INTER-FAITH PASTORAL CARE AND THE ROLE OF THE HEALTH CARE CHAPLAIN

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Abstract: This paper explores the inter-faith pastoral care provided by Australian Christian health care chaplains to patients and their families of non-Christian religions in public hospitals within the culturally diverse western suburbs of Melbourne (Victoria, Australia). Chaplains completed an 'Inter-Faith and Pastoral Care Questionnaire' followed by an in-depth interview designed to explore the strategies, techniques, knowledge and resources of chaplains ministering to adherents of traditional non-Christian religions. The majority of chaplains were found to have provided pastoral care to people of non-Christian faiths utilizing a variety of pastoral strategies. Differences were noted between Catholic and Protestant chaplains, and between lay and ordained chaplains, particularly concerning their knowledge of non-Christian faiths and their use of resources. It is argued that future chaplaincy personnel need to be better trained in order to maximize the effectiveness of inter-faith pastoral care.

Key words: Inter-faith, Pastoral Care, Chaplains / Chaplaincy.

Introduction:

Over the last thirty years the face of health care within all Australian capital cities has changed substantially, particularly in terms of meeting the various needs of people from other cultures who have migrated from distant shores as a result of poverty, persecution and war. Ministering to an increasing number of people who are from different cultural backgrounds and from non-Christian religions has the potential to present various challenges to Christian chaplains working within clinical contexts.

During the twentieth century, various theologians and religious leaders have strongly advocated for an inter-faith theology that would encourage a pragmatic and reciprocal pastoral care relationship between people of different religions. Perhaps the most progressive was that of the Catholic Benedictine, Bede Griffiths (b.1906 – d.1993) who held that the various religions were like the fingers on the hand. That is *'…the baby finger is Buddhism, the next is Hinduism, the middle one is Islam, the forefinger is Judaism and the thumb is Christianity. Buddhism is miles from Christianity, and they are all divided separately, but as you go deep into any religion, you converge on the centre, and everything springs from that centre and converges at that centre'*. Pope John XXIII, through the proc esses of the Second Vatican Council (1963–1965), published *Nostrae Aetate* and *Lumen Gentium,* both unprecedented declarations affirming the relationship of the Christian church to non-Christian religions' and which acknowledged that there are '*seeds of the Word in other religions and grants that adherents of these (non-Christian) religions may come to salvation by way of their religion'*.

The Protestant theologian and sociologist Hans Mol argued that all religious and spiritual expressions of people from different beliefs around the world develop a 'sacralization of identity' process utilizing four common 'mechanisms', namely – (i) ritual, (ii) myth (e.g., sacred legends), (iii) objectification or transcendental ordering (e.g., superior being, spiritual realm, etc) and (iv) commitment (or emotional anchoring). According to Mol the various sacralization of identity mechanisms used by religions, help to *reinforce* conflict that leads to *change* but can also *reconcile* conflict that leads to *stability*. Mol called this functionary process of religion – of change and stability – "dialectic jostling". Following Mol's paradigm, Carey and Carey et al argued that it is the sacralization of identity 'dialectic jostling' function that can be relevant to the inter-faith pastoral role of a chaplain. Chaplains may, for example, be required to help a person (irrespective of their religion) to encounter issues challenging their religious or spiritual

beliefs and (by using one or more of the sacralizing mechanisms) assist with their stability in the midst of crises or, alternatively, a chaplain may need to help encourage change (again by using one or more of the sacralization of identity mechanisms) when there is a need for progression.

Chaplaincy Research

Past research suggests that health care chaplains within Australia have provided pastoral care to people facing a variety of issues within the clinical context. These issues have included such areas as pain control, withdrawal of life support, resuscitation, abortion, euthanasia, organ donation and transplantation. It is, nevertheless, an assumption to simply believe however that Christian chaplains can, have, or do minister to those adhering to non-Christian faiths.

The Australian 'Health Care Chaplaincy Guidelines' clearly state that, as a matter of professional ethics, chaplains are to provide pastoral care to people irrespective of creed or race. Further, the newly established 'pastoral intervention codings' by the National Centre for the Classification of Health in conjunction with the World Health Organization, do not discriminate in terms of who is entitled to pastoral care.

