Recognising and Responding to the Spiritual Needs of Adults from Minority Religious Groups in Acute, Chronic and Palliative UK Healthcare Contexts. An Explorative Review.

Abstract

Background Increasing religious diversity makes spiritual care more complex in healthcare settings.

Aims To conduct a systematised literature review concerning how the spiritual needs of adults from minority religious groups are recognised and responded to in UK healthcare contexts. To consider implications for the training and practice of healthcare professionals, including chaplains.

Methods Databases, bibliographies, citations, journals and grey literature were searched. Inclusion / exclusion criteria were: primary research; in English; published July 2007-September 2017; articles, books and unpublished reports; adults; acute, chronic and palliative healthcare, UK articles and contexts.

Results Themes from 18 studies were synthesised within seven categories of spiritual need, showing a range from inadequate to excellent care being offered to Muslims, Sikhs and Hindus in six of these.

Conclusions Healthcare staff would benefit from on-going training concerning delivering quality individualised spiritual care to people from minority religious groups.

Keywords Systematised literature review, minority religious groups, spiritual needs, acute, palliative, chronic, UK.

Introduction

All UK healthcare staff are required to offer people spiritual care (UKBHC 2009, The Royal College of Nursing 2011, Gordon et al. 2011). Increasing religious diversity in the UK, however, makes offering spiritual care in healthcare contexts more complex because there are a greater variety of needs to respond to. This systematised review explores the experience of adults from minority religious groups in UK healthcare contexts by investigating primary research studies published between July 2007 – September 2017. Its aims are to examine evidence of how the spiritual needs of people from these groups have been recognised and responded to both by chaplains and by other healthcare staff.

Carey et al. (2007) describe an interfaith spiritual care paradigm for chaplaincy in a multifaith context. However, this review is seeking to assess the approaches to spiritual care of nurses, doctors, occupational therapists and other healthcare professionals, as well as chaplains. Therefore a wider two-step spiritual care paradigm has been adopted in this review instead. This simply looks for evidence that staff listen and explore others' perspectives before trying to arrange for their spiritual needs to be met. This review will also consider whether findings concerning how this has or has not been done have implications for healthcare professionals, including chaplains', training and practice.

In this review minority religious groups are understood, as they are in the 2011 census for England and Wales (Office for National Statistics / Nomis, Minority Religious Groups, 2011), to include people who self-identify as Buddhist, Hindu, Jewish, Muslim, Sikh and Other Religion. The last category "Other Religion" includes 40 more smaller religious groups (Office for National

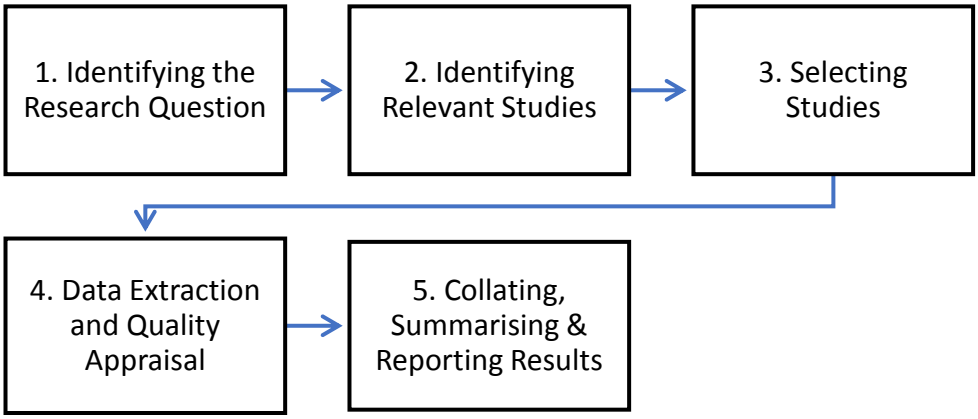
Statistics / Nomis, Other Religion, 2011). The percentage of the population belonging to minority religious groups in England and Wales was 5.7% in 2001 (British Religion in Numbers 2001) and 8.4% in 2011 (Office for National Statistics / Nomis, Minority Religious Groups 2011). Scotland showed an increase from 1.1% to 2.5% (Scotland Census 2001 & 2011) and Northern Ireland from 0.3% to 0.8% (Ninis 2011).

