Religion and Belief Matter

An Information Resource for Healthcare Staff

Foreword

Understanding and responding to the Religious and Belief needs of patients as they relate to their use of NHS services is no longer an option, but essential. This resource demonstrates not only what the faith groups themselves see as important but also why staff should try to meet and support their needs. It also highlights areas of good practice, and has included suggestions from Healthcare Chaplains and Equality/Diversity Officers for further consideration.The intention of this resource is to raise awareness of, and provide information on, the links between Religion, Spirituality, and Health.

The enshrining principle of the NHS at its foundation 60 years ago was that all people should have equality of access to the care they need. People are at their most vulnerable when they are ill, and every effort should be made to meet their needs, where possible. They should not be encountering barriers or difficulties. Indeed, it is important to remember that the overriding principle of Fair for All is that there is no room for discrimination in the NHS

On behalf of the Scottish Inter Faith Council and the Scottish Government's Health and Wellbeing's Fair for All Initiative we would commend this resource to all staff involved in the design, development, and delivery of patient care services in the NHS.

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NOTE: This resource can be made available in a range of formats. For further information, please contact the Scottish Inter Faith Council.

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Preface

I am pleased to commend this collaboration between the Scottish Government Health Directorates and the Scottish Inter Faith Council to a broad range of interests across the NHS in Scotland. Set firmly in the context of the Government's "Fair for All" approach, the report is constructed as an information and educational resource, directed to support the work of Managers, Equality\Diversity Officers and Healthcare Chaplains, but has much wider application to all those who deliver care within the NHS. It is primarily designed to help to effect the cultural changes within the NHS when it comes to understanding why religion and belief matter, and why staff should support people with these needs. As a resource for staff the report provides a helpful review of the relevant current legislation and sets out in some detail the emerging evidence base on the link between religion and health.

Based on a series of 13 meetings with focus groups, numerous examples of innovative, good practice are identified and commended for wider adoption. These meetings also highlighted a number of challenges which are still to be met and which have helped to form the recommendations with which the report concludes. In addition to its value as a new resource available to staff, the report will help also with updating of the Scottish Government's guidance on Spiritual Care within the NHS which is scheduled for issue in the Spring of 2008.

I would like to thank all of those people who have contributed to the development of this resource and particularly to thank Pramila Kaur, Alastair Pringle and Geoff Lachlan for their leadership roles in concluding this important piece of work.

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1. Introduction

SECTION A: RELIGION AND BELIEF NEEDS IN THE NHS

"The very nature of the post-modern global village we now inhabit affirms that the natural experience of life is to connect with its wonder and pursue our inquiry into identity and meaning. It affirms that there is indeed an inner 'spirit' to everything, including ourselves."

William Bloom

This resource has been produced as a result of a collaborative project between the Scottish Inter Faith Council and the Scottish Government's Patient Focus/Public Involvement initiative called "Fair for All – The Wider Challenge"[1]. It also involved close liason with the Healthcare Chaplaincy Training and Development Unit. Fair for All, representing the equality strands of Age, Disability, Ethnicity/Race, Gender, Religion and Belief, and Sexual Orientation work together to promote cultural competence and challenge discriminatory practice of any form within the NHS. This is done not only from the particular strand's perspective, e.g. disability schemes from Fair for All Disability, but also increasingly using a 'cross-strand' approach when it comes to reviewing the provision of services such as cancer management pathways. Fair for All also emphasises that patients may often experience multiple discrimination when accessing NHS services if they identify with two or more of the equality strands.

The aims of the project were:

1. **To review the context for responding to Religious and Belief needs in the NHS.**
2. **To review some of the most recent evidence from the research literature that supports healthcare chaplaincy in responding to Religious and Belief needs.**

In order for the NHS to experience the benefits of a diverse workforce, there must be equality and fairness for all by respecting and accepting differences including those of age, disability, ethnicity, gender, religion/belief and sexual orientation. Even more importantly is the need to treat patients equitably, each according to their need, as people are at their most vulnerable when ill. We must not forget the enshrining principle of establishing the NHS in 1948 was that everyone was entitled to fair access to the same healthcare.

Susan Hollins[2], a Chaplain for the NHS Healthcare Chaplaincy Strategy in England, describes the modern context for responding to patients' Religious and Belief needs:

As societies become more diverse, so within healthcare increasing emphasis is rightly being given to the particular needs and requirements of the individual patient – not only in relation to their clinical needs, but also in relation to their cultural, religious, and spiritual needs. For hospitals are places where people struggle to hang on to their individuality amid the clinical procedures set in place to make them physically or mentally well. Failing to pay proper attention to the individual – for example, taking the care to find out about their dietary requirements, whether they ascribe to any particular religion, how they would prefer to be addressed, etc.- only reinforces their vulnerability and a feeling that they are no longer in control of what happens to them.

With respect to recognising and supporting Religious and Belief needs of patients attending hospital Healthcare Chaplains have traditionally carried this out and from a Christian background. With the introduction of **HDL (2002) 76 Spiritual Care within the NHS**[3] the emphasis on Chaplaincy is now to try to respond to patients' spiritual needs and thus be more inclusive of other faiths and also those for whom religion has no particular significance in their lives. As Teilhard de Chardin[4], a French Jesuit priest, once said:

We are all Spiritual beings trying to be Human

It is fair to say that this simple statement is the philosophy underlining the new approach to the provision of Healthcare Chaplaincy, as described in the above HDL of 2002.

Christian	64.00%	3,294,600
Muslim	0.84%	42,600
Buddhist	0.13%	6,800
Sikh	0.13%	6,600
Jewish	0.13%	6,400
Hindu	0.11%	5,600
Others	0.53%	27,000
No Religion	27.55%	1,394,500
Not Answered	6.50%	

Religion and Belief : Scottish National Census 2001

However, as the 2001 census figures for Scotland[5] showed, nearly 66% of the population admitted to being 'religious' (64% Christian, 2% other faiths) so religious need cannot simply be forgotten as Chaplaincy develops a more inclusive spiritual approach. However, both patients and staff alike are confused as to what constitutes true religion. As the HDL referenced above states, **"Spiritual care is not necessarily religious; religious care, at its best, should always be spiritual."** The concept of spirituality can be even more difficult to understand.

The resource will begin with a discussion of the definitions of religion and spirituality. An understanding of these terms, and, in particular their inter-relationship, is essential if NHS staff are to fully appreciate the significance of responding to religious needs. How this relates to the Spiritual Care Policy of their Board [see **HDL (2002) 76, Spiritual Care in NHS Scotland;** to be revised in 2008] can then be better understood. Who should respond to Religious and Belief needs, and what Health Boards can do, will then be discussed.

In Section B, Supporting Information, there will be a short review of the recent evidence base explaining the link between Religion, Belief and health, followed by a summary of the relevant legislation.

Thereafter, the most significant findings from thirteen different faith focus groups that were held will be presented, but for a complete list of religious needs reference should be made to **The Multifaith Resource for Healthcare Staff**[6] produced by the Healthcare Chaplaincy Training and Development Unit within NHS Education Scotland and distributed to NHS staff in 2007. Some recommendations and examples of good practice will follow, based upon visits to Lead Chaplains and Equality/Diversity Officers in all 14 territorial Health Boards in 2007.

A list of references, publications, useful organisations and websites with further information and support can be found at the end.

Whilst this resource primarily refers to hospitalised patients, the same approach and principles can be applied to staff working with patients anywhere within the Health Service. Quoting Dr. Woods[7] :

We need to ensure whatever the individual circumstances of patients' lives they have access to the right health services for their needs. That is why we have developed the innovative Fair for All approach which provides guidance and support to help local NHS services respond sensitively and flexibly to the needs of the people they serve.

Although healthcare has always been practised regardless of any person's particular religion or belief, events in the World have demonstrated that religion remains a highly significant factor today. A recent survey amongst young people in Coventry[8] showed they had considerable interest in the 'big' questions about life, death, suffering, the origin of the universe, life after death, etc. They may not identify with traditional religions, but in their own spiritual search they are asking the same questions that the religions ask.

Recent advances in psychoneuroimmunology [the new scientific discipline of the link between our emotional / psychological state, and the nerve connections to the body's immune system responsible for fighting disease] demonstrate the science behind the link that the ancient wisdoms and religions have known for millennia – that mind, body and spirit are all interconnected.[9] Indeed the original World Health Organisation (WHO) description of 'Health':[10]

"A complete sense of physical, mental, and social wellbeing."

now includes reference to the importance of recognising '**Spiritual Wellbeing**.'[11] The significance of this will be shown in the chapter reviewing the evidence- base for supporting religious/spiritual need.

An understanding of Religion, Spirituality and their interrelatedness both to each other and to health, is essential in appreciating the importance of meeting Religious and Belief needs.

Never before have there been such compelling reasons to recognise and support Religious, Belief, and Spiritual need in the NHS.

As William Bloom[12], one of Britain's leading contemporary spirituality teachers, said at the beginning of this chapter, we now inhabit the post-modern global village which affirms 'interconnection' and the presence of 'spirit.'

Thus never before have there been such compelling reasons to recognise and support Religious, Belief, and Spiritual need in the NHS. Whilst this resource aims to ensure the needs of those following their spirituality through mainstream religions are met, it also ensures that those with a more 'Humanist' understanding are included. Recognising that this may not be relevant for all the population, the theme of the resource is really to set the **context for supporting Religious and Belief needs**, and reference should be made to **A Multifaith Resource for Healthcare Staff** for more extensive information.

