

Article

Religious/Spiritual Referrals in Hospice and Palliative Care

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Abstract: This study examines the religious/spiritual referral patterns in hospice and palliative care. Religion and death are two highly intersected topics and albeit often discussed together in hospice and palliative care, little is known about how professionals respond to religious/spiritual needs of patients/families/friends and in relation to the chaplaincy team. By means of an in-depth interviewing method, this paper reports on data from 15 hospice and palliative care professionals. Participants were recruited from across five hospice and palliative care organisations, and the data was managed and analysed with the use of NVivo. Largely, participants were keen to refer patients/families/friends to the chaplaincy team, unless the former's faith or lack thereof did not match the chaplains, in which case referrals to a religious leader in the community were favoured. This shed light to the tendencies to homogenise religious/spiritual beliefs. The paper concludes with some implications for practice and research.

Keywords: religion; spiritual care; chaplaincy; hospice; homogenization of faith; religious referral

1. Introduction

Near the end of life, many take comfort in their spirituality and religion to make sense of the impending death. What is death? What happens after death? Is there an afterlife? are certain questions that invade the individual's thoughts while contemplating the end.

While some have defined religion as a peak experience (Maslow 1970) or transcendent experience (Bellah 1976), for Malinowski (1948), religion is an instinctual response to fear of death. Religion and death share an intricate relationship and are seldom talked about without the mention of the other. Drawing on the idea of afterlife which Lifton and Lifton and Olson (1974) define as religious symbolic immortality, death is understood to be uncertain and disruptive and religion becomes an anchor point to prepare oneself for the end and deal with the disorganization that the impending death brings into one's life. It is these premises that influenced much of the work preceding and building up to the hospice movement; religion underpinned its very foundations (Clark 2000).

The hospice movement, popularised by Dame Cicely Saunders, led to the proliferation of the concept of total pain (Clark 2000; Saunders 2005), inclusive of physical, psychological, social, as well as spiritual pain at the end of life. When caring for the dying, addressing religious/spiritual needs of the patients is considered essential in improving their wellbeing and quality of life. The chaplaincy services at the hospice play an inevitable role in assisting patients who feel the need to turn to their faith to explore the meaning of life, death and what awaits after death (Nolan 2011).

Chaplains are individuals who provide religious/spiritual support to the patients which often extends to their families (Timmins et al. 2016) and healthcare staff (Butler and Duffy 2019). They are an integral part of the interdisciplinary hospice and palliative care team consisting of physicians, nurses,

and social workers, among other professionals. Spiritual care entails addressing meaning and purpose in life, and religious care “requires meeting of spiritual needs expressed through a religious belief or commitment” (NHS Foundation Trust-York Teaching Hospital 2014, p. 7).

Chaplaincy services have been found to play an important role in increased hospice enrolment (Flannelly et al. 2012) and are positively linked with patient satisfaction (Marin et al. 2015; Jankowski et al. 2011). Kestenbaum et al. (2017) and Kernohan et al. (2007), for example, have argued that patients find chaplaincy services beneficial for their spiritual needs, while Bay et al. (2008) offered that positive religious coping increased in patients with coronary artery bypass graft (CABG) who were visited by the chaplains as opposed to the group with no such visits. Donohue et al. (2017) conducted a study to explore how hospital chaplains are perceived by the parents of hospitalized children. Parents felt that chaplains’ visits comforted them and helped reduce stress. Sixty-eight percent of the parents reported that their experience of hospital chaplaincy added to their satisfaction with hospital care.