The lens of minority religious groups has not been used in previous literary reviews, so this review has the potential to reveal new perspectives. It considers documents published after July 2007 because Mowat's systematic review (2008) covers UK multi-faith healthcare chaplaincy studies published before this date; September 2017 was the latest date that could be considered. It also scrutinises whether there is new evidence regarding issues raised by previous reviews, such as the state of multi-faith healthcare chaplaincy research (Mowat 2008), the risk of institutional discrimination in chaplaincy departments (Mowat 2008), the level of provision of spiritual care in healthcare contexts (Elkan et al. 2007, Redman et al. 2008, Alam et al. 2012, Evans et al. 2012, Calanani et al. 2013) and whether collective norms can guide individual spiritual care (Elkan et al. 2007, Redman et al. 2008, Garrett et al. 2012).

Methods

This review followed the process shown in Figure 1 which was developed from headings used by Arskey & O'Malley (2005).

Figure 1 Systematised Literature Review Process



Identifying the research questions and relevant studies

The PEO Format (Bettany & McSherry 2016) was used to help to identify the inclusion criteria for literature to be reviewed, which are shown in Table 1.

Table 1 Inclusion Criteria

Key Subject	Studies which concern how spiritual needs are recognised and responded to.
Population	Healthcare patients who have self-identified as being affiliated to a "minority religious group", and healthcare professionals with care of these patients.
Context:	UK studies which concern adults in acute, chronic and palliative UK healthcare settings. Studies about patients in mental health, paediatric or maternity contexts were excluded.
Timescale:	Studies published between July 2007 and September 2017.
Methodological Approaches:	Qualitative, quantitative and mixed-methods primary research studies.
Publication Status:	Peer reviewed published articles, books and grey literature (for example, reports not published commercially or in academic sources) were considered. Theses and dissertations were excluded.
Language:	Studies written in English.
Comprehensiveness:	This review aimed to make as comprehensive a collection of relevant studies as is possible within its limited time-frame.

This process also identified that studies from other than UK national contexts would be excluded. This is because the review's aim is to establish a collection of UK studies in this field, a task which needs to be accomplished before comparisons between UK primary research findings and those from other cultural contexts can be made.

Identifying inclusion and exclusion criteria was an iterative rather than a linear process and they were refined as knowledge of relevant studies developed. These criteria shaped the research questions for this review, which are: "How are the spiritual needs of adults from minority religious groups recognised and responded to in acute, chronic and palliative United Kingdom healthcare contexts? What are the implications for the training and practice of healthcare professionals, including chaplains?"

Following a pilot search the keyword-strings shown in Table 2 were used in six electronic databases: CINAHL, Medline, PsycINFO, Web of Science, Embase and Assia.

Table 2 Electronic Database Searches

	Search-Strings Used in Electronic Database Searches – November 2017
1)	experiences OR views OR opinions
2)	pastoral OR spiritual OR religious OR interfaith
3)	non-Christian OR minority OR cultural
4)	recognition OR response OR care OR support OR needs
5)	patients OR care-givers OR relatives OR family OR "healthcare professionals" OR "healthcare staff" OR nurse OR doctor OR "occupational therapist" OR "chaplain"
6)	hospital OR "secondary care" OR hospice OR "tertiary care" OR home OR "primary care"
7)	Searches 1-6 were combined with AND

The more recent studies found by these searches were used for bibliography searches and earlier ones for citation searches. Four relevant journals, *Health and Social Care*, *Religions, Ethnicity & Health, and Diversity & Equality in Health and Care*, were searched on-line. Grey literature, that is research reports not published for either commercial or academic purposes was sought using the Google search-engine with the terms: "minority religious groups in the UK and healthcare". This produced results which were prioritised by relevance and the first hundred were screened. Grey literature was also sought in a range of media, faith organisation and regulatory websites. The results found by these five types of searches were exported to Mendeley for the removal of duplicates and review.

Selecting Studies, Data Extraction and Quality Appraisal & Collating, Summarising and Reporting Results

Titles and abstracts were scanned for accessibility and applicability. Where these criteria were met full-texts were read. If studies were then excluded, reasons were recorded. Data from each study were extracted into a uniform evidence table like that produced by Fineout-Overholt et al. (2010). The studies were also assessed for the quality and value of their evidence using questions from Polit and Beck (2014). These concerned whether data-collection methods, measures reducing bias and promoting trustworthiness and if studies had a conceptual framework which was thematically compatible with the data and supporting quotations. Extracted and appraised data was then collated, summarised and reported to give an overview of the studies, their approaches and findings. The strengths and weaknesses of each study's methods were collated and summarised and the key thematic findings were also reported to show the heterogeneity of the studies and where gaps in research exist concerning this topic.

