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Patient Reported Outcomes of Pastoral Care in a Hospital Setting

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Patient Reported Outcomes of Pastoral Care in a Hospital Setting

ABSTRACT

This study aimed to establish whether Pastoral Care (PC) visits were an effective component of a hospitalised patient's overall health experience. Outcomes of PC visits were reported by 369 patients in 7 sites across Australia. The patient reported outcomes of PC visits included: the patients felt they could be honest with themselves, with a sense of peace, a better perspective of their illness, less anxiety and felt more in control. Five factors of the PC visit significantly related to higher patient's overall outcomes: 1) having more Pastoral Care visits ($p<0.5$ 0R 0.778, CI 0.17-1.38); 2) the patient was able to talk about what was on their mind ($p<0.01$, OR1.48, CI 0.58-2.37); 3) they had something to be hopeful about ($p<0.01$ OR1.18, CI 0.51-1.85); 4); the visit focused on decisions about the patient's healthcare ($p<0.05$, OR0.70, CI 0.05-1.35); and 4) a belief in God/Higher Being ($p<0.01$, OR 1.01, CI 0.43-1.71).

Key words: PROMs, pastoral care, spirituality, hospitalised patient outcomes

INTRODUCTION

In Australia, Pastoral Care (PC) has a long history of involvement in faith-based healthcare institutions. In more recent times there has been a renewal of interest in the integration of a body/mind/spirit perspective as part of the treatment paradigm of patients and their families when making healthcare decisions. Pastoral care is defined as being rooted in a non-judgemental listening and attentiveness to patients, carers and staff. It pays supportive and enabling attention to a range of human needs and aspirations in the context of healthcare, being especially alert to questions of identity and belief (whether present as religious, spiritual or neither of those) (Raffay, Wood & Todd, 2016).

Trained pastoral care practitioners (PCP), as part of the inter disciplinary health care team, can directly influence both patients' physical health outcomes in terms of dealing with issues of spiritual distress which can lead to anxiety (Abu-Raiya et al., 2015), or higher suicide risks (Kopacz et al., 2015). PC can also lead to increased rates of patient satisfaction with overall hospital stays (Marin, 2015).

Other outcomes of PC visits include patient's emotional support, religious coping, increased mental wellbeing, relief from distress, lessening of anxiety, being more honest about themselves, feeling at peace, comfort, being understood and in control and increased family satisfaction of care (Bay et al., 2008, Jankowski et al., 2011, Johnson et al., 2014; Kevern and Hill, 2015; Risk, 2013; Snowden et al., 2013).

A recent Australian study using a self-designed survey (Ashton et al., 2016) assessed the level of consumer experience with PC services at a large hospital in Western Australia. Their

findings supported their premise that the PCPs' intervention was part of the hospitals holistic model of care and helpful to the patient.

In the Australian context, spiritual care, one dimension of pastoral care, is defined as "…providing a supportive compassionate presence for people at significant times of transition, illness, grief or loss. This care is most often delivered through attentive and reflective listening and seeks to identify the person's spiritual resources, hopes and needs…and is an integral component of holistic healthcare" (Spiritual Health Victoria, 2015, p.2). In the United Kingdom, USA and in Australia, spiritual care is more often than not provided by professionally employed chaplains.

A review of patient satisfaction studies concludes that "studies that have evaluated patient satisfaction with chaplaincy care have found that patients, in general: (1) were very satisfied with chaplains, and (2) believed that chaplains have met their emotional and spiritual needs, thereby improving their health care (Jankowski et al., 2011, p.11). However the authors conclude that "it is not clear what chaplains did or what patients found most helpful or satisfying" (Jankowski et al., 2011, p.112). Therefore, it is important to investigate spiritual care efficacy in ways that are meaningful for patients, spiritual care professionals, hospital administrators and volunteers. Patients who are visited by chaplains are more likely to endorse that staff met their spiritual needs and their emotional needs and that chaplain integration into the healthcare team affects patients' satisfaction with their hospital stay (Marin et al., 2015).

