Safety and spiritual care:
What do they mean for each other in Australian hospitals?

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Declarations

I hereby declare that, except where it is otherwise acknowledged in this text, this thesis represents my own original work.

Redacted

Signed:

Date: 30th June 2022

All versions of the submitted thesis (regardless of submission type) are identical.

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Date: 30th June 2022

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Spread between city and farm, most of my 'farmily' still have little inkling of the contents of this thesis, I am grateful for their patience. I can play more now!

Abstract

Spiritual care services provided in Australian hospitals are obliged to conform to safety agendas therein. Research investigating quality spiritual care in hospitals is growing however there is no research investigating safety in relation to spiritual care. My research examines what safety and spiritual care mean for each other in Australian hospitals. The research included a survey followed by interviews with spiritual care practitioners to explore their perspectives and engagement with hospital safety agendas. In this thesis I argue that 1) hospital safety agendas are permeated by biomedical power and authority which, paradoxically, threaten the safety of those present in them, 2) spiritual care practitioners value, engage with and contribute to hospital safety agendas, 3) hospitalisation is a biomedical intervention that generates iatrogenic distress, 4) spiritual safety is a useful concept for understanding and responding to iatrogenic distress and 5) hospitals are obliged to respond to iatrogenic distress by the provision of spiritual care. Opportunities and recommended actions are provided which would improve and support safety in hospitals.

Introduction

I was a ten-year-old child when I first witnessed the strange awe with which patients regarded doctors. My late father was an anæsthetist and for a reason I no longer recall, on this particular morning I was with him when he had to undertake a pre-op visit to a patient in PANCH hospital.[1] Rather than leave me in the car to wait, he took me into the hospital with him. He told me stand next to the wall in the patient's room and "not move a muscle". Trying hard not to fidget, I was fascinated by my often-tense father's gentleness as he spoke kindly to this patient, but I was astounded to see the look on the patient's face, because she was looking at my dad the way I did! Something was making this grown-up look at my dad in the same way as me, as though she trusted him like a hero or an angel. Dad was the tallest person I knew, and he towered over that bed and quietly reassured the patient. She thanked him many times before I was collected to leave.

Several decades later, working in hospitals as a spiritual care practitioner, I was often struck by the appearance of this same facial expression and response from many other patients towards their doctors and other treating clinicians. I likened it to the veneration of priests and saints, even deities, by the devout, and I likened hospitals to religious institutions. With my conversation partner, during my years in clinical work, I discussed my observations of hospitals, their

[1] Preston And Northcote Community Hospital. Forty years after opening it was incorporated into Northern Health, moved to Epping and the Preston/Northcote site was sold.

hierarchies, policies, procedures, spaces, dialogues, clothing, tools and artefacts, and how they resembled tiers of religious clerics, cleansing and healing rituals, sacrosanct texts, beliefs, antechambers, inner sanctums, vestments and gowns, icons and symbols.[2] Commencing the degree that led to this thesis, I was introduced to the work of Michel Foucault in The Birth of the Clinic (2003, 31-33).

> In the alleviation of physical misery, [medicine] would be close to the old spiritual vocation of the Church, of which it would be a sort of lay carbon copy. To the army of priests watching over the salvation of souls would correspond that of the doctors who concern themselves with the health of bodies.

Working in hospitals I observed extraordinary healing and curing, recovery and restoration, petition and intercession, bargaining and questioning, loss and gain of faith. I observed too the loneliness, solitude, community, solidarity and subjugation of those within them. I have made these same observations in religious contexts and I have seen that both religion and biomedicine are hegemonies with influence beyond their bounds, that reach into the private lives of citizens and the public and political life of nations. They both have adherents, dissenters, sceptics and critics, both are creators of "artificial" loci, physical spaces and relations imbued with power and, in most Australian

[2] Conversation partner: a peer with whom I have regular conversations specific to matters of spirituality, faith, religion and philosophy.

jurisdictions, biomedical and religious institutions are both required to give significant attention to the safety of those who enter their domains (Foucault 2003, 17; Salter 2013, 155; Safe Work Australia, 2022, Commission for Children and Young People 2022; Office of the Children's Guardian 2022; Commissioner for Children and Young People 2022; Department of Human Services 2022; ACT Government 2022; Department of Justice 2021; Queensland Government 2022). From the Royal Commission into Institutional Responses to Child Abuse, we now know more about the dangers and risks of harm to people when they are subject to the unfettered power and authority of religious institutions. What though of the dangers and risks of harm to people who are subjected to State sanctioned biomedical authority, structures and systems (Commonwealth of Australia 2017)?

As Chapter 1 of this thesis will reveal, safety in Australian hospitals is a complex net of systems that endeavour to raise awareness and make vigilant those who work in, visit or are admitted to hospitals. They are systems that attempt to compensate for human fallibility and unforeseen circumstances. The safety agendas of hospitals are of particular interest to me because one of my core professional interests is maintaining safety in psychosocialspiritual practice; in the interpersonal, relational space between people.

Since 2001 I have held various roles relating to spiritual care and counselling, the majority of which have been in clinical care settings and have maintained my long-held concern for safe spiritual care practice in support of the wellbeing

of people admitted to hospitals. In one sense, the seed of interest in the topic of this thesis was planted in that ten-year-old me, watching my father interact with that patient during the pre-op visit. Later, this thesis project was seeded by my sense that the spiritual care profession in Australian hospitals was yet to make a solid contribution to the ongoing discourse about safety in these contexts, and a suspicion that spiritual care practitioners could not only augment safety perspectives but offer a unique articulation of safety in hospitals. My background, knowledge and interest in the subject matter are also informed by my management roles in public health care services in Victoria. These positioning statements serve to declare my role as participant researcher and my insider knowledge of and access to the professional spiritual care sector, and to acknowledge the strengths and potential limitations implied by these factors.

The research for this thesis began with a question about what safety and spiritual care mean for each other in Australian hospitals. This question required consideration of the development of the complex web of safety strategies, the meaning of iatrogenesis and the probing of spiritual care practitioner perspectives on safety agendas in hospitals. It also required giving attention to the dynamics of power and authority in this context and the biomedical tendency to separate the physiological from the spiritual. Analysis of how all of these might converge and bear upon the safety of people admitted to hospital and their spiritual care, resulted in the first iteration of what spiritual care and safety mean for each other in Australian hospitals.

Other than being required to complete the same mandatory training modules as other professionals working in hospitals, the spiritual care sector in Australia has received little research attention as a profession that contributes to or has any influence or impact on safety in hospitals. There is no clearly articulated relationship evidenced in peer-reviewed literature between hospital safety agendas and spiritual care services. Similarly, safety in hospitals has until now received limited attention from researchers interested in spiritual care, as will be demonstrated in the literature discussed later.

Spiritual care

Clarification is needed about what spiritual care is because it is both a form of care and a vocation descriptor. Those engaged specifically in the vocation of spiritual care provision in Australian hospitals are known by various titles such as spiritual care practitioners, pastoral carers, chaplains, ministers and spiritual/pastoral care volunteers. Those *employed* by hospitals are required to provide equitable, appropriate and responsive spiritual care. From this point, I will use spiritual care practitioner (SCP) to refer to those who are employed to provide spiritual care in hospitals.

The form of care labelled "spiritual" is described by the Independent Hospital Pricing Authority as assessment, counselling, support and ritual relating to beliefs, values, and practices, which includes traditions (The Independent Hospital Pricing Authority [IHPA] 2019). This is a functional definition useful

for hospital administrations and governments. It does not address spirituality which is the focus of the care being provided.

After discussing various literature definitions, Gardner describes spirituality as "that which gives life meaning and includes a sense of something beyond or greater than the self" and that spiritual care is, therefore, care that responds to the universal phenomenon of human spirituality in all its forms and by varied definitions (2011, 24-26). An international consensus conference devised the following definition:

> Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices (Puchalski et al. 2014, 646).

The Spiritual Health Association [SHA] adds to the above definition that "spirituality can also be described as the search for answers to existential questions" (2020, 17).[3] A new offering in the sector appears to be in agreement with Gardner that human spirituality is a universal phenomenon, and also does not rely on words or concepts commonly associated with religion, such as ultimate, transcendence, sacred and beliefs. Rather, bringing spiritual care

[3] Recognised as a peak body that advocates for and promotes spiritual care in health care.

theory into conversation with contemporary neuroscience, Turner suggests that "spirit is homeostatic response to threat" (2021, 39). Spirituality might then be understood as *expression* of homeostatic response to threat, that is, expression of spirit. For the purposes of this thesis, the following amalgam of these definitions will be used. *Spirituality is the expression of spirit and involves meaning, purpose, identity, relatedness and values. Spirituality can be manifested in a myriad of ways, including beliefs, philosophies, practices and traditions, which can be spontaneous, informal or formalised.*

Thus, spiritual care attends to the spirituality of recipients of care. It requires facilitating space for deep listening, sensitive assessment and support, and sometimes ritual and/or counselling, and it must always be aligned with the expressed spirituality of the recipient of care.[4] Spiritual care provided in hospitals describes care that recognises the impact of hospitalisation on people in ways that can cause subsequent manifestations of their spirituality to be experienced as overwhelming. 'Feeling overwhelmed' describes experiences of struggling to deal with strong emotions.

A note on emotions

The topic of emotions needs further, albeit brief, comment because it is related but not central to the subject matter of this paper. "Emotional safety" appeared

[4] Professional spiritual care is not described "as 'just listening' or 'simply being present'… it requires a level of professional skill that is only attained and maintained by a specific approach to educating yourself and by an ongoing self-critically reflective stance" (Turner 2021b).

in survey responses in reference to SCP burnout and exposure to bullying, and "emotional support" was fleetingly mentioned in some interviews as part of SCP work. In hospital settings, some expressions of emotions are treated as indicators for referral to spiritual care services. For example, the "teary", worried, frightened or angry patient might be asked whether they would like to see a SCP. It would be a mistake however, to view spiritual care as a 'settling' service. It would also be a mistake to assume that a patient who is not overtly expressive is not experiencing strong emotions.

Damasio and Damasio tell us that "feelings of emotions are perceptions" of what has changed in the body, correspondingly emotions emerge when the human body experiences or senses threat (2006, 21). Strong emotions should therefore prompt us to pay careful attention. SCPs recognise that strong emotions in hospitalised people indicate they are facing significant change, their spirituality is being stirred by their current situation; it is a spontaneous expression of spirituality. Attending to patient spirituality therefore necessitates attending to their emotions.

The literature

It seems that, until now, what safety and spiritual care might mean for each other in Australian hospitals has not been directly explored. My initial literature search in June 2021 in preparation for this research used the following terms, "spiritual care" AND "safety" AND "hospital" AND "Australia". It returned 3 results, 2 of which were related to the research topic. I also

searched literature on Scopus and PubMed using the same terms. Scopus returned 46 results, 2 of which were related to the topic, the same 2 as the initial search, and PubMed returned 12 results, none of which were related to the topic.[5] These results necessitated searches for potential secondary links within spiritual care literature from the Australian, United Kingdom (UKNHS), Canadian and Aotearoa New Zealand (ANZ) contexts, all of which maintain publicly funded health care systems that incorporate professional spiritual care services. From this literature the collective suggestions are that consistent professional SCP workforce, evidence-based practice, and/or governance are significant in relation to safety and quality in hospitals.

National governance frameworks for benchmarking spiritual care services are indicated for responding to "the risk for health services in providing spiritual care that is not appropriately benchmarked against best practice", a statement that would gain strength if accompanied by descriptions or examples of how safety or risk appear in spiritual care (Holmes 2018). Like other health care professionals in hospitals, it has been recognised that a consistently qualified and credentialled SCP workforce would ensure safe spiritual care practice in Australian hospitals (Eve & Phillips 2019; Holmes 2021; Holmes 2018). It is understood that this safe spiritual care practice involves accountability, competency, critical reflection and capabilities (2019; Turner 2021b; Kelly

[5] No publication date limits were used for these searches. Comparison searches were undertaken exchanging the term "spiritual care" with "social work" and then "psychology" in turn. Scopus returned 3,814 results for social work and 23,541 for psychology, and PubMed returned 363 and 1,429 results respectively.

2012). Education and training in clinical safety was discussed in an international study of SCP responses to the implementation of SARS-CoV-2 [COVID19] hygiene procedures (Flynn et al. 2021). Snider et al. reports that Canada's spiritual care sector endorses evidence-based practice (EBP), which is understood to protect patients from harm (2019, 93). Although the literature is scarce and limited, grey literature indicates a potential meaningful relationship between hospital safety agendas and spiritual care.

The Australian Commission on Safety and Quality in Health Care [ACSQHC] asserts that spiritual care is an element of safe and high-quality end-of-life care, however safety is only alluded to with the recommendation that spiritual care needs to be provided by a "suitably skilled provider" (ACSQHC 2015, 19). Aligned with ACQHC standards is the recommendation that spiritual care be integrated with hospital safety systems (National Consensus Conference Report - Enhancing Quality and Safety: Spiritual Care in Health, 2017). The Spiritual Care Australia [SCA] "Standards of Practice" and "Code of Conduct" mention safety without being explicit about the meaning of safety, however they emphasise that spiritual care does not involve proselytising or the imposition of the SCP's beliefs or values upon others (SCA 2014, 6, 8; SCA 2017, 4).[6] The "Guidelines for Quality Spiritual Care in Health" and the "Capability Framework for Spiritual Care Practitioners in Health" align safety with high-quality care and refer to safety in relation to credentialling, but without

[6] A professional association of practitioners in spiritual care, pastoral care and chaplains.

providing definitions or descriptions of safety from the spiritual care perspective (SHA 2020; SHA 2020b). The same organisation refers to safety frequently in a guide for spiritual care documentation and reporting but again without providing definitions or descriptions of safety (SHA 2019). Telehealth guidelines for SCPs connect safety and patient consent, although this is not related to any unique elements of spiritual care practice (SHA 2020c). Safety is not mentioned in the standards or guidelines of the Australia and New Zealand Association of Clinical Pastoral Education, which is an accrediting organisation for clinical spiritual care training centres, most of which are located in hospitals (ANZACPE, 2022). Although limited, scholarly and grey literature indicate a level of awareness of safety in relation to spiritual care provision in Australian hospitals.

Literature from the United States (US) context

The cultural context, health care and hospital system, and the related professional chaplaincy sector (that is spiritual care) in the US is significantly different to that of Australia. Use of literature arising from the US that might be related to the topic of this thesis has been considered carefully.

The standards for patient safety from the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO), require consideration of "spiritual needs of patients and families after medical harm", and Berlinger further suggests that chaplaincy knowledge and expertise can be exploited to support patient safety (2004, 56). Berlinger later states hospital chaplains have "a fundamental

obligation to distinguish safe from unsafe", but neither article articulates the meaning of safe or unsafe in relation to spiritual care (2008, 30). Safety and chaplaincy have been linked by Hughes and Handzo who suggest the chaplain, as a health professional, can be "a safe haven" for defence force personnel suffering post-traumatic stress disorder. The "safe haven" chaplain needs to be calm, non-judgmental, neutral, non-anxious, provide "clear, reliable boundaries of respect", be honest, realistic and sensitive to diversity (2009, 30-32). Other than referring to the disposition of the chaplain as enabling a veteran to feel safe during the chaplaincy encounter, no explicit meaning or definition of safety is provided.