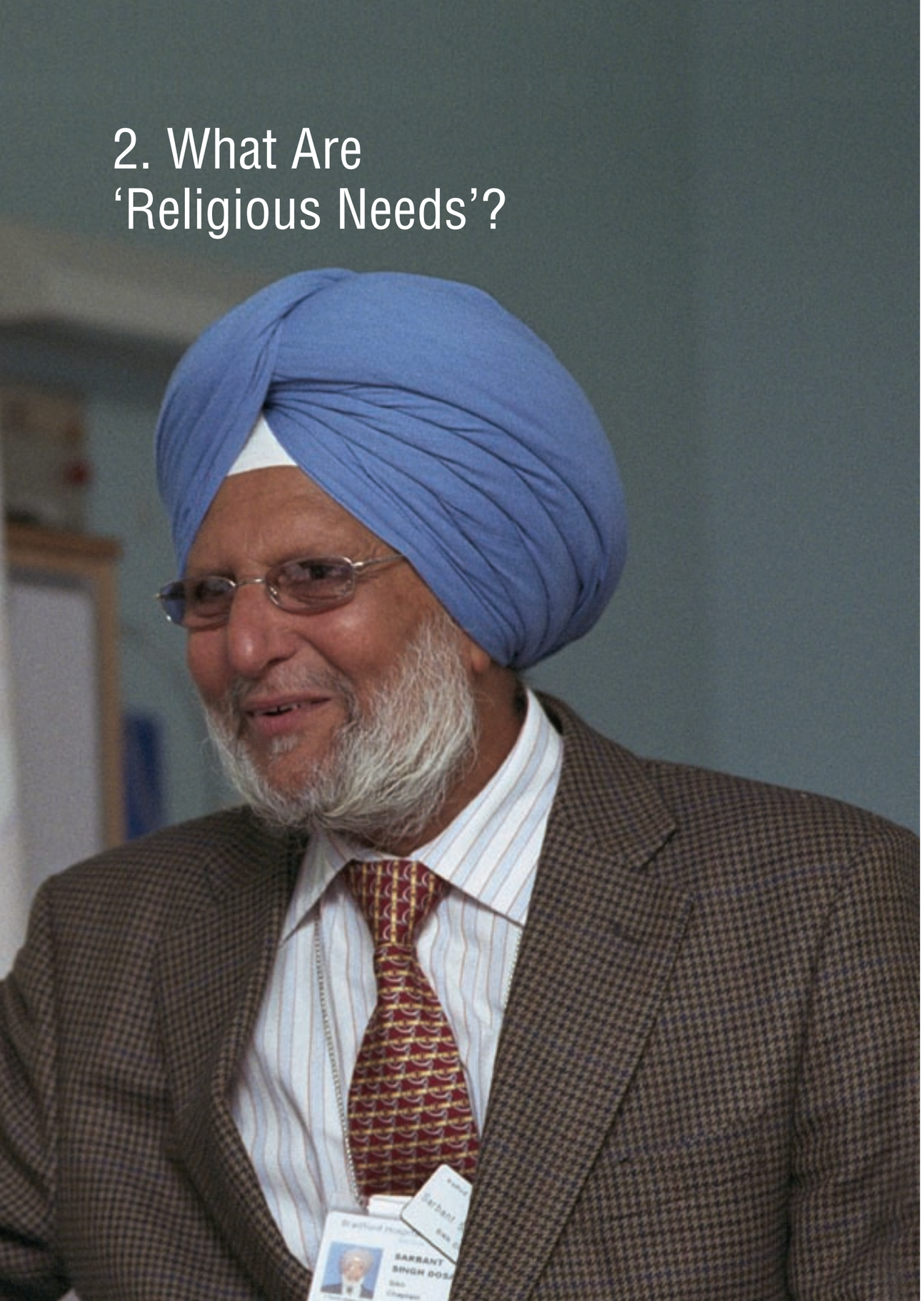
As an equality strand Religion and Belief is different from the others; for who chooses their age, disability, ethnicity, sex, or sexual orientation? Admittedly, there are some constraints on 'religious orientation', when cultural issues can strongly influence both the religion of your birth and your ability to leave it all behind. However, in the 21st century one of our cherished freedoms, underpinned by Human Rights legislation, is that of each individual deciding for themselves how they understand answers to the 'big questions' of life:

Why am I here? What is life all about? Why is there suffering in the world?

What happens after we die? What are the things of importance to me in this world?

That may or may not involve following and believing in a particular religion. The legislation that exists is primarily designed to prevent discrimination and to ensure respect for the Human Rights of the individual as they follow their chosen religion. The importance of this legislation should not be underestimated, and Equality/ Diversity Officers thus have a key role to play in raising awareness of it throughout the NHS.

2. What Are ‘Religious Needs’?



“Wherein does religion consist? It consists in doing as little harm as possible, in doing good in abundance, in the practice of love, of compassion, of truthfulness, and purity in all your walks of life.”

Asoka

2.1 What is Religion?

Asoka was a ruler in Northern India in the third century BCE and was very supportive of a multifaith approach in understanding the meaning of life. Hence his description of religion was very inclusive, but how relevant is this for today?

Whilst it is often said that “....we are now living in a secular or post-Christian society...” implying that religion and belief in “God” are no longer socially significant, this statement can be challenged. Religious belief in Britain, as expressed through church attendance, Christenings, membership, etc.[13] has now fallen with 7% of the population regularly attending church. However, Lynda Barley (Head of Research Statistics for the Church of England), using the BBC Soul of Britain and other recent Socio-Religious Surveys comments that 76% of people are now likely to admit to having had a ‘religious or spiritual’ experience in the past year, compared with 48% in 1987[14]. Spirituality, in its widest sense, has grown exponentially over the last 30 years, and people are now prepared to admit they are spiritual, but not religious[15]. As the authors of the study “Understanding The Spirituality of People Who Don’t Go To Church”[16] discovered, we do want to believe in something.

However, as the Chief Rabbi Jonathan Sacks commented recently, “.....against all expectation, Religion has emerged in the 21st. century.....with immense and sometimes destructive force.”[17] For on a worldwide level religious extremism, in many religions, is increasing.[18]

So, belief in something is important for a large number of patients and in the following chapters we shall review some research evidence as to why it can be important medically.

Religion comes from the Latin root religio which means “to bind together”. Using a common core of shared beliefs and rituals, a community is thus ‘bound together’ in their obedience to or worship of a supernatural power considered to be divine (often referred to as ‘God’).

Most religions have a belief in a supernatural being – ‘God’ (Christianity), ‘Brahman’ (Hinduism), ‘Allah’ (Islam), ‘Hashem’ (Judaism) – who can transcend (cross over) the spiritual realms into our material world. Other religions do not share this view – Buddhism, Confuscianism, Taoism – but emphasise the importance of the ‘right path’ to follow in this world, based upon moral principles, ethics, and a respect for all life.

As John Swinton[19] describes **religion**:

RELIGION asks deep questions about the very nature of human beings, their identity and place within the world, the purpose and meaning of human life, and the destiny of human kind. Organised religions are rooted within a particular tradition which engender their own narratives, symbols, and doctrines that are used by adherents to interpret and explain their experiences of the world. As such, religion provides a powerful worldview and a specific framework within which people seek to understand, interpret, and make sense of themselves, their lives, and daily experiences.

All religions include some experience, recognition, or appreciation of 'something more than this material world', and all share the core moral teaching called the '**Golden Rule**':

> Lay not on any soul a load which you would not wish to be laid upon you; and desire not for anyone the things you would not desire for you (Baha'i);
>
> Just as a mother would protect her only child with her life, even so let one cultivate a boundless love towards all living beings (Buddhism);
>
> Do unto others as you would have them do to you (Christianity);
>
> This is the sum of duty: do naught to others if done to thee would cause thee pain (Hinduism);
>
> No one of you is a believer until he desires for his brother or sister that which he desires for himself (Islam);
>
> What is hateful for you, do not do to your fellow men (Judaism);
>
> No one is my enemy, and no one is a stranger. I get along with everyone (Sikhism).

This is part of the common ground that is the foundation of every religion, and finds its highest expression in the spiritual values of our shared humanity. Such an expression of religion has no place for any extremism.

[For further information on World Religions, see the guidance **A Multifaith Resource for Healthcare Staff**].

However, the 'living heart of religion is to be found in religious experience, rather than the actual institutions, with their creed and hierarchical priesthoods'[20]. Roman Catholicism, for example, combines the experiential element with observance of its many sacramental rituals.

These features of 'institutional' religion may well explain why 64% of the Scottish population said they were 'Christian' in the last census, yet only 7% regularly attend Church.[21] It is likely that they were identifying more with the cultural significance of Christianity that is still evident today, rather than the experiential personal element. But, in times of a medical life crisis, patients will sometimes fall back on these 'cultural' beliefs.

2.2 What is Spirituality?

Spirituality has been described as 'the wellspring within, and religion the edifice to cover it'[22], thus referring to the 'mystical' or spiritual heart of all the human religious institutions as described above.

The actual word **spirit** comes from the Latin spiritus meaning 'breath', and is related in the Hebrew ruach and Greek pneuma to the concept of the stirring of air, breeze, breath, and wind. As John Swinton[23] says,

> An analogy would be human respiration, by which oxygen is taken in to sustain and maintain the existence of the person. The spirit provides a similar sustaining and nurturing role.....
>
> .....it can also be looked upon as that life force.....
>
> .....which gives the person their source of meaning, value, and a sense of inner and outward connectedness.

In the Healthcare context, the Royal College of Psychiatrists Special Interest Group in Spirituality[24] define **spirituality** as:

> ....experiencing a deep-seated sense of meaning and purpose in life, together with a sense of belonging. It is about acceptance, integration, and wholeness. For the spiritual dimension tries to be in harmony with the universe, strives for answers about the 'Infinite', and comes especially into focus in times of emotional stress, physical and mental illness, loss, bereavement, and death. This desire for "wholeness of being" lies in the essence of what it means to be human.

Therefore, at its simplest, spirituality "**links the personal with the universal**," and religion is one way of appreciating and expressing our spirituality. Humanism, for example, believes that moral values are founded upon our common humanity and experience, and must include respect for the individual person. There has been a phenomenal explosion of interest in Contemporary Spirituality (formerly described as 'New Age').[25] These are both examples of non-religious expressions of spirituality.

Spirituality relates to **all** aspects of our lives, and encompasses our physical, mental, and social states, thus being integral to the expanded WHO description of 'Health' . Spirituality, whether expressed through religion or not, must be of importance to healthcare staff involved in caring for patients. For, as John Drane[26] so aptly reminds us:

> Most people who adopt beliefs or practices – whether religious or spiritual – do so not for any great ideological reasons, but because of the existential imperative of getting from one day to the next in as meaningful and painless a way as possible.

2.3 How are Religion and Spirituality Related?

Stephen Wright[27], Professor of Health and Social Care in St. Martin's College, Carlisle - describes the relationship between Religion and Spirituality in this way:

Everybody seeks meaning, purpose, direction, and connection in life. At some point we all ask questions on what's it all about, seeking answers to all those great existential questions like 'Who am I?' Why am I here?' 'Where am I going?' and 'How do I get there?'

We all pursue relationships, work and activities that nurture and feel 'right' to us. For some people this pursuit is essentially God or Goddess-centred, expressing a belief in some divine being. For others it is essentially atheistic or agnostic, as in Humanism or Buddhism. Our SPIRITUALITY is therefore the very root of our being – who we think we are, why we think we are here, and what we should do with our lives.

RELIGION can be seen as ritual, liturgy, dogma, and the various practices that we collectively bring to our spiritual life to codify and unify it with others. Indeed some, if not most, religions provide ready-made answers to those questions we ask about the nature of our being and purpose. Religion provides a channel for the expression of our spirituality. Spirituality is the solid centre in our lives that enables us to express ourselves in the world and to cope with all the complexities and conflicts of being alive. Without it we can feel cast adrift, rootless, despairing and aimless. Thus everybody is spiritual, but not everybody is religious. We all seek meaning, purpose, relationship, and connectedness in life, but not everybody chooses to channel that quest through the more formal structure and belief system of a religion.

2.4 Summary

Perhaps the best way to understand these terms is first of to think of the meaning of 'Spirituality' – then regard 'Religion' as a way that some people understand and express their Spirituality. Thus:

SPIRITUALITY enables us to not only connect and relate to other people, but also experience some 'higher' or 'Other' state in relating to humanity and the rest of the world. It is what gives our life, as an individual, meaning and purpose. It involves NEEDS of reassurance, comfort, peace, happiness, dealing with guilt and forgiveness, listening and being listened to, feeling valued and having self esteem.

RELIGION is how some people choose to experience and express their spirituality. This will usually involve sharing with similarly-minded people in the rites, rituals, teachings, and sacred scriptures as they reverence their understanding of 'God' or the Ultimate.

BELIEF is a personal conviction or understanding about something, such as 'is there any meaning to life?' It is often accepted without necessarily any proof. Religions are Beliefs, but so are Agnosticism, Atheism, and Humanism.