From January 2008, the 'Public Hospital Patient Charter' within Victoria (Australia) came into effect, translating in 18 different languages that services are to be provided to patients in a culturally sensitive way: *'You have the right to be treated in a way that respects your culture and beliefs'*. While chaplains do not have the automatic right to minister to people of other religious faiths, they do have an obligation to respond equally to the needs of people of any faith and to ensure that people of all religious / spiritual beliefs have the right of access to religious / spiritual care.

Yet it is possible that some Christian chaplains, perhaps due to theological or pragmatic reasons, may not see interfaith ministry as their priority and may avoid or neglect such ministry. On the other hand, if Christian chaplains have in fact been ministering to people of non-Christian faiths, this begs the question, 'How and to whom do they minister?'

Research Focus

Several questions thus formed the basis of this study, namely (i) 'Do Christian chaplains provide pastoral care to people of non-Christian faiths?', (ii) 'If Chaplains are providing pastoral care to people of non-Christian faiths, to which non-Christian faiths are chaplains ministering,?' (iii) Further, 'If chaplains are providing pastoral care to people of non-Christian faiths, have chaplains found their knowledge about those faiths adequate?', (iv) Finally, if chaplains have found themselves unable to provide adequate pastoral care to people of non-Christian faiths, how have they sought to help those people?'

Method

A thorough review of the available literature revealed that there was no current empirical material that enabled the researchers to explore chaplains and their interfaith pastoral care unobtrusively. Thus a two stage non-experimental cross sectional study collating descriptively both quantitative data (using a survey) and qualitative data (using the indepth interview technique) were utilized in order to maximize the collection of material for analysis. Using two methodologies was deemed to be particularly advantageous given that this is an exploratory study involving the activities of a specialist and small occupation. It has also become increasingly accepted among behavioural and public health analysts that the combined use of quantitative and qualitative methodologies is considered the most effective in obtaining the best empirical results from descriptive studies. As noted by VandeCreek, et al and Swinton and Mowat, this dual approach has also been affirmed as being appropriate for assessing religious and pastoral care issues, and, indeed, has previously been used successfully within Australia to study health care chaplaincy.

While this research is reliant upon a chaplain's very subjective interpretation of their own experience and knowledge about another religious faith, nevertheless it was deemed that the obtained results would help to provide a gauge of a chaplain's level of self-confidence concerning the tenants of certain non-Christian beliefs and their perspective of about their pastoral care provision to people of non-Christian faiths. It is also important to note at the outset, that the primary focus of this research was upon the provision of inter-faith traditional 'religious pastoral

care', which while inclusive of spiritual issues, did not seek to specifically measure chaplaincy involvement in terms of the broader application of 'spiritual care', that may have been provided to those adhering to contemporary spiritual faiths or of agnostic, atheistic beliefs.

Survey

The total number of health care chaplains (N = 43) who had provided inter-faith pastoral care during a ten year period (1995 - 2005) within the culturally diverse North Western Health Care Network of Melbourne (Victoria) were issued an "Inter-Faith Pastoral Care Survey" predominantly exploring four main areas, namely: (i) whether they had provided pastoral care to people of non-Christian faiths and of what religious persuasion?; (ii) their level of knowledge about the 'fundamental truths' of other faiths; (iii) their approaches, strategies and techniques to care for people of other faiths; and finally (iv) their experienced challenges from engaging with people of other faiths.

Of the forty-three chaplains receiving a survey, eight (n=8: 18.6%) did not respond. Five chaplains replied in the negative, arguing that their ministry to people of other faiths was negligible (n = 5: 11.6%). A positive response was received from thirty chaplains (n=30: 69.76%) providing a favorable rate for basic descriptive statistical analysis (Figure 1).

Figure 1: Chaplaincy Survey Respondents and Interview Informants

	Chaplain Population	Negative Response	No Response	Total Positive Response
Survey 'Respondents'	43 (100%)	5 (11.6%)	8 (20.9%)	30 (69.76%)
Indepth Interview 'Informants'	30 (100%)	0 (0.0%)	0 (0.0%)	30 (100%)

NB: Chaplaincy respondents / informants had ministered at: The Royal Melbourne Hospital (n=13), The Royal Children's Hospital (n=4), The Royal Women's Hospital (n=4), The Mercy Hospital for Women (n=2), The Freemason's Hospital (n=2), North Western Rehabilitation Hospital (n=1), The Peter McCallum Hospital (n=1), The Western Private Hospital (n=1), the Western Hospital (n=1) and the Werribee-Mercy Hospital (n=1).