In summary, spiritual care *research* related most directly to safety agendas of Australian hospitals currently appears to be confined to professional accountability, capability and governance. Other scholarly literature *indicates* spiritual care interaction or relationship with safety, and grey literature proposes spiritual care interaction with safety agendas through hospital policies, systems and professional standards. My hypothesis, that contemporary Australian SCPs have a unique contribution to make on matters of safety in hospitals, required that the design of the research method include an inductive process, the details of which follow.

Methodology

The research comprised two distinct phases, with focussed recruitment of SCPs employed in direct patient care roles in Australian hospitals. These practitioners were sought for their primary engagement with safety agendas in direct-care contexts rather than management, the responsibilities of which likely affect perspective and priorities.

Methodology Phase 1: Survey

I designed the survey using Qualtrics software. The survey questions were reviewed by my first supervisor and the university HREC. A hyperlink was generated for the survey and, together with an invitation explaining the research, it was nationally distributed through the SHA newsletter and by SCA directly to their members, who number approximately 400 and the majority of which are in the health care sector.

A Participant Information Form (PIF) was provided through a hyperlink at the beginning the survey, however a technical problem became apparent in the second week after distribution. At least one respondent made contact to alert me that they were unable to access the PIF and to complain that the survey was inadequate. The plaintiff's concerns were raised with HREC and my supervisor, and we corresponded with the plaintiff several times to address the matter. Due to the anonymity of survey respondents, it was impossible to ascertain if any others were unable to access the PIF. However, all those who were later interviewed were asked whether they had accessed the PIF; most could not

remember and two said it was accessible. Because participation was voluntary and anonymous, HREC and supervisory advice was that commencement of the survey could be regarded as participant consent. The survey was also deemed adequate for its primary intended purpose or recruiting appropriate interview participants.

The survey contained quantitative questions to ascertain whether respondents matched the criteria for participation: employment in hospitals as SCPs, primarily providing direct care to patients. Free-text qualitative questions, of which there were 3, allowed participants to freely express their perspectives.[7] The last question of the survey offered an invitation to self-nominate to be interviewed. 108 surveys were opened, 70 were fully completed and 39 respondents indicated willingness to be interviewed.

Methodology Phase 2: Semi-structured interviews

The interviews enabled deeper exploration of SCP perspectives and experiences. Of the 39 survey respondents who indicated willingness to be interviewed, 14 attended individual online interviews from September to December 2021. All interview participants were employed in hospitals with clinical caseloads. Some participants also had responsibility for coordination and/or supervision of other SCPs. Informed consent was provided by participants in writing prior to interviews being scheduled and video

[7] The survey made use of a type of response format that allowed respondents to write their answers in their own style with no word limit.

conferencing software was used for the interviews, which enabled audio recording of the interviews.

The interviews made use of a question guide of open-ended exploratory questions that allowed participants freedom to vary and nuance their foci and responses. The guide included a question focused on the concept of "spiritual safety", a phrase which appeared recurrently in free-text responses to the survey's 3 qualitative questions. Prior to commencing interviews, I recognised that the survey's use of the word "safety" might have inhibited responses, so the guide was altered to include a question which sought SCP responses about their understanding of "safe" versus "safety". Noting after the first two interviews that this and some other questions were redundant, the question guide was altered for the following 12 interviews.

There were 3 participants who distinguished themselves from the greater cohort. One was a SCP who wandered so frequently at length into encounter narratives that only a few of the guide questions could be asked within the allocated time, the second was a SCP whose role and experience required a different approach to the questions, and, in response to nearly all questions, the third SCP referenced their own safety, and demonstrated a lack of insight that I would regard as unsafe for spiritual care practice.

The Qualtrics program was used to analyse the quantitative survey data and to assist with thematic analysis of the qualitative survey data. Notes were taken

during the interviews which were audio recorded, and the audio recordings were transcribed, some fully and some in part. All interviews were listened to repeatedly and further notes taken. Manual thematic analysis was used for the interview data.

Limitations

During the analysis and writing stages of this thesis I have attempted to avoid "attitudinal fallacy" (Jerolmack & Khan 2014). However, as a participant researcher and insider, it is possible that the interviews could have been affected by courtesy or social bias, because some SCPs were my peers when I worked in the hospital system. It was not possible for me to quantify the 70 fully completed surveys as a percentage of the SCP workforce in Australian hospitals because the total workforce is currently unknown and, of these survey respondents, 39 indicated willingness and were invited to be interviewed, and 14 of these self-selected to be interviewed, a figure that might be considered by some as not a representative sample. Although this research is necessarily limited as a Masters thesis, I expect it will launch further discussion about what safety and spiritual care mean for each other in Australian hospitals.

In Chapter 1 of this thesis, I discuss the background of the overarching safety agenda in Australian hospitals, and examine patient safety, workplace health and safety, child safety and cultural safety. Together these will provide contextual insight for my examination of SCP responses about their

understandings of and engagement with safety in their hospitals. I argue that a persistent underlying power dynamic threatens the safety of those present in hospitals, particularly patients, and that the responses of SCPs to safety agendas indicate both their commitment to safety and a perspective on safety that raises a challenge for power relations in hospitals. In Chapter 2 I provide descriptions of *spiritual safety* from interview participants who attempted to interpret and define the phrase and what they perceived as threats to it. This is followed by an inaugural representation of spiritual safety based on these collected reflections. Chapter 3 provides an overview of iatrogenesis, a brief explanation of iatrogenic distress and an examination of the conditions generated by the decontextualisation and reification of hospitalisation. I argue that the intervention of hospitalisation can cause iatrogenic distress, an expression of spirituality in response to threat and that it is the responsibility of all biomedical actors, agencies, governing bodies, including hospitals and their staff, to acknowledge and address it appropriately and effectively. I also argue that the concept of spiritual safety and the practice of spiritual care should be considered to mitigate and assuage the effects of iatrogenic distress. Following this, I consider spiritual safety and spiritual care as necessarily present alongside, but divergent from, biomedicine and I present suggestions of opportunities arising from the findings of this thesis. The conclusion of this thesis will draw together the key points of the Chapters, elucidating the complexity of the spatial structure and culture within which spiritual care and

safety interact in hospital settings and in which spiritual safety emerged as a concept embodied in the practitioners and practice of spiritual care.

1. Perspectives on safety in Australian hospitals

> Every point in the process of caregiving contains an inherent lack of safety
> Liam Donaldson & Pauline Philip, WHO 2004.

Most people who are admitted to hospital would surely want their time there to be free from harm, injury and danger to their lives. We usually refer to this freedom as "safety". Nevertheless, entering the dominion of biomedicine, whether patient, visitor or staff, requires surrender of this freedom and acceptance of phrases that appear similar but are in fact not the same as freedom from harm. Patient safety, workplace health and safety, child safety, cultural safety and others, all represent objectives and intentions to prevent harm. When we enter a hospital, we cannot presume we will be free from harm, for we are immediately in the company of hazards - diseases, people, environments and processes that are not our own. We are surrounded by the actions and intentions of a cultural system aspiring to safety, and artefacts that symbolise safety. In hospital we discover yet more safety labels - clinical safety, e-Health safety, medication safety, all systems geared and oriented to the prevention of harm to patients, staff and visitors. Under the authority of biomedicine and those representing that authority, the biomedical practitioners that are analogously its ministers and clergy, these temples represent to the greater communities in which they are situated, care that cures, repairs and restores. They are, however, hazardous places containing threats to the very people they aspire to support and provide care.

In this Chapter I discuss the background of the overarching safety agenda in Australian hospitals and examine prominent components represented as patient safety, workplace health and safety, and the more recent additions of child safety and cultural safety. Together the safety agenda and associated components provide contextual insight for examination of spiritual care practitioner (SCP) responses about their understanding of and engagement with safety and how it impacts their work in hospitals. I will argue that the background and prominent perspectives on safety signify a spatial structure of persistent underlying power dynamics that threaten the safety of those present in hospitals, particularly patients. I will also argue that the responses of SCPs indicate both their commitment to safety and an additional perspective that resembles something analogous to cultural safety with the challenge it raises for power relations in hospitals.

The following sections establish that social, political and economic factors drive the safety agendas in Australian hospitals. Like the religious institutions, permeated with power and authority, that were exposed by the public demand for scrutiny by a Royal Commission, biomedicine was also compelled to change in response to external pressures (Commonwealth of Australia 2017).

Safety in Australian hospitals – A potted and somewhat political history

Australia's national health scheme was established in 1970 after decades of "marked conflict" between the federal government, the Australian Medical Association [AMA], general practitioner organisations and health insurance

funds" (Graycar & Junor 1970, 48). Notably, patients were not included in discussions, nor was there any wording on safety as it pertained to patients (1970, 58). The Australian hospital accreditation program was introduced in 1974, brought about by hospital administrators who wanted to make changes in medical staffing arrangements and in accountability, and who wanted to "implement activities such as peer review", and by the AMA who wanted to ensure "complete and untrammelled professional freedom and control by medical men over areas of policy which they regard as purely medical" (Hunter 1969, 58). "Physical facilities and safety" were part of this accreditation program and included programs and systems for reporting and monitoring accidents around staff and patient safety but, again, patient voices on safety were absent (Duckett 1983, 1579). It appears that safe care of patients was assumed, and harm of patients was tolerated. Furthermore, given the power of the medical profession, it is perhaps not surprising that consideration of medical error was not publicly acknowledged, well-documented, or included in the accreditation process of the era.[8] It has been suggested that "patterns of socialisation and training within the medical profession ill-equipped them to deal with situations which acknowledged fallibility or error" (Waterson 2014, 4; Emanuel et al. 2009, 13).

In 1981, federal and state health ministers agreed that the registration of health care providers would likely help mitigate serious harm or death of patients

[8] There were no readily identifiable documents in the public domain to suggest the contrary.

(O'Neill 1994, 498). Twenty-eight years later the federal government passed the Health Practitioner Regulation National Law Act 2009 and established the Australian Health Practitioner Regulation Agency (National Health Practitioner Ombudsman 2021).

Runciman attributes delayed advances in patient safety in the 1980s to those in control of health care and hospital funding (2002, 246). He then writes, "on reflection it was apparent that this disregard for patient safety permeated the healthcare system… patient safety was simply "not on the agenda"" (2002, 246). It is pertinent to recall the decades-long conflict between the biomedical cohort and Australian governments regarding the national health scheme, through which it was proposed to give the entire population access to free health care. The biomedical agenda was described as "motivated by self-interest" and "loss of status", and the AMA was described as "grievously lacking in a sense of social responsibility"; it could be suggested that patient safety was not at the top of the biomedical agenda either (Graycar & Junor 1970, 56 & 58; Australian Government correspondence, 22 December 1948 In Hunter 1969, 183).

Between 1970 and 1990 several severe incidents drew international public attention and led to examination of managing safety in hazardous industries, mass transportation, aviation and to a lesser degree health care (Waterson 2014, 1). Aviation and health care were seen as useful comparisons because both rely on "high-technology equipment and highly proficient…professionals

functioning as teams within life-threaten environments" but with a key difference that "the aviation industry designs for safety; the health care industry often does not" ("Sentinel Events: Approaches to Error Reduction and Prevention" 1998, 176). After the Chernobyl accident in 1986, the International Nuclear Safety Advisory Group [INSAG] coined the phrase *safety culture* to refer to the "dedication and personal responsibility of all those involved in any safety related activity at a nuclear power plant" (INSAG 1992, 84).

Runciman does not mention the Chernobyl accident or safety culture, but a year after Chernobyl a group of "influential Australian clinicians" decided to establish what they called the Australian Patient Safety Foundation (APSF) to provide the basis for a national monitoring and patient safety surveillance system (2002, 246). Runciman claims that patient safety is a "nebulous concept to many", yet throughout the article it is evident that biomedical practitioners were highly cognisant of the rate of harm to patients and the need to improve patient safety (2002, 249). Not only was it not a nebulous concept for the biomedical cohort, including those who devised the APSF, but patient safety is not and has never been "nebulous" for those patients suffering harm. The APSF founders wanted to design a reporting system for incidents of harm to patients, the rate of which was high, and they wanted to ensure protection for those lodging reports (250). The desire for protection of reporters is a repeated reference that signals the fear among biomedical clinicians that reporting harm might subject them to blame and ridicule, and negatively impact their

reputation and status (246, 247, 249, 250). For a profession whose status seems to have relied so heavily on the public perception of erudite, moral authority, perceived patient harm by human error was a profound threat (250; Reason 2012, 62; Paterson 1957 In Siegler and Osmond 1973, 42).

Eight years after the APSF was established the Quality in Australian Healthcare Study was published in the Medical Journal of Australia, revealing a substantial number of preventable adverse events during which patients were harmed (Wilson et al. 1995). In 1999 and 2000 major events with international significance pertaining to safety in hospitals occurred with two key reports published from the United States and United Kingdom respectively, 'To Err is Human' and 'An Organisation with a Memory' (Kohn et al. 1999; Department of Health 2000). The reports exposed the nature of medical errors, their frequency, and their links to unexpected patient deaths (Waterson 2014, 4). It seems the veil was lifted and those outside the medical system were beginning to realise the extent of events of harm to patients in hospitals. Since these reports, further studies were conducted, and in 2007 a systematic review of these was conducted which revealed 9% of patients were affected by preventable operation or drug-related adverse events, 7% of which resulted in fatality (de Vries et al. 2008, 222). Sensitive to the threat of reputational and status damage as well as litigation and associated costs, an urgent curative response was required.

Safety culture and systems

After INSAG coined the term 'safety culture', it was adopted by a multitude of sectors and agencies, subsequently highlighting problems with its definition and measurement (Guldenmund 2010, 7, 11; Reason 2012; Waterson 2014, 371). The central problem, according to Guldenmund, was one of how to measure an organisation's progress when "safety is about behaviour, whereas culture is about the meaning of behaviour" (2010, 196). Taken at face value this simple statement appears reductionist in the face of the vastness of anthropological understandings of culture, although perhaps this can be partially qualified by the same author's explanation of safety culture as the convergence of an organisation's "...highly observable artefacts…, espoused values…and tacit basic assumptions" (Guldenmund 2010, 109).[9] Psychology professor James Reason described safety culture as an informed or knowledgeable culture which consists of interactions between "a reporting culture, a just culture, a flexible culture and a learning culture" (1997, 196). This description appears to suffer the same problem as identified by Guldenmund and a problem that overlays the already highly complex and powerful cultural system of biomedicine (2010, 196; Rhodes 1990). Though there is no consensus on the definition of safety culture and methods with which to measure progress toward one continue to be developed and debated,

[9] On anthropological conceptions of culture see Geertz (2001), Good (2011) and Rodseth (2018).

it seems to be agreed that safety culture is and requires a proactive stance (Waterson 2014, 198; Choudry et al. 2007, 1003).