One of the core values of the NHS Spiritual Care Policy is to address the fundamental human need to have a sense of peace, security, and hope, particularly in the context of injury, illness, or loss.

In its broadest sense 'spirituality' includes whatever gives a person meaning, worth, self-esteem, and value. So, including Atheistic, Agnostic, and Humanistic understandings of the meaning of life, everyone is, in someway, **spiritual**; but most people are not **religious**[28]. Religion should always have spirituality at its core; but spirituality is not always religious. For example, Humanism has a very particular spirituality associated with it. The last comment on this is from the Dalai Lhama:[29]

Whether a person practises religion or not, the spiritual qualities of love and compassion, acceptance and tolerance, patience, forgiveness, and humility are indispensable. We cannot do without these basic spiritual qualities, whose unifying characteristic is concern for others' wellbeing, acknowledging human diversity, and respecting the rights of all.

THUS:

PATIENTS' RELIGIOUS/BELIEF NEEDS ARE SUPPORTED

by taking into account, and respecting, the beliefs, rituals, liturgies, practices and cultural background appropriate to that patient,

by ensuring that the Healthcare 'system' does not at any stage compromise, or discriminate against, their religion or belief,

where possible by ensuring the availability of representatives of Faith communities who can provide religious care and services.

What the individual patient's needs are, if associated with one of the Religion and Belief groups, could be answered by referring to the appropriate chapter in the manual **A Multifaith Resource for Healthcare Staff**. Not all patients will have the same religious/belief needs according to their faith, so it is still important to ask. The WHO description of 'Health', as explained above, requires us to take notice of religious need as part of a patient's spirituality, and the next chapter will discuss who should meet these needs and why.

3. Why Respond To Them – And By Whom?

"The most beautiful and profound emotion we can experience is the sensation of the mystical. For it is the power of all true science."

Albert Einstein

3.1 Why Respond to Religious and Belief Needs?

Although our modern medical care system is based upon science, Einstein is convinced that an awareness of the mystical element of life is very important. By this he is referring to our spirituality, which some people identify with through their religious and other beliefs.

In promoting equality and diversity within the NHS today, Dr. Woods[30], the Chief Executive of the NHS, has said:

> **I believe that we need to be positive about diversity, not because the law requires us to be, but because it is the right thing to do. Thus the moral case is undeniable… and so is the business case.**

He has described three 'cases' for meeting religious/belief needs:

a) THE LEGAL CASE

Certainly there is some significant legislation relevant to religious equality, and this is reviewed in chapter 6. This is not the main reason for responding to religious needs, although Health Boards do have to comply with it.

b) THE ETHICAL CASE

As Dr. Woods rightly emphasises we should not be responding to religious needs simply because we legally have to, but because it is ethically right to.

c) THE BUSINESS CASE

This is now well understood to be an important reason for the organisation to respond to religious and other equality needs, as by being inclusive it leads to a better and more motivated workforce. This in turn increases its ability to treat its clients (in this case patients) with respect, no matter what their differences may be.

There is also another aspect to the business case. Chapters 4 and 5 will show how there is increasing evidence for the **medical case** as ultimately being the most significant in responding to religious/belief needs. As spiritual care is now recognised as an important component of **holistic care**, and religion has a spiritual basis, then patients should get the best treatment, and outcome, if their religious needs are supported.

3.2 Who Should Respond to Religious Needs?

This resource is intended to be used to inform Managers, Healthcare Chaplains, and Equality/ Diversity Officers, but it is also hoped that **all employees of the NHS will benefit from reading it**. If we are to change the culture of the workforce of the NHS so that we are all naturally more inclusive of people different to ourselves and to work in a more holistic way, then an understanding of some of the issues involved in religious and other beliefs is essential.

MANAGERS, who are responsible for ensuring equality schemes are being developed, involved in aspects of service development, and those managing staff delivering religious care;

EQUALITY OFFICERS have a particular duty to raise awareness about religious equality in both the workplace and for the patients. Equality schemes should reflect this.

HEALTHCARE CHAPLAINS are in the forefront of responding to patients' religious/ belief needs, as part of the multidisciplinary team.

ALL PERSONNEL INVOLVED IN PATIENT CARE, are of equal importance in supporting patients spiritually, and thus indirectly responding to their religious needs.

3.3 Summary

As this resource is read it will become clearer that there are many sound reasons for seeking to respond to patients' religious needs. It is a **team effort**, and should not only be left to the Chaplain. The Nursing and Midwifery Council also state that it is part of a nurse's duty, to ensure that they are able to assess patients' spiritual (and hence religious) needs.[31] Equality Officers have a duty to raise awareness about the legislation on Religion.

"...an understanding of some of the issues involved in religious and other beliefs is essential."

4. What Health Boards Can Do

"The heart that is benevolent and kind most resembles God."

Robert Burns

Each Lead Healthcare Chaplain, and some of their team, in all fourteen territorial Health Boards were visited to inform the development of this resource.

One issue raised during these visits was in trying to meet the rapidly increasing need for pastoral care of staff, and, in this respect, one Healthcare Chaplaincy department has devoted 1.9 WTE in chaplaincy to staff support alone. The NHS is proud to describe itself as "The Caring Profession", but it currently faces a need to provide pastoral care for its own staff as well, particularly in the area of Spiritual and Religious need. This is a challenge that can only increase.

At the same time as visiting the Chaplains, it was possible to meet most of the Equality/Diversity Officers responsible for supporting Religion and Belief as an equality strand. They were very warm and open, and gave up their time to describe how they were supporting religion with both staff and patients, and working with the Healthcare Chaplains. One issue here with some of the Boards was adapting to the sudden arrival of East European patients – mostly Catholic and Orthodox Christian – but with little or no English language.

Listed below are some **examples of good practice** and **challenges** in responding to the Religious and Belief needs of patients. In addition, and again based on discussions with Healthcare Chaplains and the Equality/Diversity leads, some **recommendations** and **'how tos'** have been made.

4.1 GOOD PRACTICE

There were some excellent examples of well designed and attractive patient information leaflets about Healthcare Chaplaincy, given to all new patients on admission.

Leaflets describing the Healthcare Chaplaincy department as offering Pastoral Care for staff were available in some Health Boards.

In another Board, a booklet was produced, offering a wide range of Pastoral Care services to staff, of which Healthcare Chaplaincy was but one.

One Board achieved a very high rate of 'welcome' or initial visit from the Healthcare Chaplaincy team to all patients admitted.

Some departments, covering multiple sites, had highly organised on-call rotas, to ensure a rapid response to out-of-hours work.

Another department had developed an excellent Catholic priest 'location' system, for meeting emergency needs of any Catholic patients.

There were many strong, well run volunteer training programmes.

Several Boards had very proactive Spiritual Care Team committees, where many issues were discussed related to meeting religious as well as spiritual need.

One Board held regular in-house Spiritual/ Religious Care reviews, in order to audit the performance of Healthcare Chaplaincy.

In many Health Boards, the Religion Equality/ Diversity Officer was working closely with Healthcare Chaplaincy to support Religious and Belief needs in both staff and patients.

The Equality Officer in several Boards had run Religion and Belief awareness seminars and workshops for staff with local faith communities, i.e. meetings in Mosques, Temples, etc.

In one Board, the Equality/Diversity team had carried out detailed questionnaires trying to identify the unmet needs in their particularly large recently arrived East European population.

Several hospitals had beautiful and restful quiet rooms, which were sympathetic to all beliefs, and none, and highly appreciated by both staff and patients. Some were in prominent positions, providing a quiet 'drop-in' at the heart of busy hospital activity, and an obvious asset to the organisation.

4.2 SOME CHALLENGES

As Generic, Spirituality-based Healthcare Chaplaincy develops, it will be important to ensure that the specific religious needs of all the Faith groups are responded to. For example, there are particular concerns around the needs of Catholic patients.

In some Health Boards this challenge is amplified by the arrival of East European patients, who also have additional cultural issues, especially language.

The present interpretation of the Data Protection Act is now having the effect of making contact with certain patient groups more difficult.

As the profile of Healthcare Chaplaincy rises and the demands on the service increase, it will become a challenge to maintain an out of hours on-call service. This is especially relevant to departments with small numbers of staff who work on scattered multiple sites.

The challenge of providing staff Pastoral Care as part of Healthcare Chaplaincy services is increasing in the majority of Boards.

There is still a lack of clarity about Religion / Spirituality and their relationship both with each other and to health.

Staff are generally very enthusiastic for education and awareness training in Religion, Belief, and Spirituality but this needs to be accommodated within their own work routines.

There is still a lack of consistent data collection across many Boards with respect to Religion and Belief. Religious monitoring is vital, for patient information and patient care.

4.3 RECOMMENDATIONS

- As seen in the quote from the Buddhist Focus Group (page 45), it is always vitally important to treat every person with dignity and respect.
- Never make assumptions about a person's needs. As the elderly Jewish man said in the Focus Group, 'Staff are always best to ask – rather than just assume.'
- In view of the frequency of diet being raised as an issue in the Faith Focus Groups, it is important to ensure appropriate menus are available that are suitable for all the faiths.
- Consider the use of inspirational or inter faith scriptures in patient support leaflets.
- Consider the appointment of Chaplains / spiritual care providers and or honorary Chaplains / spiritual care providers from the minority Faith Communities and other Belief Groups.
- Healthcare Chaplains should ensure good communications / links in order to call in other Religious/ Belief Leaders for support in meeting patients' particular needs.
- The 'Quiet Room' – chapel, sanctuary, meditation room, etc.- ought to be religiously neutral in its design and appearance (a number of objections were raised concerning the still prevalent Christian ambience in these rooms).
- Leads in Spiritual Care Team, Healthcare Chaplaincy and Equality should ensure that HDL (2002) 76 has been implemented, and be prepared to implement its revision in Spring 2008.
- With some Boards facing new hospital development, this is an ideal opportunity for Healthcare Chaplaincy to be involved in the initial design stage for the Spiritual Care Department.
- Consider providing educational training in Religion and Belief needs. The Healthcare chaplains and the Equality Officers can help support and deliver this.
- Health Boards should ensure awareness of the Employment Equality Regulations (Religion & Belief) 2003 and the Equality Act (Goods, Facilities, and Services) Religion & Belief 2006.

4.4 How to Achieve some of these Recommendations

- "Treat everyone with dignity and respect" has to be the overall philosophy.
- Targetted Patient Satisfaction Surveys (e.g. all Sikh patients admitted in the last three months) with respect to responding to their religious needs are useful.
- Regularly review the lines of communication from ward level to Healthcare Chaplain for being able to rapidly contact the most appropriate person to manage an urgent request for religious/spiritual support, especially out of-hours.
- Consider an 'Equality Impact Assessment' of the suitability of the Chapel/Quiet Room from the point of view of all Faiths and none.
- Consider inviting local religious leaders to an in-service awareness raising session on religious needs. It makes it more meaningful for all staff.
- Spiritual Care Committees can be a useful forum to raise issues of concern over any aspect of supporting religious need.
- For increasing the Pastoral Care of staff, cooperation between Occupational Health, Counselling Agencies, Complimentary Therapy providers, and many locally based support agencies, can be helpful in reaching more staff.
- Staff can be asked to explain what their concerns are in supporting religious/belief and spiritual needs. Then Healthcare Chaplaincy and Equality Officers can work together to address these concerns.
- If in doubt, ASK THE PATIENTS AND ASK THE STAFF what their concerns are over these issues.

