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4	Why are Some Healthcare Chaplains	4
5	Registered Professionals and Some are	5
6	Not? A Survey of Healthcare Chaplains in	6
7	Scotland	7
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14	Abstract: The professional status of UK healthcare chaplains remains partial, with volun-	14
15	tary accreditation effective in achieving around 50% registration. This study set out	15
16	to elicit reasons for this by surveying healthcare chaplains working in Scotland. An	16
17	online survey was created to gather demographic details and chaplains' opinions on	17
18	the importance of five key elements of professional status: A body of knowledge that	18
19	underpins practice; A code of professional ethics; An occupational organization con-	19
20	trolling the profession; Substantial intellectual and practical training; and Provision	20
21	of a specialized skill or service. Most respondents (38/43) agreed that chaplains should	21
22	belong to a professional body in order to maintain standards, ensure accountability	22
23	and formalize professional development. A negative minority felt that the profession-	23
24	alization agenda was not for them, but the majority stated that registration reinforced	24
25	their professional status, added credibility and a clear governance structure to protect	25
26	the public. Due to the wide interest in this issue, further UK and international studies	26
27	into the professional status of chaplains are planned.	27
28	Keywords: Professional; professionalization; chaplain; status; survey; accreditation;	28
29	registration; accountability.	29

1	Introduction	1
2	The NHS in the UK employs an estimated 916 chaplains (Clarke 2018).	2
3	Chaplains deliver specialist spiritual care to patients, carers and staff	3
4	across the NHS, offering care to everyone, regardless of their belief or faith	4
5	stance. However, despite a growing body of evidence supporting the ben-	5
6	efits of healthcare chaplaincy, they are not yet recognized as healthcare	6
7	professionals in, for example, the same way that nurses, or chiropractors	7
8	are. Registration with a national regulatory body is voluntary, and there	8
9	is no overarching strategy underpinning their recruitment, education and	9
10	professional development. Instead, their professional status is “voluntarily	10
11	accredited” by the Professional Standards Authority for Health and Social	11
12	Care (Table 1), a status equivalent to counsellors, hypnotherapists and acu-	12
13	puncturists. This article examines the reasons for this, and then obtains the	13
14	views of chaplains employed in Scotland about the relevance of professional	14
15	status. It first explains the background to healthcare chaplaincy in NHS	15
16	Scotland to show why the issue of professional status is so relevant just now.	16
17	Background	17
18	Chaplaincy as a Profession in UK	18
19	Since the inception of the NHS in 1948, chaplains have been funded by	19
20	the NHS, but managed through their various churches (Timmins <i>et al.</i>	20
21	2017). This changed in the early 2000s, when chaplains in Scotland became	21
22	directly accountable NHS employees (Kelly 2012). This is different from	22
23	England and Wales where chaplains have always been employed directly.	23
24	Recognizing the need for an overarching professional organization, the	24
25	Association of Hospice and Palliative Care Chaplains (AHPCC), the Col-	25
26	lege of Healthcare Chaplains and the Scottish Association of Chaplains in	26
27	Healthcare (SACH) created the Chaplaincy Academic and Accreditation	27
28	Board (CAAB) in 2003. The original remit of the board was to provide a col-	28
29	laborative forum to manage the professional issues faced by NHS chaplains	29
30	(UK Board of Healthcare Chaplains 2010):	30
31	It is the aspiration of all the associations that healthcare chaplaincy becomes a	31
32	healthcare profession. To achieve the status of a ‘registered healthcare profes-	32
33	sion’ healthcare chaplaincy requires to become a self-regulating profession and	33
34	a number of groups are currently working on the components required for self-	34
35	regulation. The Chaplaincy Academic and Accreditation Board (CAAB), made	35
36	up from the professional associations in the United Kingdom, has a significant	36
37	role. The work leads towards a more professional approach to chaplaincy with	37
38	regard to education, entry to the profession, relationship to faith and belief com-	38
39	munities and levels of responsibility/seniority (NHS Education Scotland 2008).	39

1 The Chaplaincy Academic and Accreditation Board became UK Board of 1
 2 Healthcare Chaplaincy (UKBHC) in 2010. Its main role now is to protect 2
 3 the public by managing an agreed code of practice, standards and compe- 3
 4 tencies for all NHS chaplains. The Board’s register of healthcare chaplains 4
 5 was accredited by the Professional Standards Authority (PSA) in 2017. This 5
 6 quality mark assured the public that any accredited practitioner is signed 6
 7 up to their code of practice (UK Board of Healthcare Chaplaincy 2014). The 7
 8 PSA oversees the nine statutory bodies that regulate health professionals in 8
 9 the UK, as well as the voluntarily accredited ones, and is accountable to the 9
 10 UK parliament. 10

11 Healthcare chaplaincy is a “voluntarily accredited” association (Table 11
 12 1). This means that, unlike nursing or medicine, for example, individual 12
 13 registration with a professional body remains an *option* for chaplains. It is 13
 14 difficult to be absolutely accurate, but around 50% of the chaplaincy work- 14
 15 force were thought to be registered in 2018. This means that around half of 15
 16 all chaplains are not signed up to the UKBHC code of professional practice. 16
 17 One systemic consequence is that job descriptions for NHS chaplains vary 17
 18 considerably (Swift, 2015a), and there is no single programme of education 18
 19 that specifically prepares chaplains for work in the NHS (Swift 2015b). The 19
 20 UK public, therefore, do not have a clear idea of what to expect from half of 20
 21 their healthcare chaplains. 21

22 Healthcare chaplains cost the NHS between £25m to £29m according to 22
 23 Clarke (2018), and at the extreme, some would like this money redirected 23
 24 to pay for “front line” services instead of chaplains (National Secular Soci- 24
 25 ety 2012). Whilst not a mainstream view, chaplains’ lack of professional 25
 26 status makes them vulnerable to such attacks, and more importantly leaves 26
 27 patients exposed to unregulated practice. It is unclear why a significant pro- 27
 28 portion of NHS chaplains are not registered with UKHBC. This study was 28
 29 designed to find out. 29

