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Abstract

Background: Chaplaincy intervention in primary care is an emerging provision; little is known about what causes a General Practitioner (GP) to refer a patient.

Aim: To discover why GPs refer to chaplaincy in primary care contexts, to understand referral processes, investigate alternative referral routes, and explore how cues relate to previously reported socio-economic health issues.

Design and Setting: A qualitative descriptive study in one urban Scottish general practice.

Methods: Semi-structured interviews were conducted with a convenience sample of GPs. Data were analysed, to the point of saturation, using thematic content analysis.

Findings: Nine GPs participated. Appreciation of whole-person spiritual care and good access predisposed GPs to refer to chaplaincy. Referral followed a series of steps precipitated by identification of bereavement, faith issues, anxiety and/or depression, and isolation. Doctors gauged the need for referrals subjectively. Sharing management with patients was routine. Female patients were referred more frequently than male patients.

Conclusion: Referrals were made on a person-centred basis. An apparent barrier of male gender and subjectivity in assessment prior to referring merit further investigation. We suggest that a model representing the referral process demonstrates good practice and may stimulate discussion about GP referral to chaplaincy.

Keywords: Pastoral Care; Spirituality; Referral and Consultation; Primary Health Care; General Practice; General Practitioners

How this fits in

Chaplaincy provision in primary care is a new but growing service in the UK. It offers a listening service, person-centred spiritual care and significant support for individuals in community settings. GPs, however, have expressed unfamiliarity with this service as spiritual care has traditionally been offered in hospitals and hospices. GPs also report uncertainty as to when and why to refer to this service. This paper is significant because it is, to the authors' knowledge, the first study to look at the reasons that GPs who do refer to primary care chaplaincy give for making these referrals. The findings will inform GPs as to what cues and triggers may be useful in identifying patients who would benefit from attending chaplaincy services, and also provides a model of the pathway through which a patient might travel from GP to chaplain. It is useful for a chaplain to have a fuller understanding of what has occurred to lead a patient to the appointment. This research suggests a high level of participation between patient and GP in considering attending the chaplain, which suggests a readiness to talk, engage or embrace change when a patient does attend a chaplaincy appointment.

Introduction

As people in the UK increasingly attend their local surgery as the first point of contact for a wide variety of problems it has been asked if GPs might now play a priestly role within British contemporary society (Pink et al. 2007). However, GPs can struggle to deliver spiritual care, and their views on spiritual care range from embracing and pragmatic to guarded or rejecting (Appleby et al. 2018). Given that up to 90% of all patient contact in Scotland occurs in community settings (NHS Scotland 2009) and with the importance of person-centred care increasingly emphasised, providing spiritual care is becoming an important activity in primary health care. NHS staff now have responsibility to provide spiritual care (NHS Scotland 2009), yet current tools for identifying spiritual need (Rhinefleish 2015), are primarily derived from hospital chaplaincy and may not be as relevant in primary care settings.

In recent years GP practices in Scotland and England have begun to use primary care chaplaincy services. Related research has focused on user experiences and on service efficacy (Kevern and Hill 2015; Macdonald 2017; Mowat et al. 2012; Bryson 2012; Bunniss et al. 2013; McSherry et al. 2016). GPs expressed uncertainty about when to refer to primary care chaplaincy (Bunniss et al. 2013), and little was known about why and when GPs might refer patients to the service. This qualitative descriptive study aimed to explore what cues and triggers prompt GPs to make referrals to primary care chaplaincy. Hanlon (2012a and 2012b) suggests that four 'modern maladies' plague modern Scotland: loss of wellbeing, obesity, addiction and depression. If GPs are the first contact for the public's malaise, then they will see much of these four presentations. Hence this study also aimed to investigate whether such issues influenced referrals to chaplaincy.

Methods

Ethics approval was obtained (see endnote).

A qualitative descriptive design outlined by Sandelowski (2000) was adopted. The underpinning approach was informed by social constructivism as this is useful for investigating social interaction, meaning and processes (Creswell & Poth 2018). Data were collected between January and May 2018.

With permission from managers, all GPs (n=12) working at one urban medical centre incorporating a chaplaincy service were approached via internal email with study information and an invitation to take part. The researcher (SG) was the practice chaplain, so to avoid any perceived coercion a practice administrator distributed information, co-ordinated responses and arranged interviews. Written informed consent was obtained prior to one-to-one semi-structured interviews conducted by SG. To our knowledge this is the only GP practice in Scotland to have a Primary Care Chaplain – therefore at the time of study there was no wider sample to draw from; hence the convenience sample.