Results

1. Results Overview

Eighteen studies were found which give patients, carers and healthcare professionals' viewpoints, only one concerns healthcare chaplains (Savage 2015). Six of these studies describe people with illnesses which are acute, eight which are palliative and nine which are chronic. Eleven studies relate to Muslims, nine Sikhs, seven Hindus, one followers of Chinese religion and one Jews and Buddhists. Seventeen studies reflect English contexts, one Scottish (Worth et al. 2009) and none Welsh or Northern Irish. Sixteen studies used qualitative research, one quantitative and one mixed-methods. The results of the literature searches are summarised in Figure 2 and Table 3 summarises the selected studies' contents.

Figure 2 Study Selection Process

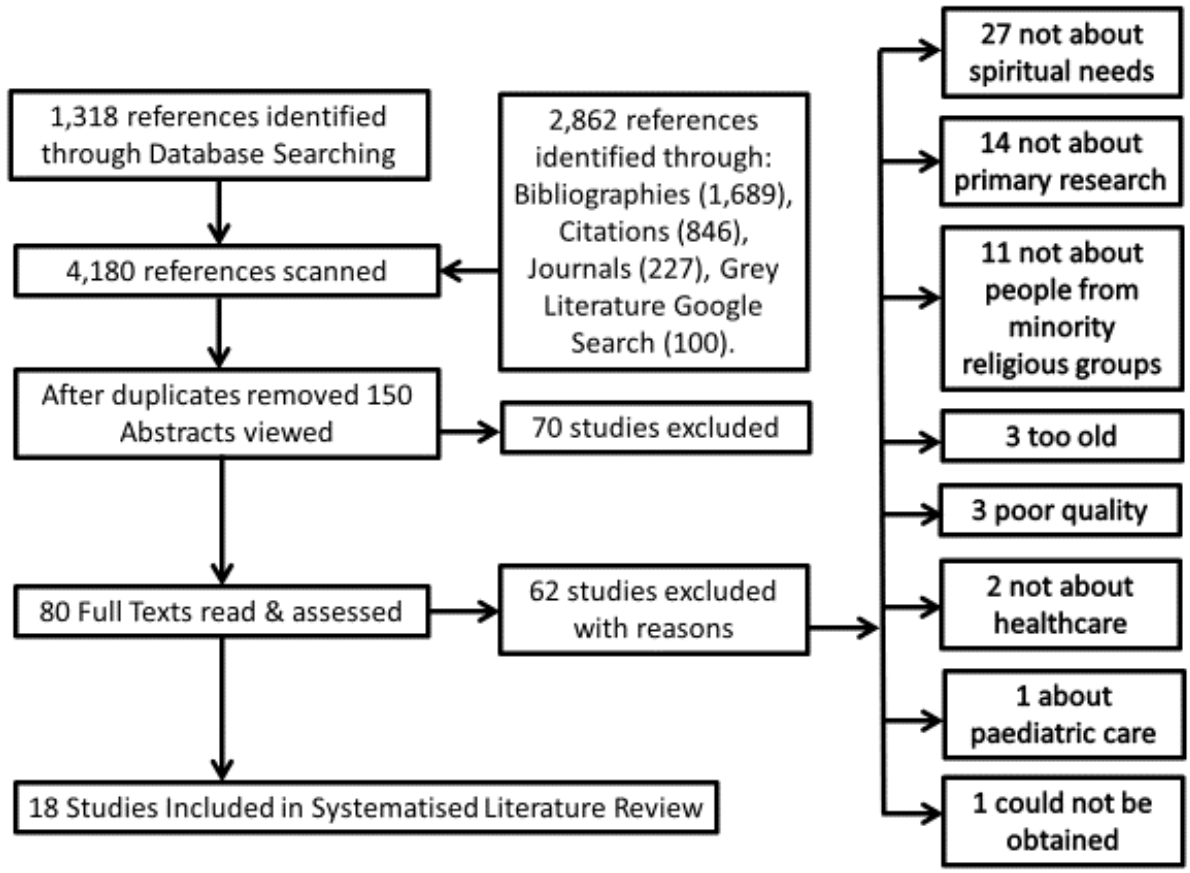


Table 3 Included Studies' Characteristics: Sample, Viewpoints, Design, Analysis & Findings

