



# Australian Chaplaincy Support of Health Care Staff: Presence, Professional and Relational

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## Abstract

The aim of the research was to explore how health care staff experienced support from hospital chaplains. The context for the study was two acute care hospitals in the South Australian Government's public health system: one paediatric, the other adult. The research utilised semi-structured interviews that were transcribed and analysed and coded using established methodologies for qualitative studies. The results and subsequent analysis revealed two overarching themes which emerged from the narratives of staff members. Support from chaplains was perceived as being (i) part of the hospital institution, (ii) a participant in the overall care team, (iii) as a symbolic presence, and (iv) available in the diverse settings of education, crisis and trauma events and debriefings. Chaplaincy support was experienced in relational and spontaneous care in serendipitous meetings with staff or at a workstation which was experienced as inclusive and respectful.

**Keywords** Chaplain · Pastoral care · Staff support · Spirituality

## Introduction

There is ample anecdotal evidence in the field of spiritual care and chaplaincy noting that chaplains provide significant and effective support to staff members. This support varies from the personal and individual, to support to groups of staff members in their workplace. To date, there is still limited published research regarding the support that chaplains provide to health care staff.

Prior to the design of this research, the literature relevant to the provision of care to staff members by chaplains was reviewed. ProQuest, CINAHL, PubMed and Springer Link were accessed. A number of articles identified that chaplains provided

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support to staff (Aiken, 2010; Carey & Cohen, 2009; Carey et al., 1997; Butler, Duffy, 2019; Jacobs, 2008; Liberman, et al., 2020; Lyndes, et al., 2012; Mowat, 2008; Orton, 2008a, 2008b) but none considered the role in a comprehensive study. The recent article by Drummond and Carey (2020) notes the importance of the chaplain's presence during COVID-19 for providing spiritual care. Increasingly, chaplains have embraced the practices of mindfulness as an effective methodology of supporting staff (Raab, 2014). Previous research (Aiken, 2010) identified that 57% of chaplains surveyed in South Australian public hospitals believed that staff support was important and were involved in its provision. A factor in their response may be that this role is included in their job descriptions.

## Purpose

The following questions were explored: How had staff received support from chaplains and what was the narrative of the support they received? How did they experience that support and its meaning for them at the time? And how would they view chaplaincy support offered to other staff members in the future.

## Methodology

This study was designed to collect data via semi-structured interviews. This method was selected to facilitate a free-flowing conversation between the interviewer and the staff member participants.

Ethics approval for this research for both hospitals was provided by the Human Research Ethics Committee (HREC) of the Women's and Children's Health Network (WCHN) HREC/14/WCHN/153. Participants for the research were recruited from the staff of two major hospitals in the South Australian public health system. Staff members at the hospitals were informed of the research and invited to participate through notices in clinical areas, and memos to workplace leadership. They were offered the option of an individual interview or participation in a focus group. All staff members who self-nominated to participate in the study were included and were provided with the HREC approved information sheet. Written consent was obtained from all participants before they were interviewed. Participation in the research was voluntary and had no bearing on the ongoing chaplaincy support available to the staff member.

To protect privacy and address conflict of interest concerns, the HREC stipulated that the researcher could not interview staff from their own hospital, in keeping with this condition demographic data or other potentially identifying information was not collected. The interview venues were selected to offer minimal disruption to workplace routine and afforded comfort and privacy. They were conducted by the author and a chaplaincy colleague. The interviews were audio recorded and professionally transcribed to ensure participant anonymity-identifying features were removed and a numerical code was assigned for each interview. Over eight hours of recordings were collected. Individual and group interviews varied from five to twenty nine minutes.

The transcripts were analysed and coded using established methodologies for qualitative studies (Braun & Clarke, 2006). Key phrases and words that staff used to describe the support they received from chaplains were grouped and coded and from these a number of themes emerged. In the coding of the themes, consistent and complementary narratives were noted along with those that provided an individual insight.

