with their experience, for individuals regardless of whether they had a faith. Individuals looked to chaplains for guidance and support because within a secular world their is insufficient liturgy or rituals. The chaplain is able to provide them with adaquate language guided by their needs.

5.5 Added Value of Chaplaincy

Chaplains care and have the space, skills and knowledge to deal appropriately with patients and family at a time when staff, need to consider important clinical needs. Staff, are therefore confident that they can provide a holistic provision for patients, guaranteeing high quality patient focused care. As a result of being calmer patients feel less pain. Due to the reduction of pain, alleviated by chaplains, less medication is used consequently reducing costs to the NHS.

Chaplains deliver care, compassionately providing practical, spiritual, religious and psychological support where others do not have the skills to deliver this. What they ensure is that individuals receive dignity and respect at the point of death and dying which is their human right. Consequently, families receive positive experiences at a point when they are vulnerable. The chaplain also facilitates closure, minimising the grieving process. This assists with a sense of wellbeing and wholeness at the point of shock. It minimises any consequential, long term, mental health problems consequently, the number of complaints are reduced and overall this saves time and money for the NHS. As role models they help create a better working environment which reduces costs.

Chaplains are competent practitioners delivering best practise, consistently. They support staff morale, reducing pressure and consequently minimising the impact on staff absence. This makes a contribution to the consistent staffing of wards, consequently reducing costs to the NHS. Additionally because of improved staffing there is greater moral leading to improved performance which results in high quality patient care: ’Reducing stress, and consequently NHS sick leave costs, and reducing pressures on the ward.

Chaplains facilitate greater communication through their listening skills and with the permission of individuals they are able to ensure the patient contributes effectively to the shared decision making: ensuring ‘no decision about me without me’.

Chaplains have the courage to embrace dying with and on behalf of patients, family and friends because they have greater awareness of what takes place across the hospital, watching

and listening to staff and patients. They establish productive relationships quickly, allowing the provision of respect, care and compassion. They courageously help family and patients come to term with death and dying through the safety of a sacred space providing rituals, liturgy and symbolism. This intensive focus on patients also enables them to have the courage confidently to highlight patients' concerns to other healthcare professional ensuring high quality care.

Chaplains are committed and have a sense of integrity because of their vocation to help meet patients and families expectations guaranteeing excellent patient care and experience. The use of chaplains in a hospital is a valuable resource which delivers to all the Six C's which guarantees the Trust's own commitment to provide high quality care for the dying and bereaved in line with the Francis Reports guidelines and recommendations.

Chapter Six Recommendations

In order to guarantee the provision of high quality care, there is a greater need for the use of chaplains especially at points of crisis and with vulnerable patients and family. Therefore there is a need to raise awareness and educate staff about the benefits of chaplains, especially when staff on wards, are extremely busy and time is limited. It would also prevent patients being neglected.

To facilitate compassion, staff need to be given greater confidence and awareness in the need to revisit the religious and spiritual needs of patients at the point of death or dying. Therefore there is a need to train staff on how to sensitively revisit and enquire about the religious and spiritual needs of patients: enabling them to help patients and family, through the use of a chaplain, come to terms with what is taking place in a safe place and by a practitioner. Additionally, this ensures that staff are patient-focused and that their needs are being met appropriatley. Their needs to be greater collaboration at ward level between nursing staff and Chaplains. Moreover, at the point that things go wrong greater collaboration between chaplaincy and the complaints department would be beneficial to the hospital.

To ensure a level of competancy in the provision of a sacred space, there needs to be increased awareness of what chaplaincy deliver to staff. It would be invaluable for staff to shadow chaplains as part of their training or induction into the hospital. This would faciliate better understanding and collaboration. For existing staff, training could be facilitated through Practice Based Educators. Spiritual and Religious provision should be included as part of the Ward Accredidation Indicators under the dignity and respect section. At present there is no provision.