Psychology professor James Reason suggested that safety culture, or a culture of safety, requires focus on the systems rather than individuals in health care (2000, 768). Reason argued that approaches to safety based on the successes of "high reliability organisations" would change working conditions and processes, rather than blame fallible humans, although he later stated that "blame-free culture is silly because there are some acts that are bad, culpable" (2000, 769; Reason 2012, 62). While safety culture remains a dynamic topic of global debate and research, systems-based approaches to improving safety have steadily gained purchase in health care (Waterson 2014; Brand et al. 2007; Emanuel et al. 2009).

System-based approaches have been implemented in Australian health care services. They are designed to encourage effective reporting, investigation and reviewing of incidents and near-misses, to encourage full disclosure, to facilitate learning and continuous improvement and, despite Reason's stance noted above, to eliminate the "toxic effect" of blame (Emanuel et al. 2009, 13).[10] Nevertheless, from academics and other professionals involved in the research and evaluation of safety culture in health care, comes a call familiar to that of anthropologists, more attention must be given to the social context in which

[10] An example is the Victorian Health Incident Management System [VHIMS], also known as RiskMan.

patient harm occurs and how power relations are involved; the *cultural* system of biomedicine (Waterson 2014, 123; Dekker & Nyce 2014, 44; Rhodes 1990). Approaches to safety that omit scrutiny of the interaction of power in accounts of safety culture have been analysed with a Foucauldian lens by Decker and Nyce, who conclude that "power is everywhere in safety work…through the workings of procedures, discourse, relationships, both up and down and laterally through and across organizations... everywhere we do safety work and safety research" (2014, 47). As a researcher in the area of safety in hospitals I have been both warned and encouraged: "power does not just repress, limit or mask through human agency. Rather, it enables and sets the stage for all human action" (2014, 47). Here we can say that safety involves power, its loci, exercise and context, and that spatial structures of hospitals are established and imbued with power. This is the context within which my research into safety and spiritual care is located for this thesis, and the examination of the following safety themes presumes the presence of power dynamics intrinsic to the culture of hospitals.

Patient safety

The previous section dealt chiefly with clinical safety. This section highlights the phrase patient safety because it is now central to delivery of care and considerations of nearly all other safety matters in hospitals. It is also caught up in Quality Improvement (QI) cycles. As a manager in State-run public hospitals, I observed the proliferation of new dedicated QI departments in

health care services, set up and responsible for ensuring organisational readiness for hospital accreditation processes.

Patient safety is defined by the Australian Commission on Safety and Quality in Health Care [ACSQHC] as the "prevention of error and adverse effects associated with health care" (2019, 5). The World Health Organisation [WHO] provides a concept of patient safety that reflects a systems approach:

> …a framework of organized activities that creates cultures, processes, procedures, behaviours, technologies and environments in health care that consistently and sustainably lower risks, reduce the occurrence of avoidable harm, make error less likely and reduce its impact when it does occur (2022).

Emanuel et al define patient safety as a discipline of applying safety science methods, and as an attribute of frequency and impact reduction and maximisation of recovery from adverse events (2009, 13). The same authors also propose that loci of patient safety actions are the microsystems, or "immediate environment[s] in which care occurs", so it can involve a variety of actors, including staff, patients, volunteers and visitors (2009, 18). These microsystems are understood as unpredictable, multitudinous, open/interactive with each other and part of the entire hospital system (2009, 18). Emanuel et al summarise what are essentially biomedical perspectives

that "patient safety (as an attribute) prevents avoidable adverse events by paying attention (as a discipline) to systems and interactions, including human interactions..." and state emphatically that "patient safety is irreducibly a matter of systems" (18). Yet their analysis only makes a passing reference to "the unequal power structure of the provider/patient relationship" (2009, 14). An anthropological perspective would acknowledge that power is involved in safety work (Dekker & Nyce 2014, 47). The coalescence of clinical patient safety systems and power dynamics is the context within which my analysis of safety and spiritual care is located.

Work health and safety

In addition to clinical safety systems, safety policies and systems apply anywhere that hospital workers labour and are not exempt from the power dynamics intrinsic to hospital culture. Work health and safety (WHS) covers employees, contractors, volunteers, consultants and business visitors.[11] Furthermore, in the hospital context WHS must also account for all people who enter hospital workers' workplaces. These include patients and families, friends and visitors of the patients and the hospital workers. WHS systems are informed by Safe Work Australia [SWA]. SWA is the statutory agency responsible for developing policy frameworks for legal accountability of employers to ensure workers' health and safety and provision for compensation (2021). Physiological safety, psychosocial safety, or "freedom

[11] Also known as Occupational Health and Safety.

from psychological and social risk or harm", and psychological (mental) safety all sit within the remit of SWA (2021b). Australian hospitals maintain sizable collections of policies and associated in-service education and training programs related to work health and safety.

WHS is big business, involving governments, insurance companies, employers, specialist legal services, an extensive raft of supporting agencies and vast sums of money. To illustrate this point, work-related injury and disease cost the Australian economy $61.8 billion in 2012-13 and in 2018-19 the total compensation figure for claims of work-related mental health conditions alone was $736 million (SWA 2021 c & d). Figures for 2019-20 for the number of "*serious"* WHS claims, place the health care and social assistance sector at the top with the highest figure (2021e, 13). It seems providing health care is not an especially healthy or safe occupation, and hospitals not wholly safe or healthy workplaces. Ever-present fiscal and reputational threats associated with work-related harm, as embodied by SWA, reveal powerful motivations for implementing safety agendas. I wish to suggest too that these corporate concerns point to a connection between WHS and "economic rationalism", a topic beyond the scope of this paper, but nevertheless representing another layer of the power-infused clinical context of my study of safety and spiritual care.[12]

[12] "Economic rationalism", closely aligned with neoliberalism, has been described as "a narrow philosophy, [that] values only the most quantifiable aspects of [health care] practice"

Child safety

Children, as patients and visitors, enter the power-infused clinical context of the hospital. Consideration of the significant child/adult power differential and the already noted involvement of power with safety, makes it evident that clinical contexts are dangerous for children. In response to The Royal Commission into Institutional Responses to Child Sexual Abuse [The Commission], Federal, State and Territory health departments mandated the introduction of policy and concomitant systems to ensure child safety is promoted, understood, fostered and practiced by all hospital workers involved in providing services to children or who encounter children in their hospital work.

The Commission brought public attention to severe abuses of power and authority within institutions that purportedly cared for children (Commonwealth of Australia 2017). The Final Report's executive summary notes that "spiritual or moral authority over a child" is an "institutional factor(s) that facilitated or enabled" abuse of children (Commonwealth of Australia 2017b, 10). Pausing to juxtapose this grave finding with the scenario of patients (children and adults) exposed in hospitals to the "moral authority" of biomedicine, we begin to comprehend the importance of implementing safety policies and systems in hospitals (Paterson 1957 in Siegler and Osmond

and as "a belief in the efficacy of market forces and the need for limited government in the face of market failure and government failure" (van Schie 1997, 284; Burton, Dollery and Wallis 2002).

1973, 42). This moral authority is "expressed in the Hippocratic Oath" and further bestowed by public perception of biomedical concern for doing what is good for the patient and right for society (1973, 42). Child safety in biomedical 'temples' that are populated by workers ordained with moral authority, generates a further contextual layer for my examination of safety and spiritual care in Australian hospitals.

Cultural safety

The power and moral authority of biomedicine has been challenged by the concept of cultural safety, a concept that emerged in 1992 among trainee nurses in New Zealand (Papps and Ramsden 1996). The focus of cultural safety was Maori health and by 1996 the concept had been expanded to encompass "age, generation, gender, sexual orientation, socioeconomic status, ethnic origin, religious or spiritual belief and disability", and it was understood that quality care could not be provided by nurses with "unconscious negative attitudes" about those in their care (1996, 496). The definition was adopted by the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives and cultural safety is now widely acknowledged as having particular significance for Aboriginal and Torres Strait Islander peoples, for their experiences of health care services and outcomes (Taylor and Geurin 2019, x, xiv; Australian Human Rights Commission, 2021). Additionally, cultural safety is considered as a singular philosophy that recognises the colonised milieu of health care

provision and that invites health care providers to accept and comprehend the "potential of contributing to colonising or disempowering others" (2019, 216).

In 2019 the Indigenous health workforce in Australia consisted of a majority of non-Indigenous people, representing an example of the colonised environment of health care. The unequivocal call to health care professionals and services is to engage in critical reflection and 'appraisal of biomedical dominance" (234; Mitchell et al. 2019, 10). Such processes enable deeper understanding of issues of power, structural and systemic racism, history and colonisation, and how these issues influence clinical practice. Health care professionals and services can then identify and take responsibility for their "considerable power in defining problems and solutions in health care" (Robinson et al. 1996, 371).

The Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health [The Framework] recognises that recipients of health care are "safest when health professionals have considered power relations, cultural differences and patients' rights" (2016, 18). The Framework also states that the "presence or absence [of cultural safety] is determined by the experience of the recipient of care …[not] by the caregiver", which is echoed by the Australian Institute of Health and Welfare [AIHW] (2016, 18; AIHW 2021). While this might indicate a shift of awareness in the power relations between the health care recipient and provider, it does reveal again the involvement of power in safety agendas in health care.

The AIHW claims its definition of cultural safety is specifically adapted for the purpose of evaluating cultural safety from the perspective of care recipients' experiences (2021). In my mind this raises at least three questions. Firstly, will data be collected, interpreted and presented with clear reference to the power relations in colonised health care contexts, and if so how? Secondly, how should the AIHW address the problem of evaluating the experiences of recipients of care who cannot communicate or who are not conscious, and thirdly, how can AIHW avoid contributing to what has been termed "deficit discourse" in relation to Indigenous health (Askew et al. 2020, 102; Fogarty et al. 2018). Deficit discourse is the label given to processes that construct Aboriginal and Torres Strait peoples in ways that focus attention on deficiencies, lack and failure (2018, 2). Deficit discourse is a colonial power tool. It creates and reinforces racialised images and overlooks Aboriginal and Torres Strait peoples' focus on individual and community strengths-based approaches to health (2020, 102).

For the purposes of evaluating cultural safety in public policy, Mackean et al suggest "reflexivity, dialogue, reducing power differences, decolonization and regardful care" as key principles to underpin such processes (2020, 340). The concept, or 'philosophy', of cultural safety offers transformational potential, but it is reasonable to suggest that Australian hospitals have a long journey ahead to effectively address the power relations that cultural safety highlights,

and that add yet another important dimension to the clinical context of the analysis of safety and spiritual care.

Spiritual care practitioners and hospital safety agendas

The SCPs who work in hospitals are working within the complex matrix of power and authority that has been described. Based on my survey, they understand and engage with hospital safety agendas and are committed to upholding safety and practicing safely. All hospital employees in Australia are required to be thoroughly drilled in workplace health and safety as well as all other mandated in-service training related to their practice. SCPs in hospitals are among these employees. The SCA Standards of Practice and the SHA Capability Framework also imply expectation that SCPs need to understand and engage with the safety agendas of their organisations, which for those working in hospitals includes WHS, patient safety, child safety and cultural safety (SCA 2014; SHA 2020).[13] Although, it is important to note that the Standards do not use the word safety.

The surveys, which I developed primarily for recruitment purposes, also provided preliminary indications of SCP awareness of hospital safety agendas. This assisted with building a picture of what safety means for SCPs and the practice of spiritual care in Australian hospitals. The survey included quantitative questions to ensure recruitment from the target group of hospital

[13] See Appendix 1 for a summary of the SCA Standards of Practice.

SCPs and three qualitative questions to allow respondents the opportunity to provide further insight about their awareness and engagement with safety agendas. A comprehensive presentation of the quantitative survey results is not included in this paper, however the key points from the survey which are pertinent for this paper are as follows and survey summary tables are provided in Appendix 2.

Most respondents were aware of in-service education and training programs related to the safety agendas of the hospitals in which they work, and a large majority of respondents also attributed importance to key activities identified as being related to safe practice (SCA 2014; SHA 2020). Nonetheless, some responses were markedly out of step with the majority.

In response to the question about in-service programs pertaining to safety provided by their hospital, one survey respondent selected "none of these" which, if understood and answered truthfully, might indicate low regard for the wellbeing of those in their care, other staff and/or themselves or ignorance of protocols (see Appendix 2, table a). It could also suggest that their hospital might be carrying a degree of risk. Another respondent added a free-text comment that could indicate insightful critique or critical lack of insight; "Most organisations have MT [mandatory training] programs to tick a box on their risk assessment. Most are time-wasting and border on insulting my intelligence." Indeed, it was noted in many hospital accreditation meetings I attended whilst a hospital employee that medical doctors and surgeons

frequently failed to complete all the mandatory training modules prior to accreditation and 'ticking boxes' was the exact description used by senior managers to describe the pre-accreditation process.

"Not applicable" responses to the safety-related activities suggested in the survey might be accounted for by differences between public and private hospitals, by differences between State and Territory health care governance frameworks, and/or by the active or passive presence of professional spiritual care bodies in particular States or Territories. However, responses of "not important" might suggest that some SCPs have low regard for professional development and accountability. Whatever the explanations for these responses, they do not align with professional expectations such as those highlighted in the Code of Conduct and the Standards of Practice of SCA, which "spell out" important professional requirements of SCPs to ensure the quality of their practice continues to improve (2017; 2014, 5).

Despite limitations of online surveys, and COVID19-related hospital workplace pressures, a large majority of respondents used the free-text questions to briefly describe 1) their understanding of safety, 2) how they engage with it in their work context and 3) how it impacts their work. Although the free-text questions allowed respondents to make their answers as lengthy as desired, most answers were four sentences or less. Respondents described their engagement with hospital safety policies and procedures, including the safety

themes described earlier in this Chapter, COVID19 precautions, family violence and elder abuse as well as an aspect of safety they labelled *spiritual safety*.

Spiritual safety appeared in survey free-text responses, and it was also referred to in responses that listed spiritual among other safety aspects such as physical, emotional, mental, cultural, ethical, clinical, gender and religious. The meaning of spiritual safety was not evident from surrounding text and, despite referring to it, spiritual safety is not defined in academic or grey literature pertaining to spiritual care in Australian hospitals or the health care sector more broadly.

Although survey responses indicated that the majority of SCPs engage with the safety agenda of their hospitals, the repeated reference to "spiritual safety" suggested to me that SCPs hold a particular or unique perspective on safety. I also wondered about the implied sense of threat, danger or harm in the phrase. Subsequently, I invited interview participants to explore the idea of spiritual safety, the results of which I examine in Chapter 2.