Forty-one staff members ( $n=41$ ), who were interviewed, described their experience of receiving support from chaplains. Individual interviews were conducted with 27 individual participants and 14 participants across 5 focus group sessions. Participants were invited to respond to the interview questions (noted below) and to share a story of when a chaplain provided them with support, their experience of that support and its meaning to them (Savage & Presnell, 1988). Interviews began with the invitation, ‘Can you tell me a story about when a chaplain provided support to you?’ Follow-up questions for clarification included, ‘I would like to know the ways that it was helpful or not?’, ‘Would you explore what this meant for you at the time?’, and ‘How would you like to see this support being offered in the future?’.

## Results

As noted in the methodology, a number of aspects of chaplaincy care for staff were identified and thematically coded. While recognizing that some chaplaincy practices are allocated to a particular theme, these can have overlapping relationships with aspects of other thematic categories. The key themes identified from this research were:

- Presence
- Professional, and
- Relational.

### Presence

Chaplains have often described what they do as ‘being present’ (Aiken, 2010; Newitt, 2015). They describe this presence as attending to a patient or family, being non-anxious, being attentive and using active listening techniques among others. There is a richness in such a presence. It was seen as being present and staff members reported experiencing chaplaincy presence as being available to provide support at their workplace or bedside, at a chance meeting or arranged appointment. They noted both the serendipitous and intentional in the chaplains’ support of them (Interviews 3, 10) (Table 1).

It was noted by many respondents that chaplains were visible around the hospital (Interviews 4, 11, 26). The visibility that staff mentioned was twinned with the chaplains being present. Staff reported their experience of the chaplain’s presence as being attentive to the situation, whether informally in the corridor or hospital café or more formally in a meeting or at a bedside (Interviews 3, 27). This speaks

**Table 1** Theme, Codes and Key Terms from Staff Comments (n = 45) <sup>a</sup>

Theme	Codes	Key terms from staff comments
Staff support by chaplains	<i>Chaplain as Presence</i>	Attentive, Active listening, Intentional, Responsive, Non-anxious, Visible, Comfortable, Not self-important, Calming, Safe, Symbolic, Flexible, Approachable, Present
	<i>Chaplain as Professional</i>	Competent, Discernment, Awareness of the ward, Awareness of hospital culture, Policy understanding, Global hospital wide perspective, Expertise in culture spirituality and religion, Understanding, Attuned to situation, Respectful, Non-judgemental, Rituals—weddings, funerals, blessings, Attentive and available, Flexible, Non-anxious, Professional, Team player, Debriefs following trauma, Staff follow-up, Mentor, Counsel (wise), Confidant, Brings resources of faith Strategic initiatives—patient care and change
	<i>Chaplain as Relational</i>	Approachable, Ability to connect, Humour, Relational, Informal, Inclusive, Respectful Corridor coffee and conversations, Personable, Welcoming, Genuine, Normal, Community Priest, Meet at point of need, Invitational, Perspective, Not limited to hospital structure and hierarchy, Inquisitive, interested

<sup>a</sup>The three themes of presence, professional and relational have a degree of overlap as staff comments often covered more than one theme

to the subtle yet powerful sense that staff had that the chaplains were available to and for them. Aligned to being visible, present and available was the sense staff had that when needed, chaplains were responsive and readily available. It was recognised that chaplains were able to manage their workload with a focus, yet a flexibility that enabled them to respond to critical issues quickly whether it be a patient issue or personal request.

Participants reported that the chaplain presence started with simply being available to the patient; to be willing to unobtrusively ‘turn up’ (Interviews 12, 16). Sometimes, that is all the staff member wanted in a particular moment; ‘... came up...it’s hard to quantify but just having someone present’ (Interview 12). Respondents variously described this as approachable, available, unhurried, present, visible (Interviews 3, 4, 8, 21). They also described it as ‘turns up, informal, present’, the use of informal having a sense of being competent in the situation (Interviews 2, 5). The informality had a sense of chaplains being comfortable in the hospital environment, competent in their practice, and not self-important. Reference was made to chaplains’ availability and their attendance at a situation serendipitously. Interestingly, the times when a chaplain was absent were also noted, as was visiting clergy being so focused on the task at hand that they did not engage with staff at the bedside. While an individual comment it serves as a reminder that significance is not always about the number of responses (Boyatzis, 1988) while being a reminder of both how easy it is to erode staff confidence and negatively impact chaplaincy ministry.