5. What Is The Link Between Religion And Health?

SECTION B: SUPPORTING INFORMATION

"Human beings need spiritual as well as material sustenance. For without spiritual sustenance, it is difficult to get and maintain peace of mind."

His Holiness the Dalai Lhama

5.1 Historical Background

This comment above alerts us to the observation well-known to the Ancient Wisdom traditions that in order to achieve "peace of mind", we need to pay attention to our spiritual needs. They understood that mind, body, and spirit were all one and were interdependent upon each other in order for someone to enjoy good health. This is true whether one appreciates spirituality through a religious worldview, or a humanistic understanding.

Interestingly the first recorded incident of hospitals to care for sick people being developed came through the religious conversion to Buddhism of Asoka, Emperor of India, around 270BCE. This religious association grew with Basil, Bishop of Caesarea, establishing hospitals in Asia Minor from around 370CE onwards, and the link between Christian religious orders and caring for the sick was responsible for considerable growth in hospital provision throughout the Middle Ages in Europe until well into the 20th century.

However, there have been considerable negative associations between religion and health over the ages, and some may persist today. Science only broke free from religious control and persecution with the 18th century 'Enlightenment'; but still one hundred years later mental illness was being regarded as 'demon possession.' A number of 'witches' burnt at the stake in medieval times may have been suffering from psychotic illness.

Another area where there exists a negative association between religion and health today is the ongoing disharmony between some followers of religion and for example, people whose sexual orientation is gay, lesbian, or bisexual, or who may be transgender. Should they also be a follower of a particular religion, this can result in a 'double discrimination' or 'multiple inequality effect,' with a resultant increased negative effect on their health. Those healthcare staff responsible for responding to religious needs of patients (Healthcare Chaplains and other Spiritual Care providers, along with Equality /Diversity Leads) should be aware of this ongoing issue, and respond to any such situation with sensitivity, understanding, and respect for the individual.

Within the Health Service context, there is clear guidance in 'Partnership For Care' (Scottish Executive, 2003), as described in the Fair for All resource "Health Topic Briefings/Personal Stories":[32]

Whatever the individual circumstances of people's lives, they should have access to the right health services for their needs. This is central to our commitment to social justice. We should extend the principles set out in Fair For All……to ensure that our services recognise, and respond sensitively, to the individual needs, background, and circumstances of people's lives.

As the 'Golden Rule' common to all religions teaches, "**Do unto others what you would have them do unto you**."

5.2 The Link

Harold Koenig, Professor of Religion / Spirituality, and Health at Duke University Carolina USA, says academic articles can challenge the research linking religion and health as weak and inconsistent and even suggest that patients might be harmed by this. For example, devoutly religious patients may refuse life-saving operations or treatments, and psychotic patients may believe that they are 'God' and thus immune from death.

However, as Koenig[33] continues,

Many patients hold religious beliefs and practices to cope with illness. Because of this, religious beliefs often influence medical decisions, especially those made when illness is serious or terminal. Many patients would like physicians to address their spiritual needs and to support them in this area. Furthermore, a growing research database indicates that in the majority of cases, religious beliefs and practices are related to better health and quality of life.

If "religious practices are related to better health and quality of life" then how might this **religious effect** be mediated? An obvious answer could be the observation that religious people may engage in less adverse health behaviour, such as smoking, drinking alcohol to excess, high risk sexual behaviours, mainlining drugs, etc. Another possible answer could be that religious people, by virtue of belonging to a "caring club", have better social contact and support structures to cope with the stress of life.

5.3 Recent Research Evidence

However, even after adjusting for these highly plausible reasons for the positive effect of Religion, Belief, and Spirituality on health, this does not completely explain the association. There is now such rapidly accumulating data on the close relationship between psychosocial functioning, neuroendocrine function, and the immune response, that a new scientific discipline of **psycho-neuro-immunology** has recently evolved (this is the link between our emotional / psychological state, and the nerve connections to the body's immune system responsible for fighting disease) .

PSYCHONEUROIMMUNOLOGY is demonstrating that what people believe, think, and feel (which is dependent upon beliefs, morals, previous social conditioning, present socio-economic conditions, social support structures, etc) has a direct effect on neuroendocrine (hormonal) **and immune functions in our bodies.**

The effects may be negative, such as those of lack of self-esteem, not feeling valued or loved, etc. arising from discrimination, social exclusion, and poor socioeconomic conditions. These effects are cumulative over time and initially reversible, but, if they go unrelieved over more prolonged periods, then irreversible changes appear, manifesting as illness. Examples would be hypertension, type 2 diabetes, coronary heart disease, cerebrovascular disease, depression, anxiety states, and many types of cancer.

There are several studies that demonstrate the link between between Religion, Belief, and Spirituality, e.g. in breast cancer, and they can be found referenced at the end of the resource.[34 35 36]

In the last two years the Glasgow Centre for Population Health has hosted two Guest Lectures on how recent advances in psychoneuroimmunology are beginning to explain the connection between mind, body, and spirit. For the first time a working theory may be emerging to explain the strongly negative effect of poor socio-economic conditions and other significant inequalities on the health of vulnerable populations. It may also explain the scientific mechanism behind the link between religion/ spirituality and health.

In the first lecture, given by Professor Andrew Steptoe **How Stress Gets Under Your Skin: Psychobiological Studies of Social Status, Stress, and Health"**[37], one of the many interesting points made was that there was a high level of association between self-reported happiness and levels of blood cortisol (the most common 'stress' hormone). Those people with the lowest cortisols were the happiest and also had the lowest blood pressures. This finding was independent of other factors such as smoking, diet, social status, and even levels of distress. He once again stressed the relationship between the higher centres of the brain (the neocortex, responsible for thinking, reasoning, and intellect) and the biological systems of neuroendocrine and immunological function, and reviewed mechanisms that can protect against adverse effects.

In particular he mentioned "social networks, coping responses, and feelings of worth, self-esteem, etc." as being protective. This fits very well with the social support provided by many religious and other social systems and the previously discussed positive values of spirituality.

The second lecture, "**Of Molecules and Mind: Stress, the Individual and the Social Environment**," delivered by Professor Bruce McEwen[38], was a more complex approach to the relationship between psychosocial conditions and the neuro-immunological pathways through which the stresses of everyday life are related to disease morbidity and mortality.

In this it was demonstrated that chronic stress can produce changes to the cellular structure of the higher centres of the brain (e.g. for intellect), which are reversible when either that stress is relieved or a coping mechanism is used. One such coping mechanism was the 'Experience Corps' in Baltimore, USA, whereby elderly volunteers were trained to become teaching assistants in primary school classrooms. Their physical and mental health, including intellectual ability, all improved, the reason given being that they had increased social interaction and support and, more importantly, felt valued, having found a meaning in later life.

A recent largescale review of over 150 research studies analysed the impact of 'wellbeing' on objective health outcomes, and concluded it was positive.[39] It was found that the impact was strongest for increasing the immune system's response against disease, and the authors felt that their findings pointed to potential biological pathways in people [the psychoneuroimmunological connection]. It would seem from this review that there is evidence that wellbeing can not only boost your immune system but also act as a buffer against stress in our lives.

5.4 Summary

For further information and understanding it would be best to read these last three papers from the references at the end of this resource. This comment was made by Harold Koenig from his recent book **The Link Between Religion and Health: Psychoneuroimmunology and the Faith Factor**:[40]

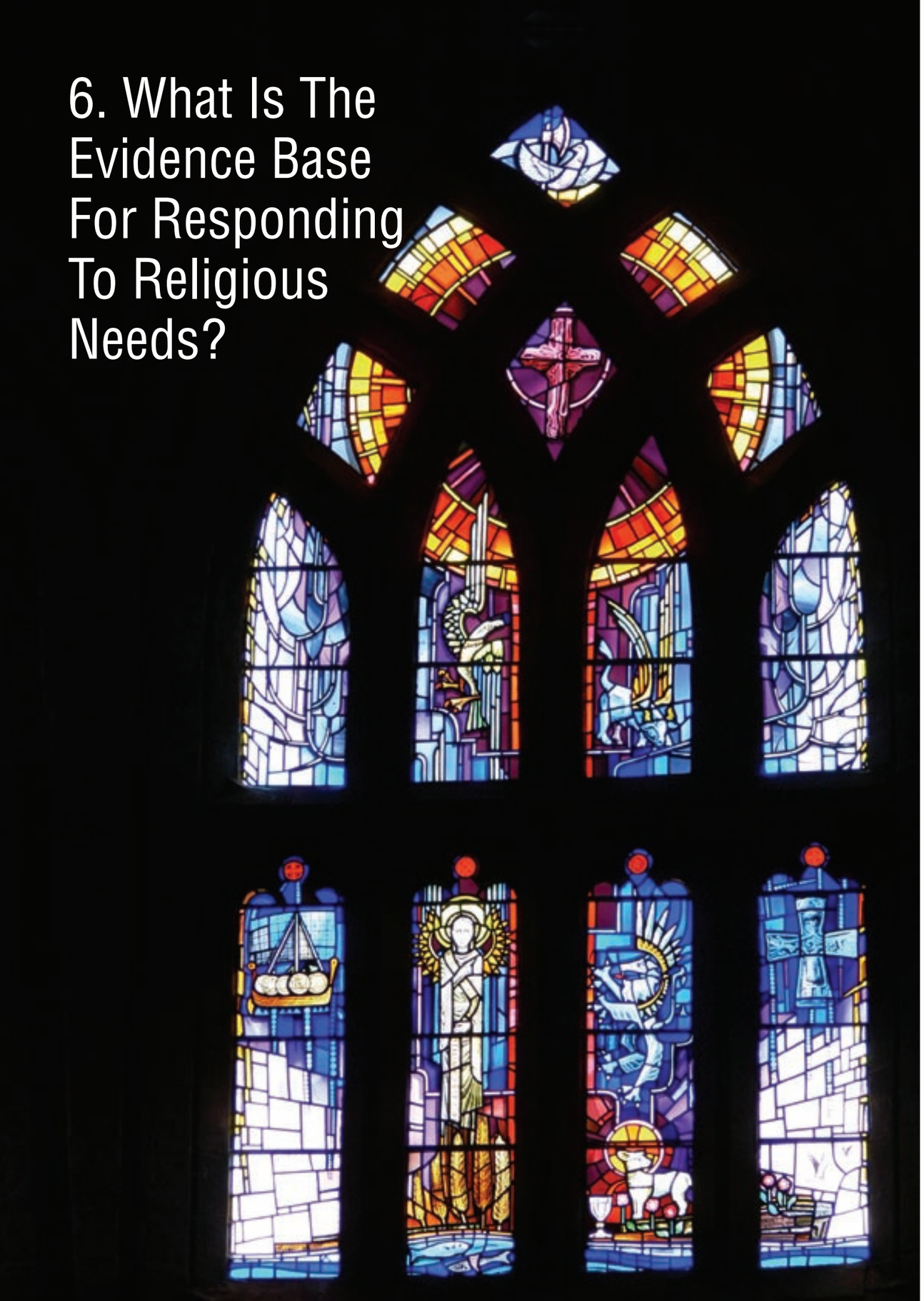
We recognise that religion has its own intrinsic value separate and apart from the health benefits that it may convey, and that those health benefits probably result only as a by-product of religious faith that has the sacred as its ultimate concern, not health. Because religion and science both search for the 'truth', neither should fear the other. It is our hope that each of these disciplines, rather than competing or conflicting, will add to each other's riches and depths. As Albert Einstein once said, "Science without religion is lame; religion without science is blind." Likewise, medical research on the religion/health relationship, we believe, will ultimately yield benefits for both our faith and our health.

