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Why are Some Healthcare Chaplains Registered Professionals and Some are Not? A Survey of Healthcare Chaplains in Scotland

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Abstract: The professional status of UK healthcare chaplains remains partial, with voluntary accreditation effective in achieving around 50% registration. This study set out to elicit reasons for this by surveying healthcare chaplains working in Scotland. An online survey was created to gather demographic details and chaplains' opinions on the importance of five key elements of professional status: A body of knowledge that underpins practice; A code of professional ethics; An occupational organization controlling the profession; Substantial intellectual and practical training; and Provision of a specialized skill or service. Most respondents (38/43) agreed that chaplains should belong to a professional body in order to maintain standards, ensure accountability and formalize professional development. A negative minority felt that the professionalization agenda was not for them, but the majority stated that registration reinforced their professional status, added credibility and a clear governance structure to protect the public. Due to the wide interest in this issue, further UK and international studies into the professional status of chaplains are planned.

Keywords: Professional; professionalization; chaplain; status; survey; accreditation; registration; accountability.

Introduction

The NHS in the UK employs an estimated 916 chaplains (Clarke 2018). Chaplains deliver specialist spiritual care to patients, carers and staff across the NHS, offering care to everyone, regardless of their belief or faith stance. However, despite a growing body of evidence supporting the benefits of healthcare chaplaincy, they are not yet recognized as healthcare professionals in, for example, the same way that nurses, or chiropractors are. Registration with a national regulatory body is voluntary, and there is no overarching strategy underpinning their recruitment, education and professional development. Instead, their professional status is "voluntarily accredited" by the Professional Standards Authority for Health and Social Care (Table 1), a status equivalent to counsellors, hypnotherapists and acupuncturists. This article examines the reasons for this, and then obtains the views of chaplains employed in Scotland about the relevance of professional status. It first explains the background to healthcare chaplaincy in NHS Scotland to show why the issue of professional status is so relevant just now.

Background

Chaplaincy as a Profession in UK

Since the inception of the NHS in 1948, chaplains have been funded by the NHS, but managed through their various churches (Timmins *et al.* 2017). This changed in the early 2000s, when chaplains in Scotland became directly accountable NHS employees (Kelly 2012). This is different from England and Wales where chaplains have always been employed directly. Recognizing the need for an overarching professional organization, the Association of Hospice and Palliative Care Chaplains (AHPCC), the College of Healthcare Chaplains and the Scottish Association of Chaplains in Healthcare (SACH) created the Chaplaincy Academic and Accreditation Board (CAAB) in 2003. The original remit of the board was to provide a collaborative forum to manage the professional issues faced by NHS chaplains (UK Board of Healthcare Chaplains 2010):

> It is the aspiration of all the associations that healthcare chaplaincy becomes a healthcare profession. To achieve the status of a 'registered healthcare profession' healthcare chaplaincy requires to become a self-regulating profession and a number of groups are currently working on the components required for self-regulation. The Chaplaincy Academic and Accreditation Board (CAAB), made up from the professional associations in the United Kingdom, has a significant role. The work leads towards a more professional approach to chaplaincy with regard to education, entry to the profession, relationship to faith and belief communities and levels of responsibility/seniority (NHS Education Scotland 2008).

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

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

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

What is Professional Status?

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

Table 1. Statutory and Voluntary Accredited Associations

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

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

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

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

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

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

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

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

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

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

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

Aim and Objectives

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

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

Funding

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

Ethics

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

Method

Design

Cross-sectional population survey design.

Participants

All healthcare chaplains employed by NHS Scotland and working in hospices across Scotland.

Data

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

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

Analytic Plan

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

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

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

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

Results

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

Table 3. Highest Qualification Crosstab with AfC Band.

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

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

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

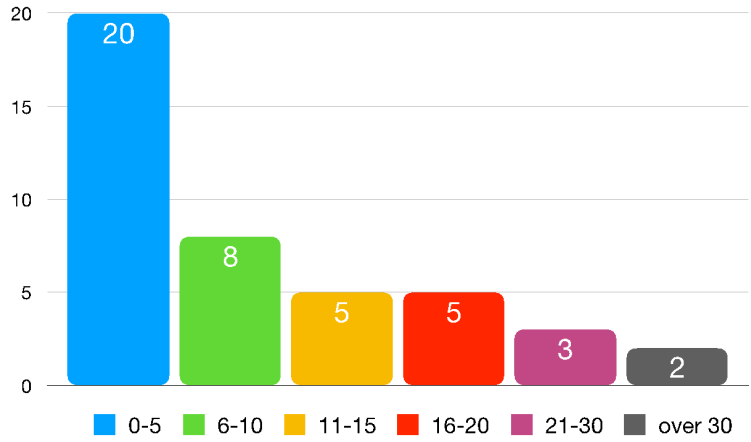

Figure 1. Time served as an NHS chaplain.