Chaplain interventions in healthcare have not been studied adequately (Murphy and Whorton 2017; Jankowski et al. 2011) particularly because there is no uniform way in which chaplain activities could be defined. Even other palliative care professionals might not have a clear understanding of what chaplains do (Timmins et al. 2018; Wittenberg-Lyles et al. 2008; Williams et al. 2004) beyond the general contributions they make toward a holistic approach to health and hospice care (Annelieke et al. 2019). To address the same, Massey et al. (2015) built an ‘inventory of chaplain activities’ composed of 100 items using mixed-methods approach. The inventory could be used as a normative in interdisciplinary palliative care teams facilitating the identification and communication about the activities and outcomes associated with chaplaincy services. With a need to define the specific skills of chaplains that make them an inevitable part of the healthcare system, Sharma et al. (2016) undertook a study and identified two important dimensions pertaining to the chaplain interventions; religious/spiritual and psychosocial. In further analysis, Sharma et al. revealed that interventions falling into the ‘religious/spiritual’ domain are unique to chaplains and other members of the healthcare system are unable to offer such interventions. However, other studies have shown that this is not a matter of inability, but deskilling in light of the drive to professionalise chaplaincy work (Pentaris 2019), while professionals like social workers have for a long time provided these services (Healy 2008); this is, of course, not surprising given the previous term used to describe social workers (i.e., almoner), while the profession derived largely from philanthropy and religious work.

Chaplains are vocationally prepared to address the spiritual needs of people from diverse religious backgrounds (Woodward 1999). Historically, chaplaincy was religion-specific and included only pastoral care (Swinton and Mowat 2007). It is recently with changing times and increased secularization that chaplaincy has made the effort to cater for people from diverse faith backgrounds or those with no belief in any faith at all (Hurley 2018; Swinton and Mowat 2007). In other words, the diversification and religious plurality that societies face since the late 20th century, but specifically into the 21st century, encompassing the growing numbers of people who identify as religiously multiple and spiritually fluid (Bidwell 2018), emphasised to chaplaincy, among other area of practice, the need to develop more and important skills when responding to religious/spiritual needs, many of which have been framed and examined with religious literacy (Pentaris 2019; Dinham and Francis 2015).

Propagated by Dinham and Francis (2015), religious literacy may be understood as the knowledge about different religious perspectives and the appropriate language and skills to address the issues of religion and belief publicly, in policy, and in professional practice.

“It [religious literacy] is a metaphor connected to the ability to read and write; like reading and writing, literacy in religion is about an understanding of the grammars, rules, vocabularies and narratives underpinning religions and beliefs” (Dinham and Shaw 2017, p. 1).

Religious literacy aims at making people informed and confident to understand and address the spiritual needs in a multifaith society. In the UK, Religious Education (RE) is compulsory in schools,

however, religious education is different from religious literacy and the latter could be understood as the (desired) product of the former (Parker 2020). Dinham and Shaw (2017) assert that schools can play an important role in increasing religious literacy by reviewing and reforming the religion and belief lessons. With this in mind, this paper draws on the theoretical and conceptual drives of religious literacy to report on findings from a study that explores religious/spiritual referral patterns to the chaplaincy team in hospice and palliative care. The objective of the present study is twofold. First, to examine the religious/spiritual referral patterns in hospice and palliative care. Next, to explore the possibility that referrals to the chaplaincy team may be a coping strategy rather than a synchronised and strategized response to religious/spiritual needs.

2. Methodology

This is a qualitative study design that used in-depth interviewing (Bryman 2016) to collect data from 15 palliative care professionals in hospice care in England, UK. The aim of the qualitative design is to allow participants to express their views in varied ways, and the researchers the opportunity to apply quality assurance to their interpretations of the data (Flick 2018).

Data was collected during April 2015 and January 2016, following approval of a University Research Ethics Committee, completion of a risk assessment, as well as approval of the Research Ethics Committees of the respective organisations (i.e., hospices and NHS clearance) where respondents were employed at the time. All interviews were conducted face to face and in the workplaces of the participants, in a private space and at a time convenient to them. Participants were recruited primarily through a call from hospice organisations (see Table 1 for hospice organisation characteristics). An invitation letter and participant information sheet were distributed to palliative care professionals through the research and education offices of the respective hospices. Professionals who were interested, contacted the lead researcher (PP) and further discussed the study and participation expectations. Thereafter, a convenient time and date were set, the participant had the additional chance to ask questions and signed a consent form prior to partaking. Table 2 shows the main characteristics of the respondents.

