

A review of  
some theoretical models of  
healthcare chaplaincy service and practice

*This paper forms part of the guidance for chaplains arising from the  
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## INTRODUCTION

This introduction does not claim to summarise or offer all that might be useful to those who want to know about the variety of theoretical models of service and practice operating in healthcare chaplaincy since 1948. Its primary purpose is to point the reader to some of the essentials required in order to approach this body of work which yields few clearly defined models. The models and part-models that are documented here include some that are reasonably developed and defined, others which are embryonic requiring work to tease them out, and those which are almost exclusively rooted in traditional notions of Christian pastoral care and ecclesial ministry.

This paper will therefore be general in character, offering a number of theoretical models as examples and pointing the reader to references for their own personal research and professional development. This paper raises questions about the theoretical base, professional identity and integrity of healthcare chaplaincy as well as its future direction and development.

How important to healthcare chaplains is an understanding of the theoretical models of service and practice which shape our contribution to healthcare? Are they essential enough to ask of ourselves the intensive work of reflecting, documenting and developing existing models and working together to create new and contemporary models appropriate to today's National Health Service?

The *Caring for the Spirit* strategy provides an opportunity for all healthcare chaplains and chaplaincy departments to think about their *modus operandi* in the NHS regarding the service it provides to the Trust, its patients and their carers. The strategy document focuses on models of service and practice in some detail (paragraphs 12-20).

Our goals in this paper:

- To provide an introduction to some theoretical models of healthcare chaplaincy service and practice, referencing primary and some secondary sources.
- To promote a critical conversation around models of service and practice within chaplaincy collaboratives and Trust chaplaincy departments.
- To promote the definition and documentation of healthcare chaplaincy's theoretical base, so patients and professionals know what we represent and what we do.

This review of some theoretical models is restricted to healthcare chaplaincy. We have not attempted to compare models of service and practice in other secular institutions where different models of chaplaincy operate. These include; University and Higher Education, the Prison Service, Industrial Mission and the Armed Forces. Some work has already taken place in this area (Legood 1999). However, it remains a potentially fruitful area for comparative research.

Following some consideration we have also taken the same line regarding multi-faith aspects of healthcare chaplaincy. We would point readers to work being undertaken by the Multi-Faith Group for Hospital Chaplaincy to develop spiritual care in healthcare among nine faith communities, and work already undertaken by Beckford and Gilliat (1996a, 1996b).

## 1. A DEFINITION OF THEORETICAL MODELS

Theoretical models are developed to describe and define the way things work through structuring what occurs and providing a rationale for it. These models provide practitioners and the public with a way of understanding, discussing and evaluating who we are and what we do. They reframe everyday practice in more technical and academic language. In this way models can be examined using different approaches to theological reflection.

These models can be audited against standards for the promotion of 'good practice' which can be shared with our colleagues in journal publications, at conferences and in local forums. They can be subjected to qualitative and quantitative research and examined for their impact on clinical outcome.

The following theoretical models have been collated from books, journals, research projects and national reports since 1948. This paper is not intended to be a systematic review of the literature on models of service and models of practice, rather its function is to stimulate thinking, promote debate and develop practice.

## 2. DIFFERENTIATING MODELS OF SERVICE AND PRACTICE

Models of service and models of practice have different aims and objectives. Service models explain the work of the department to the public, the employer and promote departmental definition. They emerge following a process of careful reflection on the institutions primary task which is 'the main purpose for which the institution exists and which it has to achieve and maintain in order to survive' (Rice 1963). Each professional group organises and is accountable for their work in relation to the primary task. Healthcare chaplaincy is shaped by the primary task of the NHS Trust, critically informed by the primary task of the faith communities and organised by chaplains.<sup>1</sup>

Practice models concern the specific work engaged with by staff and volunteers in the department. The completion of these tasks takes place in relation to and in consultation with the patient and other healthcare staff. In this way they can become integrated into a multi-professional approach to practice. They focus on clinical pastoral interventions or units of activity in the department including professional interactions with service users, recurring events such as public services, multi-professional meetings, data collection and research.

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<sup>1</sup> Lawrence & Robinson (1994) in their book developed an understanding of the primary task through distinguishing between the *normative primary task* (formal statements of the organisations activity); the *existential primary task* (what employees believe they are doing); and the *phenomenal primary task* (what can be inferred from the behaviour and activity of employees, of which they may or may not be consciously aware). This triangular understanding of the primary task affects service, assessment and practice models. In terms of healthcare chaplaincy this may be seen in the following way. The *normative primary task* translates into formal statements like 'Meeting the Spiritual and Religious Needs of Patients and Staff' (2003); the *existential primary task* into, 'Chaplaincy National Occupational Standards' (1993, 2005); and the *phenomenal primary task* into research like Hospital Chaplaincy - Modern, Dependable? (2000).

'Good practice' indicates that these practice models develop out of an assessment of the spiritual and religious needs and issues presented in particular situations. In order for spiritual and religious care to be effective within the healthcare system it is crucial that a systemic and practical link is made between models of assessment and models of practice. While this task goes beyond the scope of this paper we offer the following references for consideration.<sup>2</sup>

The following models are theoretical in the sense that they have been lived and reflected upon – they are theorised practice or practice-based evidence. As we will see some models are a mixture of service and practice having developed together for largely historical reasons. Some models no longer sit comfortably together,<sup>3</sup> while others require radical revision for use in the 21<sup>st</sup> century.<sup>4</sup>

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<sup>2</sup> The majority of NHS services are structured and informed by different models of referral, assessment and intervention or practice. This is evidenced for example by the work of the National Institute for Health and Clinical Excellence (NICE), or in government policy such as the National Service Frameworks (NSF) and encoded in systems of patient care behind the language of league tables and waiting times. During the last twenty five years interest in spirituality in society, including in healthcare has burgeoned to an extent that it is now a developing area of research from different perspectives and disciplines including; medicine, psychiatry, psychology, the psychological therapies, nursing and gradually healthcare chaplaincy. Unlike other healthcare professionals healthcare chaplaincy has never worked to explicit models of assessment and intervention despite the existence of such models and a developing literature about them primarily authored by nurses.