30 **What is Professional Status?** 30

31 There is no single agreed definition of “professional” (Evans 2008). The term 31
 32 can refer to those who get paid for doing something that most people do 32
 33 for free; footballers, or musicians for example (Malm 2009). Alternatively, 33
 34 Freidson (1994) suggested that professionals are experts in a particular field 34
 35 who control their own work. This is true of regulated healthcare profes- 35
 36 sionals (nurses, doctors, pharmacists), where commonalities of “profes- 36
 37 sional status” include having a role description, a set of agreed competences 37
 38 needed to practice, a regulatory body that ensures they maintain a standard 38
 39 of practice, and a dedicated programme of training they have to complete 39

Table 1. Statutory and Voluntary Accredited Associations

Professional regulation in the United Kingdom	
Professional bodies covered by the Professional Standards Authority for Health and Social Care	
Statutory regulators	Voluntarily accredited associations
General Chiropractic Council	Alliance of Private Sector Practitioners (foot health)
General Dental Council	Association of Child Psychotherapists
General Optical Council	British Acupuncture Council
General Osteopathic Council	British Association for Counselling and Psychotherapy
Health and Care Professions Council	British Association of Sport Rehabilitators and Trainers
Nursing and Midwifery Council	British Psychoanalytic Council
Pharmaceutical Society of Northern Ireland	Complementary and Natural Healthcare Council
General Pharmaceutical Council	Counselling & Psychotherapy in Scotland (COSCA)
	Federation of Holistic Therapists
	National Counselling Society
	National Hypnotherapy Society
	Play Therapy UK
	UK Board of Healthcare Chaplaincy (UKBHC)
	UK Public Health Register
	United Kingdom Council for Psychotherapy

to become a member (Evans 2008). Membership signals alignment with the values of that profession, and members are accountable for their own behaviour.

Medicine is widely agreed to be one of the first clearly identified professions, and is considered so because of its legal status. In 1848, the UK parliament passed a Medical Act, legally recognizing medicine as a “professional

1 occupation”. The Act set up the General Medical Council (GMC) to moni- 1
 2 tor standards of professional training, to register qualified practitioners, 2
 3 and to de-register those unfit to practice (Roberts 2009). Involving the law 3
 4 clarified and structured medicine’s relationships with the state and the 4
 5 public (Adams 2010) and set the template for other healthcare professions. 5
 6 However, the main reason for involving the law was to protect the public. 6
 7 The law ensures that relevant practitioners are qualified, competent, and 7
 8 practice within an agreed code of ethics. Consequently, when members of 8
 9 the public meet a member of a legislated profession, they know what to 9
 10 expect because that professional will have specific credentials and titles to 10
 11 signify their expertise (Law & Kim 2005). Medical doctors registered with 11
 12 the GMC demonstrate a set of values and behaviours that the public can 12
 13 trust (Wass 2006). The same should be true of chaplains, and it is unknown 13
 14 why many do not register. 14

15 There may be some very straightforward explanations. For example, 15
 16 some chaplains may have joined a chaplain association already, and not 16
 17 understand the need or value of registering with the UKBHC. There are 17
 18 many chaplain associations in the UK, and some may feel they have already 18
 19 signed up to everything they need to. There is also a cost to membership, 19
 20 and some may not see the benefit of paying. Others may recognize that 20
 21 they could not achieve the relevant level of continuing professional devel- 21
 22 opment required of registrants, and still others may not even have heard of 22
 23 the UKBHC. 23

24 Some may not understand what professionalism means in chaplaincy. 24
 25 Swinton (2013) specified five key elements necessary for chaplains to claim 25
 26 professional status: 26

- 27 1. A body of knowledge that supports and underpins their practice. 27
- 28 2. A code of professional ethics. 28
- 29 3. An occupational organization controlling the profession. 29
- 30 4. Substantial intellectual and practical training. 30
- 31 5. Provision of a specialized skill or service. 31

32 These five elements are consistent with the aspirations of the UKBHC, so 32
 33 Swinton’s (2013) work makes it clear that chaplaincy leaders in the UK have 33
 34 a coherent view of professionalism. This study will try to find out what 34
 35 working chaplains think about them. There is also the issue of professional 35
 36 identity (Table 2). Professional identity is usually defined as the way people 36
 37 see themselves within their chosen profession (Guo *et al.* 2018). The litera- 37
 38 ture on professional identity originally focused on nurses (Öhlén & Segesten 38

1 1998), but has been extended to include occupational therapists, teachers 1
 2 and medics. It is an important concept because it predicts retention and 2
 3 job satisfaction (Turner & Knight 2015; Cruess *et al.* 2014). As far as we are 3
 4 aware this is the first study to examine professional identity in chaplains. 4

5 **Table 2.** Clarity of Professional Identity Measure (Dobrow & Higgins 2005) 5

	Clarity of Professional Identity (PI) scale contains a 4-item scale. The items are rated on a seven-point Likert scale, where 1= strongly disagree, 4 = neutral, 7= strongly agree	
	1. I have developed a clear career and professional identity.	
	2. I am still searching for my career and professional identity (reverse coded)	
	3. I know who I am, professionally and in my career.	
6	4. I do not yet know what my career and professional identity is (reverse coded).	6

7 **Aim and Objectives** 7

8 To explore the relationship between professional status and healthcare 8
 9 chaplaincy. This entailed three main objectives: 9

- 10 1. To obtain Scottish healthcare chaplain’s views on being professional. 10
- 11 2. To examine whether the survey items designed to ascertain these views were 11
- 12 fit for purpose. 12
- 13 3. To generate hypotheses for follow-on study. 13

14 **Funding** 14

15 This study was funded by the Chief Scientist Office (CSO) in Scotland, ref 15
 16 CGA/18/34. 16

17 **Ethics** 17

18 Common ethical principles were applied, in particular respect for the indi- 18
 19 vidual and their personal data. Permission to undertake the survey was 19
 20 given by Edinburgh Napier University, School of Health and Social Care 20
 21 Ethics Committee. 21