So religion and belief are not incompatible with the science of modern healthcare. On the contrary, responding to the needs that arise out of those beliefs should be integral to the health service. For religion does seem to provide a social-coping system for some people journeying through life, and thus it is important to support patients with such needs. The new understanding of the relationship between psychosocial factors, the brain, and the immune system is beginning to explain how such beliefs may help certain people.

The significance of **wellbeing** is now being increasingly recognised as central to both health and the way we respond to the challenge of physical and mental disease. If our wellbeing is depressed, our immune system response is also depressed. If our spiritual needs are met, which may involve responding to religious needs, then our wellbeing is also enhanced. This should result in positive effects on our immune system.

The next chapter will look briefly at what evidence there is available to support such a view.

6. What Is The Evidence Base For Responding To Religious Needs?



"Some patients simply recover because of their satisfaction with the goodness of their doctor."

Hippocrates

"The part can never be well unless the whole is well."

Plato

6.1 Why Evidence?

As can be seen from the quotations above both Hippocrates and Plato were aware of the significance of factors other than physical medicine in curing patients. However, they would not have known of the importance of the 'double-blind random control trial,' or 'meta-analysis' of all research studies in the last ten years in order to determine the **evidence base** for supporting religious and belief needs in hospital. Since the 1990s the NHS has moved away from 'opinion-based' medical treatment to 'evidence-based,' and typically this evidence is gathered from carefully designed research studies. Can the same approach be used in assessing the efficacy of supporting patients' religious and spiritual needs in the NHS?

6.2 North American Evidence

The main source of such evidence for many years now has been the work of Harold Koenig, Professor of Medicine at Duke University and Director of the Centre for the Study of Religion/Spirituality and Health in Carolina, USA. His lifetime's work was summarised in a "Handbook of Religion and Health"[41], where he and two colleagues critically and comprehensively analysed over 1200 research papers that examined the link between religion and health from 1900 to 2000. The conclusion of the 700 page book reads:

Of more than 1200 research studies reviewed, few were initially designed to examine the effect of religious involvement on health. Only a handful of these studies were interventional studies capable of truly testing the hypothesis that religion influences health, positively or negatively. Nevertheless, in the vast majority of the cross-sectional studies and prospective cohort studies we identified, religious beliefs and practices rooted within established religious traditions were found to be consistently associated with better health and predicted better health over time. This is not to say that religious influences always convey health benefits, which they clearly do not; for sometimes the exact opposite can occur.

Basak Coruh and colleagues[42], at the University Medical Center in Richmond, USA, identified studies published in the English language between 1999 and 2003 describing the effect of religion on health outcomes. They were particularly careful to exclude 'spiritual' interventions such as yoga, meditation, tai chi, etc. and focussed more on interventional prayer, positive visualisation, and psychological well-being assessments during treatment. Again, whilst accepting that there were some limitations to the studies (although they did find 5 randomised controlled trials to review), their conclusion was that:

…religious activity appears to improve both physical and mental health.

Lee and Newberg,[43] research clinicians from the University of Pennsylvania, USA, came to similar conclusions. They conducted a critical review of the literature that described what was currently known about the clinical effects of religious and spiritual practices. As an example, one particular paper they reviewed clearly demonstrated poorer medium term survival rates in Afro-American women treated for breast cancer who were non-religious. In another study of 232 patients following elective open-heart surgery, lack of participation in social groups (church) and absence of strength and comfort from religion were consistent predictors of increased mortality. Their conclusions at the end of this whole review were:

…there is evidence that something about religion can provide health benefits…

However, caution must be exercised in making any direct comparison between the American religious-health 'scene' and the British one. Americans, by culture, demonstrate more religiosity, Healthcare Chaplaincy services are organised differently, and the academic literature itself fails to clarify whether it is religious or spiritual factors that are being investigated. Even with these provisos, it is still possible to discern a generally positive religious/spiritual 'effect' in relation to health outcomes.

6.3 British Evidence

Peter Speck[44], a research Fellow in the Faculty of Medicine at the University of Southampton, reviewed the evidence base for *spiritual care* (of which religious care is a part) in 2005. He makes the interesting comment,

It is significant that, as an important aspect of palliative care, spiritual care is included [as part of a recognised evidence base] in the recent National Institute for Health and Clinical Excellence guidance…… Thus respect for belief has become an important part of the professional codes of practice for nurses and other health professionals.

He quotes from some of the considerable literature on religious/spiritual belief and chronic or end-of-life issues. One paper showed a clear positive relationship between patients' religious practice and their ability to cope with chronic disease.

Looking at religiosity and psychological distress in parents of children dying with cancer, belief in collaboration with a 'powerful other' was associated with less distress.

With respect to lung cancer and cardiac failure, he quotes work by Murray et al[45] of Edinburgh University which showed that spiritual issues were important not only for patients but also for their carers. They expressed concern about healthcare professionals' lack of time and communication skills to uncover and address such issues. Speck's conclusion was:

A consensus is emerging in the literature that evidence exists to support the provision of spiritual care in healthcare settings.

The Royal College of Psychiatrists have recently developed a Special Interest Group **Spirituality and Mental Health**[46], the reason being that .....

…..spirituality involves a dimension of human experience that psychiatrists are increasingly interested in, because of its potential benefits to mental health.

The College believes that the evidence base for supporting spiritual needs is strong in aiding the recovery of patients with mental illness. In their information about the group they state: "Making a spiritual assessment is as important as all other aspects of medical history taking and examination. The Group seeks to promote knowledge of current research linking spirituality with improved physical and mental health." The Group continues:

The extraordinary protective effects of religion and spirituality are now beginning to be recognised in the field of mental health, with positive effects on depression, substance abuse, and suicide.

Sandra Carlisle, Research fellow in Public Health and Policy at Glasgow University, has produced a discussion paper from a literature review entitled **Spirituality and Wellbeing**,[47] and, after much critical discussion of 28 references, concludes:

Such evidence as we have is strongly suggestive of positive links between religion/spirituality and personal wellbeing…….For many writers [of these articles] a sense of the sacred, of something beyond the material world, is not just a central component of individual and social wellbeing: it is a hard-wired feature of humankind that we are not free to reject, whether we seek explanations for its existence in evolutionary neuroscience or a Divine being [or both]. For others, spiritual awareness is to be encouraged because of the benefits it can bring to the human experience, including to the multiple forms of disease found in modern society.

However, although the general consensus from the many reviews of Religion and Health in the literature was that the relationship is positive and beneficial, there were some concerns expressed. Many of the published studies had too few patients, outcomes were not clearly specified, terms were not defined well (such as 'religion', 'effect'), confounding factors were not controlled, and inappropriate statistical analyses were used. Sloan and colleagues[48] writing in The Lancet in 1999 were highly critical of published studies linking religion/spirituality to improved physical health outcomes:

Even in the best of studies, the evidence of an association between religion, spirituality, and health is weak and inconsistent……suggestions that religious activity will promote health and that illness is [therefore] the result of insufficient faith, are unwarranted.

Whilst agreeing with their criticism of the interpretation of the studies and supporting their call for more rigorous research on the subject, one must never agree with their suggestion that according to this literature, illness is the result of a simple lack of faith.

In contrast Harriet Mowat attempted to address this very issue of the need to establish the 'hard' (statistically proven and sound) evidence base in her review of **The Potential For Efficacy of Healthcare Chaplaincy - Spiritual Care in the NHS (UK) – A Scoping Review**[49]. Using very stringent criteria she only found 89 references, 57 of which were in the UK literature, from 1990 to June 2007. She stated that "Healthcare Chaplaincy seems to have a very limited evidence base for a number of reasons.....and that there is a need to mount a case for Healthcare Chaplaincy and an evidence-based reason for the case."

She continued with this statement:

However, if there is a lack of evidence of efficacy, it does not mean that the work of the Hospital Chaplain and spiritual care-giver is not efficacious. ABSENCE OF EVIDENCE DOES NOT NECESSARILY MEAN EVIDENCE OF ABSENCE. In the later pages of this report a 'theory' of efficacy is proposed. This is consistent with the inherent assumption in qualitative enquiry that a theory of practice is derived from the data and this then goes on to be tested as hypotheses.

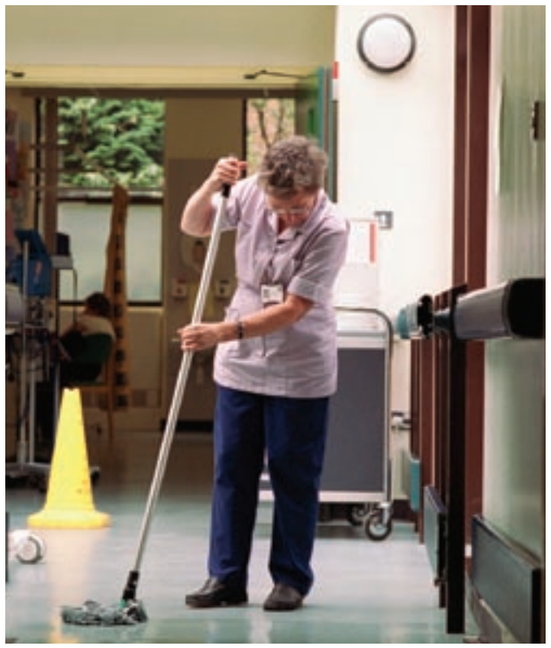
This latter statement would tend to be supported by the evidence that spiritual values and beliefs can influence the body through psychoneuroimmunological pathways, as discussed in the previous chapter.

Finally, Susan Hollins,[50] commented:

I believe it is time to pay more attention to religion in this arena of healthcare so that we may understand its relationship with spirituality, and draw upon its strengths and gifts, rather than diminishing its importance. At a basic level this entails giving serious attention to the 'religious question' posed at patient admission, and requires a rigorous education in spiritual healthcare for all caring staff.

6.4 Summary

To conclude this discussion, it must be appreciated that the influence of religious and other beliefs on physical and mental health and wellbeing is not readily measured ('quantified') using the modern accepted tools of randomised controlled trials and metanalyses, The whole field is fraught with both lack of definition and also outcome endpoints.



However, the following points are clear:

There is a theoretical basis underpinning the relationship between Religion, Belief, and Spirituality and Health.

The relationship appears to be a positive one.

The Royal College of Psychiatrists is so convinced that the evidence-base linking spirituality and mental health [depression, suicide, substance abuse] is strong, that it has established the Special Interest Group 'Spirituality and Mental health.' It is now the fastest growing and most popular Group within the organisation.

The National Institute of Health and Clinical Excellence Guidance on Palliative Care includes the provision of Spiritual Care in its evidence base.

Responding to patients' Religious and Belief needs should enable their Spiritual needs to be met, with an increased likelihood of a more positive health outcome.