In this Chapter I have discussed the overarching safety agenda in Australian hospitals and examined patient safety, workplace health and safety, as well as child safety and cultural safety. Together, this contextual insight was shown to signify a spatial structure of persistent underlying power dynamics that threaten the safety of those present in hospitals, particularly patients. I indicated that SCPs who responded to the survey revealed their commitment to safety and that the idea of spiritual safety that emerged from the survey

suggested a perspective that has not previously been described in literature and that might be analogous with cultural safety in the challenge it raises for power relations in hospitals.

2. Spiritual safety

> *…every spiritual carer sees in the interaction the profound impact of what we're doing and… nurses use phraseology like, "did you have a good chat?" And we don't have any robust language around how to push back against that, and, you know, nobody says to the oncologist after they've left the room, "did you have a nice chat?" They say, "how'd that go? Did you deal with some significant issues?" cos the concept is, "ah, that medical person does significant work with the patient". More and more as I work in this context, which is the acute care context, staff members see the work that I do. Just today I had a nurse pull me aside and say, "Jude, I saw the work that you did with the children of that dying mother and I've got no idea how you were able to do that, but I'm so glad that you were there to support that family because we couldn't have done what we did without you doing what you did, and I don't believe that most people would have a clue about how to do what you did."*

For those who notice, like the nurse in Jude's story, the highly tailored care provided by spiritual care practitioners (SCP) can appear mysterious. Jude also notes the kind of enquiry made of the specialist, an enquiry laced with high regard for biomedical authority and intervention. SCPs have been present in many Australian hospitals since their founding, many hospital founders were

SCPs themselves, yet SCPs now report frequent exclusion from clinical meetings and decision making (St Vincent's Health Australia 2022; Mercy Health 2022; Cabrini Health 2022; St John of God Health Care 2022; Calvary Care 2022). That is until biomedicine is rendered somewhat impotent by situations that speak to its failure. Such situations include failures to cure, restore and repair, for example, ceasing futile treatment, impending, sudden or unexpected death, poor prognoses, 'difficult' patients or families, intense emotional outpourings and religion-based predicaments.[14] Undervaluing and poorly resourcing a service which deliberately and directly engages with spiritual distress generated by and during hospitalisation perhaps sets the scene for what the interview participants described when asked to define spiritual safety.

Spiritual safety first arose in responses to the survey question, "what is your understanding of safety in your work context?" It could also be related to responses that referred to "spiritual harm", "spiritual abuse" and "spiritual risk". None of the survey respondents expanded on their intended meaning for spiritual safety. I undertook a literature search which returned only one article that referred to a description of spiritual safety as it pertains to health and

[14] The word 'difficult' is frequently used among clinical staff to describe people perceived as resistant to staff requests/directives/suggestions/control/management and people perceived as demanding of ward resources, including staff time and attention.

social care. In the conference report, Keenan quotes the following definition from his previous article published in the Catholic Medical Quarterly.

> The extent to which the individual recipient of care is and feels secure to practice their faith, and also in the ways in which health and social care professionals acknowledge, understand, demonstrate respect and respond effectively to their needs/concerns, as defined by them (Keenan 2017 In Keenan 2017, 39)

There are important points in consideration of this definition. Firstly, it equates spirituality with the practice of faith seating it within a religious framework. Secondly, it was published in a specific religious journal, which consolidates the limitations of it application. Thirdly, although the author has a clinical academic background, the definition appears to be a theoretical offering with no research basis.

In the current colloquial I wondered, "is spiritual safety even a thing"? What might SCPs mean by the term spiritual safety? How would they define it? What might it signify for them? These wonderings translated into an invitation to interview participants to define the term as a method of exploring its meaning. This Chapter will describe *spiritual safety* as interview participants interpreted, described and attempted to define the phrase and what they perceived as

threats to it. This will be followed by an inaugural attempt to make a representation of spiritual safety based on these collected reflections.

Spiritual safety – According to the clinical frontline

Harper, a SCP who has worked in an acute care hospital context for most of their adult working life, made this first effort to define spiritual safety during the interview: "respect for their beliefs and where they're at in that moment", but not being satisfied with leaving it as a single, simple sentence, Harper went on:

> *Because I'm so deeply conscious of the vulnerability of patients, and of their loved ones,… and in that moment they're wrestling with their illness, their reason for admission - whether it's a psychiatric illness, a physical illness, a combination, emotional issues as well – they're extremely vulnerable, and they may be wrestling with their religious beliefs, with their values learnt earlier in their life [pause] people who're are struggling with work - what happens when they can't run their business – present and future issues, and there's a whole lot of things often. Unless they're sedated, there's a lot of time to think in hospital, and it's noisy. It's not like a calming, mindfulness space. There's bells and codes and people talking and things clanging and banging and phones going off and all the rest. It's a crazy space, so it's not a good place for reflection or contemplation at all, so*

> *for the spiritual carer coming in, when they're in that space and very vulnerable, to actually respect where they're at in that moment and their expressed spirituality, that's spiritual safety to me.*

Harper portrays hospital admission as placing patients and their loved ones in a state of extreme vulnerability. Then Harper goes on to depict an aural impression of the contextual conditions of the hospital. It is noisy. The sounds identified also provide a visual impression of a busy and somewhat frenetic environment, and the Harper contrasts this with spaces and practices often understood as spiritual. In this portrayal, the context of hospital admission and constantly changing elements in the environment impact the already vulnerable patients and their loved ones; it is not a homely felt sense, hospital is "a crazy space." The sounds, the images and Harper are all part of this "artificial" locus or "collective, homogenous space"" (Foucault 2003, 7, 196). Spiritual safety is described as requiring demonstration of respect for the patient, what they are experiencing and presenting in "that space", the encounter. There could be a problem here with the generalised labelling of patients as "vulnerable". It has been suggested that, in areas where individuals and communities are consistently exposed to risk, hazards and disaster, such labelling can "constitute an act of marginalization and oppression; and mistakenly focus attention on the experiences and "cultures" of the communities exposed to risk" rather than their resilience, agency and power

(Marino & Faas 2020, 24). Does such labelling then negate spiritual safety as it is described?

Acceptance was core to Jude's description: "Spiritual safety is about being able to express what is at the heart of my experience as a human being, and the safety comes from the expression without fear of that expression leading to anything other than acceptance". This description is reminiscent of psychosocial safety, a concept typically applied in workplace teams, and it might also reflect Jude's prior work in the psychosocial sector. Jude suggests that spiritual safety refers to what is being shared (spiritual) and the condition required to do so (safety; no fear of harm). Acceptance here could be viewed as acceptance of the speaker by the SCP and/or the speaker's self-acceptance. In this sense spiritual safety could be viewed as a process and an experience.

> *…spiritual safety begins when they gain the impression or understanding that I'm going to let them be where they are, I'm not going to criticise them, I'm not going to try and persuade them they're wrong, I'm not going to ask them questions about, "how do you know that's true?" You know, any of those sorts of things. What I'm going to do, I'm going to meet them where they are, validate them in whatever is going on for them in that space. I'm not going to try and suck them out of it into my space.*

Dom's last sentence above conjures a strong image of force being applied to a patient; an action that Dom indicates would negate spiritual safety. Although

Dom suggests that spiritual safety "begins when" the patient experiences this acceptance, it could be suggested that the process leading to spiritual safety began with Dom's practice, which is underpinned by respect for the patient's current state and a non-judging and validating approach to patients and their experiences. This stance appears to be foundational for Dom's practice and part of a process of developing and maintaining spiritual safety.

What I have labelled "stance", is described by Fynn a little differently, as "unconditional regard for their spiritual experience". This description is reminiscent of Rogers' psychotherapeutic stance of "unconditional positive regard" – "a warm caring for the client…which is not possessive, which demands no personal gratification", "outgoing positive feeling without reservations, without evaluations" of the client (Rogers 1967, 62, 283).[15] The Rogerian theory appears to stand in stark contrast to the medical gaze/regard which Foucault characterises as having significant authoritative power and one that makes distinct the separation and distance between the one labelled doctor and the other labelled patient (2003, xiii). Although Rogers' approach maintains a stance that appears to match that of spiritual care, it is an approach to *therapy*, and although spiritual care is listed among allied health interventions in ICD-10AM, spiritual care tends not to be understood in Australian clinical settings as therapy (IHPA 2019). A different paper would be

[15] "The phrase "unconditional positive regard" may be an unfortunate one, since it sounds like an absolute, an all or nothing dispositional concept…unconditional positive regard exists as a matter of degree in any relationship" (Rogers 2007, 243).

required to thoroughly investigate the meanings and implications for spiritual care of the adoption of psychotherapeutic theory and approaches to their work.

All interview participants asserted that respect and affirmation of the worth of patients and validation of their experiences are central to spiritual safety. This corresponds with patients' associations of safety with clinician sensitivity and responsiveness (Hor et al 2013, 568). These safety descriptors could be claimed by other clinical professionals who provide services to patients. What remains opaque is how this kind of safety is "spiritual". Is it spiritual because of the SCP? Is it spiritual because of what the SCP is attending to? Is it spiritual because "whatever is going on" for the patient is spiritual or has been labelled by the patient as spiritual? Kim had a go at describing the spiritual aspect first.

> *If spirituality is that sense of, like where you feel most connected and where you get your sense of meaning from and where you feel that sense of transcendence in your life, wherever it is, then spiritual safety would be having that sense respected, and like if that is a flame then spiritual unsafety would be someone coming and extinguishing it.* [16]

Kim suggests spiritual safety is both the experience of having one's spirituality respected and the actions of others respecting it. Ash had a similar approach

[16] Kim's suggestion that disrespecting a person's spirituality is "unsafety" seems to equate disrespect with danger and/or harm, however the question about why the words danger or harm were not used was not asked during the interview. I remain curious and fascinated by the language used but following this curiosity would take this thesis beyond its scope.

and definition: "if spirituality is about an exploration of what is meaningful, purposeful, connecting and brings you a sense of who you are, then spiritual safety is about allowing a space for those things to be addressed". Ash's definition is more overt about the space, which could be the SCP/patient encounter space as much as it could be a physical space (eg. a quiet room) or an activity space (eg. a ritual). Space is only inferred by Kim's use of the word "coming" toward the flame.

Sandy suggested that spiritual safety is about "making it safe for the soul to show up", a quote taken from Parker Palmer which associates "spiritual" with Palmer's concept of "soul" (2004, 54).[17] This also indicates an intentional process on the part of the one offering care, which is similar to the descriptions by other interviewees and, in line with the reference to Palmer's work, "it" refers to the encounter space.

> *I understand spiritual safety as a sacred sharing between the patient and the practitioner. Then there needs to be that space. [pause] I walked into a room the other day where a patient wasn't expecting me to walk in. He was very very suspicious. Sometimes when you walk in and you introduce yourself as pastoral care, there are all these feelings that I must be on a*

[17] Palmer defines soul as "the life-giving core for the human self, with its hunger for truth and justice, love and forgiveness" (2), the "true self" (11), the "core of pure being that children are so intimate with" (14) and "a seed of selfhood that contains the spiritual DNA of our uniqueness" (32). A discussion of soul is beyond the scope of this thesis.

> *slippery slope, or somebody said something… And I virtually said, "well, no, I've just walked in because I wanted to say hello to you." The first thing I did, I noticed he was cold, so I got a blanket and put it over him. It was then that he started to pour out his story. There was no referral for this man, I just happened to walk in as a cold-call, and he must've felt some sort of connection, some sort of safety from my approach, my demeanour when I walked in. And after a few minutes he said to me, "I'm so glad you walked in. I'm so glad I can tell you everything; because you're a stranger, you're not going to judge me." [pause] So I perceive spiritual safety as nurturing that sacred space, initiating that sacred space. [pause] You just don't barge into rooms! You don't! And you don't barge into someone's spiritual space. [pause] Spiritual safety is nurturing an environment, initiating and nurturing an environment where [pause] I'm honouring that person as the human, as the spiritual whole being, and for the patient to feel safe enough to realise that the space I've created is a space that we are going to nurture together.*

Pat tells a story about walking into a patient room without a referral, apparently without knocking or seeking consent of the suspicious patient, and placing a blanket over the cold patient, again without patient consent. Then Pat decries the violation of patient spaces. The reverential regard for the patient's

space appears incongruent when placed alongside the patient encounter report. Was this an example of Jude's "spiritual unsafety"? Is the inviolability of the patient's space aspirational?

Several different descriptions of space ensue from this interview – "a room", "sacred space", "someone's spiritual space", "an environment" and "space I've created", and different actions by Pat are described as contributing to spiritual safety. Apparently without harm or disappointment, the patient responds to the different actions and collaborates with Pat.

Much of what Pat has described of spiritual safety matches earlier participant descriptions, and the seeming disjuncture between SCP aspirations and actions might be more common than can be revealed in research that does not include patient-reported outcomes. However, Pat also introduced the idea that spiritual safety involves collaboration between the SCP and the patient; "we are going to nurture together". This approach is supported in findings from a discourse analysis project in the UK's NHS, that this ongoing interaction is "jointly and locally managed" by both the SCP and the patient (Harvey et al. 2008, 57).

From these attempted definitions spiritual safety can be tentatively described as the SCP's perspective or stance and practice, the nature of what is being shared and the conditions required for this, a form of experience, a state, and a process initiated by the SCP, and maintained by the SCP in collaboration with

the patient. Further, it appears that spiritual safety is purposeful and requires deliberate actions. In this sense, spiritual safety is not a given, it is not static, and it is not fixed or established permanently. Spiritual safety requires continual attention to the ever-changing patient and context around them, which in turn requires of those caring for the patient, dynamic reflective practice, constant focussed responsiveness, explicit demonstration of respect, acceptance and unconditional validation of the patient and their current focus of attention. Noteworthy too is the revealed intention of these SCPs to ensure that the person beneath the patient label is consistently acknowledged and recognised as worthy of quality attention; equally worthy of the attention given to the condition which led to their hospital admission.

When asked the same question about spiritual safety as all the other interview participants, Max launched into storytelling, a form of discourse that "deal(s) in human agency, in complex social relationships, in emotion, in cultural difference, and other matters skirted by canonical medical discourse" (Mattingly, 1998, 274). While this is a form of discourse in which SCPs frequently engage in the hospital context, Max's storytelling revealed a stance that deviated considerably from that of their spiritual care peers.