22 **Method** 22

23 **Design** 23

24 Cross-sectional population survey design. 24

25 **Participants** 25

26 All healthcare chaplains employed by NHS Scotland and working in hos- 26
 27 pices across Scotland. 27

1 **Data** 1

2 A survey was constructed iteratively through a series of pilot tests. The 2
 3 content was constructed by the lead author using the literature on profes- 3
 4 sionalism in chaplains. Each version was commented on by lead chaplains 4
 5 in Scotland and the study steering group, consisting of specialist academ- 5
 6 ics from the UK and senior chaplains from NHS Education Scotland and 6
 7 the UK Board of Healthcare Chaplains. Academic chaplain colleagues 7
 8 from the European Research Institute for Chaplains in Healthcare and 8
 9 the Association of Professional Chaplains in the USA also commented on 9
 10 the face and content validity of the survey to support a future potential 10
 11 international study. The final version consisted of a page of demographic 11
 12 items, two questions about Swinton's (2013) five elements of professional 12
 13 status in chaplaincy, the Clarity of Professional Identity scale (Dobrow & 13
 14 Higgins 2005), and some open questions about attitudes to being a profes- 14
 15 sional chaplain. 15

16 The survey was constructed within NOVIÓ, a secure, password protected 16
 17 survey construction website hosted by Edinburgh Napier University. A link 17
 18 to the survey was circulated directly to all healthcare chaplains in NHS 18
 19 Scotland except for one of the boards, where the lead chaplain asked to dis- 19
 20 seminate the link personally to line managed chaplains. The link was also 20
 21 sent to all chaplains working in Scottish hospices, and finally, to all Scottish 21
 22 chaplains registered with the College of Healthcare Chaplains. Reminders 22
 23 were also sent, two weeks after the initial request. Some chaplains received 23
 24 the invite from more than one source, but were asked to only complete it 24
 25 once, and to ignore any further requests if they had already completed the 25
 26 survey. The survey closed 30 June 2019. 26

27 **Analytic Plan** 27

28 Recall the purpose of this feasibility study was three-fold: 28

- 29 1. To obtain Scottish healthcare chaplain's views on being professional. 29
- 30 2. To examine whether the survey items were fit for this purpose. 30
- 31 3. To generate hypotheses for the follow-on study. 31

32 For the first objective, analysis was mainly descriptive but also exploratory 32
 33 where relevant. For objective two, items were considered successful if they 33
 34 generated high response rates, and/or rich narrative data. The third objec- 34
 35 tive was met by exploring the results from the first two. For example, where 35
 36 relationships between demographic data and other items were statistically 36
 37 significant or pointed to interesting trends, these relationships will be tested 37
 38 for prospectively in follow-on studies. Free text was analysed using content 38

1 analysis (Vaismoradi *et al.* 2013). Content analysis is used to summarize 1
 2 data where theory building is not required. 2

3 **Results** 3

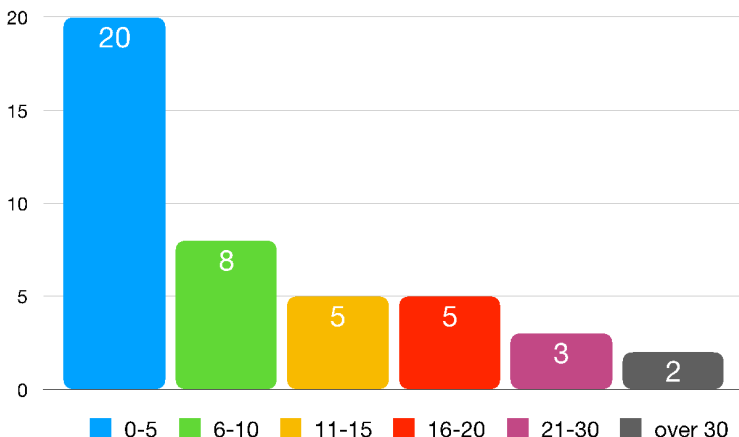
4 The survey was sent to an estimated 90 chaplains in total. Forty-three sur- 4
 5 veys were returned, a rate of 47%. Respondents mainly worked in the NHS, 5
 6 although four reported they were hospice-based. All described themselves as 6
 7 chaplains, with 15 females, 28 males, and a mean age of 54.8 years-old. The 7
 8 majority (n=34) worked full-time, with nine describing working part-time 8
 9 hours. Most held post-graduate diplomas as their highest academic qualifica- 9
 10 tion (Table 3). Half of the respondents were Band 6 (“Agenda for Change” NHS 10
 11 salary scale 1 to 9, with 1 lowest salary and 9 highest), with a further 30% in 11
 12 Band 7. One respondent was Band 5 and the remainder (n=6) Band 8 (Table 3). 12

13 **Table 3.** Highest Qualification Crosstab with AfC Band. 13

Highest qualification/ AfC band	Band 5	Band 6	Band 7	Band 8
Bachelor’s degree	1	3	2	0
Post-graduate Certificate	0	6	3	0
Post-graduate Diploma	0	8	3	1
Master’s degree	0	4	3	2
14 Doctoral degree	0	2	1	3

15 One participant reported that they did not belong to any specific faith 15
 16 group, and 11 participants said they had no recognized status within a faith 16
 17 or belief group. One said that this was only relevant outside their role, and 17
 18 then questioned the word “status”. Twenty had been chaplains between 0-5 18
 19 years, with the remaining decreasing with time (Figure 1). 19

20 Table 4 shows the responses to the first four Yes/No demographic ques- 20
 21 tions on the first page of the survey. There was room to expand following 21
 22 each question. For example, the chaplains not working in the NHS stated 22
 23 that they worked in hospices in Scotland. This is recorded in the “detail” 23
 24 column of Table 4. Sixteen chaplains had management responsibilities, 24
 25 ranging from mentoring new starts to managing large teams. The “recog- 25
 26 nized status” question was expanded on by all who said “Yes” to this ques- 26
 27 tion. The majority were ordained ministers (n=12) and priests (n=7). One 27
 28 stated this was irrelevant to their professional role. 28