Depending on how spirituality and religion are defined, various studies have shown that people want their spiritual needs considered as part of their overall healthcare needs (Hills et

al., 2005, Balboni, 2007) and that there is a positive relationship between spirituality and improved health outcomes (Lichter, 2013) including greater social support, fewer depressive symptoms, better cognitive status, co-operativeness and physical health (Konig et al 2004); however they are weak predictors of length of stay and use of health services (Koenig et al 2003).; Koenig, 2003, 2004). While patients generally wanted questions about their spirituality to be part of their healthcare plan (even if it wasn't necessarily always defined in such specific terms), doctors were often reluctant to participate in these types of discussions (Best, Butow, Olver, 2016).

Research into the effect of PC specifically on healthcare outcomes is a small and slowly growing field (Sellman et al., 2014; Snowden, 2013). Trained PCPs are reporting on their interactions with patients. Patients and their families are able to report back on their interactions with these practitioners and the effects of PC visits on their health outcomes.

This study aimed to establish whether PC provided by PCPs is deemed by patients to be an effective component of their overall health experience, regardless of the patient's stated religious/spiritual outlook.

Objectives

a) To establish the effectiveness of the PC provided to patients as reported by patients

b) To correlate the patient reported outcomes to the patients' stated religious outlook

c) To use the feedback to inform service delivery

It was hypothesised that patients from participating sites would find a PC visit from a trained PCP helpful and meaningful to their healthcare, regardless of their spiritual or religious outlook.

METHODS

Ethics

All procedures performed were in accordance with the National Health & Medical Research Council (2011) human research guidelines. Ethics approval was obtained from Human Research & Ethics Committees in New South Wales, South Australia, Tasmania and Australian Capital Territory.

Setting

The study was conducted in seven sites of an Australian Catholic health organisation where staff providing pastoral care wasre known as PCPs. These facilities have a policy that all newly admitted patients are visited by PCPs.

Participants were patients who received at least one PC visit during a hospital admission in the previous 6 months. The participants were mailed a survey questionnaire with a reply paid envelope and an invitation letter between December 2015 and June 2016. In all, 2,351 questionnaires were sent and 497 were returned representing a 21% response rate. After review of the completed questionnaires, 36 were removed from analyses due to participants reporting that they did not or did not remember receiving a pastoral care visit. Due to concerns about the accuracy of data, a further 92 questionnaires that were found to be

completed by family members were removed. Thus, a total of 369 questionnaires were included in the analyses.

The Lothian PROM, (Snowden et al., 2013, 2017) which measures the impact of spiritual care, was used in the study. The original Lothian PROM was based on the work of chaplains in Scottish healthcare and broad themes associated with chaplaincy. In the original version of the PROM there were three PROM subscales (feelings *during* the pastoral care visit, feelings *after* the pastoral care visit, and *statements* that describe the situation now). Participants were asked to score these statements on a 5 item scale from Not at all; Seldom; Some of the time; Most of the time and All of the time (see Figure 1). The 18 item PROM was identified as having good face content and validity (Snowden et al., 2013).

The Lothian PROM was adapted to the Australian context by replacing the word 'chaplain' with the word 'pastoral care practitioner', with the permission of the authors. Demographic questions were added including: age and gender, occupation, education, marital status, country where born, language spoken at home, having Australian citizenship, length of hospital stay, and the number of visits received from the pastoral care practitioner (See Demographics Table 1). An open-ended question at the end of the survey asked participants to "Please add any comments you wish to make about how the PCP's input affected you".

Data analysis

Questions from one of the three PROM subscales (*Statements*) were combined to generate two total scores to assess the participant's spiritual outlook in life. "Statements describing me now" were coded to combine "Not at all", "Seldom" or "A little", and "Some of the time" to

represent “No”; and “Most of the time” or “All of the time” combined to represent “Yes” for each individual question. Each *Statement* was dichotomized and used for analyses (see Table 2).