> *I was asked to go and see this patient here and he was in an area where I was required to be in full PPE, which I suppose had the advantage that people can't see your facial expressions or your body language. This poor chap, this poor chap… I won't go into*

details, but for an hour and a half he poured out all the hatred and anger that was in his soul and that was in his life, on me. Now, he wasn't abusing me per se, ok? So you know, he wasn't calling me all sorts of names [pause] but, yeah, I won't quote the language, Redacted by author *so I'm [inaudible] when it comes to foul language, but this was without end, and I thought, "you poor bastard, your head must be an awful place to live in". Just hearing this anger and bitterness and fury at practically everybody in his life. At the end of it when I walked away, I thought, "well, I'm not going to see any more patients this afternoon [laughs] no", I thought, "I'm just going up to the office to have a bit of a debrief if anyone's there", and someone was, "and then I'm hopping in the car and going home", cos it was just… [pause] So does that make sense? Talking about, you know, is that the sort of thing you're talking about?*

In passing, Max refers to physiological safety in the form of PPE but noting its utility for concealment of facial reactions. Indeed, Max also conceals from the patient judgement of the patient's "foul" language and thought life, revealing a divergence of cultures. Spiritual safety was not directly addressed by Max and it was yet unclear how this scenario related to the topic which triggered its retelling.

Kate: I'd be interested to hear more about what spiritual safety means in relation to that scenario for you.

Max: It means having a safe place to debrief. It means knowing, it means having enough [pause] confidence in your own [pause] How do I phrase it? [pause] When I say your own spiritual centre that almost sounds narcissistic, but your own place in the spiritual world. Knowing that you stand in love, knowing that in my own spirituality the world fundamentally is a loving place and being able to say, "ok, for whatever reason - I'm quite confident this man was telling me his truth - but for whatever reason, his truth is horrendous, and he…[pause] Part of my job is to stand there and listen and, in some way, hope that I'm lancing the boil. But if I had to do that sort of thing on a daily basis, I'm not sure how long I'd be able to… I'm not sure how long I'd be able to survive.

It seems the last two words of the interview question directed the attention of Max to further expound upon their own spiritual safety; a sense of assurance of their "place in the spiritual world" and "knowing that [I] stand in love; knowing that, in my own spirituality, the world fundamentally is a loving place". It appears that Max is applying the label of spiritual safety to a process of self-soothing in the face of the overwhelming experience of listening to intense human suffering.

Kate: I'd be interested to hear what spiritual safety might mean for that patient.

Max: I think from his perspective, the world is not a spiritually safe place. From his perspective the world and most of the people in it are out to get him… [pause] He was… [pause] As I say, I won't quote the language, I just got sick and tired of it, however that's the advantage of being in PPE, he couldn't see my eyes… [pause] I think he is not in… [pause] For him, the world is a spiritually black place; dark, harmful, aggressive [pause] and how you get… [pause] All you can do, well I think all I can do with someone in that place is stand with them and in some way try to be something that isn't dark, that isn't angry, that isn't bitter, and, [pause] not get… [pause] I've been around too long to start getting, to start trying to cheer people up. They're not asking to be cheered up, they're not asking to be told "well, you know maybe your brother wasn't such a bad bloke after all," no that's not what they need to hear! After they've told you, pretty bluntly, what they think of their brother. It's just to at least stand there and be there and hear them out because maybe that gives them some sort of security and some sort of power. Because certainly with someone like that you get the impression, possibly I'm overthinking this, but one of the issues about the black place is

that he has no [pause] he feels he has no power, he has no agency, and that everyone's out to get him…

Max's representation of the lived experience of the patient is the reverse of their own sense of spiritual safety, including Max's interpretation of the patient's sense of power and agency. Although Max does not directly identify power and agency as part of their own spiritual safety, power and agency are apparent in the decision to seek a colleague to debrief with and to leave work early.

Paradoxically, Max had received the referral to see this patient because the patient had exercised his agency by asking for someone to talk to, then exercised his agency again by choosing to engage with Max. Furthermore, the patient manifested his power in the expression and sharing of his experience; the patient's spirit was expressed. Unlike Max, the reader is not left with the impression that the patient was disempowered, lacking agency or even feeling that "everyone's out to get him". Notwithstanding Max's incognisance of these observations, according to 2 of the previously offered descriptions, the patient *might* have been spiritually safe. 1) The nature of what the patient shared was spiritual - that is, it was meaningful for him; so meaningful that he sought someone with whom to share it. 2) The conditions required to share were adequate for the patient, which is presumed based on the report that the patient shared without constraint in language or content; although whether there was any medication involved that affected the patient's lucidity or

judgement is unknown. Although the description of spiritual safety arising from Max's storytelling only partially or weakly aligns with those offered by peers, the encounter appears to have, at least, passively aligned with the principle of non-maleficence and enabled the patient's spirituality to be voiced.

Threats to spiritual safety

To elicit further insight into SCP's understandings of spiritual safety, interviewees were asked: what threatens spiritual safety, as you understand it? Consistent words used by interviewees to describe threats to spiritual safety are encompassed by descriptors such as abusive, insecure, conceited, "fixer", non-reflective, non-collaborative and incompetent. SCPs with poor training, poor documentation skills and poor knowledge were also identified as threats. Systemic and structural factors of time pressure, encounter context or clinical environment, policies and processes were all perceived as threats to spiritual safety. The most prevalent responses about threats involved clinical practice based on assumptions, that is unexamined beliefs or conclusions, and the power differential between those wearing lanyards and those receiving care. These are the focus of the following discussion.

Admission to hospital frequently renders people who usually exercise agency and power, suddenly dependent on strangers. These strangers have special knowledge, skills and lexicon, they know where everything is kept, and oftentimes those admitted to hospital are suddenly rendered dependent on these strangers to assist them with fundamental needs, such as toileting or

sating their thirst. Power differentials, or power relations, appear in different guises, including medical discourse, labelled "chart talk" by Mattingly, and storytelling (1998, 273).

Power

Sam is an SCP who is also a supervisor of student SCPs. Following is Sam's exploration of the idea of spiritual safety which reveals a problem of power for SCPs immersed in biomedicine's social and cultural realm.

> *A trusting space [pause] to be able to invite people into that vulnerable space, I think that's another quality of [spiritual safety]. Is it a vulnerable space? Where even the practitioner at times feels that sense of vulnerability of, what if I'm going to ask this question, that feels a bit vulnerable with a person that I maybe just met? But it feels like the right question, then that invites the other also into the space of vulnerability, so that's part of it. Now, is vulnerability safe? And for some people they'd say no it's not; it's not a safe space. But it's a rich space. It's a space which offers you the invitation for growth and learning and change, and without that space then often there's no outcome…. [pause] But it's about being able to provide the environment where someone can be vulnerable in a way that they still feel safe, I suppose.*

Perhaps this *commentary*, in Foucault's sense of the word, describes Sam's attempt to acknowledge "what has never been said" and the importance of vulnerability for this to occur (Foucault, 2003, ivi). For Sam, part of spiritual safety is "a trusting space", it is a vulnerable space for the patient and the SCP, a space that some say is unsafe, a space of possibility for personal growth and a space where a patient can be vulnerable and still feel safe. In this version of spiritual safety, the patient and the SCP are rendered alike with a statement that equalises the vulnerability of the patient and the SCP. The power differential between them appears to be minimised, or even erased, and the patient's feeling about vulnerability being unsafe is subordinate to Sam's expertise. It is noteworthy that, in contrast to Harper's earlier descriptions, Sam has labelled the space rather than the patient as vulnerable. Nevertheless, a power differential always exists between SCP and patient, and this differential is always visible in the artefacts of lanyards and ID cards, symbols of power and authority bestowed upon staff by the hospital.[18] Unacknowledged power differentials, say the majority of interviewees, can be a threat to spiritual safety.

Sam's reflection about growth, learning and change resulting from being vulnerable might indeed correspond with psychosocial literature, however if SCPs were to lean the encounter towards what Sam suggests should occur,

[18] These symbols also represent the power differentials between different staff members, and staff and employer.

"*growth and learning and change",* it would contradict earlier descriptions of spiritual safety. Further, spiritual care is predicated on an approach that respects and supports the agency and power of the patient to determine the agenda for the encounter, so it would be necessary to check whether Sam is conscious of maintaining the power of expertise whilst declaring the value of the vulnerable, "shadowy and more conflicted domain" of engagement (Mattingly 1998, 291).

Perhaps spiritual care would do well to formally adopt a stance akin to critical medical anthropology's steadfast commitment to self-determination of the people it seeks to support, recognising "the folly inherent in the act of imposing externally generated solutions" (Singer 1995, 99). SCPs might then be more adept at noticing their own power and positionality, reviewing how they use power and responding to Singer's question: my "involvement in whose interest?" (Alcoft 1988 in Maher and Tetreault 1993; 1995, 98).

Though the majority of interview participants viewed inappropriate use of power as a threat to spiritual safety, a key question for future investigation might be about the influence and implications of the origins of spiritual care, that is the origins of pastoral care and chaplaincy in colonising religions, with

all the trappings of traditional, institutional hegemonic power.[19] What does this mean for spiritual safety and what does it mean if it remains unexplored?

Assumptions

Partly in response to the colonising religious practice of evangelisation, contemporary professional SCPs in Australian hospitals are now committed to proscribing proselytisation in hospitals (SCA 2014, 6, 8; SCA 2017, 4) and some hospitals include specific policy statements to this effect.[20] In spite of this stance, some SCPs continue to experience prejudice from other hospital staff who exclude them from particular kinds of patient situations on the basis of assumptions about the negative influence of religion.

Jamie reflected on frequent exclusion from clinical meetings and decision-making processes for patients considering voluntary assisted dying or pregnancy termination. "Staff can have an assumption that because you're spiritual care, it would be a conservative approach that would be taken to whatever decision was going to be made".[21] Jamie regarded staff assumptions about SCPs as a threat to spiritual safety when such situations typically induce patient distress and grief – which in any other clinical scenario would usually lead to referral to spiritual care. Moreover, these decisions can raise significant

[19] The terms used by participants were power, inappropriate use of power, abuse of power, unacknowledged power differential.

[20] From author's own policy work on this topic while employed in Victorian public hospitals.

[21] This phrase, "because you're spiritual care", is not a typing error. It is colloquial phraseology that means "because you are a spiritual care practitioner".

ethical and religious dilemmas, in which many SCPs are trained to companion patients with deep respect and without judgement or persuasion.

It is unclear how Jamie knows that staff have this assumption, perhaps Jamie is also making an assumption. If correct, the clinical staff who make referrals to spiritual care might have had professional experiences of SCPs taking a conservative religious approach to such decisions in the past, they might have had distressing personal experience of religious judgement from which they draw conclusions about the clinical context. Perhaps they have formed views based on the histories of religions, their adherents, and the growing body of evidence of abuse in religious institutions in Australia (Commonwealth of Australia 2017).[22] Even so, it appears that at critical moments of spiritual significance, staff assumptions might block patient/family access to spiritual care services, a threat to spiritual safety says Jamie.

Jay recognised a problematic link with assumptions and staff, but Jay's comment was directed at SCPs.

> *…the knowledge we already have or what's already been passed on to us by others about this particular patient or family or whatever, that's a really big one. [Staff will] actually say to you, this is happening with this family, or whatever, and you go in there and it's totally not [laughs], so [pause] assumptions can be*

[22] Most often nursing, medical and social work.

deadly I guess, for spiritual safety, if you just accept that person's assessment offhand.

Jay reflected on the danger of assuming that referring staff have made a correct assessment. Stressing the point, Jay suggests that "assumptions can be deadly…for spiritual safety".[23] Assumptions were described by Jay as having the potential to undermine and detract from conversations with patients, families and staff, and took pains to stress the importance of using inclusive language and asking clarifying questions. Assumptions were described by interview participants as a common hazard requiring the deliberate attention of SCPs. Returning to the subject of religion, Jay and several other interviewees reflected on common errors of assumption where patients "…might not actually hold to the tenants of their particular faith", as listed in patient records.

A thing I am constantly teaching is that assumptions are bad! Never assume that because this patient is from this culture or that faith tradition or whatever, that they're going to be like this. The only person that can tell you what's important for a patient is the patient themselves.

Sam was emphatic, and one might be forgiven for presuming Sam avoids assumptions altogether. In fact, it appears that Sam assumes only the patient

[23] Jay was not using "deadly" in the Aboriginal and Torres Strait Islander colloquial sense, which carries positive meanings akin to amazing, wonderful, brilliant, breath-taking etc. Jay's meaning of "deadly" is akin to fatal.

can share what is important to them. Most clinical staff would concede that it is preferable to hear directly from the patient about what is important to them however a confidante of the patient may indeed be able to share what is important to them, especially in the absence of patient consciousness or capacity to communicate. Sam's statement also ignores the role of the patient's nominated Power of Attorney and Advanced Care Plan, which are both supposed to represent what is important to the patient. Additionally, in stating that "…assumptions are bad" and, in another part of the interview, that people have both "good parts and their bad parts", Sam reveals a binary worldview. Assumptions do not require value judgement, they require examination.

Perhaps there are explanations for a binary view of assumptions that the interview did not uncover. Perhaps the notion of *assumption* was misunderstood or poorly expressed by Sam, although from a tertiary educated, long experienced professional in clinical work and a supervisor of students, this explanation seems inadequate. Possibly the context of the interview distracted Sam, who had chosen to utilise a meeting room in their hospital for the interview. Part the way through the interview the room was claimed by another health professional who had booked the room, and this obliged Sam to go in search of another private room before continuing the interview. Conceivably the binaries could indicate language residue of early formation in a conservative religion, or a still unconscious and/or unchallenged belief. A statement later in the interview, "I see a lot more paradox and grey these days", seems to indicate the masking of a yet-to-be-challenged agglomeration of

contradictions. Regardless of explanations, students receiving instruction from a binary perspective, where assumptions are only bad, could lead to assumptions remaining unexamined, posing future risk to spiritual safety as described earlier by interview participants.

As identified by other interviewees who acknowledged that assumptions could be problematic, the remedy for problematic assumptions is developing awareness of and testing assumptions, after which they should no longer be assumptions but insight. Also, as acknowledged by most survey participants and interviewees, regular engagement in critical reflective practice and professional supervision are keys to gaining and expanding awareness and insight. Sam stated, "I don't tend to assess my encounters on a regular basis, you know. I know if I've done a good job". Whether or not the "good job" is an assumption on the part of Sam, what is a clear threat to spiritual safety is infrequent critical reflection and supervision.

Sam expressed tacitly knowing the quality of their work, which appears to be based on patients' verbal and behavioural responses and thank-you cards. Since Clinical Pastoral Education commenced in Australia, SCP self-reports have been used to assess their practice and gauge patient satisfaction with their care (Eve & Phillips 2019, 246, 248). Whether based on patients' responses or not, Sam's declaration of knowing the quality of their work is not "an unambiguous representation of what [Sam does] when interacting with others", it is an indicator of satisfaction with their work and patient responses

(Jerolmack & Khan 2014, 201). We cannot conclude from self-reports only whether Sam's practice has been good and whether spiritual safety has been generated and maintained. To do so would implicate us in "attitudinal fallacy" (2014). Additionally, Sam does not assess the quality of their work on a regular basis, which could indicate one or more of the following: Sam does not attend professional supervision, does not attend regularly and/or does not use it to assess their practice. This situates Sam outside the professional accountability to which most psychosocialspiritual professions ascribe, and it conflicts with other interviewees' commentary about spiritual safety.