1

2 **Figure 1.** Time served as an NHS chaplain. 2

3 **Table 4.** Responses to Yes/No Survey Questions 3

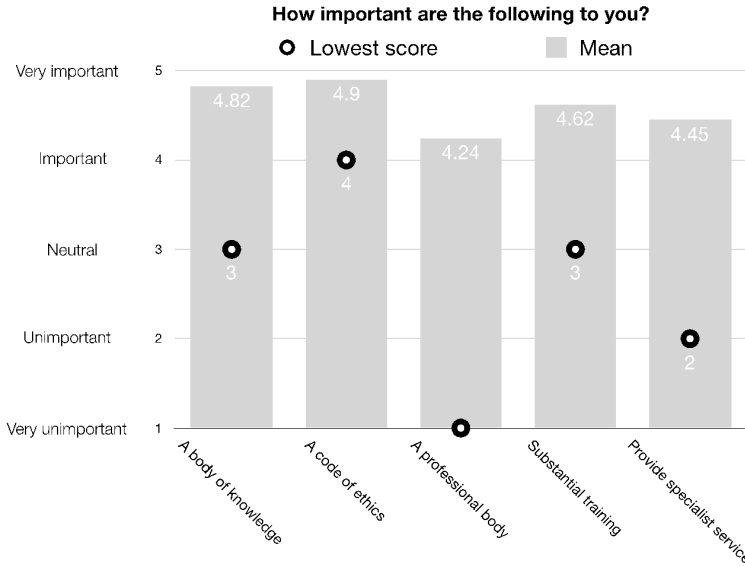
Question	Yes	No	Other	Detail
Do you work in spiritual care for NHS Scotland?	36	4	0	Hospice chaplains (n=4) do not work for the NHS
Are you a chaplain?	40	0	0	
Do you manage other chaplains?	16	24	0	
Do you belong to a specific faith/belief group?	38	1	1	One omitted the question, the “No” did not expand.
Do you have a recognized status within a faith/belief group?	29	11	0	One questioned the term “status”

4 4

5 **Measures of Professionalism** 5

6 The next set of questions asked the chaplains to reflect on the importance 6
 7 of Swinton’s (2013) five elements of professionalism in chaplaincy: *a body* 7
 8 *of knowledge, a code of ethics, a professional body, substantial training, and* 8
 9 *providing a specialist service.* Response options were on a five-point Likert 9
 10 scale from “very unimportant” to “very important”. Figure 2 shows the 10
 11 mean response and also the lowest response to each item. In summary, it 11
 12 shows that on average, these chaplains rated all of the attributes somewhere 12
 13 between important and very important, with some outliers recording less 13
 14 positive responses. 14

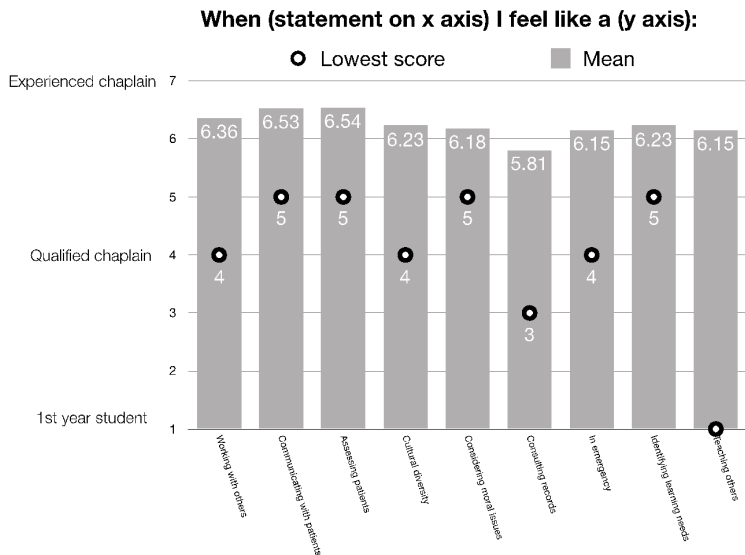
1 The next set of questions were all part of an adapted professional identity 1
 2 scale. This entailed a seven-point Likert scale, where participants ranked 2
 3 themselves on a novice-to-expert scale according to a range of statements. 3
 4 Responses are summarized here in a similar way to Swinton’s, showing the 4
 5 mean response and also the lowest for each item. Please see Figure 3. 5



6
 7 **Figure 2.** Responses to importance of Swinton’s five elements of professionalism in 7
 8 chaplaincy 8

9 The final psychometric scale was the Clarity of Professional Identity Scale 9
 10 (Dobrow & Higgins 2005). This scale contained four items to measure “clar- 10
 11 ity of professional identity”. The items are rated on a seven-point Likert 11
 12 scale, where 1= strongly disagree, 4 = neutral, and 7= strongly agree. The 12
 13 final score is calculated as the mean of the four responses, so a final score 13
 14 of seven represents complete clarity of professional identity, and one the 14
 15 opposite. The four items are below. Calculating the score involves reverse 15
 16 coding the negative items 2 and 4, then calculating the mean. 16

- 17 1. I have developed a clear career and professional identity. 17
- 18 2. I am still searching for my career and professional identity (reverse 18
 19 coded). 19
- 20 3. I know who I am, professionally and in my career. 20
- 21 4. I do not yet know what my career and professional identity is (reverse 21
 22 coded). 22



1

1

2 **Figure 3.** Mean and minimum responses to statements in the professional identity

2

3 Figure 4 shows a histogram of responses of the whole cohort. Mean score 3
 4 was 5.88(1.16) with a range of 2.5 to 7. Because the measure claimed to 4
 5 have high internal consistency, Cronbach’s alpha was calculated. The result 5
 6 (alpha=0.89) supported this claim (Spiliotopoulou 2009). 6