The following articles provide a way in to this literature which could be used to form the basis for discussion and development in the Chaplaincy Collaboratives through the development of Journal Clubs as part of Continuing Professional Development (CPD). A good starting point is a paper by McSherry and Ross (2002) as it is a literature review of spiritual assessment tools. The tools range from descriptive accounts of spiritual issues to more extensive patient spiritual histories. Some tools include religious needs and issues. The authors found that much of the literature focused on the assessment phase and rarely followed this through to the intervention and planning stage. In addition to this paper with its extensive references we would highlight the following literature; Hay (1989), Cobb & Robshaw (1998), Orchard (2000), Swinton (2001), Culliford (2002), Ledger (2005) and Hollins (2005).

The National Institute for Health and Clinical Excellence (2004) *Guidance on Cancer Services* is an evidence based approach which highlights the need for spiritual assessment to be a continuous process along the patient pathway responding to the patients changing circumstances around symptoms, treatment and their relationships with key people.

The paper by Anandarajah and Hight (2001) is an American study which utilises an assessment tool called the HOPE Questions in clinical encounters. This assessment tool has been used by Pierce (2004) in a palliative care setting.

The World Health Organisation Pastoral Intervention Coding (WHO-PI Codings) offers a code for pastoral assessment which sees the need for initial and subsequent appraisal. Returning to England the paper by Carey, Cobb & Equeall (2005) focuses on 'statistical results of pastoral encounters' in two hospitals in Sheffield. The data collected on patient and non-patient contact is shown to be transferable to the (WHO-PI Codings) therefore offering a model of consistency and measurement.

Spirituality and its assessment in healthcare are not apolitical or free of contention. Two recent articles which place some boundaries around the philosophical and political issues involved are by Draper & McSherry (2002) with a response by Swinton (2002).

<sup>3</sup> Helen Orchard's (2000) role-based research centred on six acute London Hospitals focuses on a number of systemic and organisational dynamics in healthcare chaplaincy including the historic practice of 'brokerage' where one faith community presumes to speak and act on behalf of another. This brokerage dynamic is indicative of a broken model which requires some radical thinking prior to being replaced rather than repaired. Orchard's distinction between two service model typologies, namely 'sponsor defined' and 'employee defined' warrants much further consideration as it offers a constructive analysis healthcare chaplaincy well beyond London and a mechanism for initiating change.

<sup>4</sup> The South Yorkshire Workforce Development Confederation (2003), *Caring for the Spirit* strategy indicates that the traditional parochial model operated by the Christian denominations continues to influence and shape the provision of spiritual and religious care in the NHS. However, this approach to service provision is challenged on a number of fronts including secularism, pluralism, a shortage of priests and ministers, lay ministry, and crucially the increasingly specialised nature of healthcare chaplaincy in a secular institution funded from public finance.

### 3. EMERGING MODELS 1948 – 1992

In 1948 the Ministry of Health issued guidance to Regional Hospital Boards on meeting the spiritual needs of patients and staff (Ministry of Health 1948). Subsequent guidance (1963, 1977, 1984, 1986, and 1992) influenced the organisation and development of chaplaincy practice along primarily Christian lines until the 2003 guidance (Department of Health 2003) provided a multi-faith perspective.

From the start of the NHS the appointment of hospital chaplains was predicated on bed-based calculations and staffing levels. This method, with some minor refinements continues to operate in the most recent guidance (2003). This method has contributed to shaping healthcare chaplaincy models of service and practice, and determined the number of whole-time chaplains appointed.<sup>5</sup>

However, this approach is increasingly out of step with the range of contexts in which chaplains now operate including; community based mental health work; day-case work; Primary Care Trusts (PCT); out-patient clinics and most recently free standing NHS and independent sector treatment centres.<sup>6</sup> These contexts question the appropriateness of bed-based calculations which are predicated on bed occupancy and not patient need. In a “patient-led NHS” (Department of Health 2005) how are patient’s spiritual and religious needs to be assessed? In a rapidly changing NHS there is an urgent need to look now at how healthcare chaplaincy relates to and works within an increasingly community based, day-case orientated and privately augmented health economy.

Forty years ago Barton commented that ‘most chaplains are hard working parish priests.’ This provides a clear insight into one historic and prevailing service model – the parochial model, or ‘calling in the chaplain’ (Barton 1966). This model was operational in 1948 and continues to this day. It has the effect of dovetailing a model of clerical pastoral practice (hospital visiting) with that of a particular type of service provision (part-time chaplaincy). The parochial model is a traditional model based on notions of vocation, duty and service which is offered by the churches to a variety of community based institutions. The NHS as one recipient of the Church’s ministry appears to have viewed chaplaincy as important while colluding with the churches in permitting an outdated model to continue.

The parochial model has strengths, one of which is bridging the gap between hospital and community. However, it is perhaps defined as much by the organisational needs of the churches concerned as by expressed patient need. The parochial model of chaplaincy remains a largely undefined, unregulated and unaccounted service. Accurate figures recording the number of part-time chaplains remain difficult to obtain.<sup>7</sup> The model requires a thorough reassessment and reframing within agreed levels of service provision. This should be based on an appraisal of the spiritual and religious needs of service users and the organisation of an integrated chaplaincy service to the Trust.