Communication from chaplains to wards needs to be embraced in a more robust way. Staff need to identify that often chaplains see concerns that they don't always pick up due to the pressures of the ward. However there is a fine balancing act played here between chaplaincy and the hospital. It is imporant that this is not undermined because family and patients need to percieve chaplaincy as neutral and objecctive.

Chaplains need to have more confidence in what they provide and behave more robustly rather than be on the 'back foot'. This can be achieved by them identifying areas where they can work more collaboratively with staff. At the point of death and dying patients spiritual, religious and psychological needs can sometime be more important than clinical needs. Staff need to have the courage and awareness about a patient's real needs so that they can facilitate a greater balance between clinical and spiritual needs. They should take courage to work more collaboratively because this will ensure better patient care, patient focus and fewer fines because the Trust is more in line with Francis Reports recommendations.

6.1 Expectations

An overriding perception is that chaplaincy, is vital and significant. Without chaplaincy hospitals would become factories clinically managed by human-less processes and mechanisms that overlook the care and compassion of human suffering. There was a residual unease amongst staff at the South Manchester Hospital in 2004, when senior managers considered removing chaplaincy as part of financial measures. This compelling disquiet was also picked up in the research interviews in discussions about there potentially not being a provision.

Moreover there is a need and expectation for chaplaincy. The type of provision required is not just religious and spiritual but practical, emotional, psychological, and cultural indicating that society expects chaplaincy whether individuals are religious and spiritual or not. Moreover, it suggested that healthcare professionals under pressure from compliance and

governance often fail in their attempt to support individuals who have spiritual, religious, emotional and psychological expectations. Consequently, healthcare professionals have an expectation that the presence of chaplaincy is important because they have the commitment and courage to deliver care and compassion consistently.

6.2 Recommendations for Further Research Work

There are three recommendations which are born out of this research. Firstly, it would be beneficial to chaplaincy for this research to be carried out across other hospitals in the United Kingdom. Secondly, that the chaplaincy model in place at the South Manchester Hospital should be replicated in other hospitals to guarantee a healthy ethos within other existing chaplaincy teams. Consequently they will become suitable role models to other staff in the hospital. Finally that all hospitals work towards working more collaboratively with their chaplaincy teams and gain greater insights and understanding of the work chaplains carry out. Chaplaincy in the form of religion provides a very important social function. Death is seen as something that is negative. It is part of life and with a collaborative approach it can be done well. With the assistance of Chaplains, death can be normalised. There needs to be a point where it is as good as possible. It ensures that staff are able to safeguard the dignity and respect of the patient and their family's wishes. They can guarantee the delivery of a patient and family focused high quality patient care "This is best practice." Therefore I propose a seventh C – C for Chaplain.

APPENDIX

8.1 Appendix One

Participant Information Sheet

The Role of the Chaplain in the Strategic Facilitation of Multi-Faith Sacred Space to Alleviate the Suffering Associated With Death and Dying

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

There has not been a great deal of research in this area and it is considered that greater understanding of what takes place at the point of death and dying when a chaplain is present for both the patient and their families would be very beneficial. The understanding gained would help chaplains, nurses, doctors and other stakeholders who have interest in improving the quality of patient care.

The aim of this research question is to examine how, what, where, when and why Chaplains facilitate religious and spiritual support in non-orthodox spaces to people of any faith or none in a hospital. It will look at how beneficial this is to patient care and consider the added value of Chaplains within the NHS.

Why have I been chosen?
I have asked if you can take part because you have insights and experiences of patients at the point of death and dying and I would like you to share these insights with me for my research specifically in relation to the activity carried out by Chaplains. I am unable to ask patients or their families directly and your experiences are important to this research.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive in any way. You are free to withdraw from this study at any time. All information collected from you will be destroyed. There will be no detrimental consequences as a result of your withdrawal

What will happen to me if I take part?
If you decide to take part, you will be given this information sheet to keep and asked to sign the consent form. This will give your consent for a researcher from the Theology Department at the University of Chester to contact you and who will arrange to meet you for a 20 minute interview. At this meeting a number of questions will be asked in order to gain a greater understanding of spirituality, how patients understand and know spirituality, whether this is a

benefit to them and how you see the role of chaplaincy or not in providing religious and spiritual support. With your permission the meeting will be audio taped. No-one will be identifiable in the final report.