7 **Professional Association** 7

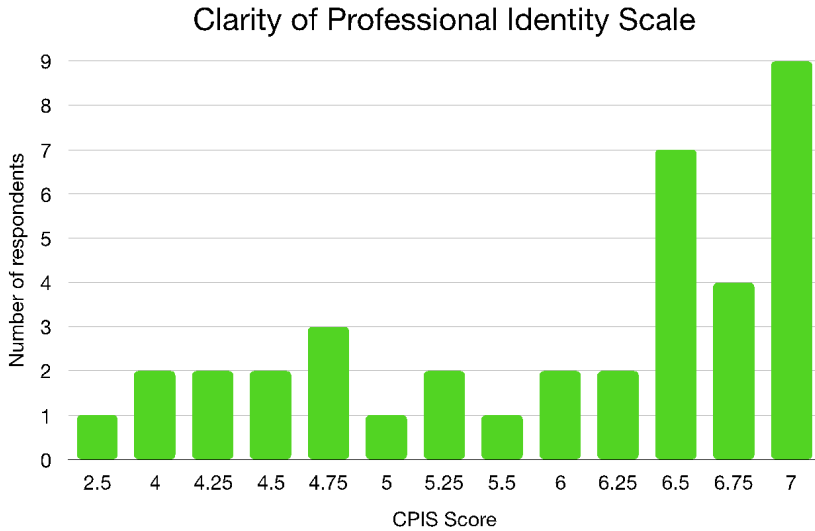
7

8 The last four Yes/No questions generated the most comment (Table 5). 8
 9 Twenty-five (62%) participants stated they belonged to a professional asso- 9
 10 ciation. Twenty-one belonged to the College of Health Care Chaplains 10
 11 (CHCC), with seven being members of the Association of Hospice and Pal- 11
 12 liative Care Chaplains (AHPCC) (five being members of both), and four 12
 13 declaring “other” without expansion. Eight of those that said no to this 13
 14 question expanded on their responses. One chose not to join at the time of 14
 15 the survey. Another was a member of the AHPCC, i.e. historical member 15
 16 who had worked in a hospice. Two were not members of any associations, 16
 17 while the fifth was a member of the UKBHC. The sixth was unaware of any 17
 18 formal registration, the seventh had not yet applied, and the eighth felt that 18
 19 a union membership was more useful. 19

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20 Thirty of 43 chaplains surveyed (70%) reported being registered with 20
 21 UKBHC, although another declared both yes and no and a further did not 21

20
21



1

1

2 **Figure 4.** Histogram of responses to Clarity of Professional Identity Scale

2

3 **Table 5.** The Last Four Yes/No Questions Related to Membership(s) of Professional
4 Body(ies).

3
4

Question	Yes	No	Other	Detail
Do you belong to a professional chaplaincy association?	25	12	2	One “don’t know”, one said “yes and no”.
Are you registered with the UK Board of Healthcare Chaplains (UKBHC)?	30	8	4	Four respondents omitted this question.
Are you registered with any other professional associations?	10	25	5	Five omitted, one nurse, others mainly counselling associations.
Do you think all NHS chaplains should belong to a professional regulatory body?	38	4	1	One said “other” and expanded “not sure if it is necessary either way”

5

5

6 know whether they were or were not. Some gave further detail on member- 6
7 ship. For instance, one stated that they registered with UKBHC in 2013 7
8 when the voluntary register was opened, and another in June 2014, as soon 8
9 as they could. 9

1 Five of the eight not registered expanded on the reasons why. One was 1
 2 working on an application. Another was discouraged because of the com- 2
 3 plicated registration process and yet another stated they were not given the 3
 4 option to register. Two different chaplains were not registered because they 4
 5 believed the UKBHC to be a biased organization concerned with power and 5
 6 status. One of the two argued that the UKBHC favoured religious chaplains 6
 7 over their non-religious peers because UKBHC insist that all chaplains have 7
 8 a faith group connection. This chaplain also thought the UKBHC focused 8
 9 more on chaplains in England, possibly at the expense of those in Scotland, 9
 10 Wales and Northern Ireland (Table 6). 10

11 **Table 6.** Expansion on Membership of UKBHC from Non-members 11

Application in progress

Closed shop merchants. Which is futile. Like all “professional” bodies it is about power and status. This is distasteful.

Never got around to what appears a long, complicated process

Not given choice

This is a biased organization which favours chaplains in England and religious chaplains. It makes no provisions for non-religious chaplains and insists that chaplains have a faith group connection.

12 12

13 The next question asked if participants belonged to any other professional 13
 14 organization, such as nursing/medicine. Ten said yes to this question, and 14
 15 eight expanded, with some of them declaring membership of multiple 15
 16 organizations. Two declared themselves members of AHPCC, two were in 16
 17 the Association of Pastoral Supervisors and Educators, three in the British 17
 18 Association for Counselling and Psychotherapy, two with the Nursing and 18
 19 Midwifery Council, and one with the British Society of Clinical Hypnosis. 19

20 Thirty-eight agreed that chaplains should belong to a professional body. 20
 21 Of the four that did not agree, one was not convinced one way or the other, 21
 22 two did not expand, and one stated that belonging to a professional body 22
 23 could be counterproductive: 23

24 Because such groups always end up being an alternative to the actual work we 24
 25 are paid to do. Over the last decade all meetings of chaplains I have attended 25
 26 have mostly been about issues of power and status. This is utterly wrong and 26
 27 counterproductive. 27

28 One of the positive responses also cautioned of the professional body: “yes, 28
 29 as long as it’s not a Dickensian one like the UKBHC”. However, to put this 29

1 into perspective, 38 participants expanded positively to this question, with 1
 2 a selection of examples discussed below. 2

3 Some chaplains believed they should belong to a professional body 3
 4 because it would promote confidence in the chaplaincy profession and facil- 4
 5 itate good governance. This would enhance trust from the perspective of 5
 6 the employer, but also service users. Chaplains belonging to a professional 6
 7 body would be expected to have consistent, safe and relevant training and 7
 8 qualifications. 8

9 According to some respondents, association with a professional body 9
 10 ensures and maintains clear professional standards, whilst also encouraging 10
 11 continuous professional development. Some felt the chaplaincy profession is 11
 12 in danger of being “diluted”, presumably because spiritual care is increas- 12
 13 ingly seen as everybody’s business (Ross *et al.* 2016; Timmins *et al.* 2015). 13
 14 Somewhat paradoxically, non-chaplains do not understand what chaplains 14
 15 do. Compulsory membership would address this issue by promoting a 15
 16 better understanding of what healthcare chaplains do whilst simultaneously 16
 17 validating their fitness to practice. 17

18 Respondents linked good governance to safe and effective practice. 18
 19 Belonging to a professional body like the UKBHC meant that chaplains 19
 20 could be held accountable for their actions, encouraging a high level of 20
 21 responsibility within the professional practice of spiritual care, as currently 21
 22 obtains in other healthcare professions like medicine and nursing. Respond- 22
 23 ents also expected that a professional regulatory body would ensure agreed 23
 24 standards are adhered to. More specifically, there should be an agreed 24
 25 minimum standard of relevant philosophical and theological education, 25
 26 practical experience and human and pastoral formation for all healthcare 26
 27 chaplains. Most chaplains believe that belonging to a professional body like 27
 28 the UKBHC raises professional standards, thus increasing confidence in 28
 29 Chaplaincy practice. 29