STUDY	SAMPLE &VIEWPOINTS	DESIGN & ANALYSIS	FINDINGS
Venkatasalu 2017.	55 British South Asian Muslims, Hindus & Sikhs. Potential patients & carers.	Qualitative; focus groups, interviews. Grounded theory.	Staff were mistrusted, patients left alone. Families give patients protection & religious care.
Savage 2015.	Circa 10,000 patients. All religious and belief groups.	Quantitative; recording chaplaincy visits. No analysis theory.	More diverse staff visit a wider cross-section of patients than primarily Christian teams.
Hipwell et al. 2015.	3 British Punjabi Sikh women tutors.	Qualitative; interviews. Descriptive analysis.	Single language, gender & religious groups with low text dependency work best for teaching.
Alhomoud et al. 2015.	80 British South Asian & Middle Eastern patients. Mainly Muslims & Hindus, taking 3 + medications.	Qualitative; interviews. Thematic analysis.	Medication problems linked to Ramadan, pilgrimage, family pressures, health professionals, etc.
Patel et al. 2015.	67 British South Asians with diabetes. Religious affiliations unknown.	Quantitative; questionnaire. Qualitative; interviews. SPSS & thematic analysis.	Social / religious / cultural beliefs, such as fatalism, reinforce meanings given to diabetes management.
Patel et al. 2014.	23 British South Asian Muslim patients.	Qualitative; interviews. Grounded Theory.	Lack of consultation with GPs about changing medication.
McClimens et al. 2014.	15 nursing students.	Qualitative; focus groups. Thematic analysis.	Religion influences patients' perceptions of healthcare. Need planned patient-centred care.
Markham et al. 2014.	134 Black & Asian people aged 14-80. Muslims, Hindus, Sikhs. Potential patients and carers.	Qualitative; discussion groups. Inductive thematic analysis.	Lack of awareness of personalised (e.g. religious) hospice care and lack of referral.
Cowan 2014.	6 Sikh carers.	Qualitative; interviews. Interpretative phenomenological analysis.	Faith is important and improves coping abilities. Cultural & religious care easier at home.
Venkatasalu et al. 2014.	55 Muslims, Sikhs & Hindus, aged 52-78. Patients and relatives.	Qualitative. Grounded theory.	Home is more than a physical location for dying.

STUDY	SAMPLE & VIEWPOINTS	DESIGN & ANALYSIS	FINDINGS
Frearson et al. 2013.	8 women, 6 men. Hindus. 1st generation immigrants. Potential patients & carers.	Qualitative; focus groups. Thematic analysis.	Home is the best place to die & for religious care. Family decision making. Barriers to caring at home.
Venkatasalu et al. 2013.	55 Muslims, Sikhs & Hindus, aged 52-78. Patients and relatives.	Qualitative; focus groups & interviews. Thematic analysis.	Avoidance is a cultural norm chosen to protect relatives. How decisions are made about support.
Mir & Sheikh 2010.	Large sample of British Pakistani Muslim patients.	Qualitative longitudinal interviews & ethnographic study. Thematic analysis.	Religious identity impacts decision-making & communication with health professionals.
Wilkinson et al. 2010.	People from black & minority ethnic groups living in Norfolk. Potential patients.	Qualitative; focus group, door-step survey & interviews. Grounded Theory.	Need more cultural & religious awareness from health providers and users.
Worth et al. 2009.	15 British South Asian patients, Sikhs & Muslims. 18 family carers. 20 healthcare professionals.	Prospective longitudinal qualitative interviews. Thematic analysis.	Hospices can offer excellent individual care. Professionals' lack training in offering individualised religious & cultural care.
Grace et al. 2008.	80 British Bangladeshi Muslim lay people without diabetes. 28 Muslim leaders. 29 GPs.	17 focus groups with Muslim lay people and leaders separately. Interviews with GPs. Thematic analysis.	Islam encourages healthy lifestyles, but practical obstacles make this difficult. Lack of cultural confidence & assumptions about Muslims' having fatalistic views hinders GPs.
Hamilton & Essat 2008.	Hindus, Sikh, Muslim & possibly Chinese former hospital patients & carers, aged 26-80.	Qualitative; 6 focus groups of 8 – 15 people. Thematic analysis.	Nurses need knowledge of religious practices, cultural sensitivity & communication strategies.
Kai et al. 2007.	106 healthcare professionals.	Qualitative; 18 focus groups. Constant comparison analysis.	Professionals need to acknowledge their uncertainty & focus more on individual needs than on cultural and religious expertise.

