

# A State Health Service and Funded Religious Care

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**Abstract** This paper analyses the role chaplaincy plays in providing religious and spiritual care in the UK's National Health Service. The approach considers both the current practice of chaplains and also the wider changes in society around beliefs and public service provision. Amid a small but growing literature about spirituality, health and illness, I shall argue that the role of the chaplain is changing and that such change is creating pressures on the identity and performance of the chaplain as a religiously authorised health worker. I shall question whether either orthodox belief or religious belonging have any significant bearing on the patients' demand for chaplaincy services. Utilising an example of chaplaincy work I shall argue that patient *need* constitutes the strongest platform for both practice development and an articulated understanding of what chaplains bring to health care. Drawing on a case study the definition and interpretation of spiritual need will be discussed in relation to chaplaincy practice. In conclusion, I shall set out the case for effective research to establish with greater precision the detail of the chaplain's practice within a state-funded health system.

**Keywords** Chaplain · Chaplaincy · Religion · Spirituality · Health · Illness · NHS

## Introduction

Hospital chaplains occupy an unusual and illuminating place in modern health care. Unusual in that it is still customary for chaplains to be licensed by a religious representative and commence their appointment with hymns and the reading of ancient texts. Illuminating because what takes place in a chapel or prayer room or at the bedside is set within what are arguably some of the major Western centres of scientific, medical and professional practice. The role of the chaplain continues to

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focus on a relationship between the health provider and local religious communities, as well as between the hospital community and its own sense of history and values. However, as can be seen in the chapels and prayer rooms for which the chaplain has oversight, the reality of religious change over the past century has been profound [1]. The remit of a chaplain in the West touches on major debates about religion and public life, spirituality and social interaction, and the ethical dilemmas of health care from life's start to its finish. Study of the chaplain's interactions reveals a complex skein of clinical, social and personal narratives that are rich in the detail of how these broader debates are embodied. It is hardly surprising that chaplains are both energised by this reality and also torn by the different demands and expectations placed on them, ranging from calls to preserve their theological identity to the expectations of health care management and cost improvement. While I write as a Christian chaplain these challenges are felt by chaplains of all faiths and this paper has applicability across all sectors of chaplaincy.

Literature about chaplains often reveals their own sense of marginality to the primary discourses of the hospital [2]. For example, chaplains have been slow to enter and develop a meaningful presence in the culture of research and development. Most chaplains have a background in the humanities and they are faced with the challenge of working in a culture where a premium is placed on clinical qualities and quantitative processes of enquiry. This is an important consideration within the politics of the hospital as chaplains vie with other staff groups to be a recognised interpreter of the patient's experience. The elements of health policy that assist the chaplain's claims include patient centred care; patient choice; compassion; and the requirements of equality and diversity legislation. It remains an advantage to the chaplain within this agenda that many patients possess their own language of religious and spiritual need. If the patient is intended to be the driver of the services they require then their use of specific terms in requesting spiritual care is an aid to the chaplain's role. This behaviour can be contrasted with other models of care where the elements of the patient's narrative are interpreted by a health professional who refers the case to the provision they believe is most likely to be effective. In some situations this happens in chaplaincy, and the creation of assessment tools for spiritual care represent some movement in that direction.

If chaplains see themselves to be unusual in health care this sense of difference may possess its own kind of virtue. In a culture that is solution orientated, and focussed on outcomes, many acute hospital staff struggle with cases where most medical care has become futile. The chaplains' frequent experience of working in those situations where loss is undeniable—coupled with a sense that they belong at the edge of the routine discourses of the ward—is a significant part of their professional claims. The challenge for chaplains is to communicate this as its own form of outcome and define the qualities that enable this kind of work to be valued and accounted for.

## Background

While health systems in the West share much in common there are also significant differences in the organisation and delivery of services. Even within the UK, taking

the example of chaplaincy, there are variations in the pattern of how services are organised. Some chaplaincy is arranged via a service level agreement with a faith community, while more commonly chaplains are employed directly by the hospital itself. In Scotland the model of chaplaincy lays strong emphasis on generic spiritual care, while in England greater weight continues to be placed on the denominational and faith identity of the chaplain. The common theme within this variety is that one way or another, chaplains are funded by the State to provide care which is broadly categorised under the headings of religion and spirituality.

