Capturing religious identity during hospital admission: a valid practice in our increasingly secular society?

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Abstract
Most Victorian hospitals include religious identity in routine admission demographic questions. However, approximately 20% of all do not have their religious identity recorded.

Missing 20% surveyed at Royal Melbourne 2014–15

NSQHS standards:
   a) “early identification & management of patients at risk of harm”

   b) “partnering with consumers/carers to design care delivery”
Methodology:
Mixed methods, cross-sectional survey of 2140 inpatients over 2014-15

Results  Quantitative component:
1) demographics congruent with Australian Bureau of Statistics (ABS) census figures.
2) Religious identity important for a significant proportion of our diverse population

Results  Qualitative component
1) complexity behind religious identity labels, census is unable to capture
2) insight into the spiritual requirements of our growing multicultural healthcare population.
1) oldest in Victoria, a major tertiary teaching hospital with approx. 600 beds

2) Royal Park Campus Aged Care, including approx 200 beds

3) Oncology, Trauma and Transplant, Neurology/Neurosurgery, Cardiothoracic, chronic conditions e.g. Nephrology, Mental Health including Eating Disorders

6) large proportion over 65, today’s list exceeds Royal Park total beds

7) between 1200-1400 deaths per annum, including Royal Park
The Department of Pastoral and Spiritual Care services

1) partly internally funded, including the Coordinator, the Palliative Care Chaplain, two part time, Pastoral Care art therapist, and casuals

2) externally funded Faith representatives: Catholic Care, Anglican, Uniting, Buddhist Council, all trained and accredited

3) volunteers, including CPE and SHV trained and accredited (Catholic, Muslim, Hindu, Orthodox, and smaller groups)

4) Royal Melbourne Centre for Clinical Pastoral Education, conducts part time units and full time intensives
Orthodox Chaplain Efstatius
perusing his large list
including Royal Park

Buddhist Chaplain Hojun
distributing Rosemary
at Memorial Service
Mainstream faith groups, “No Religion” and census figures

- Australian Bureau of Statistics: between the 1911 census and the 2011 census, No Religion increased from 0.4% to 22% (just under 4.8 million Australians). Only Catholic higher, 25%, Anglican third at 17%. Atheist, Agnostic, Humanist and Rationalist almost doubled since the 2006 census, reflecting increasing secularisation.

- Census figures fairly congruent with RMH’s patient population; those identifying as Catholic higher, 29%, due to catchment area. Anglican lower, 13%

- Second largest cohort 23%, chose No Religion almost exactly mirroring census

- Orthodox 7.5%; Muslim 4.5%; Hindu and Buddhist 4%, non-denominational Christian also 4%. Also fairly similar to census

- Heterogeneous remainder eg Baha’i, Humanist, Pagan, Pentecostal, Sikh, Spiritualist, Wiccan, Sukyo Mahikari.
Demographics: minor and major, and emerging trends

- Almost half of older people identifying Catholic declined formal sacramental care, and over 60% Anglicans. Congruent with census, decline in formal faith adherence amongst traditional Protestant Christians.

- Less so Orthodox: most older patients requested amended ID and visit

- Nearly 100% of patients who identified Muslim faith requested ID amendment

- Younger people: generic Christian (no label) Buddhist = Christian and visa versa

- No Religion (second largest cohort): 23% declined support, 29% ambivalent

- No Religion surprise: 48% receptive to pastoral care
we'd like to
talk to you
about cheeses.

Church Mice.
Qualitative component: patient choice

All the patients surveyed, including those identifying as No Religion and Atheist, were asked if they required any follow up attention. Their choices were noted, placed under one of the following six classifications, and actioned if need be.

INTERVENTION CODES:

1. Pastoral Care by RMH staff including an explicit religious/spiritual dimension
2. Pastoral Care by RMH staff plus faith community involvement
3. Faith community involvement only
4. Pastoral Care by RMH staff for emotional/personal needs only
5. Declined any Pastoral Care
6. Other, including referral to other RMH services (such as Social Work or Music Therapy)
Qualitative component: patient choice

- 77% of patients identified with a particular religion: 29% of these requested faith rep. Of these, over 40% did not have access to their own faith rep.

- Identifying Catholic, 53% requested sacramental care, most of rest receptive.

- Anglicans - CoE: over 60% declined any specific religious care, though most receptive to emotional support. Only 7% mainstream protestant declined any.

- Assumption re names/origin and age, conversion, Orth=UCA, SDA=Buddhist.

- Muslim: variety of requirements behind label – ICC language, ICU Mecca, Pall Care.

- Aboriginal (ATSI ID) Catholic/Muslim; Maori Ratana/Anglican.
Qualitative component: patient choice

- *No Religion*, second largest cohort: 23% explicitly declined, 29% ambivalent

- Of the remainder, 48% were receptive to generic supportive counselling – often of a spiritual nature, and issues including disengagement from formative faith tradition, internalised values, alternative expression (i.e. mindfulness, eco activism)

- Referral to other RMH services, i.e. Social Work, Music Therapy

- Most identifying as *Atheist* receptive to engagement – i.e. Pall anger/hegel

- Small number identifying as *Pagan, Wiccan*, receptive - dying ritual
Conclusion

- Of the 2041 “Not-Specified” patients surveyed, a significantly high proportion, 77%, requested amendment on the RMH inpatient data system. This number is a tiny fraction of the mysterious 20% of those in all major Victorian hospitals who do not have their religious identity captured on admission on any given day.

- Figures largely congruent with ABS census figures, although with the caveat that behind formative religious identity labels there was considerable variation in belief and practice. Our “’drill-down’ case vignettes illustrate this complexity of belief and practice, which the census is unable to capture.

- This complexity, informed by RMH’s very multicultural catchment area demographics. However, it is evident that other major Australian cities are similarly developing. This growth would seem to give the practice of collecting religious identity data on admission new credence, as our culturally and linguistically diverse populations increase.
Recommendations

- This study reveals the importance of capturing inpatient religious identity, and the case vignettes illustrate the importance of ongoing spiritual assessment to meet the requirements of our increasingly complex populations.

- It also casts light on the importance of hospital Spiritual Care departments and their composition.

- Generic Spiritual Care, another Allied health discipline?

- We found that the RMH model, a mixture of internally and externally funded people and a large network of providers, works with our population, not either/or, but both.

- The fact that most major Victorian hospitals continue to have significant gaps in patient data capture – not only in religious identity, but in other areas which overlap, such as Advance Care directives – suggests the need for more systematic processes and communication between healthcare providers concerning the ‘human’ aspects of healthcare.