What can be said about assumptions? Rather than placing a value judgement on assumptions, which could lead to SCPs feeling inadequate when they notice their assumptions, a constructive approach as noted earlier, is to be aware of, recognise, examine one's assumptions, after which they should no longer be assumptions but insight. This is an aspect of critical reflection, a process which stimulates both personal and professional integration and development, and directly impacts the quality of practice (Fook & Gardner 2007). Instigated in the education and training stage of professional formation, it enables students to confront and address their biases, prejudices, stereotypes, intolerances and personal "triggers", and become cognisant of their power and positionality. Ongoing critical reflection enables established SCPs to continue integration of new insights, ensuring they offer effective, appropriate, and safe responses to each unique person and situation before them.

Critical reflection also requires the input of others, and I label these others "community" (Fook & Gardner 2007, 44). I propose that a SCP's community needs to be more than a community of practice (Lave 1991). SCPs need to regard their employers, peers and colleagues in other disciplines, researchers, educators and the recipients of care as part of their community. Without regard for the input of all these actors, accountability and measures of spiritual care quality and safety will be weakened.

Furthermore, to support their understanding of spiritual safety, it is critical for the spiritual care cohort to be clear about what constitutes doing "a good job" (Sam). Therefore, the following questions need fulsome responses if SCPs are to remain faithful to their understanding of spiritual safety, safe practice and quality care, and if they wish to give an account of what they are doing in hospitals and why. How do you measure whether you have done "a good job", how do you know if the patient has experienced you doing "a good job", how do you know and measure whether your practice is safe, how do you know if patients have experienced your practice as safe and, more specifically, how is spiritual safety, as you understand it, evident in your practice?

From this Chapter's collection of interviewees' descriptions, I offer the following representation of spiritual safety for the health care context. *Spiritual safety is the assiduous respect, acceptance and unconditional validation of a person or people, their loci of meaning and present concern; their spirituality.*

We have already established that spirituality can manifest in a variety of ways. It follows that what these SCPs have identified as spiritual safety requires the persistent application of careful attention, intensive focused listening, and collaboration with recipients of care.[24] Care of this calibre requires health care providers to be thoroughly trained in critical reflection and reflexive practice, and to receive ongoing professional supervision. Additionally, as noted in Chapter 1, safety involves power – its loci, exercise and context – so spiritual safety in health care contexts requires care providers to comprehend their positionality and what it means for their practice. In Australian health care contexts, it would be pertinent for spiritual safety and positionality to be considered in the light of Aboriginal and Torres Strait Islander cultural safety.

For some people, being admitted to hospital might be where they first experience a sense of community and reprieve from alienation, experience others' concern for their health or the kindness of strangers, where they might experience validation as a survivor of abuse and protection from further abuse. Yet as noted in Chapter 1, the power-infused clinical context of hospitals threatens the safety of those present within them and most of the safety policies and systems of hospitals do not directly address power relations or positionality. In this Chapter I discussed the representation of the concept of spiritual safety that might inform an approach to reducing and responding to distress generated by and during hospitalisation. In Chapter 3, I propose that

[24] See footnote number 3 regarding skills required for this work.

hospitalisation is itself a biomedical intervention which can therefore cause harm.

3. Hospitalisation and spiritual safety

The challenge of medicine is always to make connection with people's deepest desires and needs and their sense of what has importance. It must deliver to them a life that they will in the end accept as an improvement, or it cannot claim success.
Martha Nussbaum 1994, 21.

A 92-year-old patient came into emergency with severe abdominal pain. They operated, they removed her bowel and put in a stoma and a bag. She woke up from surgery completely devastated, and they said, "she's just not progressing; we don't know what's wrong." And when I met her, she said, "why didn't they just let me die? I'm too old to deal with a change like this. This is too much to ask." She felt so overwhelmed and threatened, that she just wasn't progressing physically. She just wasn't healing after surgery. And I remember the stoma nurse saying, "there's no reason why this woman isn't progressing; she has a perfectly functional stoma but it's just not healing after the surgery; it's as though her whole body's healing journey has just ceased." And she couldn't take a step forward because she was in such emotional distress. And it took days working with her to help her process this and reach a point where she had some level of peace and felt this emotional safety. And it was only when she achieved that emotional safety that her healing journey actually continued. So it's like that sense of profound distress ceased her body's ability to progress on the physical

journey. So it's not just about spiritual safety, it's an emotional safety and the body's physical ability to do the thing which it's in hospital to do which is to heal.

Jude, the spiritual care practitioner (SCP) who shared this story, was focussed on the woman's current distress and concern and conveyed a sense of relief that she was eventually emotionally safe and began to heal. Without knowing anything more of the circumstances surrounding this patient, the story is taken as told and Jude shared it to illustrate the importance of *emotional* safety for the body to heal. Whether or not the story conveys Jude's intended point, it provides an example of iatrogenic distress, a phrase that will be discussed in more detail later, an example of the woman's spirituality and an example of the absence of spiritual safety.

The actions of the biomedical team around the 92-year-old woman did not express assiduous respect, acceptance and unconditional validation of her, her locus of meaning and present concern; her spirituality. If they had ensured her spiritual safety, the team would have discovered her locus of meaning and present central concern in life, they would have respected, accepted and validated her and her stance toward her remaining period of life. If the biomedical team had ensured her spiritual safety this 92-year-old woman may not have been devastated and overwhelmed by waking to a changed body and the complex care it would require, and there might not have been need for Jude to attend to the harm and distress caused by biomedicine. If they had paid

attention to her spiritual safety, perhaps she would have been empowered to continue and complete her life in the manner she desired; to co-create her safety (Hor et al. 2013, 571).

We do not know from the story whether the patient was conscious at the time of entering the emergency department. I expect the biomedical team would maintain that it was an emergency situation, that the woman would have died without the stoma surgery and that the Medical Power of Attorney and/or patient's family agreed to the procedure. It could equally be possible that there was no Advanced Care Plan [ACP] because such documents are supposed to be respected by treating clinicians and family members, and typically a person's ACP expresses their own values around quality of life and end-of-life care. While Jude reported supporting the woman "to some level of peace", Jude also reported that the woman herself stated that her distress was caused by the biomedical intervention.

We know that biomedical interventions sometimes cause harm, adverse events and death. These unwanted outcomes are referred to by the term iatrogenesis. It was evident in the first Chapter that hospitals in Australia maintain a raft of safety strategies to reduce the frequency of these iatrogenic incidents. Also evident in these strategies, however, were the power dynamics in hospital culture that threaten the safety of those in hospitals. What is missing from these safety strategies is recognition and acknowledgement that hospitalisation is itself a biomedical intervention and as such has the potential

to cause harm. Spiritual safety is unlikely to stop harm and distress generated by hospitalisation, but it could inform an approach to reducing and responding to harm and distress generated by and during hospitalisation.

In this Chapter I first provide an overview of iatrogenesis, a brief explanation of iatrogenic distress as it will be applied and then elaborate upon the intervention of hospitalisation to explain the effects of decontextualisation and reification that generate conditions for iatrogenic distress. I argue that hospitalisation itself can cause iatrogenic distress and that it is the responsibility of all the actors that perpetuate biomedical structures and systems to prevent, reduce and ameliorate iatrogenic distress. I then argue that the concept of spiritual safety can contribute to preventing and reducing iatrogenic distress and that the practice of spiritual care can mitigate and assuage the effects of iatrogenic distress. This is followed by consideration of what I describe as the political stance implied in spiritual safety and spiritual care, and a brief discussion of opportunities offered by the findings of this thesis.

Iatrogenesis & iatrogenic distress

The accepted etymology of the word iatrogenesis translates literally as 'doctor generated'. The term is defined in a 2006 medical dictionary as "any condition caused by the actions of doctors or other healthcare professionals" (Bloomsbury). More recently, a public health definition expands and more carefully specifies the earlier definition to include "adverse effects of

preventive, diagnostic, therapeutic, surgical, and other medical, biotechnical, cosmetic, sanitary, and public health products, services, procedures, interventions, or policies" (Porta 2018).

In 1975 Ivan Illich described three distinct types of iatrogenesis, briefly summarised as follows. Firstly, *clinical* iatrogenesis, which pertains to all conditions caused by "remedies, physicians, or hospitals… [otherwise described as] "sickening" agents"", and it includes "torts" resulting from doctors' defending against potential litigation for malpractice (1975, 22, 26). Secondly, *social* iatrogenesis, which pertains to harms from the over-reach of biomedicine into social life, or "social overmedicalisation", the promulgating and cultivating of dependence on biomedicine and patienthood (1975, 26). Thirdly, Illich describes *structural* iatrogenesis as the effect of biomedicine that disempowers people and "[destroys] the potential of people to deal with their human weakness, vulnerability, and uniqueness in a personal and autonomous way" (1975, 26-27). Illich says structural iatrogenesis arises in over-industrialised societies in which health is transformed into commodity, people into consumers and health care professionals into producers, manufacturers and retailers (1975, 27, 61, 92).

Illich maintained that the human "art of suffering and dying" had been subordinated to biomedicine and its technologies (Illich & Cerella 2017, 286). Scott Stonington, a medical doctor and anthropologist and Diana Coffa, also a medical doctor, describe structural iatrogenesis, as "clinical harm to patients

by bureaucratic systems within medicine, including those intended to benefit them" (Stonington & Coffa 2019, 703). This definition misses the deeper implications of structural iatrogenesis described by Illich. It is only applied to patients and, even then it still aligns more closely to Porta's definition (Porta 2018).

Structural iatrogenesis, as described by Illich, is the dis-ease and damage imposed on human society and culture by biomedical hegemonic colonisation (1975, 92-93). Structural iatrogenesis comes closest to encompassing high-level policies, laws and legislation, economics, systems and institutions built around and for biomedicine that cause people harm and undermine the human capacity to cope and support one another. Certainly, the claim of biomedicine over the field of public health supports the argument that iatrogenesis can also occur to those not labelled "patient". Here it might be useful to refer to the example of law-enforced restrictions on people's movement, including stay-at-home orders and curfews, imposed by governments on their populations in response to severe acute respiratory syndrome coronavirus 2. Notwithstanding any influence of these restrictions on the spread of the virus and the claims of governments about success, these biomedical interventions have been associated with a variety of harms to people around the globe, which I would suggest fit the label of structural iatrogenesis (MacKay 2021; Meyerowitz-Katz et al. 2021; Every-Palmer et al 2020; Team & Manderson 2020).

For the purposes of this paper, iatrogenesis will refer to harm to a person or people caused by or resulting from interaction with the health care system, biomedical intervention, assessment, diagnosis, plan, personnel, process, procedure, device, product, policy or structural factor, or combination of these. Therefore, iatrogenic distress will refer to distress caused by any of these factors. Here I refer again to Turner's suggestion that "spirit is homeostatic response to threat" (2021, 39), to my earlier reflection in the introduction that spirituality can manifest in a variety of ways and, that when hospitalised, people can experience these manifestations as overwhelming. Iatrogenic distress indicates the activity of the human spirit in response to threat.

Hospitalisation

Hospitalisation intervenes in daily life. It is a biomedical intervention in and of itself. We might then ask, does the process of being hospitalised cause iatrogenesis? Certainly, being hospitalised strips people of their usual social contexts - environments, living arrangements, relationships, activities, routines, foods, smells, sounds, status and schedules, their cultural contexts which are abundant with meaning, and that shape and locate human identity. Admission to hospital places people in unfamiliar contexts with perhaps little more than a few bags of personal items.

Hospitals prioritise "technology over the person, anonymity over identity, standardization over particularity, individuality over relationship and rationality over other forms of knowing" (Salter 2015, 152). Hospital

admission is a process of decontextualisation that changes people into abstracted versions of the full story of themselves, "skeletal… shadows of their actual selves" (2015, 152, 155). When taken onboard an ambulance to travel to hospital, when receiving treatment in an emergency department and/or when admitted to hospital, people are labelled patient. "The patient" then exists in the language and processes of hospital systems and its staff and from then they are perceived, documented, examined, assessed, tested, diagnosed, placed in diagnostically related groups (DRG), discussed, treated, observed and reviewed. These processes occur to patients in isolation from their usual social relations and contexts.

Hospitalisation is a standardised process that decontextualises non-standardised people. Labelling a person 'patient' reconfigures them as an object and they become a construction site of biomedical work. This process Taussig refers to as 'thingification', based on Lukács' conception of reification (1980):

> …that a relation between people takes on the character of a thing and thus acquires a 'phantom objectivity,' an autonomy that seems so strictly rational and all-embracing as to conceal every trace of its fundamental nature: the relation between people (Lukács 2013, 47-48).

'The patient' becomes a fiction, a standardised fabrication by the hospital system, environment and approach. People are reified by hospital systems,

their elemental social humanity subverted and disrupted. They are remade as patients and human relations are altered; hospitalisation is "a sudden disruption" to what usually "enables [people] to make sense of their own purpose and meaning and connection", said Sam. Patients, or decontextualised people, are not encountered by others in the hospital in the fullness of their usual selves, as people located within their communities or familial spaces.

Stripped of many social identifiers, the patient is given a plastic ID wristband, a unique reference (UR) number, a thin gown that opens at the back which frequently reveals usually barely concealed underwear or naked buttocks, and their personal belongings are stowed in a clear plastic bag. Visibly changed and with copious personal details entered into the electronic medical record, biomedical authority over the patient is presumed by the hospital and its staff. The basic needs of the patient are accommodated – meals, bathing, toileting, bedding, room temperature, lighting - and biomedical resources, goods and services are provided, as and when determined by the hospital. This process, 'the patient journey', is promoted by health care decision makers as part of the "just distribution" of scarce health care resources (Denier 2008, 73).[25] The conversion of person to patient appears to go unnoticed by hospital workers and unchallenged by the converted; perhaps it seems natural under the powerful hegemony of biomedicine (Johnston 2017). The final phase of decontextualisation is completed with the ending of visiting hours, when family

[25] A common phrase used in health care services where I was employed.

and friends of the patient are dismissed from the hospital. The unique, nuanced, complex human, reified and reduced to a mere outline of their pre-hospitalised self, waits in a bed and room not their own for the next phase of the 'journey'.

Consigned to homogenous collections, to DRGs, patients are rendered uniform and less nuanced. Reification veils and obscures social relations, alters communication and patient/clinician proximity (Taussig 1980, 5). The patient and their knowledge of their body is perceived as inferior to that of the treating team, and their contributions to treatment discussions and planning kindly tolerated (1980, 5, 9-10). The peculiar transformation of people into patients, quarantined from their usual locations and contexts, suppresses familiar senses of meaning, selfhood and power, and dilutes freedom-from-danger-and-harm; it reduces people and it changes the very meaning of safety.