What are the possible disadvantages and risks of taking part?
There are no disadvantages or risks foreseen in taking part in the study.

What are the possible benefits of taking part?
As a member of staff it is possible that you may welcome the opportunity to share and discuss your views and experiences about the needs of patients and their families in order to improve the quality of their experience. By taking part, you will be contributing to the development of the Chaplaincy service and this will help chaplains understand their role better within the NHS.

What if something goes wrong? –
If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact:

Professor Robert E. Warner,
Executive Dean of Humanities,
University of Chester
Parkgate Road
Chester
CH1 4BJ
@chester.ac.uk
Tel.

Will my taking part in the study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential so that only the researcher carrying out the research will have access to such information. The information will be stored safely for 10 years and then destroyed. No one other than the supervisor or myself will have access to the data. The information will be used only by myself as part of the work on my dissertation and it will be submitted to my supervisor and an external team of markers. All information will be anonymised and if there are any patient names they will be coded to protect their identity. All information about you will be treated with complete confidentiality.

What will happen to the results of the research study?
The results will be written up into a report for the supervisors, markers and provided for use at the Chaplaincy at UHSM. It is hoped that the findings may be used to help chaplains and other stakeholders in the NHS. Individuals who participate will not be identified in any subsequent report or publication. All information about you will be treated with complete confidentiality.

Who is organising and funding the research?
The research is organised by Giselle Rusted, student at Chester University and Chaplain at UHSM. The research is supported by her supervisor Chris Baker.

Who may I contact for further information?

If you would like more information about the research before you decide whether or not you would be willing to take part, please contact:

Giselle Rusted, Masters in Faith and Public Policy, Theology Department, University of Chester, Parkgate Road, Chester. CH1 4 BJ or email @chester.ac.uk

Thank you for your interest in this research.

8.2 Appendix Two

Giselle Rusted
Theology Department
University of Chester
Parkgate Road
Chester
CH1 4BJ

6@chester.ac.uk

Date: XX/XX/XXXX

Dear

Re: Permission to undertake research

I am carrying out some research here at UHSM as part of my research for my dissertation in Faith and Public Policy.

Title of Research: The Role of the Chaplain in the strategic facilitation of multi-faith sacred space to alleviate the suffering associated with death and dying.

Researchers Name: Giselle Rusted

Supervisors Name: Chris Baker

The aim of this research question is to examine how, what, where, when and why Chaplains facilitate religious and spiritual support in non-orthodox spaces to people of any faith or none in a hospital. It will look at how beneficial this is to patient care and consider the added value of Chaplains within the NHS.

There has not been much research carried out in this area of chaplaincy and it is for this reason that I believe that the project will be of great value to NHS chaplains, main stakeholders in the NHS associated with death and dying and those involved with ensuring that patients receive high quality patient care.

During this research I will be abiding by the ethics and protocols of University of Chester and the Caldecott protocols of the NHS. Strict confidentiality will be adhered to at all times. All data collected from the research will be accessed only by myself and the supervisor and will be stored on a laptop that is password protected and used solely by myself. Anonymity will be kept around the information that is provided and any patient information will be coded. The research will not provide information which might identify patients or participants in the way that they are described or portrayed. I hope to use a Dictaphone to record my conversations and will therefore seek your permission before you consent to take part.

If you are willing to participate a consent form will be given for you to sign.

You may contact Professor Robert E Warner if during the research process you wish to lodge any issues, complaints or concerns if they have suffered any adverse effects.