2. Key Thematic Findings

Galek et al. (2005) and Flannelly et al. (2006) describe seven categories of spiritual needs within which the key thematic findings from this present review are reported. They are: 1) Meaning and Purpose, 2) Love and Belonging, 3) Gratitude, Peace and Hope, 4) Religion and Divine Guidance, 5) Death Concerns and Resolutions, 6) Appreciation of Art and Beauty and 7) Morality and Ethics. These categories have close similarities with those in other studies (Kelly 2002, NHS Education for Scotland 2009, Ross & Austin 2015).

1) Meaning and Purpose

Galek et al. (2005) and Flannelly et al. (2006) state that spiritual care includes communicating understanding of illness to help people live through it with meaning and purpose. Seven studies (Kai et al 2007, Hamilton & Essat 2008, Grace et al. 2008, Worth et al. 2009, Markham et al. 2014, McClimens et al. 2014, Alhomoud et al. 2015) corroborate that this task is more difficult when UK Muslims, Hindus and Sikhs speak different first languages from healthcare staff and outline several difficulties obtaining appropriate interpretation support. Studies also state, however, that information leaflets which can be studied at home may be helpful (Wilkinson et al. 2010, Markham et al. 2014), especially if they are written in peoples' first language (Hamilton & Essat 2008, Alhomoud et al. 2015).

Effective communication also enables spiritual support when faith practices which have previously given meaning and purpose become more difficult during illness. Muslims with diabetes, for example, may see fasting as a religious duty and an expression of social belonging (Mir & Sheikh 2010, Patel et al. 2014) but find it problematic because it impacts on the health

requirements of regular eating and medication. Previous literature, for example Burrows (2003), has highlighted that pre-Ramadan consultations can be used to plan how spiritual and medical needs may best be met and Mir & Sheikh (2010) report doctors enabling this. Alhomoud et al. (2015) also suggest that joint planning to meet medication needs is necessary before pilgrimage and extensive travel abroad to visit family. However, studies report doctors often lacking sufficient confidence to initiate such conversations (Mir & Sheikh 2010, Patel et al. 2014, Alhomoud et al. 2015) and patients avoiding dialogue because they fear doctors will not understand their faith's importance and values (Mir & Sheikh 2010, Patel et al. 2014).

Studies (Grace et al. 2008, Worth et al. 2009, Markham et al. 2014 and Patel et al. 2014) make clear that people can benefit from consulting religious leaders. Worth et al., for example, describe Muslims and Sikhs needing help reconciling present suffering with the promise of a good afterlife. However, no studies, apart from Savage (2015), describe healthcare chaplains as people who can also be called upon to assist in such situations.

2) Love and Belonging

Mir & Sheikh (2010) give compelling evidence of how Islamic identity can trigger stereotyping in healthcare situations, resulting in people experiencing anger, stress and low self-esteem. Muslims, for example, can be seen by healthcare professionals as all equally religious and women wearing veils as oppressed. Staff are even reported assuming Muslims always want to eat curry and rice (McClimens et al. 2014), hold fatalist beliefs and are unwilling to lose weight (Grace et al. 2008). Mir & Sheikh conclude, reasonably, that such non-acceptance can cause the idealising of family homelands and detract from people building positive lives in the UK.

Venkatasalu (2017) and Hamilton & Essat (2008) describe relatives suffering significant upset when Muslim, Sikh and Hindu hospital patients are neglected. Venkatasalu reports families responding with anger towards healthcare professionals but also by lovingly attending to patients and staying to alert staff to their needs. Such experiences and responses may be typical of other sectors of the UK population too. In contrast to relatives facilitating staff-care, however, Venkatasalu (2017) emphasises that a key aspect of healthcare professional's work is enabling mutual family-care. Patel et al.'s (2015) quantitative findings illustrate benefits this can bring by showing that family and friends provision of medication, dietary and emotional support reduces peoples' diabetes related distress. Cowan (2013) and Worth et al. (2009) also highlight the need for carers to be sustained by family teamwork so that they have opportunities for other employment and rest.