Narrative and metaphors were often used by staff members to describe a situation and the chaplain’s role in it. A number of respondents spoke about the hospital being a community and described chaplains as the priest to the village or the holy person (Interviews 9, 6). A number of staff members identified a symbolic and spiritual nature being evident in the chaplains’ presence. They spoke about the chaplain’s apparent calmness and bringing a calming influence (Interview 4). Another spoke about seeing the chaplain in the unit and knowing that they were ‘safe’, even if the medical situation would have a poor outcome. (Interviews 1, 10).

The symbolic role of the chaplain being present and visible was noted by staff members. While some of the corridor contacts were serendipitous, there were also the organisational functions and events that chaplains attended to be supportive of a ward, unit or the wider hospital. While staff saw this as part of the symbolic priest to the village function, it was seen by the chaplains as a relational opportunity to engage with staff members outside of their office or ward environment.

Other functions where the priest to the village symbology was evident were officiating at significant rituals. Staff weddings or funerals, unit blessings, team celebrations and staff farewells are some of these life celebrations. While they blend with the professional and relational chaplaincy roles, they also require the chaplain to be present—by invitation. In a similar vein, the chaplain’s presence at trauma events and critical incident debriefing sessions were noted and experienced as valuable (Interviews 7, 22). In these events, there was not always much to be said and done, rather the supportive presence of ensuring staff were aware of the care available for themselves and their team from the chaplains.

It is from chaplains being present, available and attentive that their professional practice and the importance of relationship were identified by staff. It is an indication of how the edges between these three metaphors are blurred and overlap.

## Professional

There was a clear expectation from staff members that chaplains be professionally competent (Interviews 11, 14). They identified chaplaincy competence as the ability to work as a member of an acute healthcare team, possessing a good understanding of hospital policy, a global perspective of hospital and healthcare organisation and expertise in cultural, spiritual and religious care (Interviews 6, 13,25).

This broad view of competence encompassed a working understanding of the complexities of the acute healthcare context and the ability to provide spiritual care to patients and families from diverse backgrounds (Interviews 6,9). There was a clear perception that chaplains would have a good understanding of current policy issues and have a global perspective of the dynamics of the hospital organisation. Words like ‘awareness’, ‘discernment’ and ‘understanding’ were used regarding the hospital culture, systems and structures (Interviews 25, 9). While these were clearly desirable personal and professional attributes for the chaplaincy role from a staff perspective, there is little in chaplaincy training that addresses system and organisational dynamics.

Spiritual Care Australia (SCA), the professional association for Australian chaplains, has through its membership requirements and continuing education focus continually emphasised the importance of competent skills, reflective practice, personal supervision and continuing development (SCA, 2014, 2020, 2021). Staff members described their experience and their observation of the support chaplains offered them and what they provided to patients and families. They reported chaplains being attuned to the current situation, respectful and non-judgemental in approach, having a perspective that makes sense and emphasising the spiritual issues rather than a focus on particular religious practice or distinctives (Interviews 9, 15, 24). While articulating the professional competence of the chaplains, they also described their relational attributes.

## Trauma and Debrief

As acute public hospitals with emergency departments and intensive care units, patients arrive following traumatic incidents such as road accidents, workplace injury, or acute health events such as heart attacks or stroke. Staff noticed that during a crisis or trauma chaplains were checking on them while simultaneously providing support to families. Staff commented that the chaplain’s presence at times of crisis or trauma changed the dynamic of the moment and engendered a sense of safety and greater control over the situation (Interviews 2, 25).