30 The last but one free text question asked participants to describe the ben- 30
 31 efits of professionalism. As above, references were made to how professional 31
 32 status can enhance professional practice in three key areas: professional 32
 33 credibility; professional development; and regulation. These are discussed 33
 34 next. 34

35 *Credibility, validity and longevity of the Chaplaincy profession:* Most identi- 35
 36 fied credibility as a benefit of professionalism. Professionalism could: 36

- 37 • raise the profile of UK Chaplains and ensure greater trust among 37
 38 peers, colleagues, the NHS, and other places where people access and 38
 39 encounter spiritual care; 39

1	• promote better understanding about the role and position of health-	1
2	care chaplains amongst other healthcare professionals;	2
3	• give public assurance of competence and accountability while guar-	3
4	anteeing evidence-based, safe delivery of spiritual care;	4
5	• lead to external validation by the NHS and other healthcare profes-	5
6	sionals, and internal validation by chaplains themselves.	6
7	<i>Provision of professional support and development</i> was acknowledged as one	7
8	of the benefits of professionalism in the delivery of spiritual care. Some	8
9	respondents believed this can happen <i>through education</i> , specifically by:	9
10	• an undergirding of academic training;	10
11	• encouraging/mandating relevant continuous professional develop-	11
12	ment and post-grad education;	12
13	• increasing awareness of practice developments; and	13
14	• promoting research opportunities and dissemination of research.	14
15	Others commented on how professionalism promotes professional support	15
16	and development by clarifying their <i>professional identity</i> . They said that	16
17	professional status supports and informs their identity as chaplains, pro-	17
18	moting solidarity with colleagues and helping them to maintain a sense of	18
19	who they are both in the context of the care community and in their faith	19
20	communities. A few identified the <i>provision of networking opportunities</i> as	20
21	a benefit of professionalism. They explained that having the support of a	21
22	professional body is required in an ever-changing working environment.	22
23	Also, a professional body allowed them to engage with colleagues and share	23
24	experiences.	24
25	<i>Regulation</i> : Some Chaplains believe that professional bodies like the UKBHC	25
26	function as regulatory bodies. They achieve this by developing codes of prac-	26
27	tice and ethics that guarantee a standard of service delivery and account-	27
28	ability. Compulsory membership could ensure adherence to these codes and	28
29	standards, thereby raising the profile of the chaplaincy profession. It can	29
30	encourage self-reflection because chaplains are encouraged to check their	30
31	performances against agreed standards, like other healthcare professionals.	31
32	Four chaplains failed to identify any benefit of being a registered member	32
33	of the UKBHC. One stated that cronyism played a role in the recruitment of	33
34	NHS healthcare chaplains. Another believed that the AHPCC is more benefi-	34
35	cial than the UKBHC, and a third felt that the UKBHC has nothing to offer	35
36	chaplains in Scotland. According to the latter, most chaplaincy conferences	36
37	are “down South”, and deal with different issues compared to the Scottish	37

1 context. Consequently, UKBHC’s relevance and location feel remote. Interest- 1
 2 ingly, one respondent emphasized that the UKBHC will not be truly relevant 2
 3 unless registration becomes mandatory for all healthcare Chaplains, who 3
 4 themselves must be held accountable by the Board for their practices. 4

5 **Analysis** 5

6 The study succeeded in obtaining the views of healthcare chaplains on 6
 7 profesionalization. Whilst it is impossible to know the opinions of non- 7
 8 responding chaplains, the survey generated a wide range of opinion. 8
 9 Regarding item fit, most items were responded to, and often elaborated on, 9
 10 suggesting the majority of the survey was fit for purpose. There was very 10
 11 little difference between chaplains’ responses to the two banks of ques- 11
 12 tions about Swinton’s (2013) theory of professionalism in chaplains. Fur- 12
 13 ther, nearly all the answers were very positive, and so did not reveal much 13
 14 variation in response, just that most respondents think all elements are 14
 15 important and worthy of personal commitment. Possibly the greatest util- 15
 16 ity of these items was in identification of “outliers”, those respondents who 16
 17 answered unusually negatively. Understanding how these chaplains feel will 17
 18 be essential if all chaplains are to feel included. 18

19 By contrast, the Clarity of Professional Identity Scale (CPIS) appeared to 19
 20 be a more useful discriminator of attitudes towards professional identity. 20
 21 Despite 20 participants scoring 6.5 or over (out of seven) the remainder 21
 22 generated a wider set of responses (Figure 4), and so some hypothetical 22
 23 differences were tested in line with objective three. For example, it would 23
 24 be intuitive to assume that the older the chaplain, the greater the clarity 24
 25 of professional identity. Of particular relevance here, it would be useful to 25
 26 know whether registration had any impact on clarity of professionalism. 26
 27 Because the CPIS generated a reasonable spread of responses (Lund & Lund 27
 28 2017) the following hypotheses were tested: 28

29 Mean CPIS scores will be significantly different according to whether 29
 30 the respondent is: 30

- 31 1. registered with UKBHC or not; 31
- 32 2. male or female; 32
- 33 3. a member of any professional association or not. 33

34 These were tested in turn: 34

- 35 1. An independent-samples t-test was run to determine if there were 35
 36 differences in CPIS between UKBHC registrants and non-registrants. 36

- 1 CPIS scores were higher for registrants (6.07 ± 1.17) than non- 1
 2 registrants (5.55 ± 1.07), but the difference was not statistically sig- 2
 3 nificant ($p=.227$). 3
- 4 2. An independent-samples t-test was run to determine if there were 4
 5 differences in CPIS between males and females. CPIS scores were 5
 6 higher for females (6.35 ± 0.89) than males (5.63 ± 1.24), a statisti- 6
 7 cally significant difference of 0.81 (95% CI, 0.02 to 1.43), $t(34.499) =$ 7
 8 2.101 , $p = .043$. 8
- 9 3. An independent-samples t-test was run to determine if there were 9
 10 differences in CPIS between professional association members and 10
 11 non-members. CPIS scores were higher for members (5.95 ± 1.19) 11
 12 than non-members (5.56 ± 1.15), but the difference was not statisti- 12
 13 cally significant, $p = .35$. 13