Basic demographic data is provided in Figure 2. In summary of all the respondents, who had ministered in the Western Health Care Network of Melbourne, the majority of respondents were female (76.6%), part time (n=18: 60%) and had served between 6 – 10 years as chaplains. There were near equal numbers of Protestant (n=16: 53.3%) and Catholic chaplains (n=14: 46.7%) and exactly equal numbers of ordained chaplains (including those of religious orders) (n=15: 50%) compared to lay chaplains (n=15: 50%).

Figure 2: Chaplaincy Respondent and Informant Demographic Data (n = 30):

Gender	Female	23 (76.66%)	Male	7 (23.34%)
Denomination	Protestant *	16 (53.3%)	Catholic **	14 (46.7%)
Status	Ordained / Religious Order	15 (50.0%)	Lay	15 (50.0%)
Time	Part Time	18 (60.0%)	Full Time	14 (40.0%)

* Protestant = Anglican = 11; Uniting Church = 3; Lutheran = 1; Presbyterian = 1: Total = 16.
** Catholic = Roman Catholic: Total = 14.

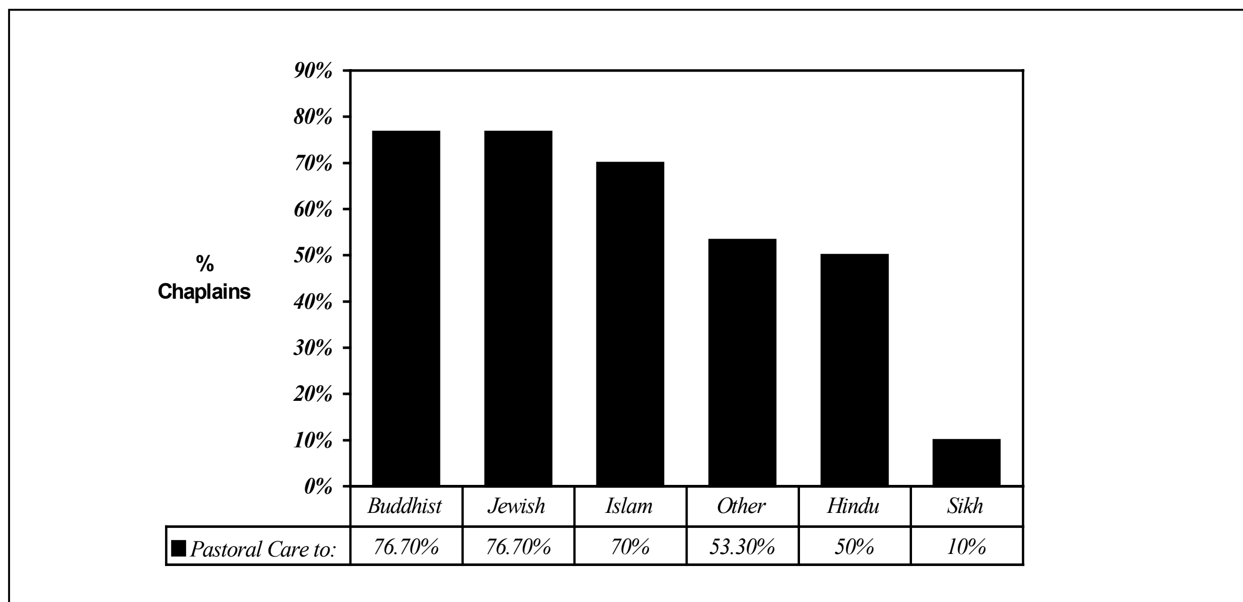
Interview

All survey respondents consented to being interviewed (n=30:100%; Figure 1). The 'in-depth' model of interviewing was used to gain greater explanation from respondents with regard to their survey responses. Chaplains who were interviewed were asked questions that paralleled the four main areas of the survey (mentioned earlier), namely (i) whether they had provided pastoral care to people of non-Christian faiths and of what religious persuasion; (ii) their level of knowledge about the ‘fundamental truths’ of other faiths; (iii) their approaches, strategies and techniques to care for people of other faiths; and finally (iv) their experienced challenges from engaging with people of other faiths. Following the signing of consent forms, chaplaincy informants were tape recorded for up to 60 minutes. All interview data gathered was fully transcribed, thematically collated and analysed using the ‘Non-numerical Unstructured Data Indexing, Searching and Theorising’ qualitative data computer program. This ensured that all transcribed interviews were collated and processed systematically enhancing accurate identification of thematic categories.