Whilst supporting patients with religious needs obviously only refers to those with religious or other beliefs, the Council for Nurses and Midwives states that Nursing staff must take notice of all patients' spiritual needs during any assessment, thus concurring with the enhanced WHO definition of 'Health.' This **Holistic** approach to medical and nursing care aims to treat the 'whole' patient, and reflects the recently described psychoneuroimmunological connection above. Mind, Body and Spirit are indeed all interconnected.

7. What Is The Relevant Legislation?

"Everyone is an insider; there are no outsiders – whatever their beliefs, whatever their colour, gender, or sexuality."

Archbishop Desmond Tutu. 2004

7.1 Human Rights Act

Echoing Desmond Tutu's words above, there can be no outsiders because we all share a common spirituality, with essential human needs of acceptance, integration, having a sense of worth and purpose in life, and being loved. These are universal human needs and values that bind us together. Thus, as with all the other equalities of Age, Disability, Ethnicity, Gender, and Sexual Orientation, it is quite unacceptable for there to be any discrimination against another person based upon their Religion or Belief.

On December 10th 1948 the General Assembly of the United Nations adopted and proclaimed the **Universal Declaration of Human Rights**. This upholds the right to free expression of religious belief (Article 18), while Article 2 forbids discrimination on the basis of religion:

ARTICLE 2: Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind according to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

ARTICLE 18: Everyone has the right to freedom of thought, conscience, and religion. This right includes freedom to change his/her religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship, and observance.

Indeed, **Article 9 of the Human Rights Act (1998)** makes it quite clear:

ARTICLE 9: A person is free to hold a broad range of views, beliefs, and thoughts, and to follow a religious faith.

Compared with the Disability and Gender Duty Guidances, Religion and Belief is not so strongly 'legislation-driven,' and until recently there was only the **Race Relations Act (1976)** and the **Race Relations (Amendment) Act 2000** which provided any formal legislative protection for religious discrimination. Unfortunately, because it was race orientated, only the Jewish and Sikh religions were covered, as well as religions which are recognised as ethnic groups.

However, in the last four years there have been two significant pieces of legislation which afford blanket protection for any religion against discrimination, and thus help make the basic principle of respect for fundamental human rights a reality:

7.2 Employment Equality (Religion & Belief) Regulations 2003

As from December 2003, this legislation makes it unlawful to discriminate against workers because of Religion or Belief. It applies also to vocational training and covers all aspects of employment including recruitment, terms and conditions, promotion, transfer, dismissal, training, and workplace facilities. 'Religion' is very loosely defined, with philosophical beliefs such as Humanism covered. It might be that the judical system would have to decide on what constitutes a religious belief.

The regulations specifically make it unlawful in the following four areas:

i) DIRECT DISCRIMINATION
Workers or job applicants must not be treated less favourably than others because they follow, or are perceived to follow, a particular religion or belief.

ii) INDIRECT DISCRIMINATION
An organisation must not have policies or practices which, although they are applied to all employees, have the effect of disadvantaging persons of a particular religion or belief – unless the practice can be justified. To justify it an employer must be able to demonstrate a legitimate business need.

iii) HARASSMENT
This is behaviour that is offensive, frightening, or in any way distressing related to a particular person's religion or belief. This may be comments or behaviour that is about the religion or belief of those with whom the individual associates.

iv) VICTIMISATION
This is when a person receives less favourable treatment than others because he/she has brought, or given evidence in, proceedings, made an allegation, or a complaint under the Employment Regulations.

In addition, employers are now expected to allow time off for **prayer**, and where reasonable, allow other religious **holy days** to be observed by the followers of that religion. These can normally be accommodated within usual entitlements to breaks and time off – there is no entitlement to additional paid leave. Employers certainly should try to ensure that workers are not forced to observe **Christian holidays** instead of working, to ensure wherever possible, that their **dress codes** do not conflict with dress requirements for certain religions, and to check that **recruitment** procedures do not limit applicants to only certain religions.

Exceptions may be made in very limited circumstances if there is a **Genuine Occupational Requirement (GOR)** for the employee to be of a particular Religion or Belief to do the job. An example of this would be the requirement for a Halal butcher to be a Muslim.

For further information on the full extent of the Regulations, and examples of discrimination, etc. there are several references – RELIGION OR BELIEF AND THE WORKPLACE (ACAS, 2006), EMPLOYMENT EQUALITY REGULATIONS 2003:

EMPLOYMENT EQUALITY REGULATIONS 2003 - TRAINING PROJECT FINAL REPORT (STONEWALL / SCOTTISH INTER FAITH COUNCIL 2007).

7.3 Equality Act 2006, Parts 1 and 2

The Equality Act received Royal Assent in February 2006, and has five main Parts with the following Provisions:

Part 1
To establish the Equality and Human Rights Commission.

Part 2
This sets out provisions **prohibiting discrimination on the grounds of religion or belief in the provision of goods, facilities, and services, education, the use and disposal of premises, and the exercise of public functions.**

Part 3
This sets out provisions prohibiting discrimination on grounds of sexual orientation in the provision of goods, facilities, and services, education, the use and disposal of premises, and the exercise of public function.

Part 4
This establishes the Gender Duty, prohibiting sex discrimination in the exercise of public functions, for public authorities to eliminate unlawful discrimination, and to promote equality of opportunity between men and women.

Part 5
This contains supplementary material, such as repeals, Crown application, commencements, and extent of the law.

Part 1, With the establishment of the Equality and Human Rights Commission (EHRC) on October 1st 2007 a single, unified Equality Commission, with a broad remit responsible for championing and promoting equality, good relations, and human rights now exists. Thus the Disability Rights Commission and Equal Opportunities Commission, along with the Commission for Racial Equality have disappeared, their work coming together under the EHRC. The new equality strands of Age, Religion & Belief, and Sexual Orientation have also joined.

However, it is **Part 2 of the Equality Act**, which came into effect on April 30th 2007 that now makes it illegal to discriminate against someone on grounds of their religion or belief when providing goods, facilities, and services. As defined, the NHS is such a provider, and this now means that not only are the *staff* of the organisation protected against religious discrimination - by the Employment Regulations (Religion & Belief) 2003 – but now the *users* are also protected. It should be noted that 'harassment' is not covered under the Equality Act.

Whilst all the main religions widely recognised in this country will be covered, so will the beliefs of Humanism and Atheism.

Thus, the provisions require that the NHS, in providing 'goods, services, and facilities,' should ensure that its users are not treated unfairly on the grounds of their particular religion or belief. Employers and Chief Executives are liable for the actions of their staff, and such unlawful action would be:

- **Refusal to provide goods, facilities, and services to a person, if it would be normal to provide them to the general public;**
- **The provision of goods, facilities, or services of an inferior quality to that which would be provided to the general public;**
- **Providing goods, facilities, or services in a less favourable manner than would normally be expected (i.e. in a more hostile, less courteous, or unfriendly manner).**
- **Providing goods, facilities, or services on different terms.**

The Equality and Human Rights Commission will be responsible for overseeing the implementation of the Act, but it will be for the courts to decide if someone has been discriminated against.

There is some strong legislation referable to both the workplace and the provision of NHS care services to patients. This places an onus on Health Boards to ensure that they are complying with these new laws.

7.4 Code of Practice on Racial Equality in Employment (2006)

This is a set of recommendations and guidance on how to avoid unlawful racial discrimination and harassment in employment. It outlines employers' legal obligations under the Race Relations Act (1976). Discrimination in employment on grounds of religion or belief is unlawful under the Employment Equality (Religion or Belief) Regulations 2003. Thus, if such a person affected is from a particular racial group, this might also amount to indirect racial discrimination.

In this way an employee of the Health Service could well end up experiencing 'double discrimination' and is an example of the increasing complexity of equality legislation.

7.5 Single Equality Scheme (SEA)

The UK government has made a commitment to harmonise the current law within the six equality strands. At the time of writing the legislation is yet to be drafted, but the commitment by the government is that the law will be 'levelled up' to the currently higher protection enjoyed by the race and gender strands. The aim behind the SEA is to simplify the law on equality, which is currently drawn from various pieces of legislation, all with differing levels of protection.

One implication of this is that the current Public Sector Duties on disability, gender, and race may be extended to cover age, religion and belief, and sexual orientation at some point in the near future.

For further information, the new EHRC website will be useful.

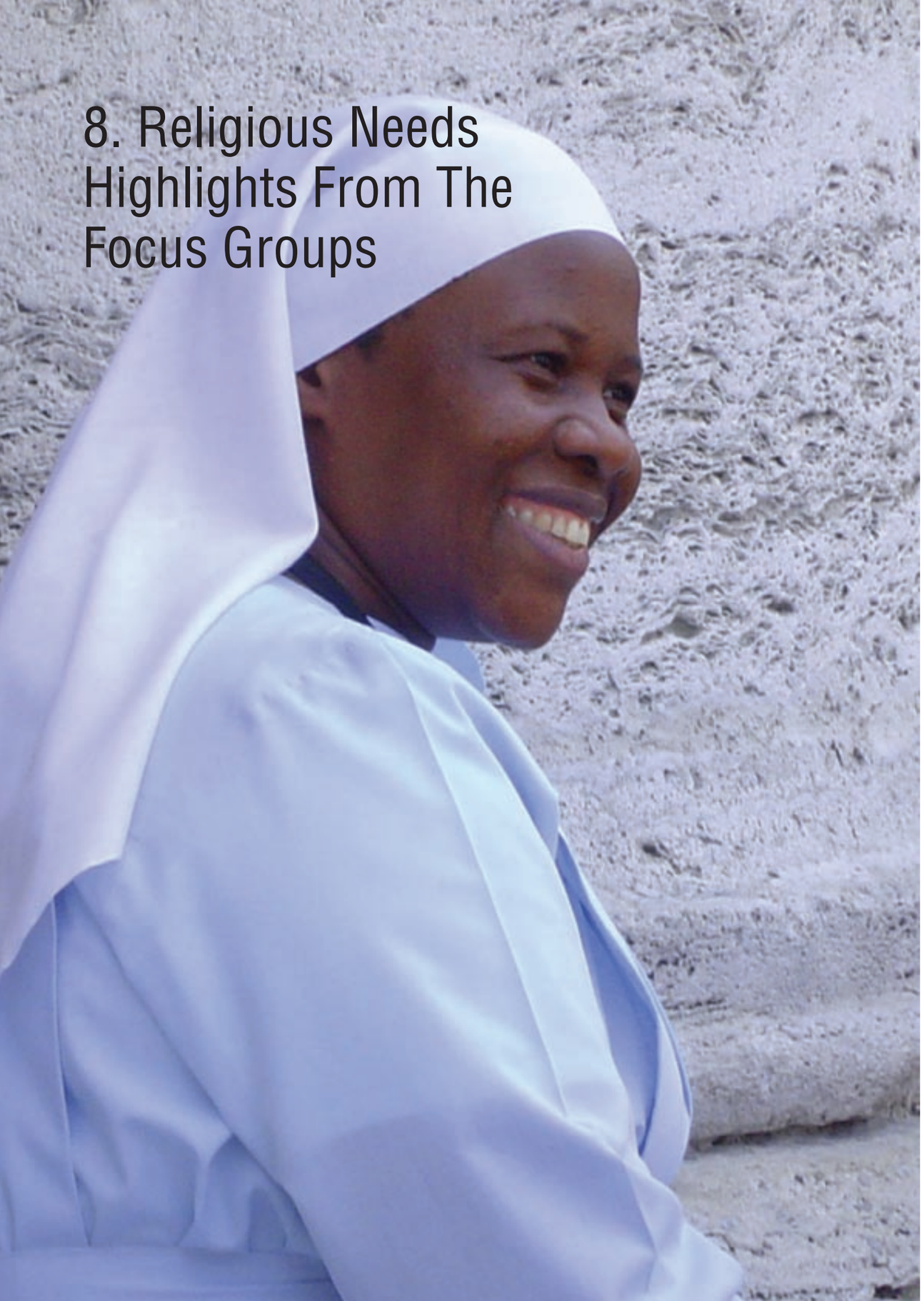
www.equalitieshumanrights.com

7.6 Summary

As can be seen there is strong legislation referable to both the workplace and the provision of NHS care services to patients. This places an onus on Health Boards to ensure that they are complying with these new laws.