To analyse what the participants felt during and after PC visit(s), two groups (Belief in God or in some Higher Being vs Not Belief) were compared on related variables. This permits interpreting the total score as meaning the same in the groups. The results were used to answer the second objective of this study, which is to ‘correlate the patient reported outcomes to the patient’s stated religious outlook’.

To measure the overall outcomes of the PC visit, a composite variable was created by combining scores from five questions about the participants’ experience *after* the visit(s). Responses to each question ranged from 1 to 5, with 1 representing “Not at all” having a positive experience, and 5 represented having a positive experience “All the time”. We created a cumulative scoring of the answers.

In the positive spectrum, there was a maximum score of 25. This means all results of outcome measures were very positive all the time (i.e. after PC meeting, the patient felt that they could be honest with themselves all the time, their levels of anxiety lessened, they gained a better perspective of their/relative/friend illness, they feel that things seemed under control and they felt a sense of peace they had not felt before). In contrast, the minimum score of 5, means all results of outcome measures were all negative (i.e. after PC visit, the patient felt that they could *not* be honest with themselves at all, their levels of anxiety *not* lessened,   they *did not* gained a better perspective of their/relative/friend illness, they *did not* feel that things seemed under control and they *did not* feel a sense of peace they had not felt before).

The combined composite scores were then dichotomized at the median (“Higher” defined as ≥median). Respondents who had not answered all of the questions regarding their experience after the pastoral care visit were assigned a missing value for its corresponding composite variable. We conducted reliability or internal consistency test, which showed Cronbach’s α 0.908, which indicated that the composite variable is accurately measuring the overall outcomes of PC visit(s) (see Spiliotopoulou, 2009). In keeping with the design of PROM (Snowden and Telfer, 2017), in this study higher scores indicate better outcomes of PC visit(s).

A statistical model was employed to determine what factors significantly related to the overall outcome of PC visit(s). Statistically significant and non-significant variables were assessed to establish the relationship between specific experiences during the pastoral care visit and patient’s spiritual/religious outlook in life to the overall outcome of PC visit(s). Ordinal Logistic Regression was conducted and resulting odds ratios, 95% confidence intervals, and p-values. All analyses were conducted using SPSS version 24. With the open-ended question, content analysis was undertaken.

RESULTS

About the participants

More than half (55%) of the participants were 71 years of age or older. Mostly female (63%) or married (54%). Almost half of participants (49%) had year 12 education or lower. The majority of participants (73%) were retired, corresponding to their age. The vast majority

(91%) spoke English at home and 78% were born in Australia. The majority (66%) of participants had been hospitalised for more than one week and 67% received more than one PC visits during the hospital stay (see Table 1 for more details on the characteristics of participants).

Patient reported outcomes of the PC visit

Reflecting on their experiences during the PC visit(s), almost all (96%) of participants "felt that they were listened to" all the time during the visit(s). The vast majority (94%) of participants felt that their "situation were understood and acknowledged" and 93% felt that their "faith and/or beliefs were valued". Slightly fewer participants (84%) felt that they "were able to talk about what were on their mind" and 64% felt that the PC visit(s) "focused on decisions about their health" (see Table 4 column b).

The patient reported outcomes of PC visits included: the patients felt they could be honest with themselves (83%), with a sense of peace (53%), a better perspective of their illness (60%), less anxiety (62%) and felt more in control (63%) (see Table 5 column b).

Five factors of the PC visit significantly related to higher patient's overall outcomes: 1) having more Pastoral Care visits ($p<0.5$ 0R 0.778, CI 0.17-1.38); 2) the patient was able to talk about what was on their mind ($p<0.01$, OR1.48, CI 0.58-2.37); 3) they had something to be hopeful about ($p<0.01$ OR1.18, CI 0.51-1.85); 4); the visit focused on decisions about the patient's healthcare ($p<0.05$, OR0.70, CI 0.05-1.35); and 4) a belief in God/Higher Being ($p<0.01$, OR 1.01, CI 0.43-1.71) (see Table 6).