Hospitalisation and spiritual safety

Admission to hospital, with its associated decontextualisation and reification, is not a minor event in life. Relocating from one's usual abode to sleep, eat and ablute in the hospital environment, surrounded by strangers, is not a minor adjustment. Aside from their bodies being investigated and discussed, in hospital, patients' feelings and preferences also become contested sites. Many of us who have been admitted to hospital can testify to the discomfort, and sometimes distress of being subjected to repeated examinations by several health professionals at a time, to being condescended to by clinical staff, being

expected to wait until midday for ablutions, being coerced into receiving a particular intervention and feeling overwhelmed by the environment, by isolation and lack of familiar faces and food, and overwhelmed by the circumstances that landed us in hospital. Within the limits of our circumstances and capacity, most of us would attempt and hope to have our current state acknowledged. Now retired, SCP, trainer, educator and manager, Val Henderson used to say, "people will give you three goes and if you don't pick it up, they'll shut off from you". Opportunities for health care professionals to respond to patients as the unique people they are, can be noticed and embraced or ignored.

One way or another, patients usually seek to have their current state and experience acknowledged. Yet hospital structures and systems, including resources, will influence what is addressed, how and when. Health care professionals are the arbiters of the current state of patients, and they decide within the hospital parameters whether patients have therapeutic needs and which of these needs will be addressed during admission. As the fragile, sometimes fractured dignity of the decontextualised and reified patient comes face-to-face with the dignity of the health professional, it seems a reasonable proposal that a risk of iatrogenic distress will be present.

> *A recurrent [threat to spiritual safety] that I see a lot is the sense patients have of their choices being taken away, which I view as a spiritual issue, and then also their dignity being taken away,*

and I see that as a spiritual issue too because it's about 'who am I?' Like, "am I worth something? Do I have value?" [pause] But it's hard to know how to bring stuff like that up [laughs quietly and self-consciously] with the nursing team if the person is feeling disrespected [pause] or even if the nurses haven't done anything wrong but the person is like "I just don't have any choices!" [pause] I mean, most nurses are quite good about trying to protect people's dignity but [pause] maybe there's something that could happen around that. [Some people with addictions are] really sensitive to pain, they're really sensitive to feeling that indignity of having to be washed by someone else or helped in the toilet and I wonder if there's some way [pause] because the nurses are trying to help and then they're getting all this abuse and aggression because they've touched on someone's sensitivities, so then the nurses get upset because they haven't been trained about reflective practice, the way that a chaplain has, so maybe there's something around that or training people to be a bit more aware of that kind of thing so that they can sort of de-escalate a bit. I don't want to be disparaging about nurses, cos they do such a good job! But sometimes you'll hear them getting a bit defensive, which is totally understandable, but it does escalate the situation. I don't know how much of it is a work that you might try to do with the

patient and how much would be something that the nurses could change. It's a tricky [pause] You know human dignity, that sense of having dignity is such a huge thing for people, it's a big issue so then it's harder to solve, it's harder to know what to do.

Kim recognises that dignity and choice can be "taken away" when persons become patients; it is described as a threat to spiritual safety, an insight sustained by other interviewees. The descriptive movement between the bodily touch of washing and toileting, and touching on 'sensitivities', blurs distinctions between physical, psychological and spiritual matters and points back to the way survey participants included spiritual safety in their 'holistic' descriptions of safety. While Kim was responding to a question about what might be a threat to spiritual safety, what is apparent from the response is that hospitals do not appear to be aware of, or actively seeking to address, iatrogenic distress related to patients' loss of dignity and choice. Indeed, the nurses described here were not yet equipped to cope effectively with patients' reactions to their loss of choice and dignity, let alone recognise the loss in the first place, something Kim attributes to lack of training in reflective practice.

Indicated here too is the problem of responsibility for addressing patients' experiences of loss of dignity and choice and the accompanying iatrogenic distress. Involved in this problem is the concept of dignity in the hospital context which is a topic beyond the bounds of this thesis and better addressed by Gaita and Turner (1998; 2021). Kim recognises opportunities for other

health care professionals to be actively involved and similarly, Fynn acknowledges the work of other health care professionals in addressing aspects of spiritual safety, in the restoration of identity. Fynn also concedes significant differences between these therapies and spiritual care.

> *Honouring someone's spirituality is safety cos you're putting them back together a bit, their identity. A lot of people feel shattered and their identity shattered, I don't know if you work with this, you're helping them restore their identity which you know the physios are trying to do and the speech pathologists, but we help with that sort of inner integrity, what that person has deemed important…*
>
> *[By integrity] I meant it as in 'being together'. You know the old hippy term? 'We're together'? That your sense of self as cohesive has some integrity, or it gets blown apart by some circumstances and so on. I think that what we do can help restore that sense of spiritual integrity which is part of their core identity and sense of being, purpose, meaning.*

Shattered and blown apart are the words Fynn chose to describe what happens to some people during their hospital admission. It would be an unusual person who has these experiences without also experiencing iatrogenic distress.

Functioning as hubs for the health care sector, it could be said that hospitals are likely epicentres of iatrogenesis and therefore iatrogenic distress. Therefore, the question of responsibility for preventing, reducing and alleviating iatrogenic distress, a safety agenda that includes spiritual safety, must be expressed in clinical, operational and governance level structures and systems, teams and personnel. However, a challenge for this responsibility is the idea that safety is co-produced (Hor et al. 2013, 576). Although it is an idea that might sit well with the current National Safety and Quality Health Services Standards that promote "patients as partners in their own care", accepting that safety is co-produced requires "adopting a perspective on power that is not vested in roles, individuals or institutions but is relational and continuously renegotiated over time when people interact" (ACSQHC 2022; Foucault 1984 in Hor et al 2013). The conundrum here is that hospitals, health care professionals *and* patients become responsible for co-producing safety, even though it is the structures, systems and hegemony of biomedicine that generate threat and goad human spirituality.

Spiritual safety, spiritual care & the politics of presence

> …a genuinely great realist never recognises as truly real that 'reified' appearance. It is clear to …[the realist] that everything that happens to the person - both inside and outside - is brought about by the reciprocal effects of relations between people. Thus [the realist] immediately translates every such

> fetishistic appearance and manifestation into their true reality: into the language of concrete relations and connections between people. (Lukács & Miller 2013, 47)[26]

A Marxist philosopher is perhaps an unlikely bedfellow for spiritual safety, but the resistance of reification and the centrality of human relations and connections resonates with the core concerns of spiritual safety and the SCPs who described it. Spiritual safety, the assiduous respect, acceptance and unconditional validation of a person or people, their loci of meaning and present concern, their spirituality, requires those who claim to care for patients to be realists, to see through reification, to perceive the humanity of those in their care, and it requires genuine human relations, connections and interactions. Thus, if safety is indeed co-produced between people rather than roles, power and positionality must also be transparently acknowledged (Hor et al. 2013, 575). Co-producing safety, including spiritual safety, is then also a political stance because deferring to the patient's present experience and need, privileging and advocating for the agenda of this decontextualised person, does not necessarily prioritise the authority of health care professionals.

> *A senior doctor and his retinue appeared in the ward and surrounded the bed of Lee, who had been weeping and*

[26] "Fetishistic" in this context relates to the appearance of "an object having magical powers or inhabited by a spirit… Marx sarcastically employed a supernatural metaphor to illustrate the independent movement of commodities in capitalism as if they were under a spell (Marx in Issa 2017, 104)".

> *struggling with being in hospital. The doctor intended to examine Lee's abdomen. I was already present with Lee, as a SCP, and I checked in with her about whether she was ready for this examination, because the doctor had apparently not noticed Lee's teary, puffy eyes and her waning energy. She assured me she was ready, but then I had to ensure that the doctor asked Lee's consent before pulling back the bed covers.*[27]

It can take practiced courage to resist the aura of biomedical authority, to confront the dominant loci of power, to reveal the imminent risk of iatrogenesis, and run the risk of being tagged as obstructive. Safety might indeed be co-produced, but it is also political in a domain where, as medical anthropology has demonstrated, "…medicine is pre-eminently an instrument of social control" (Taussig 1980, 13).

Psychiatry academics, Balboni and Peteet, maintain that spirituality and religion must be considered within the "culture of medicine" and considered by medical practitioners because "the intertwining of medical decision making and religion/spirituality does not lend itself to a division of labour approach. Whose role is it to *deal with* a patient's religious beliefs when his or her medical decision is based on them?" (2017, 7).[28] Whose role indeed? These writers give a cursory nod to 'chaplains' providing spiritual care, but they neglect the

[27] This scenario is drawn from my clinical work. No identifying information has been included, other than my own.
[28] My emphasis.

central premise of spiritual safety and core principles of spiritual care practice. Professional spiritual care maintains that it is the 'role' of the person who possesses the beliefs to 'deal' with the beliefs. Spiritual safety and spiritual care are predicated on not exercising authority over someone else's spirituality. Therefore, if a health care professional, be they SCP, doctor, social worker or dietician, wishes to have any role in relation to another person's beliefs, it needs to be that of ensuring spiritual safety, as they hold space, listen deeply and support the person as *the person* 'deals' with their own beliefs.

Balboni and Peteet seem to reflect the same presumption of authority as the AMA last century, that they should have authority over anything they deem part of their medical domain (Hunter 1969, 58). It is a simple matter to concur with them that spirituality pervades human life and decision-making; it is simple because this is not in contention here. Based on the representation of spiritual safety in this thesis, to approach patients' beliefs as clinical problems that require medical intervention would be the beginning of spiritual abuse and iatrogenesis. It is worth recalling here that patient consent must be sought for any provision of care, a potential win for patient authority and their spiritual safety.

Spiritual safety has significant implications for medical decision making and interventions and, therefore, effective spiritual care is an essential element of all such complex processes. Further, the persistent exclusion of SCPs from complex life and death discussions and interventions, described by Dom in

Chapter 2, is an experience that is not unique to this practitioner or to their hospital. The circumstances appear fraught. We do not know whether exclusion of SCPs means spiritual care is being provided by others or whether the spiritual safety of patients is being overlooked.

Safety agendas of Australian hospitals require that patients have access to the care and services they require (ACSQHC 2021). Irrespective of clinician biases or perceptions of spirituality, spiritual care or SCPs, if patients require spiritual care, it ought to be provided. A tenant of professional spiritual care practice, one that aligns with spiritual safety, is that proselytising is not acceptable (SCA 2014, 6, 8; SCA 2017, 3, 5). It was a stance taken to prevent exploitation of patient vulnerability to win religious converts, however the meaning of "proselytise" has application outside religion too; it includes attempting to force, persuade or cajole others to change their view, opinion or allegiance. This would include attempting to make a patient change their mind to accept a health care intervention, which is a scenario I have encountered many times in my professional roles. Regarding spiritual safety and complex decision-making, there would be value for future research to consider juxtaposing proselytisation with biomedical rationality and persuasive reasoning. Certainly, spiritual safety must be established in medical decision-making processes so the importance and relevance of people's spirituality can be acknowledged and affirmed. Demotion of spiritual care and the resulting

suppression of patient access to such care does not align with spiritual safety and risks causing or perpetuating iatrogenic distress.

SCPs are passionate about the work they do and the intrinsic worth of all people; the first motivation for most SCPs who opted to be interviewed for this thesis. It is a values-based movement, yet they tend to resist being described as political. I recall a session at an SCA conference where my conversational use of this descriptor was hotly resisted by a surprising number of vocal delegates.[29] Even though it has been resisted and seems to be understated, the political stance of the SCPs I interviewed was evident in their practice of privileging patient agendas, not exerting authority over patients, advocating for recognition of the person of the patient, revealing and naming unethical processes, resisting discourse and language that reduces the uniqueness or worth of a person, and their efforts to shield the vulnerability of encounters from intrusion or misunderstanding. Salter's assertion earlier, about the nature of hospital priorities, reveals the significant divergence of the spiritual care approach from that of the bulk of health care professions in hospitals (2015, 152).

The transformative power of professional spiritual care does not reside in biomedical therapeutic priorities. It is co-created in the relational space between the SCP and the patient, family, visitor or staff member. It is not power

[29] Between 2010-13

exercised in collusion with biomedical control; it is power that disrupts "entrenched power inequalities" present in hospitals (Hor et al. 2013, 576). It is power that manifests spiritual safety. This radical attention to people and preservation of spiritual safety is not only political in its resistance to control and authority over patients, but it also places SCPs in a somewhat extraordinary position within hospitals.

Opportunities & recommendations

The findings of my research suggest that there are opportunities for governments and their agencies, hospitals and the spiritual care profession to improve their commitment and engagement with the safety of patients. At a minimum, all these actors ought to regard themselves as obliged to review their responsibilities, policies, strategies, action plans and roles regarding iatrogenic distress, with reference to hospitalisation as a medical intervention, and include spiritual safety as a foundational concept and spiritual care as a core component of appropriate and effective response.

The table in Appendix 3 contains suggested opportunities for the abovementioned actors, as well as researchers, and corresponding examples of recommended actions, but specific comments need to be made before concluding. Policy change is a key recommendation primarily for the purpose of signalling deliberate culture change and to provide the basis for other recommendations, including strategic planning and related activities. Formal processes of policy development, dissemination and implementation will

provide clear messaging that hospitalisation is implicated in iatrogenic distress, and that spiritual safety and spiritual care need to be incorporated into the safety agendas of Australian hospitals.

I have explained iatrogenesis and iatrogenic distress, elaborated on hospitalisation, including how decontextualisation and reification generate conditions for iatrogenic distress, and argued that hospitalisation provokes spirituality in a manner that can produce iatrogenic distress. I have also argued that actors involved with biomedical structures and systems, including hospitals and their workers, are responsible for addressing iatrogenic distress, which requires attention to spiritual safety and provision of spiritual care. Implications of spiritual safety for spiritual care and its practitioners were considered, and opportunities and recommendations indicated by the findings of this thesis, were provided.

Conclusion

In this thesis I have illustrated the complexity of factors involved in safety agendas of Australian hospitals and how the loci and context of power in hospitals is implicated and threatens the safety of those present in them, particularly patients. Through the analysis of the surveys and interviews with SCPs, it became clear that they are aware of, engage with and value their hospitals' safety agendas. Moreover, that SCPs offer a unique perspective on safety. I noted the phrase "spiritual safety" in survey responses and examined interview participants' contextual understanding and embodiment of spiritual safety in their practice in the Australian hospital context. From this I presented a description of spiritual safety to highlight what it means and what is required to establish and maintain it in the hospital setting. I discussed how and why hospitalisation is a biomedical intervention wherein the spatial structure and culture of hospital settings can lead to the decontextualisation and reification of the patient experience. I explained that these processes, that suffuse hospitalisation, can generate conditions that cause iatrogenic distress, and that iatrogenic distress is revealed as a spontaneous expression of spirituality. I argued that this obliges biomedical actors to ensure appropriate attention to establishing and maintaining spiritual safety and the provision of spiritual care to respond to iatrogenic distress as it occurs in hospitals. In Chapter 3, I considered the implications of spiritual safety for spiritual care in hospitals and spiritual care practitioners, and I detailed some of the opportunities and recommendations that the findings of my research suggest. In closing, safety

and spiritual care mean much to each other, no doubt more than can be encapsulated in a Masters thesis. When we understand iatrogenic distress is an expression spirituality, spiritual safety must be understood as an essential consideration in hospital care and safety.