Results

In overall terms one of the key results from this research was that the majority of chaplaincy respondents (93.3%) indicated that they had provided pastoral care to people from non-Christian religions. One chaplain was ‘unsure’ (3.3%) and another chaplain replied in the negative (3.3%). Of those respondents who had engaged people of non-Christian beliefs, the majority indicated that they had provided pastoral care to people from the Jewish faith (76.66%) and the Buddhist tradition (76.66%). The next largest religious category identified by respondents was the provision of pastoral care to people of Islamic belief (70.0%), followed by that of ‘Others’ (53.33%), comprising Aboriginal, Maori, Shinto, Baha’i, Sai Bala, Jehovah Witnesses, Mormon and Confucianism. Finally there were those of the Hindu faith (50.0%) and the Sikh faith (10.0%) (Figure 3).

Figure 3: Percentage of Chaplaincy respondents (n = 30) providing Pastoral Care to people of Non-Christian Faiths.



NB: ‘Other’ = Aboriginal, Maori, Shinto, Baha’i, Sai Bala, Jehovah Witnesses, Mormon and Confucianism

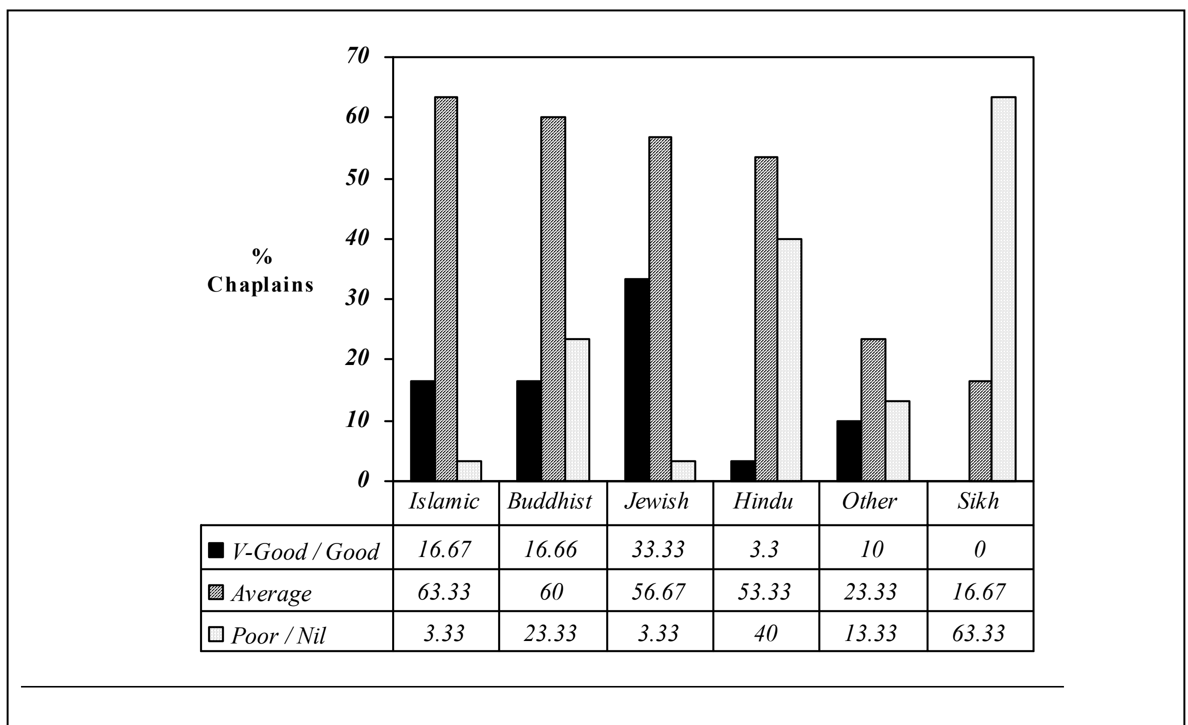
As the survey required categorical responses from chaplains regarding gender, denomination, status and time fraction (Figure 2), chi square tests were subsequently undertaken to compare chaplaincy sub-populations (i.e., male *cf* female chaplains; part time *cf* full time chaplains; ordained *cf* lay chaplains) with regard to their pastoral care to people of non-Christian faiths. Only the results that were found to be statistically significant are presented here. A chi square test revealed that the degree of association between the employment status of chaplains (i.e., ‘full time’/‘part time’) and the provision of pastoral care to people of the Islamic faith was statistically significant *(p = 0.0034)* indicating that full time chaplains (100%) had significantly more involvement with those of Islamic faith than part time chaplains (50%). A chi square analysis also revealed that the degree of association between the denominational affiliation of chaplains (i.e., Catholic /Protestant) and their involvement with people of the Hindu faith was statistically significant *(p=0.0281)* indicating that Catholic chaplains (71.4%) were more significantly involved with people of Hindu faith than the surveyed Protestant chaplains (31.2%). There was however no statistically significant difference between Catholic and Protestants in their perceived knowledge about the Hindu faith *(p=.0921).*