Following a critical incident or trauma, formal and organised support in the form of debriefing sessions were offered by the hospital to staff and could take either a formal or informal format. Formal debriefs organised following an incident included

a psychologist and the chaplain in attendance. In the informal space, it was the chaplain ‘checking up’ on the team and individuals both following the incident and a number of days after a traumatic event. It can also be the intentional follow-up of a staff member who has indicated that they are struggling, the ‘heads up’ from one of their colleagues, or the pastoral intuition of the chaplain. The dynamics of shift work and family life on nursing and medical staff meant that some were unable to attend the formal debriefing sessions. Here staff noted the effectiveness of the support that chaplains provided outside of the formal sessions. A number of staff noted that it was the chaplains who took the initiative in this follow-up (Interviews 15, 28).

### **Team Approach**

Multi-disciplinary teams are used in health care to manage complex patient care needs and communicate important information across disciplines. Chaplains were included in the various unit multi-disciplinary teams; however, there was an interesting caveat. Alongside being part of the team, responsive to their needs and active in responding to patient referrals, chaplains were also seen to have an independence from the unit (Interview 11).

This may be due to a number of factors or perceptions: partly a recognition that the chaplain covered a number of units and belonged to them as well, the independence of not being managed by unit leadership, the priest to the village—with the understanding that the chaplain was there for all. These factors allowed the chaplain to be an independent resource outside of and not compromised by unit or ward internal organisational structure, dynamics and politics. (Interviews 3, 5) In this, chaplains were seen to bring an independent view and a perspective different yet complementary to the nursing and medical lenses. Given the priestly image, there may also be a sense of personal confidentiality in that a conversation with the chaplain was not part of their reporting or management structure.

### **Counselling and Mentoring**

Staff members saw chaplains providing them with mentoring and counselling, being able to offer advice while appreciating a differentiation from a formal counselling role. Chaplains’ participation in clinical debriefing sessions following a traumatic incident may inform this understanding. Chaplains’ expertise in grief and loss care was identified and included support for staff when a patient or staff member had died, or a staff member’s a personal crisis. It is interesting that this was described as a ‘confidant’ and ‘not a counsellor’ and possibly links with chaplains being seen as a colleague and the ‘village priest’ (Interview 7).

The description of the chaplain as confidant is a description that does not carry the weight or sense of the confessional practice of a priest, rather it is indicative of a conversation within the context of a professional relationship. A staff member described this as the chaplains being able to offer ‘advice’ or ‘tips’ (Interview 2). This is interesting as one of the WHO Spiritual Interventions for the role of chaplains is spiritual counselling. Others were clear that counselling was part of what

they had received. Grief and loss was identified in this area as an example of chaplaincy support (Interviews 1, 23, 25). Staff members' various perceptions around this may be due to the relational yet informal way that they experienced chaplain support compared with structured meetings. Often conversations of depth were over a coffee.

## Relational

The ability to connect with and relate to staff members was seen by staff as a key personal quality for chaplains. In South Australia, chaplains are interviewed and selected based on a Job Description that identifies the skills and abilities needed to fulfil the tasks of the role, and the Person Description that details a number of character traits including the ability to relate well, a robust nature and a sense of humour. Respondents identified the significance of the chaplains' personality and character traits. High on this list for staff was the ability of the chaplain to relate well with good rapport, being welcoming, approachable and genuine. Also important to them were being respectful, trustworthy and the strong Australian cultural value of being competent yet informal. One respondent captured the essence when they noted 'It's to do with relationships'. (Interview 20).

A significant aspect of chaplaincy ministry is building respect and trust with staff by demonstrating competence and providing quality care. Many healthcare staff are protective of the patients and families in their care, and there is a well-developed and practiced gatekeeper effect evident. Staff in this research identified that chaplaincy team members were welcome in their ward because of their respectful and inclusive attitude and practice.