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<sup>5</sup> In 1976 there were 107 whole-time chaplains. This rose to 260 by 1986. Source: *A Handbook on Hospital Chaplaincy*. Hospital Chaplains Council. 1987. Subsequent guidance from the Department of Health (HSG) 92(2) and in 2003 continues to employ a bed-based calculation despite a rapidly changing healthcare context.

<sup>6</sup> In 2005/6 the British Medical Journal ran a series of articles in the Education and Debate section examining the potential implications of the governments planned market reforms in healthcare including an article by Chris Ham (2005).

<sup>7</sup> Beckford JA & Gilliat S (1996), Orchard H (2000) & *Caring for the Spirit* (2003) all make reference to the lack of accurate figures regarding part-time chaplains and the absence of a central source of information. However, there are currently an estimated 1,500 part-time chaplains in the NHS.

From the 1960s onwards some chaplains and chaplaincies developed new models of service and practice arising from whole-time posts in a hospital. It is here that we first begin to see models influenced by the needs of patients, staff and the institution. It is here that we begin to see the development of reflection on practice through writing and research. Here are three examples.<sup>8</sup>

### 3.1. *Autton's mixed model (1968)*

Norman Autton wrote extensively on pastoral care issues in hospital settings (Autton 1963, 1966). He sees the chaplain's role as representing the hospital to God and God to the hospital. One expression of this relationship is the centrality of the sacraments which provides a transcendent dimension to the human dilemmas of illness, suffering and death. The chaplain is a 'technician of the sacred' and should be as 'professional' as the doctor. He is 'self-contained, clear about and confident' in his role. Speck's comment that Autton's chaplain is 'professional, priestly and prophetic'<sup>9</sup> indicates the nature and extent of the role.

Autton placed particular emphasis on the chaplain as priest, whose task was to model and offer a silent prayerful presence in the hospital. Central to this service model was a sense of *professional poise* or how to *be with* patients in their suffering. He stressed the importance of the chaplain learning from these experiences through reflection and supervision. He actively supported and developed the training of chaplains and the role of lay visitors for hospital ministry.

### 3.2. *Faber's conversational model (1971)*

Heije Faber's approach to healthcare chaplaincy is significantly different to Autton's and his book was probably written in response. Like Autton, Faber wrote extensively about the relationship between religion, sickness and health (Faber 1976). He was a Dutch Reformed Calvinist whose model of chaplaincy finds focus in 'the conversation' between the chaplain, the patient or member of staff. Faber offers a structure for working with pastoral conversations informed by Clinical Pastoral Education (CPE) and in particular the 'verbatim report.' He provides an example of working with this approach (Faber 1971).

With the exception of Anton Boisen one of the 'founders' of CPE, Faber is perhaps the first non-American chaplain to prioritise the centrality of the pastoral conversation and reflection upon it in acute and mental health settings. This approach originated through his pastoral and academic interest in bringing the modern psychologies, particularly Freudian psychoanalysis, into conversation with Biblical theology for use in pastoral care. Faber's chaplain wrestles with his role, its various discourses, and experiences the tensions of being an 'insider/outsider' in the modern hospital. He is an 'amateur and generalist among professionals.'

Faber's conversational model with its use of the 'verbatim report' resonates with today's emphasis on clinical supervision (Ward 2005), research into narrative approaches to practice in medicine, pastoral care and psychotherapy, and the influence of CPE throughout different parts of the world.<sup>10</sup> The narrative structure of

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<sup>8</sup> The following three models by Autton, Faber and Wilson were the subject of a paper by Stephen Pattison (1980). In the preparation of this paper we have drawn on his article.

<sup>9</sup> Speck P (2002) this was the inaugural lecture in a new annual series. The subject of this first lecture focused on the contribution of Norman Autton to healthcare chaplaincy. This lecture and subsequent ones can be accessed at [www.mfghc.org.uk](http://www.mfghc.org.uk)

<sup>10</sup> Narrative-based medicine is one form of discourse currently gaining ground in medicine as a response to the more 'scientific' aspects of evidence-based medicine (Greenhalgh & Hurwitz 1998). The development of the therapeutic culture has conversation as foundational in psychoanalytic, cognitive and humanistic therapies (Monk 1996). There

pastoral care equips Faber's chaplain to give voice to the different roles within chaplaincy including that of pastor, minister, clown, counsellor and prophet (Cusick 2005; Beardsley 2006).

### 3.3. *Wilson's primary task model (1971)*

Michael Wilson was a medical doctor who trained for the Anglican priesthood in later life. His approach to chaplaincy developed from his role-based research.<sup>11</sup> Wilson's service model focuses on the need to foster a creative relationship between the hospital, community and organised religion. Illness, disease and death are not individualised, rather they are social phenomena requiring attention from a socio-economic perspective.

According to Wilson the primary task of the hospital is 'to enable patients to learn from the experience of illness and death how to build a healthy society.' Rooted in this understanding of the primary task his service model develops out into the community and church in an organic way. For Faber, hospitals are primarily agents for building a healthy society and should not to be reduced to simply functioning as centres where medical treatments and procedures take place. Wilson wanted the churches to work together with the hospital and its chaplaincy department, fostering good relationships with patients and staff, and where necessary challenging hospital policies, practices and values.