Yours sincerely

Giselle Rusted

University of Chester

8.3 Appendix Three – Consent Form

Title of Project: The Role of the Chaplain in the Strategic Facilitation of multi-faith sacred spaces to alleviate the suffering associated with death and dying.

Name of Researcher: Giselle Rusted

Please initial box

1. I confirm that I have read and understood the participant information sheet, dated ……., for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my care or legal rights being affected. ☐
3. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent (if different from researcher)	Date	Signature
_____	_____	_____
Researcher	Date	Signature

8.4 Appendix Four – The Reseach Questions.

Title of Project: The Role of the Chaplain in the Strategic Facilitation of multi-faith sacred spaces to alleviate the suffering associated with death and dying.

Research Questions:

The questions below will look at casual validity i.e. secularism v religion and religiosity v atheism

These will only be used as a prompt

1. What is your understanding of the words religious and spiritual?

2. Are you religious and spiritual?

3. Can you share with me some of your experiences of spirituality and religion at the point of death and dying when either a chaplain or not has been present?

4. What significance, if any, do you understand that religious beliefs and spirituality has for patients at the point of dying and death?

5. For those who request spiritual and religious support and it is denied what would be the impact on the quality of patient care at the point?

6. What impact does religious and spiritual care have for family and staff?

7. Do you think that other health care professionals can provide religion and spirituality?

8. Do you have anything else you like to contribute?

8.5 Appendix Five: Demographics of Wythenshawe.

Demographics of the immediate locality, Wythenshawe, kindly provided by Alison Peacock, Mission Planning Officer at Church House in Manchester. Below are a selection of graphs which demonstrate the world view and community of the chaplain. Many patients and family from Wythenshawe present themselves at the hosptial. Added to this are other local communities and comunities across the North West, parts of Wales, the midlands and other parts of the country which are not identified here. These people come from further afield due to the specialist service provided at this south Manchester Hospital.

References

Beaumont, J., & Baker, C. (2011). *Postsecular Cities. Space, Theory and Practise.* London; New York: Continuum.

Bruce, S. (2002). *God is Dead.* Oxford, Massachusetts: Blackwell Publishing.

Bussing, A., & Koenig, H. (2010). Spiritual Needs of Patients with Chronic Diseases. *European Journal of Medical Research.* Retrieved from http://www.ncbi.nih.gov/pmc/articles/PMC3351996

BBC News. (2013) 50,000 march in NHS cut protest in Manchester. Retrieved from http://www.bbc.co.uk/news/uk-england-manchester-24286582

Brown, G. C. (2009). *The Death of Christian Britain. Understanding Secularisation 1800 – 2000.* Oxon, New York: Routledge.

Bryman, A. (2012). *Social Research Methods*. Oxford: Oxford Press.

Casanova, J. (2011). What is a Public Religion? In Helco, H & W. M. Clay (Eds.), *Religion Returns to the Public Square*. Washington: Woodrow Wilson Centre Press

Casey, P. (2011). Separating Religion and Spirituality. *The Journal of Health Care Chaplaincy. 1* (1) 38 – 49.

Collins, N. (2013). Liverpool Care Pathway' of little benefit' to dying patients. *The Telegraph* retrieved from http://www.telegraph.co.uk/health/healthnews/10380898/Liverpool-Care-Pathway-of-little-benefit-to-dying-patients.html 16/10/13 06.00hrs.

Cornwell, J. (2008). The Kings Fund. *Developing a Culture of Care and Compassion Blog*, retrieved from http://www.kingsfund.org.uk/blog/2012/10/developing-culture-compassionate-care.

Creswell, W. J. (2009). *Research Design. Qualitative, Quantitative and Mixed Methods Approaches. Third Edition.* California, London, New Delhi, Singapore: SAGE

Deflem, M. (1991). Ritual, Anti-structure and Religion: A Discussion of Victor Turners. Processual Symbolic Analysis (1991). *Journal for the Scientific Study of Religion 30* (1), 1 – 25.