Conversations in hospital corridors were experienced as examples of the chaplains' relational style (Interview 3). A wide variety of descriptors were used by respondents in describing the character and personality of the chaplains including relational, personal, welcoming, approachable, respectful, informal, genuine, normal and calm (Interviews 4, 5, 19, 23).

In this vein, respondents spoke of the support they received from chaplains as individual and personal. Staff members experienced and appreciated the chaplain as a confidant and guide, a subtle expectation of spiritual care from the village priest (Interviews 7, 10, 12). There was, however, a chaplain who was overly focused on a task and not able to engage in a wider view or a relationship with staff. Competence and functionality without relationship and engagement or 'target specific care' alone were not embraced by staff (Interviews 5, 27).

## Holy Person

Chaplains are pastoral and spiritual care practitioners and often from a faith tradition which has trained them and formed their practice. Their place of work and context, in terms of this research, was the secular institution of a public hospital. The emphasis of the Spiritual Care Department is on meeting people at their point of need, be it patients, their carers or staff. A number of staff responses were clear about the



hospital being a community and identified the chaplain as the holy person or priest to the village. (Interviews 3, 6), one who provides spiritual guidance and support, bringing the resources of faith and humanity into focus.

Yet, they also described the chaplain as not being religious and non-denominational (Interviews 7, 21, 31) a nuanced appreciation of chaplaincy in a secular healthcare environment, the relational nature of the role, and yet an understanding of the spiritual and at times religious nature of the role. It is reflective too, of the highly secular Australian community where there has always been an aversion to ‘bible bashing’ and a suspicion of religion and its perceived arrogance, and the almost surprise that the chaplains at the hospitals studied did not exhibit those behaviours.

Clerical collars and other distinctive religious indicators are not worn by chaplains in either hospital surveyed. Yet staff identified experiencing a spiritual role and presence from the chaplains. In the secular Australian context, the culture and ethos is one where issues of faith and spirituality are acknowledged and sometimes embraced, but religion is often viewed with suspicion. There was strong affirmation of the welcoming and relational presence of chaplains. Often staff would advocate for chaplains with patients and families, and from their own experience of chaplaincy care indicate that the patient would be safe with the chaplain, respected and helped by them (Interviews 1, 9).

Another indication of being seen as the priest to the village, yet not overbearing was the new ‘Sacredspace’ at one site. This was embraced by staff as being a place to reflect, pray, meditate or to be, yet not a religious or denominational place, rather one for everyone. The space has no religious identifiers as permanent fixtures (Interview 2).

There was a clear recognition that the chaplaincy ministry was conducted in a secular health care institution, a market place of ideas and values, yet in the context of a village and community (Interviews 1, 11). Within the staff members’ responses, there was a fascinating mix of expecting chaplains to be the ‘priest to the village’ or community of the hospital, yet to be comfortable and at home in this secular milieu or ‘health care marketplace’. The ability of the chaplain to be inclusive and comfortable with diversity was noted by staff.

### **Coffee and Corridor**

‘Coffee and corridor’ became a metaphor for the serendipitous conversations that chaplains have. The ‘how are you’ in the corridor that became a time of sharing or an invitation for a coffee to discuss issues in more detail. In these moments, there was the recognition by staff that chaplains are paying attention to them and are interested in them. In my reflection on my practice, I realised that the cup of coffee at the Playdeck café became a time of connection and communion, a sacred moment in a secular space, a sacrament, as I shared with a staff member.

Coffee and corridor can be both a metaphor and a reality, a picture of an important aspect of chaplaincy, that of relationships, paying attention to staff, sensitive to the moment. It can also be a description of chaplaincy practice where acknowledgement of staff members and engagement with them can lead to a conversation

about themselves, a hospital issue, a team member or patient. It can be a pastoral care encounter with the staff member or lead to a referral to care for another person (Interviews 22, 27). It is the sacred moment of hearing the story of celebration or grief.