Table 4. Responses to Yes/No Survey Questions

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

Measures of Professionalism

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

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

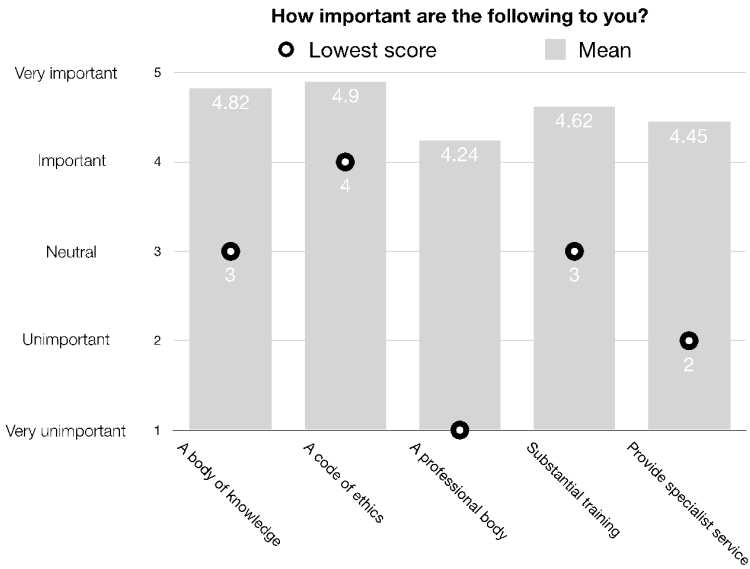

Figure 2. Responses to importance of Swinton's five elements of professionalism in chaplaincy

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

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

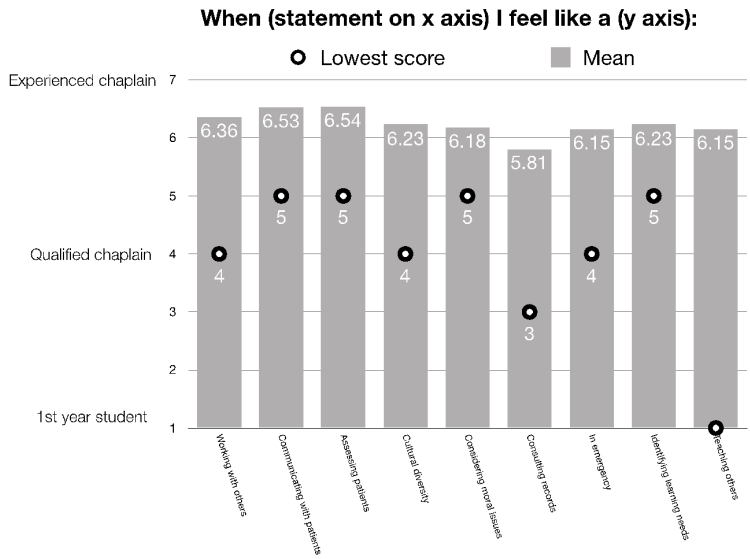

Figure 3. Mean and minimum responses to statements in the professional identity

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

Professional Association

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

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

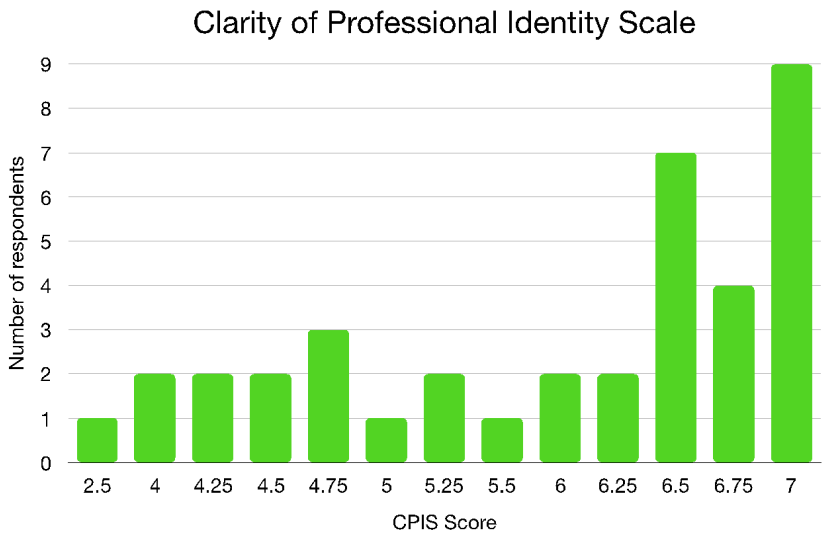

Figure 4. Histogram of responses to Clarity of Professional Identity Scale

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

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

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

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

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

Application in progress
Closed shop merchants. Which is futile. Like all "professional" bodies it is about power and status. This is distasteful.
Never got around to what appears a long, complicated process
Not given choice
This is a biased organization which favours chaplains in England and religious chaplains. It makes no provisions for non-religious chaplains and insists that chaplains have a faith group connection.