3) Gratitude, Peace and Hope

Four studies indicate that preferred food enhances peoples' contentment; halal or vegetarian food prepared with uncontaminated utensils, for example, matter greatly to Muslims and Hindus (Wilkinson et al. 2010, Markham et al. 2014, McClimens et al. 2014). Dietary concerns also appear to be a crucial barrier to people accessing hospices (Markham 2014) hence Worth et al.'s (2009) reassurance that Muslims and Sikhs were satisfied with food in central Scotland hospices is significant. The individualised provisions that these hospices offered also included prayer facilities, video telephone calls abroad and Asian TV and were reported to be greatly appreciated. Likewise, gratitude was expressed to acute hospital staff by a woman who was asked if she was a Muslim, offered a prayer room and, at her request, reminded by staff of

prayer times (Hamilton & Essat 2008). These examples indicate that person-centred care is fundamental to people experiencing positive emotions such as gratitude, peace and hope.

This stress on individualised care is congruent with Kai et al.'s (2007) recommendation that the emphasis in healthcare professional's training is shifted from staff developing cultural and religious expertise to offering excellent individualised care. Kai et al. (2007) report that doing this eased self-perpetuating uncertainty experienced by staff which sometimes led to practice inertia. Worth et al. (2009) also suggest that staff who adopt this style of working could be supported with real-time cultural and religious advice. Kai and Worth both state, however, that teaching individualised caring still requires some content-based learning and so their recommendations may not be completely incompatible with angry calls from service users (Hamilton & Essat 2008) for staff to have more cultural and religious knowledge and sensitivity.

4) Religion and Divine Guidance

Worth et al. (2009) describe the importance of institutional support for people from minority religious groups, for example, through the provision of religious facilities in hospices and hospitals for customs like ablutions before prayer. Contrastingly, Savage's study (2015) describes possible institutional discrimination in healthcare chaplaincy departments with a high proportion of Christian staff, because they are unlikely to visit as wide a cross-section of religious people in hospital as more diverse teams do. Savage's research, however, lacks rigorous methodology and so his conclusions cannot be relied upon.

Three studies describe Muslims, Hindus and Sikhs valuing their homes as havens where religious and cultural rituals can be practised, such as bathing before eating and praying (Frearson et al. 2013, Venkatasalu et al. 2014, Venkatasalu 2017). Religious practices are perceived to be easier to practise at home than in hospital. Frearson et al.'s study (2013) illustrates the importance of home to Hindus by describing how some Hindus are willing to receive personal care from staff of a different gender to themselves, if this enables staying at home. It is relevant, therefore, that factors which could contribute to patients not being able to stay at home exist in British South Asian communities, such as low awareness of potential palliative support at home and a lack of GP home input (Cowan 2014, Markham et al. 2014).

Two studies (Grace et al. 2008, Cowan 2014) recommend linking healthcare education with public faith-placed and faith-based learning, to raise awareness of available palliative support and chronic illness self-management. Hipwell et al. (2015) refer to the social learning style of Sikh Punjabi culture and indicate that such courses are effective if they use a single language to ensure comprehension and homogeneous religious groups to enable open dialogue by reducing fear of causing offence. The example is given of Sikh couples attending courses about diet at a Gurdwara to help husbands understand why their wives need to cook less calorific meals.

5) Death Concerns and Resolutions

Studies (Frearson et al. 2013, Venkatasalu et al. 2013, Cowan 2014, Venkatasalu 2017) indicate that what helps Muslims, Hindus and Sikhs die with "a comfortable heart" (Markham et al. 2014), includes: last wishes being fulfilled, patients not being alone and seeing family and old friends, death not being spoken of in front of the dying person and receiving cultural and

religious understanding. The studies' findings differ, however, about appropriate numbers of visitors for a dying person, with Venkatasalu's and Cowan's research indicating preferences for the opportunity to receive groups, whilst Markham et al. (2014) and Frearson et al. (2013) report a liking for smaller numbers. Amongst first generation immigrants Venkatasalu et al. (2014) also found thoughts turned to their homeland when thinking about death, and consequently people wanted the end of life to be like its beginning. This study reports tentative evidence of Muslims aspiring to return to die in their homeland and Hindus, whilst being strongly attached to their heritage, being more likely to want to adapt it in their new country instead.

Venkatasalu (2017) offers his own "considerations for nursing practice" for British South Asians who do die in hospital. These include allowing Hindu mourning rites involving crying-out-loud and enabling silence for Muslims. The presence of these guidelines raises the question posed by previous literature reviews about the value of collective guidelines for individual care. Mir & Sheikh (2010) suggest that the absence of dialogue in patient-professional relationships contributes to professionals relying on collective norms to inform decisions, in other words, on being informed by presumed social identity rather than actual personal circumstances. Patel et al. (2014) and Alhomoud et al. (2015), however, state that national guidelines about managing Ramadan and fasting could help professionals to facilitate discussions about them.