### **Perspective and Practice**

As well as sharing their experience of chaplains supporting them, staff members shared their perspectives of what the chaplains were doing and what they offered. Their description of their workplace as a community or village with the chaplains as the village priest is one. They identified that the chaplain offered a non-medical perspective, brought connections from outside the intensity of the hospital and although being part of the care team had an independence from it (Interview 18). The chaplain's role as an ethical resource not being bound by team structure and management alliances was noted by staff (Interviews 15, 18).

In both hospitals, the chaplains had taken strategic initiatives that were recognised by staff. They identified the chaplains as being proactive, innovative, seeking to improve patient spiritual care and embracing change (Interview 31). One hospital saw the development of a 'Sacredspace' to replace a Chapel and the implementation of an innovative triage chaplaincy model with a focus on the patients and families most in need (Interview 2). This was accompanied with an emphasis on spiritual care for all rather than religious care for a few (Interviews 2, 6, 7). The bereavement program was another initiative identified by staff (Interviews 2, 14). Staff noticed the respectful practice of the chaplains and their informal yet professional approach. The experience of chaplains was described as being aware, inquisitive and interested (Interviews 4, 6, 7).

### **Discussion**

The acute care public hospitals in which the research was conducted are secular, multi-cultural and multi-faith environments; marketplaces of ideas. In this mix of ethnically, culturally, religiously and spiritually diverse environment staff noticed that the chaplains were comfortable with and respectful of diversity. They had the professional skills and abilities to navigate and advise on the complexities of the multi-cultural and religious needs of patients, families and staff. Chaplains were able to provide advice and insight into the religious and cultural needs of patients enabled staff to have a greater appreciation of patient needs and feel more comfortable in providing their care. Staff members saw this as practical, educational support from the chaplains enabling them to provide better care for patients and families.

While 'woven' and 'layers' are appropriate metaphors for research with a narrative emphasis, there were three overarching themes that emerged from the staff interviews; the chaplain as present, as professional and as relational. While these three themes provide a clarity and structure, they are not static and rigid. Using the 'woven' and 'layers' metaphors, there are often links and connections across the

interviews as the insights, experiences and observations of staff members overlap or blend.

In the interviews, staff differentiated between who the chaplain was and what the chaplain did. Staff satisfaction with the support chaplains provided to them was high. Indicative of this was the number of staff members, from bedside nurses, doctors, domestic services and executive leadership who volunteered to be interviewed.

Staff members reported their positive experiences of chaplaincy support and offered clear descriptions of chaplaincy care and shared their insights into how they perceived this. They identified that when chaplains were called or approached they were responsive, available, relational and respectful. Staff understood the role that chaplains had in the wider life of the hospital, outside their ward or unit, in liaising with leadership and connection across the hospital's clinical and organisational components. Staff invited chaplains' participation and leadership in staff education and unit debriefing sessions following a critical event or trauma.

The staff member narratives of the support that they personally received from chaplains included seeking them out for advice, support and counsel around a range of issues that included work, management and personal life and that chaplains were a trusted guide in these areas. Interestingly the themes of counselling, guidance and advice are components in the WHO Spiritual Intervention Codes under which Australian healthcare chaplains work (WHO, 2017). At the same time, the historical pastoral care interventions of guiding, sustaining, nurturing, healing and reconciling (Clebsch & Jaekle, 1975) were evident as staff described the care that they received from chaplains.

Staff members recognised the chaplains role of caring for patients, their families and carers, particularly in moments of crisis or trauma. Of interest was that while a chaplain was present with a family, nursing and medical staff were freed up to attend to other parts of their role an insight that was also noted by Grosssoehme (2006). They saw this as the chaplains supporting them and enhancing patient and family care. During trauma events or critical incidents staff reported that chaplains being present fostered a calmness in them.