Department of Health. (2008). *ELO Care Strategy. Promoting high quality care for all adults at the ELO.* 16/07/2008 Retrieved from https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life

Department of Health. (2010). *Spiritual Care at the ELO: a systematic review of the literature.* University of Hull, Staffordshire and Aberdeen. Retrieved from https://www.gov.uk/government/publications/spiritual-care-at-the-end-of-life-a-systematic-review-of-the-literature

Education For Scotland. (2009). *Spiritual Care Matters*. *An Introductory Resource for all NHSScotland Staff.* Retrieved from http://www.nes.scot.nhs.uk/media/3723/spiritualcaremattersfinal.pdf

Fair For All – Religion/Belief, (2007). *Religion and Belief Matters. Information Resource for Health Care Staff*. Retreived from http://www.healthscotland.com/uploads/documents/6378-Religion%20and%20Belief%20Matter.pdf

Franz, K. (2013). In the Land of Unlikeness: A Reflection on the Risky Adventure of Being Chaplain. *Health and Social Care Chaplaincy* (2013). *1*.(1).

NHS Careers. (2013) Francis Report retrieved from http://www.nhscareers.nhs.uk/promotions/implications-of-the-francis-report/

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods 5*(1) 1- 11.

Graham, E. (2013). *Between a Rock and A Hard Place. Public Theology in a Secular World*. London: SCM Press.

Graham, E & Lowe, S. (2009) *What Makes A Good City? Public Theology and the Urban Church.* London: Darton, Longman and Todd.

Gray, E. (2009). *Doing Research in the Real World.* London, UK; California, USA; New Delhi, India; Far East Square, Singapore: Sage Publications Ltd.

Habermas, J. (2010). *An awareness of what is Missing. Faith and Reason in a Post Secular Age*. Cambridge, UK; MA, USA. Polity.

Hay, D. (2002). The Spirituality of Adults in Britain – *Recent Research. Scottish Journal of Healthcare Chaplaincy*. *5*(1), 4 – 9.

Health, Social Services and Public Safety (2010). *Living Matters Dying Matters. A Palliative and ELO Care Strategy for Adults in Northern Ireland*. Retrieved from http: //www.dhsspsni.gov.uk/8555_palliative_final.pdf

Heelas, P., & Woodhead, L. (2005). *The Spiritual Revolution. Why religion is giving way to Spirituality.* Malden, USA, Oxford, UK, Victoria, Australia: Blackwell Publishing.

Herbert, D. (2003). *Religion and Civil Society. Rethinking Public Religion in the Contemporary World.* Hampshire, England; Burlington, USA: Ashgate.

Independent Review of The Liverpool Care Pathway. (2013). *More Care Less Pathway*. A *Review of the Liverpool Care Pathway*. Retrieved https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf

WWW.Parliament.UK. (2013). Care Bill: Lords third reading. Retrieved from http://www.publications.Parliament.uk/templates/briefingpapers/bppdfdownload.aspx?bp=sm06753

Jaye, C., & Macleod, R.D. (2010). *The liminality of Palliative Care. 7* (2) 1 - 8

Liamputtong, P. (2007). *Researching the Vulnerable*. London: Sage Publications Ltd.

McBeath, C. (2009). Sanctuary and Liminality. In Reader, J. and Baker, C. (Eds.), *Entering the New Theological Space*. Surrey, England & Burlington, USA.

Miles-Watson, J. (2009). Betwixt and Between: Anthropological Approaches to Blurred Encounters In Reader, J. and Baker, C. (Eds.), In *Entering the New Theological Space*. Surrey, England & Burlington, USA.