Interfaith Knowledge

As illustrated in figure 4, in overall terms the majority of chaplaincy respondents believed they had an ‘average’ knowledge of most non-Christian faiths (e.g. Islamic: 63.33%; Buddhist: 60%; Jewish: 56.6%; Hindu 53.3%) - except concerning Sikhism about which the majority indicated their knowledge regarding this particular belief system was ‘poor’ or ‘nil’ (63.3%). The only non-Christian faith however, that the majority of chaplains believed they had a

'very good' or 'good' knowledge about, was that of Judaism (56.67%). 'Other' religious faiths received only a minority of chaplains indicating their knowledge level was 'very good' or 'good' (10%) or 'average' (23.33%). It is important to note however that 53.3% of chaplains did not indicate involvement with people from any 'Other' religious faiths and thus could not provide a response about their knowledge level of such faiths. Of those who did indicate involvement with people of 'other' faiths however, only 13.3% indicated that their knowledge was 'poor' or 'nil' (refer Figure 4).

Figure 4: Percentage of Chaplaincy respondents (n=30) indicating their level of knowledge about the fundamental truths of Non-Christian faiths.



	Islamic	Buddhist	Jewish	Hindu	Other	Sikh
V-Good / Good	16.67	16.66	33.33	3.3	10	0
Average	63.33	60	56.67	53.33	23.33	16.67
Poor / Nil	3.33	23.33	3.33	40	13.33	63.33

NB: 'Other' = Aboriginal, Maori, Shinto, Baha'i, Sai Bala, Jehovah Witnesses, Mormon and Confucianism

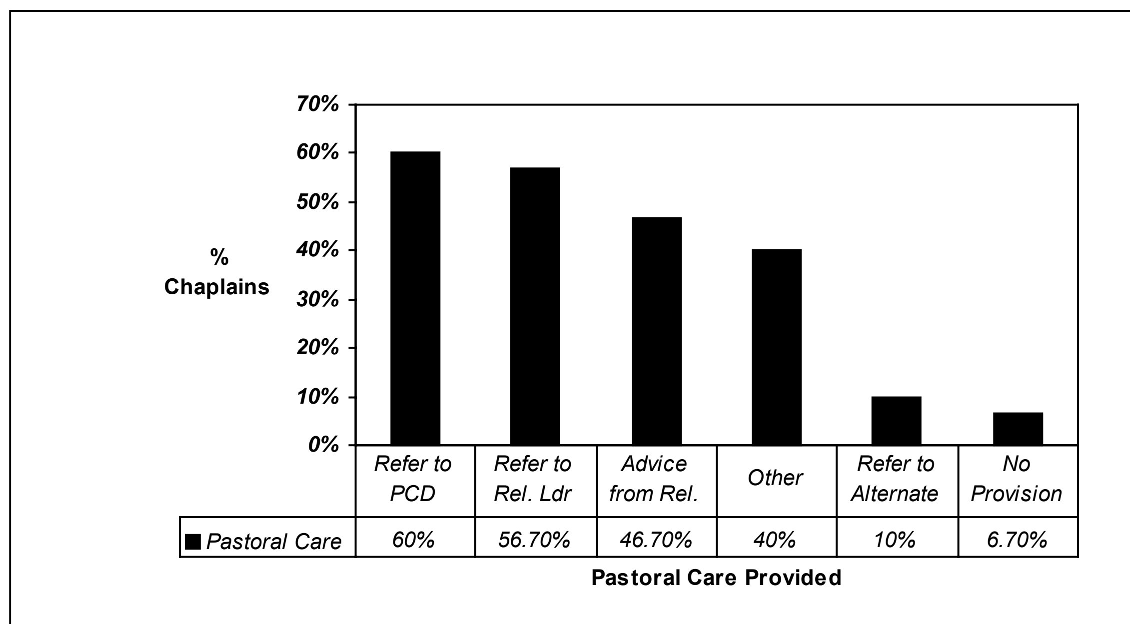
Statistical analyses were undertaken comparing chaplaincy sub-populations with their perceived knowledge of non-Christian faiths. Chi square tests revealed that the degree of association between the denominational affiliation of chaplains (i.e., Catholic / Protestant) and their perceived knowledge of the Buddhist faith was statistically significant *(p = 0.0122),* indicating that Protestant chaplains - having a 'good' (31.25%) or 'average' level of knowledge (68.7%) - were more confident about Buddhism than Catholic chaplains ('good': 0%; 'average' 50%), a