So Wilson developed a service model of hospital chaplaincy along similar lines to that of a 'university teaching department.' Here hospital chaplaincy would research the social, personal and theological dimensions of illness and suffering with reference to peoples spiritual and religious needs. In this service model the chaplain would be like a dean of humanities in the modern technological and scientific hospital. The chaplain would be the guardian of the human condition most deeply felt. Wilson saw opportunities for the chaplain to be experimental by using himself in role for the good of others. Wilson's chaplain is 'an intellectual liberal,' 'a generalist' whose roles include: prophet, priest, healer, administrator, judge and servant.

One aspect of his practice model involves the chaplain developing a Socratic approach to organisational issues. In role the chaplain can ask difficult questions and verbalise some of the unvoiced concerns within the organisation.<sup>12</sup> Here the chaplain puts into words what the psychoanalyst Christopher Bollas terms 'the 'unthought known' within the organisation (Bollas 1987). Prayer, contemplation, thinking and action are at the centre of Wilson's model and contribute to the development of what we might term today the 'reflective practitioner.'

James Woodward comments on the enduring relevance of this model in Birmingham and beyond. He highlights its relevance for chaplaincy regarding the development of its knowledge base, its transcendent dimension and an ecumenical and multi-faith approach to practice (Woodward 2000).

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are a number of tools and approaches for analysing conversations including: the single case-study, action-learning sets and discourse –analysis. The task of supervision and mentoring in professional development is primarily located in talking, listening and interpreting a range of human interactions (Foskett 1988, Ward 2005).

<sup>11</sup> For a critical appraisal of Wilson's contribution to pastoral theology and hospital chaplaincy go to *Contact* 2000. 131. The whole edition is devoted to an appreciation of his work.

<sup>12</sup> The prophetic role of the healthcare chaplain is perhaps more rhetoric than reality? (Lawrence 1995) specifically addressed the systemic issue of the chaplain being well placed within the organisation to ask difficult questions.

#### 4. FURTHER MODELS AND CRITIQUES 1996-2004

With the publication of *Being There – Pastoral Care in Times of Illness* (1988), Peter Speck, then chaplain to the Royal Free Hospital in London, offered the healthcare chaplaincy community a model of care centred on pastoral contacts with patients and staff in one-to-one and group settings. The heart of this approach resides in the ‘presence’ and timely interventions of the chaplain who when in role represents a myriad of things and sentiments including organised religion, ministry, a spiritual dimension, a source of hope and a sign of contradiction. The task of the chaplain is to offer pastoral care to people in situations of ultimate concern. For this the chaplain needs to acquire skills in counselling and inter-personal relationships to place alongside their ministerial formation and religious tradition.

In his book Speck makes the distinction between ‘spirituality’ and ‘religion’ and invites healthcare chaplains to do the same in their work. However, Speck does not see spirituality as totally separated from religion; rather religion is to be seen as a subset of spirituality (King, Speck, Thomas 1994). Today this distinction is commonplace in healthcare chaplaincy<sup>13</sup> and in multi-professional discourse (Speck, Higginson, and Addington-Hall 2004). Most of the service and practice models we look at in the remainder of this paper have been influenced by this distinction between ‘spirituality’ and ‘religion.’

The distinction between ‘spirituality’ and ‘religion’ has spawned a rapid growth in research being conducted into spirituality in healthcare. In the United States of America research in this area has developed within a different political, economic, religious and healthcare context to that of Europe. Across the Atlantic healthcare chaplaincy has been at the forefront of this research (Koenig, McCullough & Larson 2000) (VandeCreek, Burton 2001).

The nursing profession - who in the United Kingdom have a responsibility for the spiritual needs of patients<sup>14</sup> - have contributed many research papers to the debates around the definition and location of spirituality in healthcare. Healthcare chaplaincy in the United Kingdom is slowly addressing the need to include an evidence-based approach to practice.<sup>15</sup>

The National Institute for Health and Clinical Excellence (NICE) is the government’s response to the need for clinical and service improvement. In 2003 they issued Guidance on Palliative Care which includes a chapter on Spiritual Support (NICE 2004). It provides an evidence-based approach to the organisation of practice models and is a good example of how to organise and take forward the spiritual and religious agenda within NHS healthcare chaplaincy at strategic and patient levels.

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<sup>13</sup> The following guidance and documents have contributed to developing and endorsing the distinction between ‘spirituality’ and ‘religion’ in healthcare chaplaincy: The Patients Charter (1992); Meeting the Spiritual and religious Needs of Patients and Staff (1992, 2003); NHS Northern & Yorkshire Chaplains & Pastoral Care Committee (1995); Hospital Chaplaincy: Modern, Dependable (2000), and Caring for the Spirit (2003).

<sup>14</sup> Spiritual care is part of the nurse’s role (UKCC). As a profession nurses have conducted research into spirituality focusing on its content, measurability and meaning (see footnote 2). Much of this research has been at the theoretical and conceptual end of the spectrum and as such has had a very limited effect on patient care.

<sup>15</sup> There are a number of pioneers in this field including work by: Mark Cobb, John Foskett, Helen Orchard, David Lyall, Peter Speck, John Swinton and Michael Wright. The College of Healthcare Chaplains has a Research Network which meets twice a year in Derby in the spring and autumn to promote an evidence-based approach to practice. The ‘Caring for the Spirit’ Strategy emphasises the need to evidence the quality of care offered by chaplains to patients and staff.

The guidance sees spiritual assessment as a continuous process to be addressed at critical points in the patient journey including; “the development of new symptoms, distressing side effects of treatment, the emotional and social consequences for patients of life changing illness and changes in relationship with key people.” This model of assessment demonstrates how chaplains working in a multi-professional way can offer an integrated and evidenced service to patients and their carers.