Symbolically, chaplains were seen as 'priest to the village', pastors to the community, the shaman, the holy person, with one hospital's central area variously described as the 'family hub', the 'community centre' or the 'village square'. Again, an indication that staff differentiated between 'what the chaplain did' and 'who the chaplain is'. This community and relational understanding and sense of belonging is a key factor that enabled chaplains to be effective in providing care to staff.

The care that staff reported that they experienced was in a dynamic engagement and fostered by active relationship building by chaplains. In some cases, this dynamic process and building of confidence and relationship occurred over a series of visits. In other cases, often around an incident to trauma, the care for staff was of a more immediate nature and sometimes limited to one visit.

Respondents reported that chaplains provided support to them by being professional and present during and after a clinical trauma or critical event. In the workplace, the chaplain was recognised as a team member who belonged to, but was not constrained by ward or unit dynamics. At other times, the chaplain's support was on a more personal level with discussions around career future, family life dynamics,

changing situations or sickness of a family member. The chaplains were seen by staff as one of the key enablers and providers of their support.

If there is a key word or practice that is foundational to staff experiencing chaplaincy support, it is relational. It was the relational approach of the chaplains that enabled the personal conversations that supported staff members. Chaplains were experienced as people who were present, who listened, were attentive, able to offer insight or advice, and invited to provide education or trauma support. Hospital staff described their experience of chaplains' relational and engaged care for patients and families and their experience that the same care was provided to them.

## Limitations

A number of limitations affected this research. It is likely that staff who chose to participate had experienced positive interactions with chaplains. Another factor is that all chaplains in the two hospitals were from a Christian faith tradition. The HREC requirement for the anonymity of the participants prevented the collection of demographic information. This research condition also restricted interviewers from interviewing participants in their hospital of employment.

## Conclusion

The research project corroborated and confirmed anecdotal evidence and assertions by chaplains regarding the support that they provide to staff members and the value that they place on the support they receive. How chaplains support staff is nuanced and multi-faceted including specific individual support, working with groups of staff, in organisational roles, providing ethical and cultural advice.

Important to staff in accepting chaplains' care is the chaplain being professionally competent and part of the organisation. Staff identified a variety of chaplaincy roles including the usual expectation of patient and family care, and from their experience as a key provider of staff support.

A clear conclusion from the research is that chaplains need to be relational in their approach to ministry and functional competence alone was not embraced by staff. The secular nature of the hospital system in SA's public health setting means that it is a market place of ideas. Chaplains need to be able to embrace diversity and difficult and challenging conversations. Chaplaincy bodies, faith communities or institutions who appoint Chaplains need to be attentive to these issues and changing community expectations. It is essential therefore that in the public health context, that chaplains appointed are not only competent in cultural, religious and spiritual practice, but also able to relate and engage.

Appointing organisations and hospital administrators would be wise to recognise and appreciate the depth and breadth of the chaplaincy role. Of interest in the research is that while described as the village priest, the support appreciated was not of a religious tone, rather one that is spiritual, relational, attentive and relevant. The effectiveness of chaplains being a circuit breaker in work and personal situations was

evident in the corridor or bedside conversations with staff where a different perspective or insight was offered by the chaplain. While counselling sessions are important and have their place, the immediacy and timely nature of this circuit breaker effect is unlikely to be achieved in a formal setting and was often related to the importance and serendipity of the moment.

The study demonstrates that proactive, relational chaplains not only support staff, but through this support enable staff to fulfil their roles more effectively. The ability therefore of chaplains to be able to provide effective care to staff and patients is a question that deserves further research.

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## Declarations

**Conflict of Interest** The author/researcher has served as a chaplain for over 20 years in the Australian Army Reserve and is Emeritus Chaplain at the Women’s and Children’s Hospital, South Australia, and is an Alumni of Drew University, New Jersey, USA.

**Ethics** Ethics approval for the research for both hospitals was provided by the Human Research Ethics Committee (HREC) of the Women’s and Children’s Health Network (WCHN) Adelaide, Australia: HREC/14/WCHN/153. All participants involved signed ‘Participant Information Consent Forms’.

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