In the post-war ferment which saw the creation of the National Health Service (NHS), chaplains were not a political priority. It would be accurate to say that when 5 June 1948 arrived chaplains were simply swept up into the service as part and parcel of nationalisation. Although there has been no systematic review of how chaplains responded to these changes at the time, there is evidence that some welcomed the new service as an opportunity to reinvigorate their professional standing in health care. Just six months before the NHS was founded the chaplain at St James's Hospital in Leeds concluded his report to the governing body by writing:

You will see from the various aspects of the report that a change is developing throughout the country regarding the Chaplains' position in the Hospitals. For a period, far too long, the Chaplains' department has been in the background of the Medical profession... [3]

In the decades which followed a small literature reflecting on the role of the chaplain emerged, usually authored by chaplains [4]. This literature reflects the place of religion in society at the time. In the 1950s, for example, chaplains had an assumed place in a service that met the health needs of an overwhelmingly Christian population, where religious diversity was minimal and church-going continued to be a routine activity for a sizeable minority of the population [5]. As time went on this picture began to change, with the number of people in England practising their faith in public worship declining. The scope and meaning of this change is the subject of debate, with sociologists of religion such as Grace Davie advancing the theory that belief has persisted even though church participation has declined. Others have postulated the alternative view that both believing and belonging have fallen away [6], and the most recent surveys of religion in the general population appear to lend to support to this [7].

It may seem surprising that as religious observance in the population as a whole declined the number of chaplains expanded throughout the twentieth century (49 whole-time chaplains in 1963 compared to 352 in 1998 [8]). This expansion has many possible causes. Health care as a whole grew during this period; all staff groups in the NHS expanded; religious change has led to a greater need for support as people are less well resourced to meet their own spiritual needs; and chaplains have become better at marketing the services they provide under the banner of spiritual care. At the same time the figures for whole-time chaplains reflect a pattern of change where part-time posts have been amalgamated to create full-time ones leading to change with minimal expense. It is likely that as the number of chaplains

has risen, set against the overall increases in health spending, the cost of chaplaincy as a proportion of health care has in fact fallen throughout the last 60 years.

In contrast to the first fifty years of the NHS the initial decade of the twenty-first century has seen unprecedented attacks on the inclusion of chaplains in the NHS from groups such as the *National Secular Society* [9]. This has come at a time of cost savings and efficiency improvements for the NHS corresponding to the global financial crisis. Chaplains have reacted by identifying more strongly with the behaviours and principles of the allied health professions. They have established a voluntary register; defined criteria of continuing professional development; and become more integrated into the NHS pay system for on-call and out-of-hours working. While it may appear that some of these actions are co-incidental there is a case to be made that they stem from the pressures and expectations of a health culture intent on deepening accountability and requiring evidence of value and efficacy in all aspects of its operation.

### A Case Study of Contemporary Chaplaincy

The following case is a composite study drawing on a range of different patient encounters. All identifying features of each case have been removed so that the final case, as presented here, cannot be attributed to any one patient to ensure that patient confidentiality has been maintained. The case comes in two parts and the first section is an exploration of the situation prior to the chaplain's arrival. Drawing on comments arising during the chaplain's presence on the ward, this narrative creates the process of reflection and thinking that led to the chaplain being paged. It tries to fill out the process, usually hidden from the chaplain, by which someone arrives at the decision to seek particular religious or spiritual support. While the text is a fiction, it draws on fragments of comment from both patients and staff that illuminate the path to calling a chaplain. It also uses insights gained from a fourteen part television series, aired in 2004 ("St. Jimmy's") when the filming often captured the reflection of patients and relatives about why they had called a chaplain and what the visit meant to them. This took place without the chaplain being present and is an intriguing record of the range and character of the needs that draw a chaplain into a situation.

The case is set on a paediatric surgery ward at approximately 8 pm on a weekday evening.

Jane was stressed. Her child is ill and the doctor has just told her that he might not survive the night. Jane knows that other members of the family would want her baby christened. But Jane doesn't believe - at least not in the way most people talk about religion and belief. For her there was no fairy-godmother God. Enough had happened in her own life, of pain and rejection, for her to know that. Trust had been betrayed, and her childhood view of the universe had collapsed in bitterness. There was no God who had come to her rescue; no divine restoration of all that had been taken from her. Jane could not bring herself, in the flux of these feelings, to tidy herself into a box

labelled “Anglican”, “Methodist” or “Quaker”. As her precious child teetered on the brink of life, Jane could not summon the strength or desire to create a God who would help her. But she knew it mattered to others, to members of her family. There was also the thought, the germ of an idea, that maybe sometime in the future she might find some kind of faith and would come to regret not having her baby baptising. As she took in the real possibility that he would die in the coming hours the nurse asked if there was anything she wished to do - whether Jane would value the support of a chaplain. The nurse’s question opened a door for Jane to share her reflections and concerns. As someone working alongside chaplains the nurse assured Jane that her beliefs would not be judged and that a chaplain would listen to her and, if requested, advise her. Jane thinks about it and decides that she probably would like her baby baptised and asks the nurse to call the chaplain.