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

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

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

One of the positive responses also cautioned of the professional body: "*yes, as long as it's not a Dickensian one like the UKBHC*". However, to put this

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

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

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

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

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

Credibility, validity and longevity of the Chaplaincy profession: Most identified credibility as a benefit of professionalism. Professionalism could:

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

- promote better understanding about the role and position of healthcare chaplains amongst other healthcare professionals;
- give public assurance of competence and accountability while guaranteeing evidence-based, safe delivery of spiritual care;
- lead to external validation by the NHS and other healthcare professionals, and internal validation by chaplains themselves.

Provision of professional support and development was acknowledged as one of the benefits of professionalism in the delivery of spiritual care. Some respondents believed this can happen *through education*, specifically by:

- an undergirding of academic training;
- encouraging/mandating relevant continuous professional development and post-grad education;
- increasing awareness of practice developments; and
- promoting research opportunities and dissemination of research.

Others commented on how professionalism promotes professional support and development by clarifying their *professional identity*. They said that professional status supports and informs their identity as chaplains, promoting solidarity with colleagues and helping them to maintain a sense of who they are both in the context of the care community and in their faith communities. A few identified the *provision of networking opportunities* as a benefit of professionalism. They explained that having the support of a professional body is required in an ever-changing working environment. Also, a professional body allowed them to engage with colleagues and share experiences.

Regulation: Some Chaplains believe that professional bodies like the UKBHC function as regulatory bodies. They achieve this by developing codes of practice and ethics that guarantee a standard of service delivery and accountability. Compulsory membership could ensure adherence to these codes and standards, thereby raising the profile of the chaplaincy profession. It can encourage self-reflection because chaplains are encouraged to check their performances against agreed standards, like other healthcare professionals.

Four chaplains failed to identify any benefit of being a registered member of the UKBHC. One stated that cronyism played a role in the recruitment of NHS healthcare chaplains. Another believed that the AHPCC is more beneficial than the UKBHC, and a third felt that the UKBHC has nothing to offer chaplains in Scotland. According to the latter, most chaplaincy conferences are "down South", and deal with different issues compared to the Scottish

context. Consequently, UKBHC's relevance and location feel remote. Interestingly, one respondent emphasized that the UKBHC will not be truly relevant unless registration becomes mandatory for all healthcare Chaplains, who themselves must be held accountable by the Board for their practices.

Analysis

The study succeeded in obtaining the views of healthcare chaplains on profesionalization. Whilst it is impossible to know the opinions of non-responding chaplains, the survey generated a wide range of opinion. Regarding item fit, most items were responded to, and often elaborated on, suggesting the majority of the survey was fit for purpose. There was very little difference between chaplains' responses to the two banks of questions about Swinton's (2013) theory of professionalism in chaplains. Further, nearly all the answers were very positive, and so did not reveal much variation in response, just that most respondents think all elements are important and worthy of personal commitment. Possibly the greatest utility of these items was in identification of "outliers", those respondents who answered unusually negatively. Understanding how these chaplains feel will be essential if all chaplains are to feel included.

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

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

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

These were tested in turn:

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

CPIS scores were higher for registrants (6.07 ± 1.17) than non-registrants (5.55 ± 1.07), but the difference was not statistically significant (p=.227).

2. An independent-samples t-test was run to determine if there were differences in CPIS between males and females. CPIS scores were higher for females (6.35 ± 0.89) than males (5.63 ± 1.24), a statistically significant difference of 0.81 (95% CI, 0.02 to 1.43), t(34.499) = 2.101, p = .043.
3. An independent-samples t-test was run to determine if there were differences in CPIS between professional association members and non-members. CPIS scores were higher for members (5.95 ± 1.19) than non-members (5.56 ± 1.15), but the difference was not statistically significant, p = .35.

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

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

1. age;
2. time served as a chaplain;
3. highest academic qualification;
4. Agenda for Change banding.

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

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

Free Text Analysis

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

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

Discussion

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

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

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

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

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

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

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

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

Limitations of the Study

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

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

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

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

Conclusion

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

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

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

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

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