Interviews were audio recorded and transcribed verbatim. With the use of NVivo (version 25, (Bazeley and Jackson 2019)), all data was organised and prepared for analysis. Thematic analysis was adopted, via NVivo, to examine the data. The six steps of thematic analysis (Braun and Clarke 2006) were followed to ensure rigorous data analysis and accurate interpretations. First, the researchers familiarized with the data; this involved the first researcher doing the transcriptions and re-reading the texts several times. Next, initial codes were generated; this process helped distinguish between semantic codes (meanings expressed verbally) and latent codes (covert meanings). This step required thorough and systematic review of the transcripts, which also helps appreciate the multiple ways in which extracts can be coded. The third step in the process included the search for themes; all codes were listed and clustered in specific themes as those emerged, while extracts were collated under respective themes. Once the emerging themes were identified, both authors reflected on them and decided upon the most representative information, based on the data. Fourth, all themes were reviewed and broken down into subthemes, to ensure irrelevant codes and themes were extracted. The next step was to develop thematic and concept maps that reflect the identified themes, name them in most accuracy and prepare the ground for the final step in thematic analysis; i.e., producing a report. In the fifth step, a thematic map (Figure 1) and a concept map (Figure 2) were introduced to better depict the themes and the process of religious/spiritual referrals that this paper identifies. These maps were decided upon by both authors prior to progressing to reporting on the findings.

Table 1. Hospice organization characteristics.

	Hospice 1	Hospice 2	Hospice 3	Hospice 4	Hospice 5
Located in a city	x	x	x	x	
Located in a rural area					x
Foundational roots in religious beliefs and the Church	x	x	x	x	x
Provide palliative and hospice care to people of all faiths and none	x	x	x	x	x
Maintaining quality of life until the end	x	x	x	x	x
Provide holistic care	x	x	x	x	x
Support patients and families and friends	x	x	x	x	x
Have a day centre	x		x		
Have a chaplaincy	x	x	x	x	x
Provide services in the community	x	x			x
Promote education and research	x	x	x		

Table 2. Main characteristics of respondents.

Gender	Female × 12 Male × 3
Age (mean = 45.7)	21–30 × 1 31–40 × 4 41–50 × 8 51–60 × 2
Religious (non) affiliation	Christianity × 5 Islam × 1 Non-religion × 7 Atheist × 2
Discipline	Nurse × 6 Doctor/Consultant × 4 Counsellor × 2 Social worker × 3
Years of practice (mean = 13.4)	0–5 × 2 6–10 × 3 11–20 × 8 21 < × 2
Inpatient unit *	13
Outpatient unit *	5
Services in the community *	3

* Participants may practise both in inpatient and outpatient units, as well as contribute to the service provisions in the community.

3. Findings

This study examined one practical aspect of religious/spiritual care in hospices. Specifically, it explored how hospice and palliative care professionals respond to religious/spiritual needs by way of referrals. This is a small segment of a larger study that looked at religious literacy in end of life care altogether and measured it on varied levels, inclusive of foundational and organisational. This paper presents two routes to religious/spiritual referrals when responding to religious/spiritual needs of patients, their family members and/or friends: referrals to the chaplaincy or religious leaders in the community, when the former is unavailable or lacking offer. Figure 1 depicts the findings, Figure 2 shows, in a snapshot, the religious/spiritual referral process in hospice care, while the subsequent sections discuss each in detail and provide extracts from the interviews to support the themes.

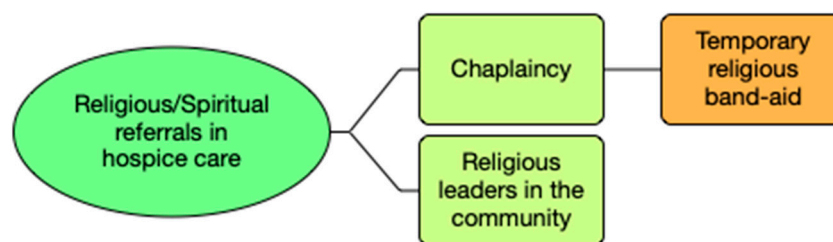


Figure 1. Responding to religious/spiritual needs via referrals.