Patient reported outcomes and stated religious outlook

There were eight statements that describe the participant's outlook in life: 1) I see myself as a spiritual person; 2) I believe in God or in some Higher Being; 3) I am a religious person; 4) I feel a need to experience love and belonging; 5) I feel a need to find meaning & purpose in life; 6) I feel a need to be hopeful; 7) I feel I have something to be hopeful about; and 8) I feel I am in control of my situation (see Figure 1).

In this study 72% of patients stated that they believe in God/Higher Being. More than half of all participants (56%) saw themselves as spiritual or religious. This is less that than recent census data which shows 70% of Australians declared themselves having religion/faith (ABS, 2017).The majority (74%) of participants felt that they have something to be hopeful about (see Table 2 for more details of the participants' outlook in life).

Correlations among the participants' statements reflecting their outlook in life were significant. For example: a belief in God/Higher Being was significantly related to the participant's being a spiritual person. Being a spiritual person was significantly linked to the participant's feeling of a need to find meaning and purpose in life. Feeling a need to find meaning and purpose in life was significantly related to the participant's feeling that they needed to be hopeful (see Table 3).

Only two statistically non-significant correlations were found: 1) between the patient's feeling in control of their situation and feeling of a need to experience love and belong and 2) between the participant's feeling in control of their situation and feeling a need to find

meaning and purpose in life (see statement 8 in Table 3 that shows Pearson Chi-square *p* value).

The 8 statements of participants' outlook in life showed strong internal consistency in a sample of 369 patients (Cronbach α = 0.852). This indicates that participants responded in a consistent manner (Spilioutopoulou, 2009) (see Table 3).

There was significant link between participant's believing in God/Higher being with feeling that their situation was understood & acknowledge during PC visit(s). More participants who believed in God/Higher Being (96%) felt that their situation was understood and acknowledged than those who did not belief in god/Higher Being (89% of participants) (see Table 4 column a).

> "*As someone who is not religious and not spiritual, I would prefer visits from specialist nurses or social workers." (a patient in ACT)*

Another significant link was between participant's believing in God/Higher being with feeling that their faith and/or belief were valued during PC visit(s). More participants who believe in God/Higher Being (97%) felt that their faith and/or belief were valued than those who did not belief in God/Higher Being (83% of participants) (see Table 4 column a).

> "*I believe that in a society there are too many people of too many religions or beliefs, that it isn't necessary to have pastoral care in hospital, as most have their own rabbi, priest etc. Others that do not believe in any form of religion are embarrassed." (a patient in Tasmania)*

Nevertheless, in general, participants who reported believing in God/Higher Being did not significantly differ in their experience *during* a pastoral care visit from those who did not believe in God/Higher Being. The vast majority of participants who did not believe still reported that they were "listened to" (92%), that they were "able to talk about what were on their mind" (80%), which is an important finding and speaks to inclusiveness of the pastoral care service.

> *"As awkward as I am talking to someone who is listening to my problems, I reflect now that it was an experience that was indeed helpful."(a patient in NSW)*

Feedback to inform service delivery

The different aspects of the pastoral care role which participants found beneficial speak to the diversity of the pastoral care role and multiplicity of ways in which the practitioners assist patients and their families. The patients frequently described and appreciated emotional support and guidance that they had received, relating not only to the most immediate circumstances of the hospital stay, but extending to life and relationships on the outside.

> *"My experience with the PC practitioner was brief but dealt with a very complex situation involving other members of the family. The co-ordination with other health professionals involved in the situation by the practitioner was so practical and helpful, it made a huge difference to all involved." (a patient in the ACT)*

Most commonly, respondents commented that pastoral care was associated with *"kindness", "friendliness", honesty"*, *"care"* and *"understanding"*. Some people described a sense of spiritual bond with their practitioner. Respondents appreciated having their personal views respected and acknowledged, the pastoral care practitioner's ability to make people at ease and the facilitation of a broad conversation about different aspects of life.