6) Appreciation of Art and Beauty

Galek et al. (2005) and Flannelly et al. (2005) both describe the relevance of aesthetic appreciation to spirituality. However, these are not discussed in any of the 18 studies covered by this review. This suggests that this subject could usefully be researched further.

7) Morality and Ethics

Grace et al.'s (2008) carefully-phased focus group study, reports Muslim leaders confirming that living healthily reflects Islamic teaching. However, it also records moral conflicts for Muslim women between modesty customs and taking public exercise and between traditional hospitality and abstaining from rich foods. This study suggests that teaching about healthy lifestyles may not be enough to change the complex hierarchy of values which can influence Muslims' lifestyles.

Fatalist beliefs about life being dictated by chance or God's will, raise ethical issues about people's personal responsibilities and the way in which spiritual support is offered. Grace et al. (2008) report religious leaders declaring that fatalistic beliefs are misinterpretations of Islamic teaching and do not remove people's responsibility to live healthily. Patel et al. (2015) concur but describe how first generation British South Asian immigrants may not see links between their religious fatalist beliefs and their choices about eating and exercise. Reflecting this, Patel's study states that strategies are needed which challenge fatalist beliefs concerning diabetes, thereby implying that recognising and responding to spiritual needs may not mean following people's preferences and can involve questioning the lifestyles and beliefs of both individuals and their social networks.

Filial-piety is described by well-researched studies (Frearson et al. 2013, Venkatasalu et al. 2013) as the honourable duty of care younger generations traditionally offer to their elders, by protecting them from difficult discussions and taking decisions on their behalf. Frearson et al. (2013), state that this outlook is strong amongst second, as well as first, generation Hindu immigrants. This family-centred approach to caring (Venkatasalu 2017), however, potentially conflicts with the UK medical principle of autonomy which is usually applied through open discussions with patients about their diagnosis and prognosis and by seeking their opinions about treatment decisions (Worth et al. 2009, Venkatasalu et al. 2013, Markham et al. 2014). This is clearly a sensitive area of care where tactful negotiation is required by professionals if patient preferences are to be followed and informed consent obtained from relatives (Venkatasalu et al. 2013). Ethical challenges will also face healthcare professionals If differences are detected between patient and family outlooks (Worth et al. 2009).

Worth et al.'s study (2009) of Muslims and Sikhs in Scotland highlights the experience of people who have an additional vulnerability to illness such as low income or uncertain legal status. It gives the example of a Sikh man with multiple long-term health conditions who was also homeless and an asylum seeker. It also states that healthcare professions have a moral duty to prioritise such patients' care and, if necessary, to act as their advocate.

Discussion

1. How the Findings Answer the Research Questions

The 18 reviewed studies show that the spiritual needs of adults from minority religious groups are sometimes recognised well and receive a positive response in UK healthcare contexts. Good practice is described as high quality individualised care. People expressed delight because provision was made for prayer, contacting relatives abroad, preferred food (Worth et al. 2009) and consulting doctors who understand medical matters concerning faith (Mir & Sheikh 2010). This review has found that six of the seven categories of spiritual need described by Galek et al. (2005) and Flannelly et al. (2006) have been recognised and responded to, to some extent, the exception being appreciation of beauty and art.

However, there has also been considerable and consistent evidence of the spiritual needs of minority religious groups not being addressed. Healthcare professionals have not always seen people's religious identity as a valuable resource (Mir & Sheikh 2010). In acute settings the lack of attentive end-of-life care and sensitively applied religious knowledge has caused despair and angry criticism from patients and relatives (Hamilton & Essat 2008, Venkatasalu 2017). In chronic contexts professionals have failed to recognise when medical and spiritual needs overlap and to initiate necessary conversations with patients (Mir & Sheikh 2010, Patel et al. 2014, Alhomoud et al. 2015). In palliative-home situations there has been a lack of GP involvement contributing to low awareness of potential support (Cowan 2014, Markham et al. 2014). It is therefore clear that people from minority religious groups also do not always receive the benefit of the six categories of care referred to above.