This scenario enables us to see into the immensely fraught and difficult world of those who are faced with situations that demand urgent action. Jane does not have the luxury of time in arriving at a decision about her baby. Despite the pressures her thinking is focussed and clear. There is a dilemma between the more traditional expectations of her family and Jane’s sense of integrity about her own convictions. In a previous generation perhaps Jane would have gone along with the expectations of others and suppressed her own views. Jane is also aware that beliefs change and that her future self might come to regret a decision not to go ahead with a baptism. With the nurse’s confidence about how the chaplain will respond to her position Jane feels able to seek the support of the chaplain.

The chaplain meanwhile is sat at home watching a quiz show. When the call comes the chaplain is told that there is a request for the baptism of a seriously ill baby. Taking down the name and ward the chaplain sets off to the hospital, arriving within 40 min.

On arriving the chaplain went to the nursing station where the nurse and the mother of the child were standing. After introducing himself, the chaplain asks whether there is anything particular the mother wishes to be included in the baptism of her 18 month old son, who is gravely ill. After a brief silence the nurse speaks first saying: ‘we’re not very religious’. The chaplain does not react to this, and the mother then speaks, confirming the nurse’s statement – ‘I’m not really a believer’ – adding: ‘but I don’t know that I won’t be in the future and I might come to regret not having my child christened now’. The chaplain responds positively to the directness of the mother’s declaration and instigates a discussion about what the mother would wish the service to express. This discussion features love, hope and a desire for what is best for her child. Equipped with a frank understanding of the situation, and the hopes of those who will be present, the chaplain goes to meet the child and prepares to conduct the service.

This case scenario provides a glimpse of the social and religious change in Western societies as it is expressed on a hospital ward. The chaplain is met with neither an affirmation of orthodox belief nor the concealment of religious doubts.

Here there is a willingness by the mother to articulate a lack of belief, perhaps encouraged by the nurse's assurances that the chaplain will not judge or reject such a statement. While recognising the reality of her own absence of faith the mother cannot discount the possibility that such faith may become important for her in the future. Her request is an expression of love for her child and the baptism proceeds on that basis alongside the chaplain's representative role for the wider Christian community. The mother neither believes nor belongs but requires the chaplain to act in order to keep open certain future possibilities for herself and, by implication, for her child and for their relationship. It is reasonable to suggest that the mother has spiritual needs which are connected to several concerns including:

- Her future self
- A future for her child beyond death
- Her future relations with other family members
- Connection to deceased family members who were baptised

Through ritual the chaplain has the capacity to affirm the possibility of these links and to hold open for the mother her ability to explore these in the future. The need is spiritual in that it concerns belief (or even the possibility of belief) and the nature of loving relationships that effect a sense of hope, meaning and purpose. It would be accurate to describe certain features of this encounter, and the concerns of the mother, as existential. A central part of the mother's dilemma may be bound up with a belief that religion is too narrow a category for her to enter honestly. Yet the whole situation is somehow in the camp of religion—and this feels like precisely the place where a religion-like word—"spirituality"—performs a surrogate function.

In order to meet this spiritual need a religious practice is required by an authorised figure and there is anxiety that the request might be judged unworthy. The approach is supported by a member of the nursing staff who vocalises the basis on which the request is being made. Given the intense nature of the situation the chaplain needs to use pastoral skills honed in the clinical context to mediate the religious tradition and recognise how best to honour and support the request of the mother. The chaplain is able to access, through experience and education, a theological platform to inform his actions, largely drawn from practical theology [10]. While such resources do not necessarily concern baptism they provide tools for decision making and recognise the nature of the patient's need as a legitimate basis for exercising a ministry intended to heal, even when an individual shows no evidence of belonging to the chaplain's religious tradition. (There are theological resources that explore the role of women as those whose actions change the predicted course of events and widen the accepted understanding of religious ministry and meaning [11]). Engaging with theology in this kind of practice can be risky and untidy. It is strongly rooted in specific experiences and this can be an important position from which to fashion a theology that is at once useful and potentially able to generate new ways of understanding religious care [12].

In a dire and distressing situation such as this there is no scope for nuanced conversations about the sacraments and theology. New situations need to be reflected upon to improve future actions, and this fits with a professional approach that has regular supervision and reflective practice built into the hospital's

expectations of the chaplain. For many chaplains the theological oversight of the chaplain by the faith community is often the weaker part of this arrangement.