The interview was structured using Robson and McCartan's (2011) model from social research. Questions were designed to allow GPs to speak freely about a range of triggers and cues for referral (see Box 1). The interview ended with questions which allowed a range of answers and 'story' in the response. Questions allowed for both an inductive approach, where an open approach eliciting any kind of response was adopted, as well as an inductive strand of investigation where theoretical influences and presuppositions, such as Hanlon's modern maladies criteria, were explored. An approach suggested by Bowling (2014) was adopted for two questions (1 +9 – see Box 1), in which a socially unacceptable answer was assumed. This was intended to counter the effect of being interviewed by a colleague and make it more likely that participants would speak candidly.

Three questions were added after the initial interviews identified new issues for further exploration. Doctors spoke about ‘gut feelings’ or ‘instinct’ so a question about this was used in later interviews. Question 4 asked about the ‘type of patient’ and raised conflicting answers about the age and gender of patients referred: this issue was also explored further. Single versus multiple issue referring was also further investigated. These issues formed the basis for ongoing attention as they were not only added to the interview schedule, but also were the divergent views explored in the analysis stage.

Box 1: Interview guide

1. If you refer a patient to chaplaincy what things act as a trigger for you to make the referral? Can you give examples of this?
2. What you have recognised about successful referrals to the chaplaincy service? In what ways does this inform subsequent referrals?
3. What can you tell me about a mental or actual list of criteria or cues that you use for referral to chaplaincy? What does this consist of?
4. Please describe to me a particular 'type' of patient whom you are more likely to refer to chaplaincy.
5. Please tell me what you know of Phil Hanlon's loss of wellbeing, obesity, addiction, depression identification of modern maladies? In what ways would 'LOAD' inform your treatment plan?
6. How useful are the inclusion/exclusion criteria which have been drawn up for the chaplaincy service at ///? Are you aware of these criteria? What do you think of them?
7. What are your views about the Chaplaincy Service leaflet? Do you find that the list of possible reasons for referral in the Chaplaincy Service leaflet informs you when making or not making a referral?
8. How do you choose between chaplaincy and other services (e.g. primary care mental health team)? Can you give me an example of this?
9. When you don't refer a 'possible chaplaincy' patient what alternative treatment routes do you suggest to patients? What is your thinking behind this choice? Again, can you give me an example of this?
10. What is your view on the place of spirituality in health care?
11. What is your view on the role of chaplaincy in health care?

Interviews took place in a quiet room at the medical centre, lasted around twenty minutes and were audio-recorded and transcribed verbatim. For each participant, background demographic data were also collected. Brief researcher reflections were noted immediately after each interview. A reflective journal was also kept fortnightly during data collection and analysis. Data

collected on an ongoing basis in the surgery as part of routine evaluation were used for comparative purposes.

Data analysis began after the first interview and was performed concurrently with interviewing, using the principle of data saturation to determine the final number of interviews. Based on Guest et al's (2006) findings that most themes emerge by six interviews, and because this was a homogenous sample with a focused research question that was not personal (Polit and Beck 2017), the first boundary for data saturation was set at six interviews. It is accepted that when three further consecutive interviews reveal no new codes, data saturation could be considered to have been achieved (Frances et al. 2010). Hence data saturation was judged to have been reached at nine interviews as no new codes arose from the coding of transcripts seven, eight and nine.

Data analysis

After recording and transcription data were analysed and coded thematically using Burnard's guidelines (2008). Descriptive codes and categories were derived from terms found in the transcript, as well as from questions used in the interviews. Where possible, quotes were used as code labels for sections of text, in order to stay close to the data (Charmaz, 2006). Field notes and reflections on the interviews gave insight into observations as analysis began.

Transcripts were read and using Burnard's (2008) 'open coding model' initial common ideas or codes were identified by manually noting around 80 words and phrases on the transcripts. These ideas were then grouped into categories with similar meanings. This was a fluid stage where codes shifted between categories as best fits were established. The evolving analysis was reviewed by EC who also independently analysed the first three transcripts. Comparisons of coding and categorisation were discussed before the rest of the transcripts were analysed. As suggested

is good practice by Attride-Stirling (2001) a model (Figure 1) was developed to enhance the analysis and reporting process of the themes.