Research is beginning to demonstrate spiritual belief as a predictor of clinical outcome (King, Speck, Thomas 1999) (VandeCreek & Burton 2001) (Speck 2005). Numerous studies have been conducted by Koenig et al into religious belief and mental health (Koenig, George, Peterson 1998). Much research in the United States has been devoted to examining the relationship between intercessory prayer and health outcomes, however there has only been one Cochrane review in this area (Roberts, Ahmed & Hall 2001) which was inconclusive.

In 2006 the Caring for the Spirit project based in South Yorkshire Strategic Health Authority will be commissioning a Literature Review to produce a readable and rigorous overview of the research on healthcare chaplaincy – spiritual care, to place alongside the published Standard for Research (Speck 2005)). The completed review will provide practitioners with evidence to inform practice and will add to the knowledge base of researchers in the field. Material from the completed review will be used in the chaplaincy collaboratives to inform research-awareness, research-activity and continuing professional development.

#### *4.1 Walter's critique of three models (1997)*

In this paper the sociologist Tony Walter critiques three traditional healthcare chaplaincy models. These models reflect the way spiritual and religious care has been organised in palliative care and has extended into acute care.

*The religious community model* is predicated on the religious origins of the hospice. The Christian concern for 'love of neighbour and the destination of the human soul' informs the care offered which is generally religious and liturgical. Sacramental confession, absolution, communion, last rites and burial shape this model of service and practice. The overtly religious nature of this model is challenged by secularism, pluralism and the distinction between religion and spirituality.

The religious community model is fundamentally challenged by questions like: how are spiritual needs recognised when not all patients use religious language? In a secular NHS how are spiritual needs identified? Can spiritual needs assessment be taught to frontline healthcare staff? Is religious belief required to conduct spiritual needs assessment? (Ross 1994) (Carroll 2001). Finally, who leads in the NHS on the spiritual care of patients?

The second model of *calling in the chaplain* is primarily a service model and offers a partial solution to these questions. In Christianity, religion and spirituality is traditionally the clergy's sphere of competence. Christian ministers of religion, be they chaplains or parochial clergy are familiar with this model. It is a traditional one and is theoretically easy to operate for all concerned as it is situation specific. However, it assumes that only some patients, usually those with a religious belief have spiritual needs and that non-clergy are unable to meet these needs. The model operates on the understanding that in Britain religion is a 'private matter' and therefore establishes a system where meeting the needs of patients is based primarily on their religious practice.

It is deficient in that it does not attempt to address the spiritual needs of patients who have no religious affiliation. This type of model often operates in smaller Trusts and chaplaincies where there is a preponderance of part-time chaplains whose primary work is church based parochial ministry.

Thirdly, *the spirituality as a search for meaning model* has been gaining ground in Europe and the United States (Faber 1971) (Speck 1986) (VandeCreek & Burton 2001). It can be seen as a service and practice model and is predicated on an existentialist approach to spiritual care (Walter 2002) which becomes the responsibility of all staff.<sup>16</sup> The model assumes all patients have spiritual needs alongside physical, psychological and social ones.

Walter identifies two general problems with this approach, namely separating spiritual needs and care from psychological care, and the 'routinization of spiritual care.' McSherry and Ross have remarked on the lack of specificity in the language of spirituality arguing that psychological language adequately covers this area of experience (McSherry & Ross 2002). However, Pattison (1994), Hollins (2005) and Swinton (2002) among others argue to the contrary. The 'routinization' of spiritual care may become a source of role conflict as this model 'de-clarifies' the chaplain's role opening the way for role confusion.<sup>17</sup>

The third model also runs into difficulties in a multi-faith context where patients who are not accustomed to expressing their spiritual needs within this predominately western philosophical discourse may be assumed to have none (Markham 1999).

#### 4.2 Woodward's Service Model (2002)

In line with current NHS good practice this service model places patient need at the centre (Department of Health 2005). The model develops the idea of 'building a healthy hospital community' reminiscent of Wilson's service model. Woodward's understanding of the hospital's primary task is that stated in the Chaplaincy Health Care Standards (1993, 2004). His service model is based around five concentric circles.

*The focus – the centre – the patient* – whose spiritual and religious needs the chaplain is there to meet.

*The patient's family, carers and friends* – are viewed as crucial because of the relationships existing between them and the patient. Their presence can affect patient recovery.

*The professional carer – health care worker* – has developed significance as the average length of stay in acute hospitals has decreased. Chaplains support staff both personally and in delivering the best possible care.

*The community and institution of the hospital* – seeks to engage chaplaincy in the organisational workings of the hospital. This can involve chaplaincy being a bridge-builder of good communication between people; sometimes challenging the way

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<sup>16</sup> Many authors mention that spiritual care is to be distinguished from religious care and that crucially it is not the preserve of any one profession. For example Orchard (2000), Caring for the Spirit (2003).

<sup>17</sup> The boundaries between different healthcare professions have never been static and healthcare chaplaincy is no exception. The professional boundaries between healthcare chaplaincy and nursing, staff support, patient advisory liaison (PALS), bereavement staff and the range of clinically based counsellors regarding the spiritual needs of patients and staff requires constant attention and clarification. Nancarrow and Borthwick (2005) examine some of the dynamics at work between these professional boundaries in the healthcare workforce.

decisions are made; encouraging good practice, and giving much-needed positive feedback.

*The wider context of the hospital* – involves fostering links between the hospital and the wider community. The assumption is that we cannot build a healthy hospital community without developing good links with the community who ‘own’ the hospital.