considerable percentage of whom acknowledged a 'poor' level of knowledge about Buddhism (42.8%).

Interfaith Care

Figure 5 indicates what action chaplains pursued when they were unable to provide pastoral care of people from 'other faiths'. The majority of chaplains (60%) referred back to their own pastoral care department for advice. Other chaplains (56.7%) simply referred people to their own particular religious leader. Approximately 46.7% of chaplains however made the effort to gain advice directly from the patient's / family's non-Christian religious leader. Forty percent (40%) of chaplains undertook 'other' means of ensuring some form of pastoral care. Ten percent (10%) of chaplains referred patients to another pastoral care department outside of their hospital. Only 6.7% of chaplains made no provision to minister to people from 'other faiths'.

Figure 5: Percentage of Chaplaincy respondents (n = 30) indicating their strategies for assisting people of non-Christian faiths.



NB 1: PCD = Refer to other chaplains / pastoral care workers within Pastoral Care Department.
NB 2: Rel. Ldr. = Refer directly to Religious Leader of relevant non-Christian faith.
NB 3: Advice from Rel = Contact and gain advice directly from non-Christian religious organization or leader.
NB 4: Other = Variety of strategies (e.g., use of relevant literature, use of interpreter, use of family member).
NB 5: Refer to Alternate = Refer or seek advice from alternate PCD (e.g., Chaplains at another hospital within Western Heath Care Network).
NB 6: No Provision = Beneficent acts were not undertaken.

Statistical analyses were also undertaken comparing chaplaincy sub-populations with the strategies used to assist people of non-Christian faiths. Chi square tests revealed that the degree of association between the religious status of chaplaincy personnel (i.e., ordained / lay) and their contact with non-Christian religious advisors was statistically significant *(p=0.0281)* indicating that ordained chaplains (66.6%) tended to be more involved in contacting non-Christian leaders to help people of non-Christian faiths than lay chaplains (26.6%). Further chi square tests investigating the degree of association between the religious affiliation of chaplains (i.e., Protestant / Catholic) and whether they referred issues of pastoral care to religious leaders of non-Christian faiths was found to be statistically significant (p = 0.0303), indicating that Catholic chaplains (66.6%) were significantly more involved than Protestant chaplains (26.6%) in referring patients and their families to religious leaders of other faiths whereas a greater percentage of Protestant chaplains (56.2%) tended to take the initiative and contact non-Christian religious leaders directly to help ensure the continuity of pastoral care.

Interfaith Skills, Techniques and Functions

The qualitative data gathered from the indepth interviews revealed that chaplains had a variety of ways of assisting people of non-Christian faiths. Given the volume of material gathered from the in-depth interviews, a summary table of the qualitative data is presented at Figure 6.

The qualitative data was thematically coded into three main categories: (i) The application of 'pastoral approaches, strategies and techniques', such as chaplains giving an appropriate introduction, the provision of religious resources, appropriate physical comfort, exploration of any relevant personal religious experience and the provision of referral information about available religious leaders of the patient's faith; (ii) General pastoral skills which included 'being there' with patients and their families experiencing crises, 'listening' or 'hearing their story', 'developing rapport' and 'providing reassurance' that their religious beliefs would be respected; and (iii) Specialist pastoral 'religious functions' were noted such as the reading or provision of 'religious literature' (e.g. Qu'ran), discussions about the patient's beliefs or 'theology' (particularly effecting bioethical decision making), the conduct of, or assistance with appropriate rituals and, ultimately, the reinforcing of the patient's religious identity and commitment to their faith. These specific religious functions were found to be easily sub-coded using Mol's sacralization of identity mechanisms (refer Figure 6).