NICE (2003). *Guidance on Cancer Services. Improving Supportive and Palliative Care for Adults with Cancer. The Manual.* London. Retrieved from http:///www.nice.org.uk/nidemedia/pdf/csgpmanual.pdf

Macmillan Cancer Support. (2013). *Macmillan Cancer Support respond to the Liverpool Care Pathway review*. Retrieved from Http:// www.macmillian.org.uk/aboutus/news/lates_News/Macmillian/CancerSupportrespondstoLiverpoolcarepathreveiw.aspx

Mount, H. (2013, August 15). *Can you speak Elema, Nahuatl or Uyghur? Then you'll find someone to chat to in Manchester, where 200 languages are spoken by its population of just 480,000. The Daily Mail.*

Wee, B (2013). *Improving Care in the Last Days of Life.* Retrieved from NHS England http://www.england.nhs.uk/2013/10/30/bee-wee/

National Secular Society. (2014). *Chaplaincy Funding and the NHS.* Retrieved from http//: www.secularism.org.uk/nhs-chaplaincy-funding.html

National Secular Society. (2013*). Hospital Chaplains largely unaffected by cuts to NHS frontline services.* Retreived from http://www.secularism.org.uk/news/2013/06/hospital-chaplains-largly-unaffected-by-cuts-to-nhs-frontline service.

Goodall, M. (2009). How to See The Wood For the Trees In Reader, J. and Baker, C. (Eds.), *Entering the New Theological Space.* Surrey, England & Burlington, USA.

Reader, J., & Baker, R. (2009). *Entering the New Theological Space.* Blurred Encounters of Faith, Politics and Community. Surrey, England; Burlington, USA: Ashgate.

Reder, M., & Schmidt, J. (2010). *Habermas and Religion in An Awareness of What is Missing in Religion in A Post Secular World*. Cambridge UK; MA, USA: Polity.

Silverman, D. (2000). *Doing Qualitative Research*. London: Sage Publications Ltd.

Thody, A. (2006). *Writing and Presenting Research*. London: Sage.

Biggam, J. (2011). Succeeding with your Master's Dissertation: A step-by-step Handbook. Maidenhead: Open University Press (electronic book).

Swift, C. (2009). *Hospital Chaplaincy in the 21st Century. The Crisis of Spiritual Care in the NHS.* Surrey, England and Burlington, USA: Ashgate Publishing Ltd.

Smith, R. (2012). Patient Care will suffer under budget cuts warn NHS finance bosses. *The Telegaraph* Retrieved from http://telegraph.co.uk/health/healthnews/9568068/Patient-care-will-suffer-uner-budget -cuts-warn-NHS-finance-bosses.html

Speck, P. (2004). Spiritual Care in Health Care. *Scottish Journal of Healthcare Chaplaincy. 7* (1). 21 – 25.

The Kings Fund (2014) The Francis Inquiry Report. *Patient Centred Leadership,* retrieved from http://www.kingsfund.org.uk/projects/francis-inquiry-report

Brown, P., & Bickley, P. and Woolley, P (2013). Religion and the National Health Service. A report for Barking and Dagenham Primary Care Trust. *Theos*. Retrieved from http://www.nelft.nhs.uk/_documentbank/Religion_THEOS_Barkingdagenham_complete_draft5_2.pdf

Turner, V. (1969). *The Ritual Process. Structure and Anti Structure*. New York: Aldine De Gruyter. Hawthorne,

UHSM. (2010). *About Us.* http://www.uhsm.nhs.uk/ABOUTUS/Pages/AboutUs.aspx 21/12/2013

Uncatergorised, (2014). Three Hundred and Sixty Degree Feedback. Retrieved from http://www.hsj.co.uk/news/workforce/nurses-to-get-360-degree-feedback-in-drive-to-improve-appraisals/5057464.article Posted July 19, 2013 in Uncategorized

Ward, G., & Hoelzl, M. (2008). *The New Visibility of Religion.* London & New York: Continuum.

WHO. (2014). *WHO Definition of Palliative Care.* http:// www.who.int/cancer/palliative /definition/en/ 16/1/14