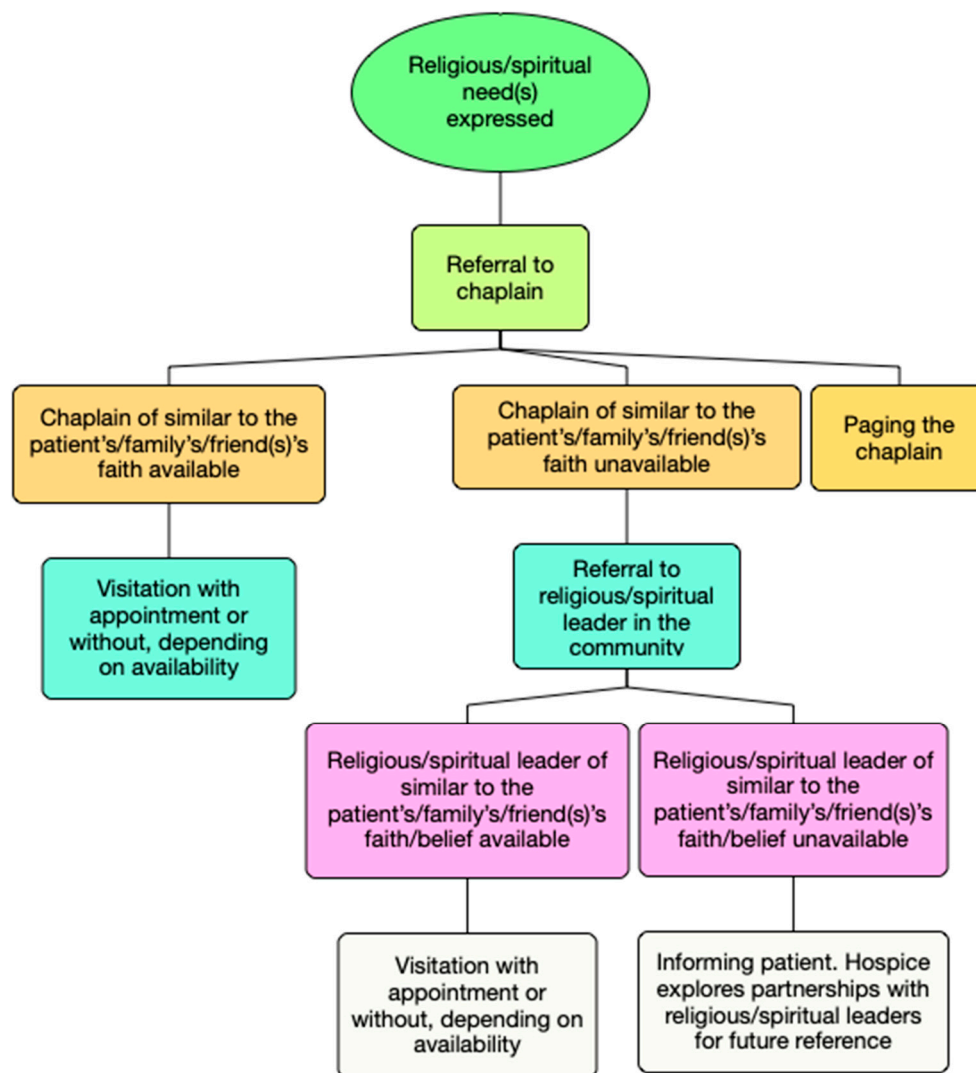


Figure 2. Religious/spiritual referral process in hospice care.

3.1. Referral to the Chaplaincy

Without exception, participants ($n = 15$) suggested that those responsible for a patient's, their family members' and/or friends' religious/spiritual needs are chaplains and other staff members associated with the chaplaincy. Participants claimed that chaplaincies in hospices play a significant role, if not being the main source, in responding to religious/spiritual needs of hospice patients.