Concerning healthcare professional's practice, Worth et al.'s (2009) excellent research recommends that they receive "real-time" advice when supporting religious people. However, Worth's study does not identify who could supply this support; the authors of this review suggest that this may be a key task for healthcare chaplains to undertake. Grace et al. (2008) and Cowan (2014) recommend that local community and religious centres and leaders should be used to help professionals develop faith-based and faith-placed healthcare education, which Hipwell et al. (2015) state will benefit from a homogenous religious and language approach. However, because the evidence base for these ideas is limited further research is needed, including concerning what relevant projects have been tried since these studies were written.

Concerning the content of health professionals' training, studies reporting staff views place more emphasis on teaching an individualised approach to cultural and religious care. This gives professionals confidence (Worth et al. 2009, and Kai et al 2007), prioritises vulnerable patients (Worth et al. 2009) and is greatly appreciated by patients and relatives (Hamilton & Essat 2008, Worth et al. 2009). However, all studies, especially those giving the perspectives of people from minority religious groups (Hamilton & Essat 2008, McClimens et al. 2014), stress the importance of some content-based learning too. This is because religious and cultural knowledge sensitively used can enable, for example, consultations about fasting during Ramadan (Patel et al. 2014, Alhomoud et al. 2015, Mir & Sheikh 2010), seeking meaning in suffering (Worth et al. 2009) and perhaps the understanding of previously unrecognised spiritual needs (Patel et al. 2015). Content-based training, however, may benefit from being shaped for each medical discipline, as Venkatasalu (2017) does in offering "considerations for nursing practice" concerning offering end-of-life care in acute hospitals. It is important to note, however, that studies consistently indicate that collective guidelines should be used as descriptive theoretical knowledge to

support person-led care rather than as prescriptive practical check-lists. The authors of this review also consider that the research and delivery of such sensitive training sometimes falls within healthcare chaplains' remit.

Concerning chaplains, Mowat's previous systematic literature review (2008) raised the issues of potential institutional discrimination in healthcare chaplaincy departments and the significant lack of research about multi-faith healthcare chaplaincy. Only one primary research study was found concerning these matters, which confirms that the dearth of this research has continued and explains the relatively small amount of discussion about healthcare chaplaincy in this systematised review. Although Savage (2015) reiterates the on-going risk of institutional discrimination in healthcare chaplaincy departments, because of his study's limited methodology the only conclusion that can be drawn is that further research is needed concerning this issue. This is a challenge which healthcare chaplains need to respond to. Part of this response may include comparing the results of literature from a UK context, reported by this review, with findings in other international contexts, to assess how far findings are transferable between various cultural contexts.

2. Limitations

Seventeen of the included studies concern English healthcare settings; therefore, this review neither addresses the whole UK context nor an international context. Also, within its limited time-frame this systematised literature review could not complete an exhaustive search and this was particularly true of grey literature. it is likely that more primary research material exists on specific faith traditions which database searches is unable to discover. The fact that a single reviewer (MS) undertook searches and data extraction may increase a risk of bias.

Nevertheless, this may have been reduced by the perspectives of the second author (EC) and an additional reviewer (DM) who both commented on the extracted data.

Conclusions

This review adds the following findings to those of other literature reviews. Firstly, it describes literature from July 2007 – September 2017 describing how people from Islam, Sikhism and Hinduism have received spiritual care in acute, chronic and palliative healthcare contexts. Secondly, it reveals the lack of research about the spiritual needs of people from other minority religious groups in these contexts during this period. Thirdly, it shows the continuing absence of quality research about multi-faith healthcare chaplaincy and that the question raised by Mowat (2008) and Savage (2015), concerning potential institutional discrimination in healthcare chaplaincy departments, remains unanswered. And fourthly, it re-emphasises the on-going need for healthcare professionals to be trained in how to engage in consultations regarding individualised spiritual needs provision.

These findings, along with others in this review, mean that future healthcare policy and research will benefit from considering:

1. How real-time cultural and religious support can be given to healthcare professionals to enable them to meet the needs of individual patients from minority religious groups effectively.
2. How training can be developed to enable healthcare professionals to offer high-quality individualised spiritual care to every person.

3. How the efficacy of faith-based and faith-placed healthcare education can be researched further.
4. Whether appreciation of art and beauty is relevant to the spiritual needs of minority religious groups in healthcare contexts.
5. How practice can be evaluated to ensure that institutional discrimination is not occurring in hospital chaplaincy departments.
6. How further research can be commissioned about how people from minority religious groups, apart from Islam, Sikhism and Hinduism, experience their spiritual needs being recognised and responded to in UK acute, chronic and palliative healthcare.

Tables and Figures

Tables

Figures