Several measures were used to enhance rigour and trustworthiness. Independent analysis allowed the initial codes and categories to be agreed and emerging themes to be discussed. A 'reflexive approach' was exercised using field notes and journal entries and the researcher asked: 'How does my being a chaplain and a colleague affect the data collection process?' Analysis of the data was both inductive and deductive. Whilst looking for the answers to the 'a priori' questions the researcher also strove to listen carefully to the doctors' answers and to adjust expectations in light of the findings as is advised in descriptive work (Bowling, 2014).

Issues of gender, age and single versus multiple issues for referral were identified as contradictory or deviant and were attended to specifically by isolating the parts of the transcripts containing them, cutting them out and specifically analysing these quotes.
As is suggested is good practice by Parahoo (2014) validation of themes was sought once a synthesis of findings was achieved. When the model was approaching a final version, it was discussed with one of the participants, as a form of participant validation. The doctor was enthusiastic about the model and felt it represented what had been expressed in interview and what is experienced when making referrals to chaplaincy. A larger member checking exercise took place when a wider conference group of around 60 chaplains and GPs interested in, or experienced with, primary care chaplaincy reported that the model accurately reflected their experience. Those attending were from a range of situations in both Scotland and England, and some present had more than 15 years of experience in primary care chaplaincy.

Findings

No doctor declined involvement, though due to data saturation three potential participants were not interviewed. Nine GPs were interviewed. Table 1 shows the range in age, length of time since qualifying, and duration of employment at the study site. All doctors referred to the chaplaincy services at the study site, yet only two had referred to chaplaincy services elsewhere in previous jobs. A high proportion of doctors professed to be Christian (77%).

Table 1: Demographic characteristics of participants

	Variable	Number
Age	25 - 39 years	4
	40 - 54 years	5
Gender	Male	6
	Female	3
Ethnicity	White	9
Religious Affiliation	Christian	7 (5 practising)
	Jewish	1
	Atheist	1
Years as GP	0 - 3 years	4
	15 - 25 years	5
Years at study site	0 - 3 years	4
	10 - 13 years	4
	20+ years	1
Worked elsewhere with chaplaincy	Yes	6
	No	3
Referred elsewhere to chaplaincy	Hospital	1
	Primary care	1
Refer to chaplaincy at study site	Yes	9
	No	0

From an initial 82 codes, 30 data categories were established which were distilled into 11 final categories. These were grouped into three final themes (i.e., **Environmental milieu and**

predisposing factors, 'Step process' involved in referral, Alternative routes for referralswith six subthemes (see Box 2).

Box 2: Themes and subthemes resulting from content analysis

Main themes and sub themes

Environmental milieu and predisposing factors

- Perceived importance of spiritual care and the value of primary care chaplaincy, including appreciation of time for the patient to talk.
- Access factors
- 'Comfortable referring'

A 'Step process' involved in referral including identification of presenting issues.

- 'Modern malady' triggers
- Intuition and subjective assessment
- Barriers and facilitators to referral

Alternative routes for referrals

Environmental factors predisposed GPs to consider referral, a process involving a series of steps. Identification of presenting issues guided the GP in the referral with mental health issues, bereavement, spiritual and relationship issues, and isolation most commonly triggering a referral. A patient's entrance to this process could be advanced by facilitators. Alternatively, some barriers operated to reduce the likelihood that a patient would be referred to chaplaincy. Alternative routes could also be offered.

Theme - Environmental milieu and predisposing factors

Several factors which influenced the doctors' attitude towards chaplaincy were identified. These played an important role in predisposing the GPs to consider referral to primary care chaplaincy.

Subtheme: Perceived importance of spiritual care and the value of primary care chaplaincy

Doctors spoke repeatedly of the importance of being able to offer spiritual care to patients:

> *'I think it (spiritual care) is massive, such a big part for patients' health ... even if not religious or spiritual at all they (patients) might really want that at the time. It makes such a big difference. … all about making the person's care the best that it can be and that is involved in it – the spiritual perspective.'* GP9.

Sub-theme - Ease of access

Six doctors said that issues of access to the service positively influential making a referral. Doctors mentioned shorter waiting times, the 'in-house' nature of the service, the relaxed style of the room and the approachability of the chaplain. A referral was more likely due to these factors.