We have got a spiritual care coordinator within our hospice, who facilitates our chaplaincy team and, therefore, a variety of different religious denominations, and actually non-religious denominations as well. So, there is a group of them [chaplaincy staff] that provide spiritual care that is done in a holistic way (nurse, Christian).

When someone says they have religious or spiritual concerns, I tell the priest to go talk to them. It is a matter of fact as I am concerned (counsellor, non-religious).

They have a chaplaincy here. And they have a Roman Catholic and a Church of England on staff. They also have other people—a list of people that are called in and it is led by one of the nuns (doctor, non-religious).

Almost half the participants (n = 7) openly exemplified how they might inform a patient that if they have any religious/spiritual concerns, needs or wishes, they (i.e., staff member) will gladly inform the chaplaincy and invite someone to come and talk to the patient, but without an indication that they (i.e., staff member) would also provide any room for discussion themselves.

I suppose the other belief is I do not know whether there is a God or not. So, once with a patient, I said, is it important to you that you find out [about God's existence] or [are] you happy with where you are at the moment? If you want to talk about it, I can find someone to come and talk to you (doctor, atheist).

If it is a question about faith and the meaning of life or afterlife, I am happy to offer the minister of the religion that they [patient] follow to come in and provide this service (doctor, Christian).

Equally, if I had no understanding of a particular person's request, then I would try and find an Imam, a Rabbi, somebody who perhaps know their faith. To try and support them in whatever they need in expression (social worker, atheist).

We ask them, 'shall we send the chaplain?' And sometimes we send an Imam or someone else, almost like a substitute chaplain (nurse, Muslim).

Calling the chaplain is evidently the first thought crossing professionals' minds when at the receiving end of queries or concerns associated with the meaning of life, distress, faith and emotions. The following extract shows that this tactic is not merely a response to a request, but possibly a coping strategy within their professional setting, and a temporary solution to a much bigger issue. Few participants (n = 3) saw such referrals, albeit making them as a temporary band-aid to stop religious/spiritual bleeding, yet the cut remains open.

And I always feel that calling the chaplain is a bit like calling a psychologist. It is, you know, they [patients and family] are emotional; it is a bit messy. We need to call somebody in to stop that happening, so that we do not have to deal with it (social worker, non-religious).

Reminiscing on the work of [Coble \(2017\)](#), hospice and palliative professionals may not have the time, right skills, or be in the right role to negotiate existential issues with their patients. Reflecting this on the extract above, however, shows additional reason to suspect that unless referrals are made on a competency-based fashion, which is not what this study shows, referrals to the chaplain can often be seen as a temporary solution, indeed.

Two participants, both nurses and in the same hospice (in a rural area), suggested that it is irrelevant if the chaplain is needed while they are on site and duty; they will still be called in to attend to a patient's needs.

While the Catholic priest is in on Thursday, but that patient may be dying on Tuesday night, so we have to get the priest in for Tuesday night. So, there is that person, because that is what is important to him [patient] (nurse, Christian).

3.1.1. Impromptu Visits from the Chaplain

Few participants (n = 5) openly suggested that chaplains and other members of the chaplaincy team will often 'cruise' the corridors, common areas and rooms of the hospice in order to offer impromptu support, regardless of being requested or not.

Well, chaplains [will come]. Someone from the chaplaincy team [is] here every day. They will interact with people [patients and family members] (doctor, non-religious).

The chaplaincy team is part of the permanent establishment and it is there [in the hospice]. And will actually proactively spend their time in the building, going around, offering company. They are available to the people and particularly being able to help people performing their ritual or whatever they want to do. And they will sit in the coffee bar and they are the ones that when someone starts to cry or something they will probably go over there; they want to approach and offer a form of support (nurse, Christian).

3.1.2. Avoidance

Participants (n = 9) also shared views that indicate the tendency to avoid engaging in conversations and support related to religious/spiritual needs or other emotional or existential demands that are often associated with religion and chaplaincy (Lopez 2018; Timmins et al. 2018).

So, obviously, I direct people to the chapel and the chaplaincy team, and I often say to people that even if they do not believe, they are very welcome in the chapel to also speak with someone if they need to (doctor, Christian).