> *"I always looked forward to seeing the pastoral care practitioner. It was as if she had always been a friend, so easy to talk to and I could see it in her eyes that she was listening." (a patient in South Australia)*

Some participants explicitly emphasized the pastoral carers' ability to engage with them and offer genuine support even when they identified as non-religious. These participants stated that the practitioners they saw were respectful of their personal philosophies, a quality that the patients described as positive and trustworthy. Some participants focused on the *"comforting"* and *"reassuring"* qualities of the practitioners; others described them as *"supportive"* of their wishes regarding hospital care, illness and recovery. Several respondents emphasized that the pastoral care workers were *"understanding"* of the participants' inability to interact with them at times, due to the pain, suffering and confusion sometimes associated with a hospital stay.

> *"The question of my absence of faith didn't arise with any of the ladies, and so to that extent my personal philosophy was respected." (a patient in ACT)*

“Although I am not religious or believe in God, they always spend one on one time with me, talk with me, let me talk about my situation if I’m upset (…) even to my family too.” (a patient in South Australia)

“It was most helpful to me to talk with a person with empathy and insight, not only for my present hospital admission and surgery, but also about my life generally. She helped with some perspectives and insights in my personal situation and relationships and provided gentle food for thoughts.” (a patient in NSW)

“When placed with so many emotions –my own and those around me, it was wonderful to have such a great team available on [Palliative Care Ward] to turn to, to cry, to talk, to get help.” (a patient in Tasmania)

DISCUSSION

Many participants in this study who saw a PCP and who appear to benefit from PC interventions do not describe themselves as either believing in God/Higher Being or being religious or spiritual. However, in general, participants who reported seeing themselves as a spiritual or religious person did not significantly differ in their experience during a pastoral care visit from those who were not religious or spiritual. The vast majority of non-

spiritual/non-religious participants still reported feeling their faith and/or beliefs were valued which is an important finding and speaks to inclusiveness of the pastoral care service.

The patient reported outcomes of PC visits from this study indicate that the patients feel that they could be honest with themselves, with a sense of peace, and a better perspective of their illness. They reported feeling less anxious and more in control. This finding is similar with other studies that showed spiritual care provided listening presence, emotional support and help in coping with illness (Kevern & Hill, 2015; Risk, 2013).

Informing service delivery

Five factors were found to significantly impact on patient experiences which can provide guidance to pastoral care practioners in their encounters with patients. These include: having more PC visits; allowing the patient to talk about what was on their mind during this visit; helping the patient identify something to be hopeful about; focussing on decisions about their healthcare and supporting their belief in God/Higher Being if this was important to them (see Table 6). "*Being able to talk about what was on their mind"* was found to be more important than being listened to, having faith/beliefs valued, or being understood in a recent study of the revised Scottish PROM (Snowden et al., 2018)

These findings are supported by a Delphi study where three key themes influencing patient reported outcomes from a PC interventions included being heard and understood, feeling there is a place for "not having a solution", and feeling there is a place for "that which cannot be said" (Vermandere et al., 2013).

The broader role of pastoral care

The feedback from participants suggest that in many cases pastoral services extended beyond the emotional and spiritual care, with the pastoral care workers also taking on the roles of mediators and advocates and assisting with the organization of social support and other practical matters for patients post-discharge in conjunction with other health professionals.

The patients and their families described the impact of these interactions as deep and lasting. Some described being able to change their attitudes to life or their illness as a result; others described the feelings of calm and comfort; and others articulated feelings of gratefulness and appreciation for the service that stayed with them post-discharge.

This study suggests that hospitalised patients in the acute setting, palliative care and aged care benefitted from a visit by a pastoral care practitioner. Importantly the pastoral care visit was considered helpful to those who did not consider themselves spiritual or religious. It is important to provide context for the patient to verbalise their concerns.

> *"At the end of one's life, Medical care with chemical preparation is not enough – spiritual care becomes even more important. In fact, it is essential to be able to survive without being permanently damaged." (a patient in the ACT)*

Limitations

The low response rate suggests the results should be viewed with caution. They are however, representative of this population, which is difficult to engage once the patient leaves the facility of care. The six month time frame from receiving a pastoral care visit could be perceived as a recall bias, however, the original intention was to recruit family members and

an ethical requirement was not to approach family members under six months from the patient's death.