Woodward asks ‘where God is in all this and to whom are hospital chaplains accountable?’ His model offers a theological dimension to complement the ‘skills based approach’ of secular culture. This raises an obvious but curiously neglected discourse about the location of theology in healthcare (Orchard 2002).

#### 4.3 Cobb’s Contextual Model (2004)

The question, ‘where is chaplaincy in relation to the system?’ mobilises issues around the primary task of healthcare chaplaincy, its professional identity and boundaries. Cobb identifies the ‘disciplinary,’ ‘hospital’ and ‘faith communities’ as three contexts in healthcare chaplaincy.

In the *hospital community* chaplains have a moral commitment to promote well being and avoid harm. Like other healthcare professionals chaplains belong to a community of service, but unlike most they are not a recognised profession. However, chaplaincy is shaped and informed by professional and contractual responsibilities. Distinctively among healthcare staff chaplains work not only with patients and carers but also with staff.

A *disciplinary community* operates around the development of a formal body of knowledge, skills and its recognition by the HPC or similar body. This complements and develops the training and formation which chaplains acquire in their faith community.

The *faith community* provide an initial training for the would-be priest, minister, Rabbi, Imam and so forth. Only some faith communities have formal mechanisms for validating their representatives which can be an issue when appointing chaplains to NHS chaplaincy posts. Not all faith communities have the equivalent role of a chaplain.

Cobb’s model is not designed to be a model of service or practice. However, it articulates the function and relationship between the three organisational contexts which shape the chaplain’s role and positions chaplaincy in relation to three systems which need to be held in a fine balance. Crucially, the model influences the models of service and practice which can be practised on a day to day basis in healthcare chaplaincy teams.

## 5. NATIONAL REPORTS AND DOCUMENTS

### *5.1 Health Care Chaplaincy Standards (1993, 2005)*

The Health Care Chaplaincy Standards identify four objectives flowing from the primary task: to assess the standard of a chaplain's performance in five key roles; to inform and shape training for health care chaplains; to enhance the performance of those delivering chaplaincy services; and to assist the planning of chaplaincy service provision within the health service.

The fourth objective points to a service model developed through five key departmental aims and objectives:

- Identify and assess needs for chaplaincy provision.
- Manage and develop a chaplaincy service.
- Provide opportunities for worship and religious expression.
- Provide pastoral care, counselling and therapy.
- Provide an informed resource on ethical, theological and pastoral matters.

The key roles are divided into 'units of competence' which are subdivided into 'elements.' The 'units of competence' are another way of describing models of practice. The absence of a theological dimension in the Standards has received comment (Woodward 2002).

The Standards develop a competency based approach operating from the accumulation of units of competence which develop the reflective practitioner. The model focuses on the practitioner, their skills, abilities and competencies (Kerry 2000). The revised document includes a competency in research (Speck 2005) and one for supervision is in preparation.

### *5.2 Hospital Chaplaincy – Modern, Dependable? (2000)*

Helen Orchard's role based research set out to answer the following question: 'What service models can be identified for chaplaincies in acute London Trusts and to what extent can their performance in meeting the needs of the local population be assessed?' The study posed four question areas:

- Does chaplaincy *have* a recognised remit?
- How do chaplains respond to patients from different religious traditions?
- What implications does the developing nature of healthcare delivery have for chaplaincy?
- What implications does the changing nature of society have for chaplains?

Orchard's systemic and role-based research found that the chaplaincy services lacked clarity when it came to documenting and publicising the aims and objectives of the service. This translated into a paucity of documentary evidence regarding service and practice models. She notes a shift from patient-centred to staff focused chaplaincy services, citing changes in religious adherence and quicker patient treatments. Her research documented a lack of integration between the healthcare chaplaincy service and the Trust. From this peripheral position developing a multi-professional approach to practice is problematic.

The service models identified by Orchard can be seen through the lens of referrals which include 'blanket visiting, prioritised visiting, denomination/faith specific visiting and mixed-faith visiting.' The need for chaplaincy to record data of its activities was highlighted.

Orchard's research into models of service finds focus in the section 'Considering the Fit.' Here she examines the service model of each Trust Chaplaincy according to fifteen parameters which fall into two typologies, '*sponsor defined*' and '*employer defined*.' The Caring for the Spirit project team considers this typology to be of fundamental importance when considering the service model in any given chaplaincy department, and consequently the practice models which can be developed from it.

### *5.3 Caring for the Spirit: A strategy for the chaplaincy and healthcare workforce (2003)*

'Caring for the Spirit' (CFS) distinguishes between models of service and practice. It provides skeleton examples of a number of service models and practice models as detailed below. The strategy suggests that practice models can be 'aggregated into service models.' However, this approach runs the risk of neglecting the importance of attending first to the primary task of healthcare chaplaincy and then applying this within an organisational context. In each of the following five sub-sections we mention one model that is offered as an example in Caring for the Spirit.

#### *5.3.1. A theoretical model of spiritual care*

This six feature service model is a reworking by Mark Cobb of a community model proposed by David Lyall (2001). Cobb's adapts Lyall's parish/community model for use in a healthcare context.

#### *5.3.2. A four step practice model*

This simple four step practice model involves: Assessment > Care planning > Care > Review. Two examples are provided demonstrating its applicability to meeting spiritual and religious needs. The model, influential in nursing practice and the therapies, can also be used in chaplaincy. For example:

- At what stage did the patient consent to receive spiritual care?
- What is the relationship between the chaplains care plan for the patient and those prepared by other healthcare professionals working with the same patient?
- What is the patient's involvement in setting goals and outcomes for this element of care?
- What happens when the patient is transferred to another service or discharged from hospital?