Such avoidant behaviours (also see (Pentaris and Thomsen 2018)), as discussed in the next segment of the paper, may be the result of various factors, such as lack of time, or lack of comfort within one's skills and knowledge to address religious/spiritual matters, or a growing fear of death and its consequences.

3.2. Referral to Religious Leaders in the Community

The interview extracts above allude to the practice of referring patients and/or family members and/or friends to religious leaders in the community, when a chaplain of the person's faith and background is unavailable.

We also have contact with leaders of religious groups within the local area, who can come and facilitate religious ceremonies for patients, if that is unable to be provided by the chaplaincy teams (nurse, Christian).

Alternatively [when chaplains are unavailable], there are people within the community who are able to be called upon and come in and run last rites and do whatever they have to do (counsellor, non-religious).

This practice takes us back to the idea that only someone with the same faith as the patient can support them. This is reminiscent to Pentaris (2019) arguments and will be discussed in the next section.

3.3. Religious/Spiritual Referral and Homogenisation

Referral to the chaplain or a religious leader in the community is also rationalised with matching one's religious/spiritual distress and needs with the professional carer's religious/spiritual background.

After a while, it became quite apparent that what she needed was somebody who she could identify with on a religious level. So, she had spiritual distress, but she made sense of it through her religion, and what she actually needed was a priest (nurse, Christian).

4. Discussion

When a religious/spiritual need is expressed by the patients, they are at once referred to a chaplain. If the chaplain of the same faith as the patient's is available, then he is contacted and if not then referral is made to a religious or spiritual leader in the community. The findings of this study suggest that matching the chaplain's faith (or lack thereof) with the patient's (or family's/friend's) appears important in these practices, and this importance is found within the premises of adequately responding to religious/spiritual needs. In other words, this study emphasises previous works (Pentaris 2019, 2018b) that acknowledge the risks of generalisations and unifying approaches (Pentaris and Thomsen 2018) to a multi-diverse religious and spiritual environment, wherein individuals of the same affiliation wear their belief differently.

4.1. Homogenisation of Religion/Spirituality

The Cambridge dictionary defines the term homogenisation as “the process of changing something so that all its parts or features become the same or very similar” (Homogenisation n.d.). Thus, homogenisation implies similarity or uniformity. In the present study, homogenisation refers to the matching of the patient's religious/spiritual distress with religious/spiritual background of the chaplain or the religious leader. This ‘sought similarity’, whereby the patient plays a vital role in inducing a sense of familiarity between the patient and the chaplain or the religious leader. The familiarity gained through the process of homogenisation becomes pivotal for the patients dealing with something as uncanny and unfamiliar as death. As unfamiliarity in the form of impending death dominates life, anything familiar becomes a source of relief. Contradictorily, when this ‘sought similarity’ is led by the professional, then we are facing high risks of practising within constructed misunderstandings of what a patient wants and what a chaplain can offer. Just because a doctor is a self-identified woman, for example, it does not mean she cannot attend to a self-identified man.

The patients are able to ‘identify’ with the chaplain/religious leader of the same faith as the shared faith acts as a point of convergence. Here, identification is with the ‘embodied religion’ of the chaplain/religious leader (Patel 1994). The embodied faith is perceived to be more important than the acquired knowledge of different religions (also see (Pentaris and Christodoulou 2020)).

Homogenisation can be understood in different ways. Homogenisation is also pertinent with many death rituals and across different communities (Davies 2017). One of the examples is of the cleansing ritual (in Judaism, Hinduism, Islam), where only men can cleanse a male dead body while preparing for the funeral and only females are allowed to cleanse female dead bodies. The cleansing ritual is an example of matching of the sex of the deceased with the sex of the cleansing ritual performers. In a broad sense, homogenisation in death rituals becomes evident when the religion of the deceased is matched with the rituals of the same religion. In death rituals (performed for an individual who identified himself/herself as religious), homogenisation is an accepted norm. The dead body is treated in accordance with ethics of the faith one belonged to. Homogenisation creates the idea of the whole that one thing belongs to the other.