There are also information and selection bias (Sica, 2006). In a study such as this, it can never be known how people who decided not to participate would have responded. Those who returned the questionnaire may be motivated to represent themselves in a positive way (Furnham, 1986). However, this study shows that meetings with Pastoral Carer are useful both for patients who consider themselves as religious/spiritual or not.

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Table 1. Demographics and hospitalisation of participants

Participants' characteristics	N (%)†
Age	
≤55	55 (15)
56-70	113 (30)
71-85	154 (42)
≥86	47 (13)
Gender	
Male	135 (37)
Female	234 (63)
Marital status	
Never Married	26 (7)
Widowed	106 (29)
Divorced/Separated	37 (10)
Married/Partner	197 (54)
Highest level of education	
≤ Year 12	181 (49)
TAFE certificate/diploma, Business	98 (27)
College	87 (24)
University degree or higher)	
Employment status	
Full-time	51 (14)
Part-time	19 (5)
Unemployed	27 (8)
Retired	271 (73)
Country where born	
Australia	271 (78)
England	31 (9)
New Zealand	9 (2)
Other	39 (11)
Speaks a language other than English at home	337 (91)
No	28 (9)
Yes	
Hospitalisation Characteristics	
Length of hospital stay	
< 1 week	125 (34)
1 week- 1 month	178 (48)
1-3 months	43 (12)
>3 months	17 (6)
Number of Pastoral Care visits	
Once	159 (43)
Twice	73 (20)
Three times	50 (14)
Four times	34 (9)
>Four times	53 (14)

† Totals may not sum to 369 due to missing values

Table 2. Statements indicating the participants' outlook in life

Statements	Yes[1]		No[2]		Total[3]	
	N	%	N	%	N	%
1. I see myself as a spiritual person	180	56	141	44	321	100
2. I believe in God or in some Higher Being	236	72	90	28	326	100
3. I am a religious person	184	56	144	44	328	100
4. I feel a need to experience love and belonging	221	71	90	29	311	100
5. I feel a need to find meaning & purpose in life	186	59	128	41	314	100
6. I feel a need to be hopeful	209	66	106	34	315	100
7. I feel I have something to be hopeful about	233	74	83	26	316	100
8. I feel I am in control of my situation	236	71	96	29	332	100

Note:
1. Yes" is a combined answers of "most the time" and "all the time"
2. No is combined answers of "not at all, "seldom" and "some of the time"
3. Totals N do not sum to 369 due to missing values

Table 3. Pearson's *p* values showing correlations among statements indicating the participants' outlook in life

Statements [1]	1	2	3	4	5	6	7	8
1. I see myself as a spiritual person								
2. I believe in God or in some Higher Being	0.000							
3. I am a religious person	0.000	0.000						
4. I feel a need to experience love and belonging	0.000	0.000	0.000					
5. I feel a need to find meaning & purpose in life	0.000	0.000	0.000	0.000				
6. I feel a need to be hopeful	0.000	0.000	0.000	0.000	0.000			
7. I feel I have something to be hopeful about	0.000	0.002	0.003	0.000	0.000	0.000		
8. I feel I am in control of my situation	0.014	0.010	0.009	***0.099***	***0.104***	0.016	0.000	

Note:
1. Statements in horizontal and in vertical line are in the same order.
   In horizontal line, statement 1 is 'I see myself as a spiritual person'.
   Statement 2 is 'I believe in God or in some Higher Being'. Etc.