Sub theme - 'Comfortable referring'

The comfortable attitude that many GPs demonstrated in relation to referring to chaplaincy was unexpected; and was a factor predisposing to referral. This was due both to confidence in the service and to the doctor's understanding of the consultation process and their ability to cope with ambiguity when working with a patient towards a solution. This idea of doctors being relaxed and confident despite some uncertainly about the referral process was found echoed in the reflective notes written by the researcher during the analysis process:

> *'Doctors don't seem to NOT refer – increased my confidence. They obviously don't refer many patients – but if a patient is appropriate and interested the Doctors seem happy to refer/suggest.'* Researcher's reflective notes.

This confidence may be based on assurance about the referral process and an understanding that patients will return if an issue is unresolved.

An appreciation of the usefulness of spiritual care, factors to do with good access to the service, and a confident approach to referring all contribute to a positive attitude towards referring to spiritual care services in primary care. A referral was therefore more likely because aspects of the service are appreciated by doctors who are already comfortable with the inexact nature of referring.

Theme – The referral process involves a step approach

GPs progressed through a series of steps in relation to a referral to primary care chaplaincy. Issues which initiated a referral or acted as a barrier to a referral are discussed within this process. The process may be linear and one-off, or cyclical; perhaps occurring over several consultations and a period of time.

Step 1: Identification of presenting issues

All GPs mentioned the identification of presenting issues which acted as triggers or cues to initiate thinking about referral to chaplaincy services. Bereavement, mental health, and spiritual or religious issues were most commonly cited as reasons to refer to chaplaincy services. Table 2 lists the 15 issues most commonly mentioned by the doctors.

Table 2: Presenting issues, by frequency of GPs reporting the issue

Presenting Issues	Number of GPs identifying issue
Mental health	9 (all)
Bereavement	8
Spiritual/religious issues	7
Stress	5

Depression	4
Relationship issues	4
Loneliness/isolation/lack of support	4
Trauma/crisis	3
Anxiety	3
Awareness of the issues identified by Hanlon - 'LOAD'	2
Security	2
Work issues	1
Poor health	1
Body image	1
Non-verbal cues (tears)	1

One doctor spoke succinctly of this identification of issues:

> *'So, the kind of things that trigger a referral are patients that have come with mild to moderate, usually mental health problems or social problems that they are finding very stressful, typically anxiety, depression or they have had a recent bereavement, or they are finding a particular event in their life very stressful.'* GP2.

Social isolation or a lack of support was cited by four doctors as a reason to refer a patient to chaplaincy and two specifically mentioned loneliness as a main characteristic of those that they refer.

Using 'Modern Maladies' as a referring criterion

This study explored a possible connection between the modern maladies of loss of wellbeing, obesity, addiction and depression as outlined by Hanlon (2012a, 2012b) and a referral from a GP to chaplaincy. Only 2 doctors spoke of using these ideas specifically to guide a referral. However, depression and loss of wellbeing were respectively mentioned by 4 and 3 doctors as a presenting issue which would lead to referral to chaplaincy. Addiction is an exclusion criterion for referral to chaplaincy so was not used to guide referrals to this service.

Step 2: Gauging readiness

The second step in the referral process involved the GP gauging the openness or readiness of a patient to engage with chaplaincy. Of the doctors interviewed seven GPs mentioned this step. Other terms used in addition to 'openness' were '*receptive*', '*ready*' and '*not closed'*. One doctor described gauging this type of openness:

> *'… you know my opening question is usually "Have you thought about talking more about this recently?" and some people just close up immediately as soon as you say that, and you know they are not going to be able to work this (chaplaincy). Particularly if they found it difficult enough to come to me to tell me how they are feeling, you get a sense that they don't like talking, … So, I would maybe just not even mention it, just go in another more indirect route.'* GP2.

Gauging a patient's openness was important in determining the appropriateness of a referral.

Sub-theme - Intuition and subjective assessment

An element of subjective assessment was often used in conjunction with identifying presenting issues and gauging readiness. Of the nine GPs, seven said that some level of intuition was used in decisions about referrals. When doctors spoke of intuition, they used terms like '*gut feeling*', '*internal clocking'*, '*gut instinct'* and '*get a sense'*. A measure of intuition may therefore be used when judging readiness:

> *'I suppose I get a kind of gut feeling about people who have other needs going on… so we probably should all work more towards evidence-based medicine and criteria…but actually sometimes you just see a person in front of you and think, 'You could really do with chatting to someone.''* GP8.