14 It is important not to over claim from such exploratory hypothesis test- 14
 15 ing. The sample is small and the groups were not normally distributed, so 15
 16 these results need to be replicated before they are considered generalizable. 16
 17 Nevertheless, the t-test is robust to violations of normality and homogene- 17
 18 ity of variance (Lund & Lund 2019), and the fact that there are significant 18
 19 findings *despite* the small size of the sample makes these results worth test- 19
 20 ing prospectively in a larger cohort. With all those caveats, it appears that 20
 21 women have a stronger clarity of professional identity than men in this 21
 22 cohort. There is also a trend towards clearer professional identity in those 22
 23 engaged with both UKBHC and other professional associations. This means 23
 24 the CPIS is useful, and these hypotheses will be tested in the follow-up UK- 24
 25 wide and international studies. 25

26 The following relationships were also tested. There will be a significant 26
 27 relationship between CPIS scores and: 27

- 28 1. age; 28
 29 2. time served as a chaplain; 29
 30 3. highest academic qualification; 30
 31 4. Agenda for Change banding. 31

32 These were all initially tested using Pearson's product moment, and whilst 32
 33 there was a significant moderate correlation between highest academic 33
 34 qualification and Agenda for Change banding, there were no significant 34
 35 correlations between any of the four variables and CPIS scores. Age was the 35
 36 most closely associated, but the correlation was the *reverse* of the expected. 36
 37 There was a non-significant moderate negative correlation between age 37
 38 and CPIS, $r(40) = -.315$, $p = 0.051$. This is interesting as it suggests younger 38

1 chaplains may be more confident than older ones. This test needs to be 1
 2 repeated in the follow-up studies. 2

3 **Free Text Analysis** 3

4 The majority of the chaplains who responded to the survey expressed 4
 5 positive comments about having professional status. There was clear evi- 5
 6 dence of benefit to most. They saw professional support and development 6
 7 as beneficial, and largely supported the role of regulation. Figure 5 sum- 7
 8 marizes these data by classifying them as pertaining to one or more of the 8
 9 following three overarching themes: professional credibility, professional 9
 10 development, and professional governance. All negative responses have 10
 11 already been reported in the results section, but this model could incor- 11
 12 porate those comments too. A professional chaplain is a credible chaplain 12
 13 who works to develop personally within an agreed governance structure 13
 14 (Figure 5). 14

Three-Set Venn Diagram (UX Communication)

austyn.snowden | July 1, 2019



15

15

16 **Figure 5.** Thematic analysis of free text comments showing the meanings attached to the 16
 17 idea of professionalization. 17

1 Discussion 1

2 The survey was a successful way of gathering and evaluating current 2
 3 working chaplain opinion on professional status. The volume and quality 3
 4 of data returned was good. Response rates to surveys have been deteriorat- 4
 5 ing steadily over the last 30 years (Gummer 2019). If the cohort is exter- 5
 6 nal, e.g. customers, then the expectation would be for a 10-20% return at 6
 7 best. If the cohort is internal, i.e. within organizations, then the response 7
 8 rates tend to be higher at 30-40%. This survey was sent to chaplains from 8
 9 within the organization, so could be considered “internal”. However, the 9
 10 survey was constructed and analysed by a team external to the chaplains 10
 11 and could in that regard be considered “external” to participants. In either 11
 12 case, return rate is at the very top end of what could be expected, mean- 12
 13 ing that chaplains in general had engaged very well with this research. 13
 14 This in turn suggests the topic is important to them. No-one who started 14
 15 the survey failed to finish it, suggesting the length of the survey was not 15
 16 onerous, and the depth of the comments returned suggests that those who 16
 17 responded felt safe enough to say whatever they wanted to, without fear 17
 18 of reprisal. 18

19 The quality of the return was likely a function of the many iterative cycles 19
 20 it took to construct the survey in the first place. By involving chaplain lead- 20
 21 ers from the start, and listening to their comments as the survey evolved, 21
 22 the end result was a survey fit for purpose. For example, it is unlikely the 22
 23 UK professional body was previously aware of some of the more negative 23
 24 responses. The UKBHC is explicitly open and keen to hear all comments 24
 25 so they can integrate them into the future development of chaplaincy in 25
 26 the UK (UKBHC, personal communication). This is important, because 26
 27 if UKBHC is to achieve its goal of becoming the professional body for all 27
 28 chaplains then these comments will need to be addressed. 28

29 As far as content is concerned, the demographic items were all completed 29
 30 well, allowing for a comprehensive description of the responding cohort. 30
 31 The free text generated was clear and unambiguous and therefore straight- 31
 32 forward to summarize and analyse. The items about attitudes to theoretical 32
 33 aspects of professional status did not yield much data. This could mean 33
 34 there is no theoretical or conceptual block to chaplains becoming profes- 34
 35 sional, and that the main issues continue to be practical ones. For example, 35
 36 the mean response on opinions about Swinton’s five elements of professional 36
 37 status in chaplaincy was so high it did not really tell us anything new or 37
 38 useful, over and above identifying those people who were more sceptical 38
 39 about professional status, and those people managed to articulate their feel- 39
 40 ings eloquently in free text comments. However, we propose to keep a set of 40

1 questions about theory as there may be different responses to these items in 1
 2 the UK as opposed to Scotland. 2

3 Likewise, the questions about proficiency levels of chaplains were again not 3
 4 particularly informative outside of identifying those people who were more 4
 5 sceptical about professional status. However, there were a number of items in 5
 6 this scale that are not mentioned anywhere else, such as attitudes to record 6
 7 keeping, and so these questions will also be kept for UK-wide follow-up. 7