Similarly, this study shows that, almost in a ritualistic way, palliative care professionals seek to match a patient's religious/spiritual identity with that of the chaplain. In his extensive account about religious literacy in end of life care, Pentaris (2019) highlighted the risks we take when such decisions (i.e., matching of identities) are taken without the influence of the patient, or those involved, though. This said, it is important to reminisce Saunders's intentions to accommodate all and none faiths, regardless of the service provider's background (Clark 2005). Yet, this idea requires further development, especially when needing to avoid religious microaggressions in end of life care (Pentaris 2018a).

However, as the study alludes to, sometimes patients will request this matching of identity. It is intriguing to note that unlike the ‘imposed/normative homogenisation’ in death rituals, patients ‘seek homogenisation’; i.e., they try to create a comfort zone for themselves by creating an anchor point to explore the meaning of death in another person capable of assisting them in exploring those meanings (chaplains/religious leaders) and having the same religious identity as theirs.

Drawing on [Hopper \(2007\)](#), homogenisation can also be understood as a ‘grouping factor’ bringing together the aspects which are perceived to be similar. Where homogenisation could help form categories (cognitive and otherwise), it engulfs or pushes back the specific unique characteristics of different things that come together as homogenous entities. Thus, homogenisation risks generalisation, as discussed earlier. The present study sheds further light on the referral practices of healthcare professionals, especially the intention to match a patient’s religious affiliation and/or belief with the chaplains or a religious leader’s in the community. Religious plurality is indeed of importance, whereby the many religions residing in the same community are acknowledged ([Weller 2008](#)), but we should not ignore religious diversification; each religion is diverse in itself, depending on how one lives by it. [Woodhead and Catto \(2013\)](#), drawing on the changes that religion in Britain has seen since 1945, highlight that the main characterisation of religion is its diversity; faith and belief are now understood through subjectivity and individual preferences. Similarly, and in relation to this study, religious/spiritual referrals appear to comply to religious plurality but not necessarily religious diversification, a fact highlighted in [Pentaris \(2019\)](#) and [Pentaris and Thomsen \(2018\)](#) previously.

This further leads to a necessary discussion about lack of training of healthcare professionals to respond to such needs and measure the right way in doing so. Of course, this is not a blanket statement but one that has been argued by [Sansó et al. \(2015\)](#), among others, who opine that little or no spiritual training has led palliative professionals to acquire low levels of professional awareness and engagement with patients. [Cooper et al. \(2010\)](#) argued that the lack of competencies that will systematically assist with the training and education of palliative professionals was a barrier to implementing effective spiritual training. Moving beyond the 2010s, however, spiritual training has become central across palliative care settings ([O’Brien et al. 2019](#)). However, what remains of question is whether such training and education invites curiosity and exploration of religious diversification, as well as plurality, or perpetuates tendencies to apply generalised knowledge, which leads to homogenised practices.

4.2. Avoidance of Conversations and Coping Strategy

The healthcare workers at once refer the patients to the chaplaincy team or religious leaders in the community as though they feel unable to address or even initiate the discussion because they do not feel equipped to address the religious/spiritual needs (also see ([Pentaris 2019](#))). It seems like chaplaincy is treated as a ‘one stop solution’ for the spiritual needs of the service users, pointing at the assumed impermeable boundaries between different roles in healthcare altogether, with respect to dealing with the religion and belief. There is a ‘lack’ that is felt which is coped with by diverting the conversation about religion and spirituality towards a chaplain. It becomes a way to cope with the ‘felt lack’. This could be either because of the fear of going wrong or because personally not much importance is placed on religious/spiritual beliefs at the end of life. This is evident in the cross-country analysis of hospice and palliative care professionals’ skills in religious literacy and cultural competence by [Pentaris and Thomsen \(2018\)](#). In their study, they found that avoidant approaches are very common among professionals in end of life, but not as a way of responding to religious/spiritual issues, but as evidence of a coping strategy when faced with the challenge of responding to a set of needs one feels inadequate to respond to.