This subjective assessment was used in assessing whether the presenting issues should direct a patient towards chaplaincy or towards an alternative intervention, and also in evaluating the readiness of a patient to engage with spiritual care services.

Step 3: Sharing information and presentation of treatment options

All GPs spoke of a third step of sharing information and discussing treatment options. This involved providing a leaflet. Often the patient was encouraged to read this and think about whether they would like to use chaplaincy services. One very clear theme for all GPs was the importance of presenting a patient with choice and options.

Step 4: Formal recommendation

The fourth step was not observed by all doctors. This involved a more formal referral, along the lines of a prescription, or the actual booking of appointment.

Sub-theme - Barriers to referral

Several barriers to referral were identified throughout this step process (see Table 3).

Table 3: Barriers to referral: frequency of reports

Barrier	Frequency of interview reports
Lack of patient openness	7
Presenting issue in exclusion criteria	6
Gender/age	6
GP uncertainty	6
Patient uncertainty	4

Lack of patient openness or readiness

Lack of patient openness was mentioned by seven participants and was connected to the 2nd step of gauging openness. Lack of openness might result in a doctor not mentioning chaplaincy as an option, or the patient rejecting it early in the process:

> *'Generally, it becomes quite evident quite quickly when you raise the whole subject of chaplaincy whether they are quite closed to that.'* GP1.

Patient opinions and reactions about this type of intervention were judged carefully by the doctors.

Presenting issue in exclusion criteria

Patients presenting with issues that would receive a referral to a specialist service were those with active addictions, severe mental illness, some sexual issues or extreme trauma.

Gender and age

Five of the participants said that they would be more likely to refer women because they assumed that women would be more open. Most doctors also said that they would refer older patients. Routinely collected data at the study site shows that most patients who attend chaplaincy are over 40 years old, a quarter are retired, and around 80% are female.

GP uncertainty

The novel nature of the service created barriers for some doctors, this is despite the comfortable referring noted earlier. Uncertainty ranged from forgetting the existence of chaplaincy as a referral option, to being reluctant or unsure as to who and when to refer. Here the benefit of

good working relationships with the chaplain was seen. Exposure and training appeared to ameliorate uncertainty, as is expressed by this doctor:

> *'Once I was more open to it (chaplaincy) and understood what it was, then there was never a reason not to (refer) really. Anyone can benefit.'* GP9.

Several GPs spoke about the value of and desire for more feedback from chaplaincy about patients who had attended.

Patient uncertainty

Patient uncertainty operated as a barrier, especially when patients showed a reluctance to talk about issues. Patient choice remained a priority throughout, but some GPs had strategies to counter patient uncertainties about the value of talking, or a fear that the service was overtly religious.

Factors facilitating referral

It was found that female gender, patients showing a need for whole-person, spiritual or religious care, or expressing a desire to talk or work through issues also acted as facilitators in the referral process. These were in addition to the predisposing factors already identified.