#### *5.3.3. Person-centred and holistic practice models*

The person-centred models seek to promote patient involvement with their treatment and care. While many are based on different accents within the biomedical model which focuses on pathology, treatment, prognosis and outcome; the therapeutic value of holistic models is in vogue.

Within the hierarchy of evidence-based medicine, the voice and view of the patient is clearly mentioned (Sackett & Haynes 1995) and is now prioritised in current government policy (Department of Health 2005).

#### *5.3.4. A narrative-based practice model*

The social movement of evidence-based practice mobilised a reaction termed narrative-based practice (Greenhalgh & Hurwitz 1998). Its starting point is the narrative structure in the doctor-patient relationship. It operates from the premise that in the past the patient's story or illness experience has not been sufficiently valued.

The American pastoral theologian Charles Gerkin developed models of pastoral care from narrative theory. This approach to pastoral care is mediated through conversation and story and has links with Clinical Pastoral Education (Gerkin 1997).

One aspect of narrative models is their movement between past, present and future. At different times the chaplain can shift their stance from listening to the patient's story, to encouraging them to articulate a particular aspect, to actively representing the story of the faith community and in so doing offer sustenance and care.

#### *5.3.5. The spiritual healthcare workforce practice model*

This service model is predicated on a multi-professional approach to spiritual healthcare. Initially it requires chaplains to provide education and training for staff on spiritual, cultural and religious concerns. In this way it is expected that other professionals will be more able to work with chaplains in meeting patients spiritual needs.

The model requires an imaginative approach be taken to where, when and how spiritual and religious concerns present themselves along different care-pathways. It offers chaplains the opportunity to play an important part in the training and education of staff about spiritual healthcare, and in so doing modelling a multi-professional approach, addressing spiritual concerns in healthcare and promoting chaplaincy-spiritual care.

It requires of chaplaincy departments some knowledge about the training curriculum for different professions (so that pre-registration training can be planned in) as well as keeping a close eye on a variety of NHS documents and professional publications (like the Department of Health's *Essence of Care* and the GMC's document *Tomorrows Doctors*). The *British Medical Journal* which is published weekly with its accompanying *BMJ Careers* is one simple way of accessing some of this information. Trust IT Departments will help you set up systems to access selected NHS material at publication.

Although some commentators foresee problems in this service model (Walter 1997), the education and training of staff in spiritual healthcare will provide them with the knowledge and skills required to enable them to work with chaplains when spiritual concerns present in patient care.

## 6. APPROACHING CLINICAL PASTORAL EDUCATION

Clinical Pastoral Education (CPE) is a branch of pastoralia informed by psychoanalytic theory. It originated in Worcester State Hospital, Massachusetts in the 1920s and 30s through the collaboration of Anton Boisen and Richard Cabot (Stokes 1985). In 1967 the Association for Clinical Pastoral Education was founded. It developed courses focusing on pastoral situations in healthcare while using the 'verbatim report' as a learning tool in supervision.

CPE is grounded in the notion of 'the human living document' which is the lived experience of self and 'other' in any encounter (Gerkin 1984). It has developed and spread throughout many parts of the world including North America, Canada, South Africa, New Zealand, Australia, Ireland, Sweden, Hungary and Germany. The recent consensus paper between the five largest healthcare chaplaincy organisations in North America is further witness to its central role as one model of service and practice in healthcare chaplaincy (VandeCreek & Burton 2001).

In CPE training the 'verbatim report' is a way of recording and reflecting on pastoral conversations with patients. The written verbatim becomes the focus in a supervisory conversation between chaplain and supervisor for the purpose of personal and professional development. While it may never become a central approach to chaplaincy practice in England (despite the recently formed United Kingdom Association of Clinical Pastoral Education UKACPE) CPE remains an influential model of service and practice.

The 'Caring for the Spirit' document mentions the contribution of CPE in the section headed 'training programmes' for NHS chaplains. While the strategy does not venture how this approach or aspects of it might be developed within the NHS in England, the Spiritual Healthcare Development Units and Chaplaincy Collaboratives may focus on the 'verbatim report' and its use in supervision when considering the education of chaplains from foundation courses through to Continuous Professional Development (CPD).

## CONCLUSION

This introduction to some theoretical models of service and practice in healthcare chaplaincy has a threefold purpose.

- Introducing the reader to some theoretical models of healthcare chaplaincy including primary and some secondary source material.
- Promoting their analysis and discussion in chaplaincy collaboratives and teams.
- Contributing to the organisation and documentation of a theoretical base from which to conduct interactions with patients and staff.

Among the many strands of this review that might be highlighted for development we suggest that the following three areas require immediate attention and focused strategic work within chaplaincy collaboratives.

1. Since 2004 the government and NHS have been steering a course designed to prioritise the development of Foundation Trusts by 2008, increase patient choice within a competitive market, develop practice based commissioning with general practitioners and redesigned Primary Care Trusts, expand capacity through franchising Independent Treatment Centres alongside NHS services within a system where quality is regulated through payment by results.<sup>18</sup> With one stroke this links in theory - evidence-based practice which prioritises researched best practice, patient choice and a competitive market economy in healthcare.

Increasingly the public are being provided with more choice about which treatments are available where and when in a system where money follows the patients to hospital or independent treatment centre. General practitioners and patients will have alternatives to hospital care from among the new independent treatment centres.

At the time of writing Strategic Health Authorities are being restructured reducing 28 to 10. The new SHAs will focus on developing the new system of commissioning while maintaining a strategic perspective of the NHS in their area. They will continue to provide performance management, leadership and have responsibility for ensuring that key national objectives are met and that the service provided to patients is of a high quality.