## Religion and Spirituality

The case study has suggested that religion and spirituality are entwined. For many patients in the UK who do not adhere to formal religious practices their spiritual expression remains shaped to a degree by Judeo-Christian religious heritage. When the cosmologist Martin Rees was awarded the Templeton prize in 2011 he was challenged about his church attendance (as someone avowedly non-religious). He responded by saying that such practices were ‘the customs of my tribe’ [13] (the Anglican Church). In a culture which focuses on the individual such a response was striking and original. In the case study the link to previous generations, and even the beliefs of a future self, might be described as tribal behaviour.

Understanding the way in which spirituality and religion are linked is likely to be more fruitful than attempting their separation. The drive to create a separation is worthy of study in itself as there is evidence to suggest that ideology is driving a conceptual division even in the face of what is happening on the ground [14]. There are increasing suggestions that nursing in particular sees in these classifications a route to extending its professional claim over the patient [15]. Internationally the definitions of spirituality in the nursing literature are broad. They range from research findings which equate religion with ritual [16] to others that see spirituality as simply a description of how religious care is implemented in health care practice [17]. The production of this work has done little to clarify the situation and, as the research demonstrates, various kinds of separation have been constructed that may serve to illustrate the tensions between academic writing and the behaviours they attempt to describe. Criticism of how spirituality is being addressed ranges from philosophical analysis based on reductionism [18] to consumerist economics [19] through to professional practice [20]. For the moment, the aims of defining spirituality and establishing its clear separation from religion appear to be unrewarding. (As the author of one NHS-funded review put it: ‘Defining spirituality and distinguishing it from religion may turn out to be a room with no doors’ [21].) It is unlikely that we shall get further in our understanding of this without a serious, systematic and comprehensive exploration of how the terms are being used in *practice*.

If patients are not representative of the general population (patients are older and, not surprisingly, sicker than the average citizen) chaplains as a group also possess some unusual features. There are chaplains who have embraced the language of spiritual care and renamed their hospital department accordingly. There is evidence that a significant number of chaplains are hesitant about the rigidity found in some forms of religious organisation [22]. For those chaplains who are divorced or in same-sex partnerships there can be sensitivity to religious authority and hierarchical structures. For these and other reasons chaplains themselves may share in promoting a view of religious care that is more limited than the behaviours attributed to spirituality. They may support narratives which restrict religion on the ward to

tightly defined and limited activities, from admission (‘what religion are you?’) to the exercise of particular rites (‘would you like Communion?’) through to specific components of care (religious diet; ‘last offices’). In planning multi-faith prayer spaces hospital chaplains are likely to go with the grain and interpret spirituality as an anonymous space which patients and visitors populate with their own beliefs.

### **The Chaplain as Publicly Funded Religious Employee**

Earlier I noted the criticisms that have been levelled at hospitals for employing chaplains. These have emanated from organisations committed to excluding all forms of public expense on expressions of religious activity. The main criticism levelled at the employment of chaplains has been directed at the NHS rather than the Ministry of Defence or the Prison Service. This may be because the latter are closed institutions and the suggestion that local religious leaders could enter them and deliver spiritual care is unfeasible. Military and penal institutions have unique security considerations and, in the case of the British Army, chaplains are one of a very small range of support services that can be deployed with troops overseas (another example being medics). It follows that secular criticism of the Army’s employment of chaplains has not been so strongly linked to cost reduction but instead to the creation of an equivalent pastoral care function for which anyone could apply [23]. It is notable that in its comments on chaplaincy in hospital the *National Secular Society* has not identified a similarly discrete pastoral care role beyond existing religious provision.

In the debate against publically funded chaplaincy provision there is sometimes the impression that large numbers of chaplains are present with too little to do. However, figures produced from an NSS survey found there to be 500 whole-time chaplains in acute hospitals in England [24]. These chaplains provide a round-the-clock response throughout the year in addition to their standard hours of employment and it is hard to think that the staffing level is excessive relative to the scale of need. Not surprisingly, the evidence of need is more difficult to define than the number of chaplains employed. However, some recent data has provided a useful estimate of the scale of potential need for some of the work chaplains are contracted to provide.