Further summaries and more detailed explanation about the Equality Act Part 2 (2006) can be found in GUIDANCE ON NEW MEASURES TO OUTLAW DISCRIMINATION ON GROUNDS OF RELIGION OR BELIEF IN THE PROVISION OF GOODS, FACILITIES, AND SERVICES (Dept for Communities and Local Government, April 2007).

The Act itself can be found at www.opsi.gov.uk/acts/acts2006.



8. Religious Needs Highlights From The Focus Groups

"There is no reality except the one contained within us. This is why so many lead such an unreal life. They take the images outside them for reality and never allow the world within to assert itself."

Hermann Hesse

8.1 Structure of the Focus Groups

Hermann Hesse's comment above reminds us of that kernel of *spirituality* and its associated needs as being at the heart of reality in the unjust, unfair, and confusing world we inhabit. Those people who try to make sense of this world through their religion have different needs, according to their ethnicity, culture, and the particular religion they follow. This then enables them to strengthen their "...world within..." and to cope better with their illness and hospitalisation.

Whilst the guidance **A Multifaith Resource for Healthcare Staff** contains a comprehensive review of the religious needs of 12 faiths, it was still thought to be relevant to hold Focus Group meetings. This was to enable their key concerns to be heard.

Therefore, after contacting various local religious leaders, 6 – 8 volunteers, from each of the 12 faiths, met informally with the project leader to discuss their religious need concerns on being admitted to hospital. The following very open question was used:

"From a religious point of view what was important for you when you were in hospital?"

With 27% of the Scottish population professing "*No religion*" in the 2001 National census, it was also felt important to include a Focus Group with members of the British Humanist Society. Humanists feel that a significant number of people in this group share their views with respect to religion and spirituality. However, the question asked had to be changed to:

"From a Humanist's point of view what was important for you when you were in hospital?"

8.2 Key Concerns From Each Group

The key concerns relevant to each faith/belief group are summarised below. For a more detailed description of religious needs please refer to **A MultiFaith Resource For Healthcare Staff**. Interestingly, the Focus Group meetings did not reveal any particular religious need that was not covered by this document.

BAHA'I FAITH:

Baha'is are very concerned to receive prayer when ill. The fasting period in March is commonly observed. There are particular requirements with the death customs, the body being treated with great respect.

> Baha'is believe very strongly in equality, and respect for all other religions is always encouraged. We are very supportive of the NHS policy of Spiritual Care in Scotland. (Baha'i woman in Glasgow)

BUDDHIST:

Buddhists are mainly concerned to ensure that dying is accomplished with calm, quietness, and dignity, and that education of the staff on religious issues is very important.

> We Buddhists really do not have a lot of religious needs – we just ask that there is respect for our dignity, and that there will be peace and quietness if we die in hospital. (A Buddhist monk)

CHRISTIAN (ROMAN CATHOLIC):
Roman Catholics are primarily concerned about the need to frequently receive the Sacraments, which require a Roman Catholic Priest to administer. The availability of more *Eucharistic* chaplains might help this. Mention was also frequently made of delays in obtaining the services of a Roman Catholic priest.

> The Chaplain was a lovely man, but I really needed the Sacraments from a Priest ..... and it took two days to find one!
> (recent Roman Catholic patient)

CHRISTIAN (PROTESTANT):
The Protestant Christian group seemed more concerned about the lack of Bibles in hospitals, and would certainly expect a visit from the Healthcare Chaplain.

> The hospital experience was fine – but it was disappointing not to find the Bible on my bedside locker. (recent Church of Scotland patient)

CHURCH OF JESUS CHRIST OF THE LATTER DAY SAINTS (Mormon):
Mormons' main need was to be able to take *non-caffeine* drinks in the ward, rather than tea or coffee. Hot chocolate would be acceptable. They felt the Mormon scriptures ought to be available if needed.

> We value modesty in dress – but due to the design of the hospital x-ray gown, it was impossible to even try to maintain this!
> (recent Mormon female patient)

HINDU:
Appropriate food was mentioned quite firmly as the main concern here, as hospitals don't seem to appreciate just how strict their vegetarianism is. Hindus also feel quite firmly that only the Hindu priest can meet their religious needs, and would like to see the appointment of more Hindu Chaplains for Glasgow and Edinburgh.

> Hindu assistant/honorary Chaplains would provide a great service in visiting Hindu patients in Glasgow hospitals – any chance?
> (Elderly male Hindu – frequent user of hospital services)

HUMANIST:
Humanists' main need was to ensure freedom from exposure to any religious rituals, rites, or creeds, and that the quiet room /sanctuary ought to be completely religiously neutral. They also felt that more Humanist volunteers were needed in hospitals, as they suggest that they are probably the largest 'belief' group.

> We would really like to see different, more 'inspirational' scriptures provided in hospitals, because we get no comfort from all the overtly religious texts. (a Humanist patient)

JEHOVAH'S WITNESS:
Jehovah's Witnesses' main concern was with staff stereotyping them (i.e.'difficult patients to manage, because they won't cooperate with modern medical treatments like blood transfusion'). They felt very strongly that staff education was very important, as their views on receiving blood transfusion / blood products is now more in line with mainstream medical thinking.

> The staff were lovely – they gave me a birthday cake and presents. Unfortunately, in our belief we do not celebrate birthdays or Christmas!
> (recent Jehovah's Witness patient)

JEWISH:
Because of a wide range of practice in Judaism, it was felt that it was best for staff always to ask about religious needs. Kosher food was emphasised as being of paramount importance for most orthodox Jews; this is not so much of an issue with Reform Jews.

> Because of a wide range of practice amongst the Jewish Community, staff are always best to ask – rather than just assume we all wish to eat only Kosher food. (Reform Jewish man)

MUSLIM:
Again, suitable food seemed to be the main need here. Some Halal diets provided can lack variety, and some persons have experience of hospitals which offer *no* Halal food. There were concerns over lack of modesty, especially with the standard hospital gown, but the main issue which was raised frequently was the considerable delay in obtaining circumcision for male babies. It was also felt that only the Imam or other religious leader can meet their religious/spiritual needs.

> We need the newborn baby to hear the words 'Allah' as soon as possible. Unfortunately, the nurses had radio 1 blaring loudly during the delivery, and all my wife could hear was an ugly, swearing rap-singer. (Concerned young Muslim father and husband)

PAGAN:
Pagans feel that they are the most discriminated religious group using the NHS, and, as a result they will sometimes not reveal their belief. They felt that the answer to this was more staff education, particularly as some staff members will be followers of Pagan traditions. However, they also suggested that the use of less religious and more 'inspirational' scriptures would benefit all religious groups. They were very keen to be visited by the Healthcare Chaplain, so long as he maintained an Inter Faith approach. They would like their religious group name to be spelt with a capital 'P'.

> All I did was to hold my newborn baby towards the sunlight in the window and utter a prayer to the Sun-God, from whom all energy and life ultimately comes. Unfortunately, by lunchtime all the other mothers, and even some of the staff, were convinced I was a witch.
> (A recently delivered Pagan mother)

SIKH:
Food was raised as an area of concern, as it is often assumed that Sikhs eat Halal, when, in fact, most practising Sikhs are vegetarian as well as teetotal, and never use tobacco. It was felt that the Sikh scriptures ought to be available, and that only their Giani or Granthi (minister of religion) can really say prayers for them.

> Although I hold five degrees and have been a teacher in Scotland for over twenty years, the staff insisted on shouting loudly at me in broken English when I was admitted to hospital with my fractured leg.
> (An elderly Sikh man)

8.3 Summary

Thus, as can be seen, there are still significant issues raised here in meeting the religious needs of different groups. Awareness training of staff is all important to appreciate these needs, whilst basic respect for the patient will go a long way towards meeting these needs. If there is any doubt about a particular need, then the staff must simply **ask**.

Summary of Some Key Findings From The Focus Groups:

Unsuitable menus (Muslims, Sikhs, Hindus);

Lack of caffeine-free alternative drinks (Latter Day Saints);

Lack of modesty in gowns (Muslims, Hindus);

Stereotyping (Jehovah's Witnesses);

Lack of dignity in dying (Buddhists);

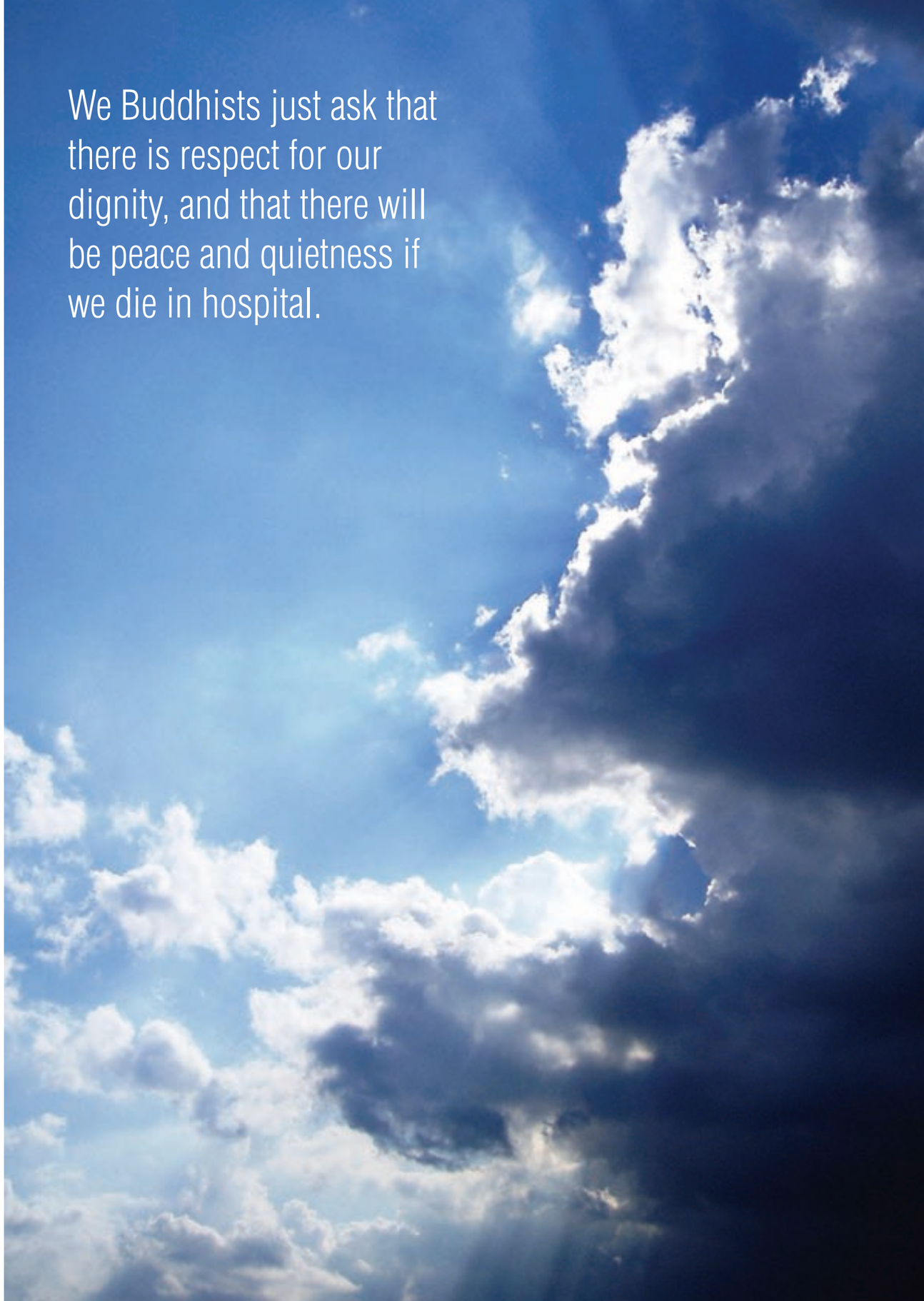
Difficulty in obtaining the Sacraments (Catholic Christians);