Using participant observation, [Pentaris \(2018a\)](#) studied how lack of religious literacy leads to religious microinvalidations on the part of the healthcare workers in end of life care. Based on [Sue \(2010\)](#) concept of microaggression, he found that healthcare workers unconsciously negated the importance of religion and belief at the end of life. This is a significant point in relation to this study; if avoidance is common, via referrals, then both service users and healthcare professionals are facing major challenges. The former because they may be experiencing microinvalidations in light of the referral process (see [Figure 2](#)), and the latter because they remain precarious of their inability to adequately respond to religious/spiritual needs without initiating a process of negation of experience.

As explained in the findings section, calling the chaplain at once is a temporary solution and a temporary band aid. The healthcare workers feel that the ‘emotions could be messy’ and they refrain

from dealing with it. This, of course, is not to recommend that referrals to the chaplaincy team and other religious leaders in the community is unnecessary or inappropriate. However, catering for religious/spiritual needs of patients, their families and friends in end of life care, inclusive of hospice and palliative care, is a task beyond the pragmatic solutions that the idea of matching one's faith with that of a chaplain's can offer. This area is the remit wherein deeper emotional and existential queries lie; and these are dimensions of care that experts like social workers cover, but not without collaboration with those providing religious support.

4.3. Religious and Spiritual Struggles

This study focused on hospice and palliative professionals' tendencies in making religious/spiritual referrals. In order to fully appreciate this, though, we also ought to refer to the potential religious and/or spiritual struggles that staff members may have faced in their past, or currently facing, and which influence those responses and reactions pertinent to the referral system. According to [Abu-Raiya et al. \(2015\)](#), such struggles are questions and/or doubts about one's faith and relationship to God or other deities. In their account, [Abu-Raiya et al. \(2015, abstract\)](#) detail three main forms which religious and/or spiritual struggles make take: '(1) supernatural struggles, (2) interpersonal struggles, and (3) intrapersonal struggles'. Experiences of this like may impact on mental health and wellbeing, while practice when working with patients, family members and/or friends can also be distorted. This said, the present study may also need to be considered within the context of staff members also facing religious/spiritual struggles which can potentially prevent them from properly engaging with patient needs in this way. Of course, this is a hypothesis that requires further testing in research.

5. Limitations of This Study

The present study is not without its limitations. Given that only one of the organisations involved here was in a rural area, it is difficult to draw any conclusions that could be, in any circumstances, generalised. The study's participants derive from five organisations, which is another challenge. Despite the adequate number of interviews that qualitatively offer insights about religious/spiritual referrals in hospice care, the characteristics of these organisations are understandably similar. This reminds us of the influence of socio-political and other environmental factors on any given study. This said, the findings in this study may need re-testing elsewhere, were we to assume applicability.

6. Implications for Practice and Research

The religious/spiritual process that this study records in UK hospices ([Figure 2](#)) is telling of its limitations as well. Drawing on this study's data, the recognition of the high risk for religious/spiritual homogenisation in end of life care, when in fact the emphasis is/should be on person-centred care ([Tudor et al. 2004](#)) and advance directives ([King 1996](#)), is necessary, and the fact itself concerning. Moving forward, practice can further acknowledge the chances of microinvalidations entering their arenas and better prepare professionals on how to avoid such outcomes, while move away from the tendencies to homogenise service user beliefs or lack thereof. With this in mind, education and training may be of interest; expanding on professionals training to become better equipped to respond to religious/spiritual needs, not with dependency to chaplains and religious leaders, but in collaboration with them, may be key.

This study focused on the religious/spiritual referral process from the professionals' point of view. Further work is necessary that can explore the role of chaplains and religious leaders in the referral process, as well as patient views about how satisfied or not they may be with being referred. As we saw at the start of this paper, patient satisfaction, when interacting with the chaplain and/or religious leader, is increasing, but only once the latter matches their belief, and it has been their choice to see them. This study highlights slightly different gaps in research, however, which require future attention.

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