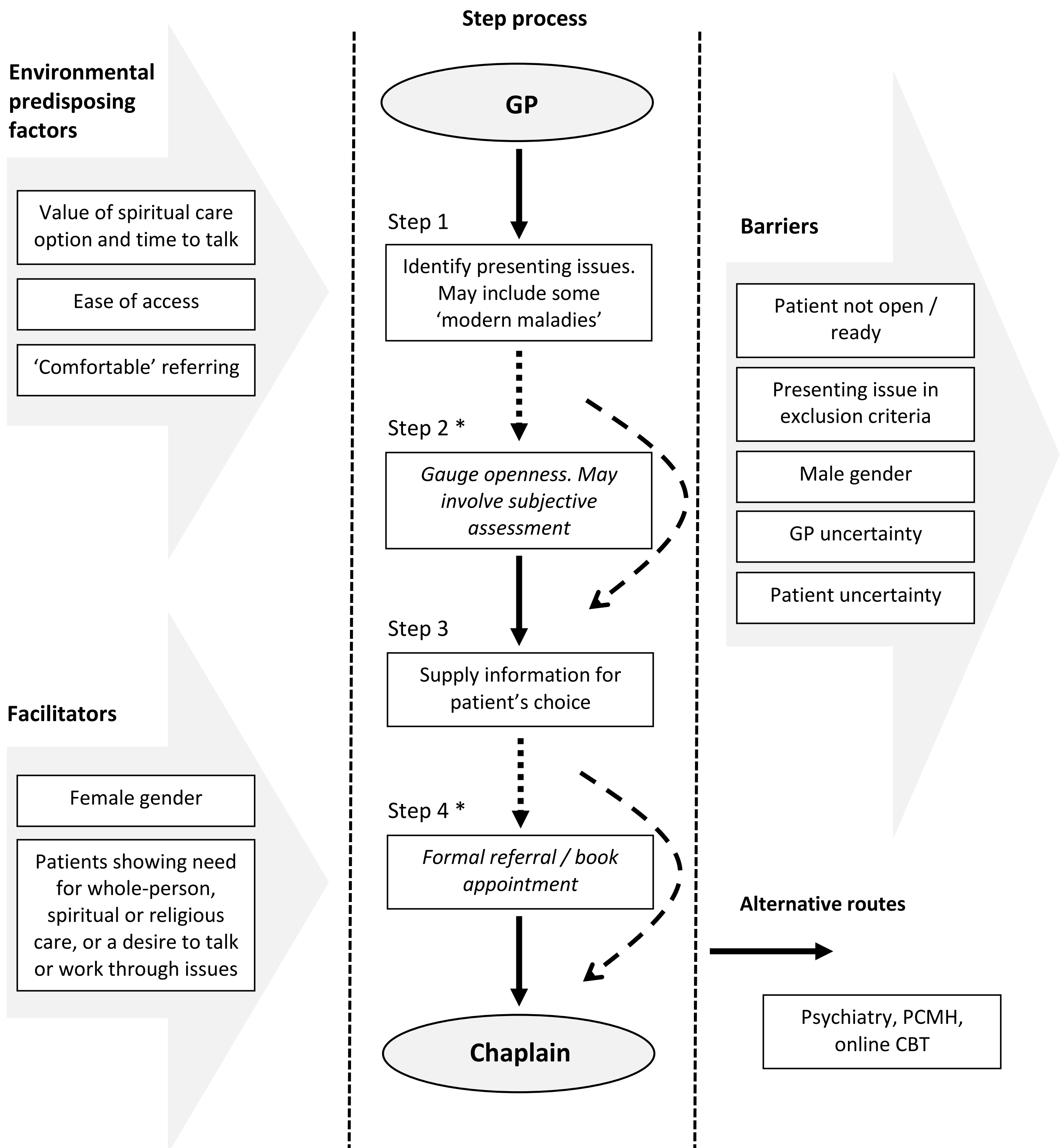
Theme – Alternative routes

Alternative referral routes reported were psychiatry, primary care mental health services, online resources, addiction services, and specialist grief counselling. Medication was also seen as an alternative route, although this could operate in tandem with chaplaincy.

Figure 1 is offered as a conceptual model of the process of GP referrals to primary care chaplaincy. The steps are shown from top to bottom in the middle of the diagram, showing the progress of a patient from GP to chaplain. On the left are the predisposing environmental factors and

facilitators which serve to make a referral to chaplaincy more likely. Barriers to a referral are shown on the right, interrupting the steps and drawing a patient out of the process, and potentially into the alternative referral routes shown on the bottom right portion of the diagram.

Figure 1: Conceptual model of the referral process



*Not all doctors use 2nd and 4th steps

Discussion

Summary

A clearer picture now exists as to what happens at the study site when a patient visits a GP who then makes a referral to primary care chaplaincy. Doctors, of a range of experience and age, are well disposed towards chaplaincy as a referral option due to an understanding of the importance of spiritual care and appreciation of the good access to the service. This creates an environment in which referral to spiritual care is both possible and valued. Presenting issues, such as mental ill health, bereavement, loneliness and spiritual issues act as triggers, or occasionally as barriers, to referral. GPs are content to refer to chaplaincy despite their reservations, and dependent on the patient's choice and participation. This process continues via a series of steps and may be cyclical or occur over time. There may be a bias towards referring female patients and older patients. This is reflected in both what the doctors said, and information gained in evaluative material from this site and from other similar services (Bunniss 2013; McSherry et al. 2016). Male gender and youth therefore may be barriers to referral.

Two main findings are firstly, the identification of loneliness as an issue which appears to trigger a referral to primary care chaplaincy. This is of interest for future developments of a more specific tool to aid doctors identify the most suitable patients to refer to chaplaincy services.