Figure 6: Summary table of qualitative data derived from in depth interviews listing chaplaincy pastoral approaches, techniques, strategies and specific religious functions undertaken / provided to people of non-Christian religions by Christian Health Care Chaplains:

I Pastoral Approaches, Techniques & Strategies

Pastoral Introduction	Sensitive self introductions and offers of support; Clear identity badge; Wearing of Christian cross / badge on lapel; Wearing of colourful clothes; Flower/s for women; Toys for children.
Physical Resources	Provision of Sacred texts (e.g., Qu'ran, Torah); faith specific pamphlets; faith specific pictures and icons; pastoral care manual / reference.

Personal Experience	Exploration of a patient's personal experience or background to explore faith connection / development and any religious issues/ concerns.
Professional Referral	Use of non-Christian religious leaders; social workers; interpreters; genetic counsellors; bereavement support, etc.
II General Pastoral Skills	
Being There / Presence	Through physical presence, chaplains encountered patient feelings of aloneness or alienation in a 'foreign context', provided advocacy, support and comfort.
Listening / Hearing	Time was spent with patients listening intently to their life story / religious perspective and discerning / assessing their deep feelings and concerns.
Developing Rapport / Relationship Building	Rapport and chaplain-patient relationship developed through the acknowledgement and respect for patient's life and religious experiences; Emotional and practical support provided to assist with addressing issues.
Providing Reassurance	Chaplains reinforced principles of unconditional love; affirmation and encouragement of religiously sensitive / culturally respectful practice that helped to enhance patient well-being.
III Specialist Pastoral Religious Functions	(Using Mol's Sacralization of Identity Mechanisms)
Sacred Literature / Myths:	Reading of sacred texts (e.g., Qu'ran; Psalms) and recounting of non-Christian significant religious stories, legends and religious / spiritual leaders.
Theology / Objectification / Transcendental Ordering:	Expression / sharing of specific faith, knowledge, theology, philosophies, beliefs, structure, values and ethics.
Ritual:	Provision, organization and / or assistance with non-Christian religious blessings, prayers, worship services, funerals and other rituals.
Commitment:	Through the use of non-Christian sacred literature, expression of faith specific theology, support from other relevant religious leaders and the enactment of rituals, the patient's faith commitment is encouraged, maintained and developed during times of crises.

Interfaith Challenge

Given the involvement of the majority of Christian chaplains in assisting people of non-Christian faiths it would not be surprising that chaplains may have found their own faith challenged by regularly ministering to people of different philosophies and beliefs. Indeed sixty percent of chaplains indicated that their faith had been challenged by learning about 'different ways to God' whereas 6.67% were not sure, while 33.3% stated that their faith had not

been challenged – some refusing to be 'syncretistic' in their thinking. Several reasons were given by those who felt that their faith had been challenged, namely: (a) they developed an understanding about, and thus tolerance to, other faiths, (b) acknowledged that, given other people's unique religious journeys and experiences, there were 'matters beyond our comprehension', (c) there were 'areas of common ground' such as the existence of sacred texts and / or teachings, (d) they practiced the ritual / act of prayer and (e) the common practice of reverence or respect towards a superior being / spirit, transcendental order or sacred object/s.

Discussion

The collated results from this research indicated that the majority of Christian chaplains had provided pastoral care to people of non-Christian faiths, particularly those of the Buddhist, Jewish and Islamic traditions, and that chaplains believed they had an average knowledge of these traditions with the least knowledge about Hindu and the Sikh traditions. Chaplaincy informants indicated a variety of pastoral skills, methods and specific religious functions that were undertaken to ensure the provision of pastoral care to people of non-Christian faiths. However, when chaplains were unable to provide pastoral care to those of non-Christian faiths, the majority contacted their own pastoral care department for advice and / or referred the patient and their families to their respective religious leaders residing within the local community. Other chaplains (predominantly Protestants) determined it appropriate to contact non-Christian religious leaders directly so as to personally ensure the provision and continuity of adequate pastoral care.

While it can be argued that the amount of interaction between chaplains and people of other faiths simply reflects the particular religious adherence of inpatients and outpatients attending their respective hospitals, nevertheless the results provide evidence that, even though the chaplains surveyed were of the Christian religion, the majority were non–discriminatory in applying the principles of pastoral care. A minority of chaplains however seemed some-what indifferent (adopting a 'sink or swim' attitude) or deliberately avoided the care of people of non-Christian faiths. Perhaps this may have been due to a lack of opportunity, but more likely, based upon the research results of this study, it can be argued that the non-compliance of some chaplains to care for people of non-Christian faiths was more than likely due to a lack of knowledge and training.