8 Finally, the CPIS showed considerable promise in its potential to differ- 8
 9 entiate between groups who have different perspectives about professional 9
 10 identity. For example, it showed that females had significantly higher clarity 10
 11 of professional identity than men in this cohort. This will be tested again 11
 12 in the larger follow-up study. That younger chaplains showed a tendency 12
 13 to have greater clarity of professional identity needs further exploration, 13
 14 as it is somewhat counter-intuitive. One explanation given for trends like 14
 15 this is the Dunning-Kruger effect (Ehrlinger *et al.* 2008), an Ignobel prize 15
 16 winning theory explaining why the most incompetent tend to overestimate 16
 17 their performance the most, whereas experts tend to underestimate their 17
 18 competence in relation to peers. However, this finding needs to be replicated 18
 19 before it is explained, and so the only recommendation here is to hypoth- 19
 20 esize the relationship in the larger follow-up study. 20

21 The scale has been historically useful in exploring relationships between 21
 22 personal attributes such as self-efficacy and perceptions of career success 22
 23 (Dobrow and Higgins 2005). The internal consistency of the scale was .89 in 23
 24 the current sample, indicating strong reliability (Spiliotopoulou 2009), and in 24
 25 short it appears to be a useful indicator and will be kept in the follow-up study. 25

26 Finally, despite the majority expressing positive views about professional 26
 27 status, the few negative comments about registration suggest that some 27
 28 chaplains feel excluded by UKBHC. The knock-on effect of inadvertently 28
 29 excluding some chaplains may be inconsistency in the quality of service 29
 30 delivery and possibly inequality of outcomes for service users. Despite these 30
 31 voices appearing to represent the minority, a substantial effort needs to be 31
 32 made to help articulate these voices across the UK as this study rolls out. 32
 33 It is only by listening to each other that we can better understand how and 33
 34 why these feelings of exclusion arise. 34

35 **Limitations of the Study** 35

36 Although the results generated a wide range of opinion and in some 36
 37 instances were sufficient to test some basic statistical correlations, a larger 37
 38 response rate would have increased confidence in the responses even fur- 38
 39 ther (Streiner & Norman 2008). 39

1 A further flaw in the item design was the lack of reversed questions (Lietz 1
 2 2010). The vast majority of the questions were framed positively, and this 2
 3 is known to engender “yeah saying”, whereby the respondent generalizes 3
 4 between questions and may not be concentrating as hard as they would have 4
 5 if some of the questions had been reversed (Knapp *et al.* 2009). Reversing 5
 6 questions within a scale has been shown to improve its reliability (Streiner 6
 7 & Norman 2008), and it is interesting to note that the only measure that 7
 8 contained two negatively worded items, the CPIS, was the measure that 8
 9 looks the most likely to be able to answer some of the follow-up hypotheses. 9
 10 Further, it is often the case in surveys that the people who respond are posi- 10
 11 tively motivated to do so. This did not always appear to be the case here, as 11
 12 there were some vocal dissenters amongst the respondents. Nevertheless, 12
 13 they were in the minority, so further thought should be given to reaching 13
 14 out to any groups that feel marginalized in the follow-up study, because 14
 15 without these responses, a full picture cannot be obtained. 15

16 Related to this, it is not clear that all chaplains had access to the survey. 16
 17 In a few cases, Lead Chaplains had asked to act as gatekeepers (Snowden 17
 18 & Young 2017) for the survey. In short, the lead would send the survey 18
 19 link to them instead of directly to the chaplain, and they would then dis- 19
 20 seminate the survey. Due to the confidential and anonymous nature of the 20
 21 survey, it is unknown if all chaplains received the survey invitation. Again, 21
 22 further thought will be given to avoiding any potential for gatekeeping in 22
 23 the follow-up study, as it is well known that the more links there are in any 23
 24 process, the more chances there are for something to go awry. 24

25 In summary, although many significant associations have been found, 25
 26 and consistent patterns have emerged, all that can be concluded from this 26
 27 is that they raise interesting hypotheses (Kahneman 2011). These will be 27
 28 tested in the UK-wide study next. There are also plans to construct an inter- 28
 29 national version of the survey, as there is global interest in chaplains’ rela- 29
 30 tionship with professional status. The next iteration of the survey therefore 30
 31 gives another chance to improve on its design. Chaplains around the world 31
 32 do their best to deliver person-centred spiritual care coherent with the cul- 32
 33 tural needs of the local context. It will be interesting to find out the degree 33
 34 to which similarities and differences in their views on professional status 34
 35 impact on their ability to deliver this in a systematic and strategic manner. 35

36 **Conclusion** 36

37 The majority of chaplains working in Scotland who responded to this survey 37
 38 were positive about professional status for chaplains. The benefits were 38
 39 clear: a professional chaplain is a credible chaplain who works to develop 39

1 personally within an agreed governance structure. Professional credibility 1
 2 was important for personal worth and status with both patients and fellow 2
 3 health professionals. The need for professional development was also clear, 3
 4 so that the evidence base for chaplaincy could grow systematically and con- 4
 5 sistently in line with a widely understood governance framework. These ele- 5
 6 ments would raise the public profile of chaplains but also support personal 6
 7 reflection on practice. The key thread running through the free text was this 7
 8 balance between the need for internal and external validity, with profes- 8
 9 sional status essential for both. For these chaplains, unifying the profession 9
 10 under one umbrella organization is the obvious next step. 10

11 However, not all chaplains felt this way. A small but vocal minority was 11
 12 highly sceptical about the need for professional status, seeing it as a dis- 12
 13 tasteful vanity project, wasting valuable time that could be better spent. 13
 14 These chaplains describe the leaders of this agenda as biased and “closed- 14
 15 shop merchants”, accusing them of “Dickensian” ways of working, and 15
 16 “cronyism”. Less personally damning but important procedurally was the 16
 17 apparent complexity of the professional board’s application process. There 17
 18 was a feeling that all the important decisions and activity happened else- 18
 19 where for these participants. It will be interesting to see if these feelings 19
 20 are replicable across the country. If so, they will need to be strategically 20
 21 managed and addressed. 21

22 Finally, the survey was successful. It generated a good response rate, and 22
 23 the responses themselves were rich and relevant. A version of this survey 23
 24 will be repeated across the UK next, and if response volume and quality 24
 25 mirrors this Scottish study, the outcome will be a well-informed UK chap- 25
 26 lain leadership and workforce. 26

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