For several years now *Picker Europe* has conducted inpatient surveys of discharged patients across the NHS in England. Some of the Trusts employing their services opt to include questions about religious identity and practice while in hospital. The results show a consistent group of patients—about 15% of total responses—who state that not only do they have a religious identity but they practice their faith while in hospital. As certain exclusions apply to this data (there is no information from patients who died during your hospitalisation) the figures are more likely to be under rather than over reported. If we extrapolate the 15% across the total number of patients treated by the NHS in a given year it equates to approximately 1.58 million episodes of patient care. Using another statistic from the *Picker* data, an estimated 322,000 of these patients were unable to practice their religion as they wished during their stay. The number of chaplains employed in the health service seems a small provision set alongside this level of desired and actual

practice. In no service is it envisaged that all patients will require the same NHS treatment at the same time. Levels of provision match real needs and for those patients who benefit from practicing their faith when they are ill, and may require assistance, there is no evidence of chaplaincy being over-provided. Freedom of religion is a human right and, where an institution by the nature of its work has residents unable to exercise that right unaided, it is surely both reasonable and humane to make some provision enabling the realisation of that right.

In England chaplains officiate at the funerals of those who die in hospital without financial means or a family willing and able to make the arrangements. It is typical for chaplains to perform this role in hospitals around the world. A significant proportion of these services may relate to a baby miscarried before term or still-born. There is evidence that in the trauma of a termination due to foetal abnormality chaplains play a valuable and sustaining role for those involved [25]. This is specialist work and the location of the chaplain within the hospital—discharging a religious function with spiritual benefits—is essential. Most community faith leaders will have little experience of working in these situations and have consequently developed limited skills in meeting such specific needs. While grief and sorrow are not medical conditions the human effects of loss are often so great and distressing that a caring organisation will want to make provisions for these circumstances. The chaplain is uniquely placed to provide this care and does so with the mandate of the hospital as well as the endorsement of a local community. No other figure on the staff embodies this linkage between hospital and community.

There are many benefits from the relationships to local communities that chaplains represent, but there is no doubt that some religious views can be harmful to patient's wellbeing. So, for example, pastors who advocate that their parishioners discontinue taking HIV medication because it shows a lack of faith are unsuitable to call to emergency situations in the middle of the night. The employment of chaplains from many different faiths in the NHS is a safeguard to the quality and practices of care being given to patients. No one can pretend that modern health care is simple. To work effectively in the hospital chaplains need to belong to the organisation and know its routines and expectations. From information governance through to infection control and medical ethics, the chaplain can only provide competent care when the context and regulation of that care is understood. The potential harm that can be caused by thoughtless and ill-informed action is not to be underestimated. The spiritual and religious crises that arise in the hospital can test the judgement of even the most experienced chaplain. It lies in the chaplain's power to exacerbate distress; to leave patients feeling judged; to use partial knowledge to set patients against clinicians; and to increase the risks of infection by a failure to follow proper procedures. There is plenty of evidence that chaplains have seen and understood these risks and developed their training and practice accordingly [26].

## Conclusions

The changing expression of religion and spirituality in the West has increased the need for chaplains who are skilled in providing bespoke care. Traditional

assumptions about religious practice no longer meet the contemporary context and spirituality often functions as a neutral territory for exploring existential concerns. It is important to keep in mind that this turn to the spiritual (rather than the religious) is not experienced in the same way across the world. In effect the UK has moved to a situation in which religion has become restricted to a narrow range. Several years ago I was speaking with a Muslim colleague about the circumstances in which a person might become exempt from fasting in Ramadan. When he explained that an illness caused this to happen I said: “So the physical takes precedence over the religious”. He replied quickly, “No, the physical need becomes the greater religious priority”. Around the world today, and taken over the course of Western history, it has been normative to see religion as a whole-life commitment rather than a segregated activity. There are ample frameworks through which it would be possible to see each dimension of the earlier case study as a matter of religion. Equally there are some who would want to cast the incident in purely spiritual terms. Both are possible, but to do one to the exclusion of the other would be to dishonour the richness of the episode. We need the two frameworks—and chaplains are the hospital staff embodying the strengths and tensions of how these world-views co-exist.

Chaplains are a tiny workforce in the NHS. They recruit, train and monitor a larger group of suitably qualified volunteers, as well as providing a continuous call-out facility to those in various states of personal crisis. A compassionate and caring NHS will want to retain this professional service and encourage its continuing development as a unique resource to the hospital as a whole. For this to be the case it is vital that chaplains, faith leaders and health managers participate in more research to understand the contribution of the chaplain to patient care. If, as Thomas Tweed suggests, religious theory is a “purposeful wandering” and “sightings from sites” [27], then the unusual location of the chaplain will generate enlightening case studies [28] that help to understand not just the chaplains role but also the processes of religious and spiritual change more generally. This could lead to the kind of *practice-based evidence* that enables us to understand with greater insight the human toll of illness and its evolving spiritual dimensions.

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