Indeed, from a more critical perspective, the results suggest that chaplaincy respondents were only 'average' in their knowledge concerning non-Christian religions, but particularly poor with regard to the Hindu and Sikh faiths; that some chaplaincy respondents did not refer people to religious leaders of non-Christian faiths, particularly lay chaplains; that while Catholic chaplains were more involved in helping people of the Hindu faith, Protestant chaplains tendered to be more proactive (even more helpful) in terms of making direct professional contact with non-Christian religious leaders; further, despite the research being conducted within a high density multi-faith region, approximately 16% of the total chaplaincy population (n = 7/43: 16.2%) were either 'not sure' or had not provided pastoral care to adherents of non-Christian religions or were fully aware that their ministry to people of other faiths was negligible.

Chaplain Effectiveness

For chaplains to be more effective at interfaith pastoral care it can be argued that continuing education needs to be provided for all chaplains (irrespective of gender, denominationalism or employment status) about the fundamental tenants of non-Christian faiths (but particularly with regard to the Sikh and Hindu faiths). It is also important to acknowledge that whereas the majority of Protestant chaplains indicated having an above average knowledge of Buddhism, the opposite could be said to be true of Catholic chaplains who seem to require further education with regard to this particular faith system. To achieve such improvements, comparative religious studies could be encouraged and resourced at theological colleges or within secular university institutions (by federal and state governments in conjunction with religious institutions) so as to assist Chaplains with the care of non-Christian patients plus their families, and thus also aid the progress of migrant social integration within the community.

Further given that the majority of chaplains (93.3%) in a high multi-faith area such as the Western Health Care Network of Melbourne had, at some point, provided pastoral care to people from other faiths, it

seems obvious that these chaplains may require additional support to assist them in their ministry. Additional support could be given particularly with regard to those from Jewish, Buddhist and Islamic faiths, simply because of the substantial and increasing number of these people seeking support and thus the increasing likelihood of chaplains engaging with people of other non-Christian faiths. Additional support could be provided for example, by the various government health services in conjunction with established chaplaincy support groups (e.g., Australian Health and Welfare Chaplains Association, Health-care Chaplaincy Council of Victoria) by providing special in-service training of Christian chaplains, aimed to meet increasing interfaith needs. In addition the appointment of non-Christian chaplains to health care facilities could also be supported by both government, Christian and non-Christian communities alike. There could also be a role, in highly populated multi-faith cities, for an 'Interfaith Community Chaplain' to be appointed by governments as a co-ordinator and liaison for interfaith activities and support – which would be particularly valuable during times of community crises.

Finally assistance could be provided to chaplains with regard to physical resources such as improved multi-faith chapels for patients and their families plus multi-faith information kits to assist clinical staff. As noted (Figure 7; 'physical resources') the production of a pastoral care manual for the support and help of chaplains and clinical staff has commenced within some pastoral care departments. This resource concept could be expanded for the benefit of those of 'non-Christian faiths' in, welfare, defence, mental health, aged care and correctional institutions.

Following Mol's sacralization of identity mechanisms, and the paralleling 'pastoral religious functions' identified by chaplains as part of this research (refer Figure 6: 'Specialist Pastoral Religious Functions') , it would seem that Christian and non-Christian religions may have more in common than what first seems apparent. Any argument questioning whether Christian chaplains can provide traditional religious pastoral care to people of non-Christian faiths is finalized by this study. The answer is 'Yes', they can and have done so, through using the various 'sacralization of identity' mechanisms and facilitating specific religious functions for the well-being of non-Christians. It is important to acknowledge however that there is a need to involve a larger sample of chaplains engaged in interfaith ministry. Quality assurance research could also be undertaken surveying / interviewing those of non-Christian faiths who have received support from Christian chaplains, particularly researching whether Christian chaplains can deliver 'spiritual care' to people of more contemporary spiritual beliefs.

Irrespective however of possible future research goals, given the growth of non-Christian faiths within traditionally Christian regions, it can be argued that there is an immediate and obvious need for an increase in training and resourcing of Christian health care chaplains to cope with the current changing demand within increasingly multi-faith societies.

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