Harassment (Pagans);

Need for more 'inspirational scriptures' (Muslims, Pagans, Humanists);

Some 'quiet rooms' still too overtly Christian (Humanists, Jews);

Delays in obtaining ritual circumcision (Muslims).



Conclusions

"You can cure rarely, relieve often, and comfort always……"

Sir William Osler

Anyone who has worked with patients for any length of time in the NHS will be acutely aware of the truth in the above quotation. After visits to the Health Boards there is no doubt that Healthcare Chaplaincy is a significant part of the frontline of where 'comfort' is taking place, supported obviously by all other caring staff in the NHS. However, as has been described earlier in the resource, this 'comfort' can have far-reaching consequences in supporting patients' spirituality by meeting their religious needs. Reflecting both the current description of Health as given by the WHO, and what the Ancient Wisdom Traditions have known for millennia, mind, body, and spirit are all interconnected and dependent upon each other. This is the basis of **Holistic Healing**, and the practice of Psychiatry is leading the way in adopting this, having established what is now the fastest growing Specialist Interest Group in their profession, that of 'Spirituality and Mental Health.'

Current research developments in the field of psychoneuroimmunology are now providing the science to support the belief from these Ancient Wisdoms. As these concepts become more mainstream in managing patients, the role of Healthcare Chaplaincy in meeting religious and spiritual needs is going to increase tremendously. Thus, it is timely that Chaplains are at present developing their own profession, with Standards[51], Competencies, Continuing Professional Development, and a Postgraduate Chaplaincy qualification. In addition, the evidence base for the efficacy of Healthcare Chaplaincy is developing, and the previously quoted study by Dr. Harriet Mowat, provides a detailed and critical review of the UK literature.

Healthcare Chaplaincy is working towards being recognised as an Allied Health Profession. Chaplains can then fully participate in providing care for the other third of the holistic concept of health – that of the **Spirit** - as part of the hospital's Multi-Disciplinary Healthcare Team. Responding to patients' particular Religious needs can already go a long way to supporting their Spiritual needs.

However, it must not be forgotten that all staff have a role to play in helping to respond to patients' Religious, Belief and Spiritual needs. The Nursing and Midwifery Council stipulate that assessing spiritual need (of which religious need can be a part) is an essential duty of a nurse in practising holistic care.

In conclusion, it is important to recognise and respond to patients' particular religious/belief needs as this can be a significant part of their spiritual care. It has also been shown that the most complete and effective understanding of the concept of 'Health' should include **spiritual health**. As Rabia, a female Islamic mystic of the 8th century said with such insight, about a particular illness she was experiencing:

The source of my suffering and loneliness is deep within my heart. This is a disease no doctor can cure. Only union with the 'Friend' can cure it.

In 21st century scientific medical care, it is important we acknowledge and respect each individual's understanding of their own '*Friend*,' especially if it is appreciated through their particular religious or spiritual beliefs. There is a strong ethical, legal, and business case for so doing and thus ensuring the NHS is inclusive to all of any faith or belief. However, the evidence is accumulating that the **medical** aspect of the business case is becoming increasingly important. Religion is intimately related to spirituality, which is itself an essential component of the holistic understanding of health.

The Fair for All Religion and Belief Project completes the work of the six equality 'strands' of the Scottish Government Health Directorate funded Fair for All Initiative, which started in 2002. It is significant that all these equality strands of Age, Disability, Ethnicity/Race, Gender, Religion and Belief, and Sexual Orientation will be amalgamated into a new Directorate of Equalities and Planning within NHS Health Scotland as from April 1st 2008. This will ensure that all NHS Boards are supported to respond to the needs of all parts of the population in equalities in a co-ordinated way.

Summary of the Message of This Resource:

Treat all patients with respect and dignity.

Always ask if unsure of anyone's particular religious and belief needs.

Responding to these needs is an important part of the Holistic Care of patients.

All staff have a role to play in responding to these needs.

There is increasing evidence that responding to such needs will result in a better health outcome.

As an organisation, Health Boards need to comply with recent Equalities legislation.

Concerning the above, staff awareness levels need to be raised in order to achieve the cultural change in patient care as described by the Scottish Government Health Directorates.

This cultural change within the NHS is unlikely to be achieved unless the religious, belief, and spiritual needs of the staff are responded to, as they strive to support such needs in patients.

Whilst not yet mandatory in data collection, it is good practice for staff to record a patient's Religion or Belief.

" I believe in the Religion of Love, whatever direction its caravans may take, for love is my religion and my faith."

Ibn Arabi (Andalucian, 1165-1240).

GLOSSARY OF SOME TERMS USED

AGNOSTICISM
The belief that it is impossible to know whether God exists.

ATHEISM
The belief that there is no God.

BELIEF
A strongly-held personal conviction or understanding that something is true, without necessarily any proof or evidence for it.

DISCRIMINATION
This is treating someone less favourably than others, simply on the basis of their particular age, disability, ethnicity, gender, religion, or sexual orientation, for example.

DIVERSITY
The recognition and valuing of difference in its broadest sense. It is about creating a culture and practices that recognise, respect, value and harness difference for the benefit of patients, carers, the public, and members of staff.

EQUALITY
This is the creation of a fairer society where everyone can participate and has the opportunity to fulfil their potential. It is mostly backed by robust legislation designed to address unfair discrimination based on membership of a particular group, and to provide equality of opportunity.

EVIDENCE-BASED
With reference to the medical management of patients, this refers to the use of treatments that are based upon 'reliable grounds for belief ' (=evidence) that they result in the improvement of a particular patient's disease. The opposite is '**opinion-based**' treatment, which could result in a variety of different treatments for a disease. The results of different treatments for a disease can be analysed statistically to produce different 'levels' of evidence, i.e. a 'high' or 'hard' level is the most convincing proof of the best treatment for that disease, leaving little doubt that it should work.

HOLISTIC
This word comes from the Greek 'Holos' which means whole. As applied to healthcare this refers to treating the patient "as a whole", i.e. by taking into account their physical, mental, social, and spiritual state – the complete person. Psychoneuroimmunology describes how this whole is connected [see following page].

The **British Holistic Medicine Association** has the following aims for staff working within the NHS:

- To be more compassionate and caring
- To treat patients with more dignity
- To treat patients as 'whole' people, thus relating to all the circumstances that can affect their health and response to treatment.

HUMANISM
The rejection of religion in favour of a belief in the advancement and understanding of humanity through its own efforts.

PSYCHONEUROIMMUNOLOGY
This is the scientific study of how social and psychological factors that affect our state of emotional wellbeing can influence the body's immune system (responsible for fighting disease) through neuroendocrine pathways (nervous connections that regulate hormone levels). Thus the mind and emotions are connected through the nervous and hormonal systems to the immune system. As our spirituality influences our wellbeing, **mind, body and spirit** are all interconnected.

RELIGION
This is the sharing with like-minded people in the rites, rituals, teachings, and sacred scriptures as a way of reverencing, worshipping, and following a belief in 'God' or the 'Ultimate'. It can be very personal and enables someone's spirituality to be understood and expressed.

SPIRITUALITY
This is what gives our life meaning and purpose, and connects us with the rest of humanity. It involves the recognition of certain basic needs in all people:
to be loved and give love, feel valued and wanted, have self-esteem, reassurance, comfort, peace, happiness, to be able to deal with guilt and forgiveness.....to mention a few. These are all positive values that contribute towards the greater good of humanity, and thus enable people to feel a connection with others. This may, but not always, involve the belief in some higher 'Power', the 'Ultimate', 'God', etc.

WELLBEING
This is a term increasingly used in a Healthcare context. It involves our personal happiness, contentment, and health and relates to our understanding of spirituality. It does not depend upon personal wealth, but it is more to do with our being at ease with ourselves and the world.

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0141 245 1800
[this will be changing by early 2008]

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Fair For All:
www.fairforall.org.uk
[Details for all six equality strands can be found here]

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[The location for Fair For All from April 1st 2008]

Equality in Care e-library Resource:
www.elib.scot.nhs.uk

Equality and Diversity Information Project
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British Humanist Association
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Designed by **Irwin Stuart Design** 0141 572 9000

ACKNOWLEDGEMENTS

This guidance booklet could not have been produced without the tremendous co-operation and support given to me by so many different people. I personally wish to acknowledge and thank the following individuals and groups:

Pramila Kaur, Chief Executive, Scottish Inter Faith Council.

Dianna Wolfson, Convener, Scottish Inter Faith Council.

Ravinder Kaur Nijjar, Executive Committee Member, Scottish Inter Faith Council.

Chris Levison, Healthcare Chaplaincy Training and Development Advisor.

Alastair Pringle, PF Manager, Scottish Government Health Directorates.

Lead Healthcare Chaplains and all other Chaplains who gave up so much of their valuable time during my visits to all 14 territorial Health Boards.

Equality/Diversity Officers who also took time to share with me their work in supporting religion/belief in the Health Boards.

All 12 different religious representatives who organised Faith Focus Groups, and their many friends who so willingly shared their needs with me.

Ron MacLaren and his friends from the Scottish Branch of the British Humanist Society who also organised a Focus Group.

All my Fair for All colleagues in the other equality strands of Age, Disability, Ethnicity, Gender, and Sexual Orientation who offered such constructive advice.

Dr. Harriet Mowat, Mowat Research, for discussion, encouragement, and kind sharing of her own work on this subject.

Calum Henderson, our Office Administrator, who kindly kept my computer ticking.

Grateful thanks to the design team, Paul Fee and Jenny Clayton who redrafted this many times.

Many thanks to April Lachlan for her assistance with the images.

My wife, Maggie, who cheerfully proof-read the whole document many times.

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