Secondly, the active participation of patients in the referral process is salient to the chaplain as understanding of this suggests readiness for change on the part of the patient. Appreciation of this may affect the way that a chaplain approaches working with a patient.

It was interesting that although awareness of Hanlon's socio-economic health related ideas might not have been extensively and explicitly reported by participants, some of these presenting issues do fit with Hanlon's loss of well-being criterion, most markedly those patients presenting with some level of depression.

In view of the uncertainty expressed by GPs it is clear to see why communication from the chaplain in terms of feedback about whether a patient attended chaplaincy, and more generally in terms of being known and the service understood, is valued.

Strengths and Limitations

The proposed model (Figure 1) is, to the researchers' knowledge, new, and although the respondent validation exercise was small in scale, response at the study site was positive. The larger group of chaplains and GPs reported resonance with the model which further enhances the credibility of this study.

Limitations of this study include the presence of the chaplain acting also as researcher, although measures were taken to limit the influence of this relationship on recruitment and data collection. Interviews lasted on average 20 minutes; a longer interview might provide richer findings. Additionally, the single site nature of the study may limit transferability of the findings. Data saturation was achieved, but a more varied purposive sample might have yielded richer data. A large proportion of the GPs interviewed identified themselves as Christian – this is not representative of GPs as a whole and may have affected the data. No new themes emerged after the 6th interview. This could be a limitation due to the homogeneity of the sample. However, it may also be that there are a finite number of reasons as to why GPs refer patients to chaplaincy services and most of these were uncovered in the course of this study. The interview was focused and short and this type of interview is expected to achieve saturation earlier (Guest et al. 2006) Other studies into Primary Care Chaplaincy revealed similar findings on other aspects of chaplaincy services in GP, for example the presenting issues were very similar to those found here (Bryson, 2012; Bunniss et al. 2013; McSherry et al. 2016). This adds weight to the suggestion that there are a limited number of themes to be discovered in this specific area.

Comparison with existing literature

Findings concerning presenting issues, GP uncertainty, and access factors are comparable with evaluation data from the study site and with other literature on primary care chaplaincy efficacy (Kevern and Hill, 2015; Macdonald, 2017; Mowat et al. 2012; Bryson, 2012; Bunniss et al. 2013; McSherry et al. 2016). The one exception to this was the issue of loneliness or social isolation which was found to be a more common trigger for referral in this study. Mild concerns held by GPs and by patients about a novel service were also like those raised by previous studies, as was a desire for increased feedback from chaplain to GP (Mowat et al. 2012; McSherry et al 2016).

Implications for research and /or practice

Further research is needed to explore chaplaincy referral processes more widely, particularly in relation to referral patterns for males and young patients. And as the addition of social isolation into the list of commonly identified presenting factors was a new finding it would be interesting to see if a similar study in a different location also revealed this – there has been much in the news in the last three years about the issue of loneliness in UK society and this may have raised GPs' awareness of this as an area for concern, although no mention of media coverage was made. Perhaps this need might also be addressed by the type of service provided by the Social Prescribing services that some GP surgeries are now using (NHS Scotland, 2019).

Conclusion

This study achieved its aim of uncovering key referral triggers, some of which were unanticipated. Reasons for GPs to refer to primary care chaplaincy are found in the appreciation of the value of spiritual care and /or the potential therapeutic value of talking. Quick access and a local service are an important factor in triggering a referral. Modern maladies did not influence GP thinking in the identification of issues which led to a referral. However, bereavement, depression, anxiety, issues relating to faith, and in addition female gender and loneliness, were important factors in assessing the need for referral. Further research using a more varied sample of GPs is indicated.

The model (Figure 1), based on this study's findings, is useful for both doctors and chaplains. It could be used to educate doctors as to the type of issue which can prompt an appropriate referral to primary care chaplaincy; thus, addressing a need identified by previous research (Bunniss et al. 2013). Creating a tool that further enables accurate referral to spiritual care by GPs would be profitable. This might incorporate some of the presenting issues and could also include loneliness. For chaplains to have more understanding about the GP referral process and the confident way in which GPs make referrals is helpful and empowering. An understanding of the level to which patients are involved in the process may cause an adjustment in chaplains' expectations of how ready patients are to change or engage with spiritual care and may therefore result in more efficient or effective interactions.

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