Table 4. What participants felt during meeting with pastoral care practitioner

during meeting I felt	% of patients who believe in God/ Higher Being or not (a)		p	% of all patients (b)
	Believe	No		
I was listened to	97[1]	92[2]	0.065	96[3]
My situation was understood and acknowledged	96	89	0.026	94
My faith and/or beliefs were valued	97	83	0.000	93
I was able to talk about what was on my mind	85	80	0.202	84
We focus on decision about my health	62	67	0.268	64
N	236	90		326

Note:

1. 97% of participants who *believed* in God/Higher Being felt they were listened to
2. 92% of participants who *did not* believe in God/Higher Being felt they were listened to
3. 96% of *all* participants felt they were listened to during Pastoral Care visit(s).

Table 5. Patients' reported outcomes of pastoral care visit

After meeting with pastoral care practitioner, I felt	% of patients who believe in God/ Higher Being or not (a)		p	% of all patients (b)
	Believe	No		
I could be honest with myself about how I was feeling	87[1]	72[2]	0.002	83[3]
Things seemed under control again	70	45	0.000	63
My level of anxiety had lessened	68	46	0.000	62
I had gained a better perspective of my illness	65	50	0.016	60
A sense of peace I had not felt before	62	29	0.000	53
N	236	90		326

Note:

1. 87% of participants who *believed* in God/Higher Being felt they could be honest with themselves about how they were feeling
2. 72% of participants who *did not* believe in God/Higher Being felt they could be honest with themselves about how they were feeling
3. on my mind83% of *all* participants felt they could be honest with themselves about how they were feeling during Pastoral Care visit(s)

Table 6. Factors related to higher outcomes of pastoral care visits

Factors	N	%	Adjusted OR (95% CI)
1. Pastoral care visit(s)			$p = 0.012$
Twice or more	155	63	0.778 (0.17 - 1.38)
Once (reference)	91	37	0
2. Participants outlook in life			
a. I believe in God or some Higher Being			$p = 0.001$
Yes	170	69	1.01 (0.434 - 1.71)
No (reference)	76	31	0
b. I feel I have something to be hopeful about			$p = 0.001$
Yes	181	74	1.18 (0.51 - 1.85)
No (reference)	65	26	0
3. During pastoral care visit			
a. I was able to talk about what was on my mind			$p = 0.001$
Yes	206	84	1.48 (0.58 - 2.37)
No (reference)	40	16	0
b. We focus on decisions about my healthcare			$p = 0.034$
Yes	157	64	0.70 (0.05 - 1.35)
No (reference)	89	36	0

Note:
OR odds ratio adjusted for all other factors in the table
CI confidence interval

Figure 1.

Lothian PROM

During my meeting with the Pastoral Care practitioner I felt …

	Not at all	Seldom	Some of the time	Most of the time	All of the time
I was listened to	☐	☐	☐	☐	☐
We focused on decisions about my/my relative's/friend's health care	☐	☐	☐	☐	☐
I was able to talk about what was on my mind	☐	☐	☐	☐	☐
My situation was understood and acknowledged	☐	☐	☐	☐	☐
My faith and/or beliefs were valued	☐	☐	☐	☐	☐

After meeting with the Pastoral Care practitioner I felt...

	Not at all	A little	Some of the time	Most of the time	All of the time
I could be honest with myself about how I was really feeling	☐	☐	☐	☐	☐
My levels of anxiety had lessened	☐	☐	☐	☐	☐
I had gained a better perspective of my illness/the illness of my relative/ friend	☐	☐	☐	☐	☐
Things seemed under control again	☐	☐	☐	☐	☐
A sense of peace I had not felt before	☐	☐	☐	☐	☐

Statements that describe me now...

	Not at all	Seldom	Some of the time	Most of the time	All of the time
I see myself as a spiritual person	☐	☐	☐	☐	☐
I believe in God or in some Higher Being.	☐	☐	☐	☐	☐
I am a religious person.	☐	☐	☐	☐	☐
I feel a need to experience love and belonging	☐	☐	☐	☐	☐
I feel a need to find meaning and purpose in life.	☐	☐	☐	☐	☐
I feel a need to be hopeful.	☐	☐	☐	☐	☐
I feel I have something to be hopeful about	☐	☐	☐	☐	☐
I feel I am in control of my situation	☐	☐	☐	☐	☐