Part and parcel of these reforms witnesses the reduction of Primary Care Trusts by the end of 2006 from 302 to around 100. PCTs will support and manage Practice Based Commissioning. They will assist GPs with clinical and financial information enabling them to negotiate contracts for services needed. The PCT will be the custodian of the taxpayers' money. Their focus will also shift from providers of services to become commissioners of services alongside general practitioners.

Organisationally, professionally and personally change is sometimes experienced as threatening, anxiety provoking, unnecessary and unwelcome. However, change is constantly occurring and provides opportunities for movement and development to occur. For some it is welcomed with relief as it provides an opportunity to do things differently, or even to start again. The current changes in the NHS pose a number of

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<sup>18</sup> Between November 2005 and February 2006 the British Medical Journal ran a series of articles examining the government's planned market reforms to healthcare provision which looked at many of these issues in more detail.

opportunities and demand some strategic responses from healthcare chaplaincy. The following questions require thoughtful attention and might be focused on in a chaplaincy collaborative:

- Given that most, and probably all, NHS services will change and develop in response to the current wave of NHS reforms how will healthcare chaplaincy organise itself now for the future?
- How well do we understand the foundational changes taking place in the NHS and their potential impact on healthcare chaplaincy?
- How and where do we strategically position healthcare chaplaincy as a service inside the emerging market economy which incorporates NHS and private healthcare?
- How can we best position healthcare chaplaincy to meet the spiritual and religious needs of patients and staff in an evidenced and accountable fashion utilising the best of our theological traditions?
- How might we reframe healthcare chaplaincy to take account of the increasing shift of healthcare into the community?

The current changes sweeping through the NHS challenge healthcare chaplaincy to devise new, flexible and responsive models of service and practice. As professionals in healthcare we cannot assume that the inherited models – some of which are mentioned above – are necessarily appropriate for the present-future. We cannot assume that a secular NHS, increasingly positioned in the community and operating on the lines of a market economy will see the need to provide spiritual and religious care in the absence of evidence regarding its efficacy.

One commentator has noted that the development of independent treatment centres threatens to reduce the work of the district general hospital to the extent of questioning their future viability (Ham 2005). Amidst all this change it is crucial to perceive the clear shift towards; (a) community based treatment, not only in mental health but also in acute care; (b) the increasing use of the private sector in a mixed healthcare economy; and (c) the apparent development of some very large teaching hospitals.

These changes are set to have a marked impact on all healthcare provision in the NHS, including healthcare chaplaincy. Thoughtful, imaginative and strategic action is required now if effective models of service and practice are to be constructed to meet the spiritual and religious needs as they emerge within the competitive market of NHS healthcare.

2. The traditional parochial model requires reframing if it is to contribute effectively to a multi-professional, pluralistic and evidence-based approach to practice. The Caring for the Spirit Strategy estimates that there are around 3,000 part-time chaplains working in the NHS in England. Of these perhaps the majority are working along lines similar to the traditional parochial model outlined above.

By using Orchard's (2000) 'sponsor defined' and 'employer defined' typology, Trust chaplaincy teams and their managers can map, benchmark and reorganise their service model for changing times. We are not primarily thinking here of situations where part-time chaplains are integrated members of large well managed teams, but rather places where several part-time chaplains 'constitute the team', or where they work alone and in isolation, or in geographical areas where they operate in a dispersed fashion.

Through an understanding of current part-time chaplaincy working practices we propose that the chaplaincy collaborative structure is a good place to tease out new and flexible models appropriate to a patient-led NHS as it moves increasingly into the community. The changing landscape of acute care in the community requires mapping across the NHS and private sector providers. This may possibly require chaplaincy collaboratives and Trust chaplaincy departments to develop models of service and practice in conjunction with commissioners, providers of care and crucially local denominational provision. This will require extensive conversations with the Christian denominations around their deployment of priests, ministers and deacons within healthcare contexts and a re-examination of current practices. This is likely to be challenging and long term work. However, it has the potential to stimulate fresh thinking on best practice models in part-time chaplaincy, and the reframing of a traditional parochial model in the ever changing arena of public healthcare and Christian 'parochial' ministry.

In an NHS which is increasingly community based one of the roles of part-time chaplaincy may be to create models of service and practice which are able to focus and specialise on acute care in the community, including in the NHS and private independent treatment centres. Such a service model could herald real opportunities for acute part-time chaplains to utilise their presence and strategic contacts in the local community for the development of a more community based healthcare chaplaincy work. Here acute chaplaincy can learn from the way community based mental health chaplaincy has developed its practice.

3. The NHS culture is characterised by collaborative working (Nancarrow & Borthwick 2005). Many healthcare professionals are organised into multi-disciplinary teams where the boundaries between one profession and another are increasingly fluid. Through workforce planning new strategies have been developed for different occupational groups including healthcare chaplaincy (SYWDC 2003).

Only one of the models cited in this paper is predicated on an explicitly multi-disciplinary approach (5.3.5). This is not to criticise the other models reviewed as each has its own strengths and weaknesses. It is simply to highlight the increasing need to develop models of service and models of practice, which clearly place the healthcare chaplain within a multi-professional team approach such as those evidenced in Hospice and Palliative Care Chaplaincy (AHPCC 2006).

This does not mean that chaplains lose sight of the transcendent and religious dimensions of their work. Rather, it requires chaplaincy to work towards a deeper, more distinctive and holistic integration of service and practice models and to actively foster collaboration with other healthcare professionals.

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