Appendix 1 - SCA Standards of Practice

Standard 1: Delivery of Care
- Promote spiritual wellbeing and continuity of care.

Standard 2: Assessment
- Assess, evaluate and respond to individuals' spiritual care needs.

Standard 3: Teamwork and Collaboration
- Collaborate with practitioners and other staff and volunteers involved in the care of the individual.

Standard 4: Accountability
- Comply with organisational reporting requirements, policies and regulatory guidelines.

Standard 5: Ethical Practice
- Adhere to all relevant codes of conduct and practice.

Standard 6: Respect for Diversity
- Model and promote respect for human diversity in the provision of spiritual care.

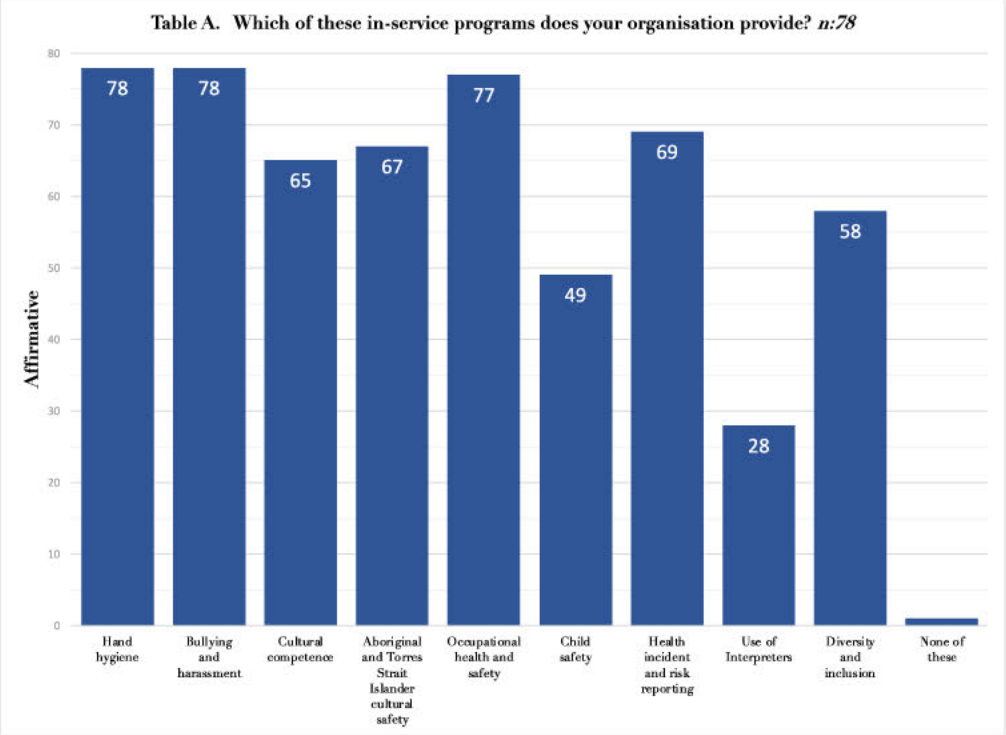
Standard 7: Supervision
- Engage in regular formal supervision.

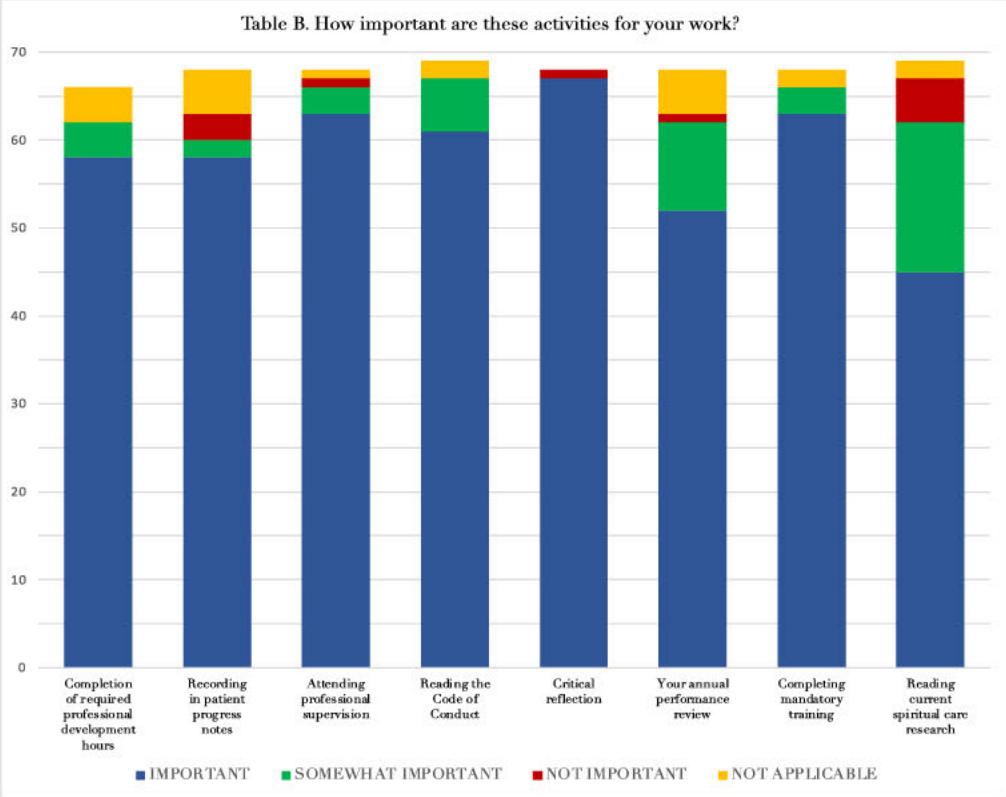
Standard 8: Self-Care
- Accept personal responsibility for self-care.

Standard 9: Continuous quality improvement
- Enhance the quality of spiritual care through continuous quality improvement.

Standard 10: Knowledge and Continuing Education
- Demonstrate commitment to the development of professional capacity.

Appendix 2 - Survey summary tables





Note: Professional supervision is significantly distinctive from and in addition to standard line-management.

Appendix 3 - Opportunities and Recommendations

Governments & their agencies	Policy changes to ▪ Acknowledge iatrogenic distress as a patient safety matter. ▪ Acknowledge the role of governments and their agencies in mitigating the impact of iatrogenic distress. ▪ Acknowledge that iatrogenic distress is caused by and during government-sanctioned health interventions ▪ Support the development of health care standards pertaining to mitigation and effective response to iatrogenic distress.
Hospitals	Policy changes to ▪ Recognise and acknowledge that iatrogenic distress is caused by and during hospital admission. ▪ Imbed iatrogenic distress and spiritual safety in safety agendas. ▪ To recognise spiritual care as a primary response to iatrogenic distress
	Strategy development and review for mitigation of and responses to iatrogenic distress. Examples of recommendations include: ▪ Patients invited to rate their level of emotional comfort/distress throughout their hospital admission, in the same way as they are asked to rate their level of pain.[30] ▪ Mandatory referral to spiritual care to include: - Patients and families for complex decisions about medical intervention, - Family/staff meetings regarding end-of-life, - Patients and families prior to planned/expected end-of-life events, including voluntary assisted dying, pregnancy termination, palliative care, rapid decline, - Patients and families involved in unexpected/adverse/ critical events, and - Bystanders/onlookers to critical incidents. ▪ Mandatory presence of a professional SCP for discussions with patients regarding voluntary assisted dying and pregnancy termination.
	Strategy and action plan development to recognise and transparently address the use of power and authority in clinical contexts – to acknowledge positionality. Examples of recommendations include:

[30] For a discussion of the Cancer Distress Thermometer see Biddle et al. 2016.

	▪ Requiring all future direct care health care professionals to have successfully completed at least entry level training in critical reflection from outside their traditional faculty. ▪ Encourage all existing professional clinical care workforce to undertake training in critical reflection. ▪ Recognising exemplary practice of critical reflection, humility and spiritual safety.
Spiritual care profession	Strategy and action plan development to ▪ Positively influence the culture of hospitals and the care of those admitted to hospital. ▪ Agree on a representation of spiritual safety to use in hospital and health service discourse to encourage and develop understanding in hospitals of spiritual safety and the role of spiritual care as it relates to safety. ▪ Advocate for spiritual safety and iatrogenic distress to be recognised in hospital safety agendas, through policies, procedures, practice guidelines, standards, codes of conduct. ▪ Encourage the development of deeper understanding and engagement of SCPs with the concept of spiritual safety and iatrogenesis, what these concepts mean for patients, families, visitors, staff, hospitals, for their practice and for health care at large. An example of a recommendation: - Develop core components of formation training and education directly related to safety and spiritual safety for SCPs. ▪ Consider adoption and development of bystander intervention training to support spiritual safety practices of students and SCPs.[31] ▪ Advocate for the development of deeper understanding and engagement with the concept of spiritual safety, what it means for the work of health care professionals and for the organisations in which they work. An example recommendation: - Develop education and training in critical reflection, especially as it relates to spiritual safety, for health care professionals for credit towards professional development and postgraduate qualification. ▪ Promote the spiritual care contribution to hospital safety agendas. An example recommendation: - Participate, support, fund (and seek funding for), propose and conduct research.

[31] Bagchi et al. 2020; 2022.

	- Build the body of research describing the use and impact of spiritual care in hospitals as it relates to safe, high-quality care.
Researchers	Suggested future research ▪ Study and test the concept of spiritual safety. ▪ Explore patient-reported iatrogenic distress and mitigating factors. ▪ Examine the impact of critical reflection training on clinicians' capacity to respond to patients experiencing iatrogenic distress. ▪ Explore clinical staff perspectives on iatrogenic distress. ▪ Investigate economic implications related to iatrogenic distress. ▪ Study relationships between power/authority use/misuse in hospitals and experiences of iatrogenic distress.

References

ACT Government. 2022. “Working With Children Checks”. Accessed 24 March 2022. https://www.act.gov.au/childabuseroyalcommission/formalresponse/working-with-children-checks

Askew, Deborah A., Karla Brady, Bryan Mukandi, David Singh, Tanya Sinha, Mark Brough, and Chelsea J. Bond. 2020. "Closing the Gap between Rhetoric and Practice in strengths-based Approaches to Indigenous Public Health: A Qualitative Study." *Australian and New Zealand Journal of Public Health* 44 (2): 102-105. https://dx.doi.org/10.1111/1753-6405.12953.

Australia New Zealand Association of Clinical Pastoral Education. 2020. “Standards and Committees.” Accessed 15 March 2022. https://www.anzacpe.org.au/standards-committees.

Australian Commission on Safety and Quality in Health Care. 2021. “Comprehensive Care Standard.” Accessed 2 August 2021. https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard.

Australian Commission on Safety and Quality in Health Care. 2021b. “Partnering with Consumers Standard.” Accessed 2 August 2021. https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard.

Australian Commission on Safety and Quality in Health Care. 2015. *National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care*. Sydney: The Australian Commission on Safety and Quality in Health Care.

Australian Human Rights Commission. 2021. “Cultural Safety”. Accessed July 30, 2021. https://childsafe.humanrights.gov.au/diverse-needs/cultural-safety.

Australian Institute of Health and Welfare. 2021, “Summary and Key Findings”, *Cultural safety in health care for Indigenous Australians: monitoring framework*, Accessed 30 July 2021, https://www.aihw.gov.au/reports/indigenous-australians/cultural-safety-health-care-framework/contents/summary.

Bagchi, Ann D, Adam Thompson, Kasny Damas and Elise Corasim. 2020; 2022. "Step UP! to Stamp Out Stigma: Adapting and Testing a Bystander Intervention to Reduce HIV-Related Stigma." *Journal of Public Health* 30 (1): 185-193. https://doi.org/10.1007/s10389-020-01284-1.

Balboni, Michael J. and John R. Peteet. 2017. “Introduction.” In *Spirituality and Religion within the Culture of Medicine: From Evidence to Practice*. New York, NY, United States of America: Oxford University Press. https://doi.org/10.1093/med/9780190272432.003.0001.

Berlinger, Nancy. 2004. “Promoting Patient Safety: Implications for Pastoral Care.” *The Journal of Pastoral Care & Counseling* 58: 55-61. https://doi.org/10.1177/154230500405800107.

Berlinger, Nancy. 2008. "The Nature of Chaplaincy and the Goals of QI: Patient-Centered Care as Professional Responsibility." *The Hastings Center Report* 38 (6): 30-33. https://doi.org/10.1353/hcr.0.0083.

Biddle, Lucy, Sangeetha Paramasivan, Susan Harris, Rona Campbell, James Brennan, and William Hollingworth. 2016. "Patients' and Clinicians' Experiences of Holistic Needs Assessment using a Cancer Distress Thermometer and Problem List: A Qualitative Study." *European Journal of Oncology Nursing: The Official Journal of European Oncology Nursing Society* 23: 59-65.

Brand, Caroline, Joseph Ibrahim, Christopher Bain, Catherine Jones, and Belinda King. 2007. "Engineering a Safe Landing: Engaging Medical Practitioners in a Systems Approach to Patient Safety." *Internal Medicine Journal* 37 (5): 295-302. https://doi.org/10.1111/j.1445-5994.2007.01310.x.

Burton, Therese, Brian Dollery and Joe Wallis. 2002. A Note on the Debate over 'Economic Rationalism' in Australia: An Application of Albert Hirschman's Rhetoric of Reaction." *History of Economics Review* 36 (1): 1-9. https://doi.org/10.1080/10370196.2002.11733375.

Cabrini Health. 2022. "About us." Accessed 9 March 2022. https://www.cabrini.com.au/about-cabrini/.

Calvary Care. 2022. "Heritage." Accessed 9 March 2022. https://www.calvarycare.org.au/about/heritage/.

Choudhry, Rafiq M., Dongping Fang and Sherif Mohamed. 2007. "The Nature of Safety Culture: A Survey of the State-of-the-Art." *Safety Science,* 45 (10): 993-1012. https://doi.org/10.1016/j.ssci.2006.09.003.

Commission for Children and Young People. 2022. "Who do the Standards Apply to?" Victorian Government. Accessed 24 March 2022. https://ccyp.vic.gov.au/child-safe-standards/who-do-the-standards-apply-to-page/.

Commissioner for Children and Young People. 2022. "Child Safe Organisations WA." Accessed 24 March 2022. https://www.ccyp.wa.gov.au/.

Commonwealth of Australia,.2017b. "Preface and executive summary." *Final Report, Royal Commission into Institutional Responses to Child Abuse.* Barton, Australian Capital Territory.

Commonwealth of Australia. 2017. Royal Commission into Institutional Responses to Child Abuse. Barton, Australian Capital Territory.

Cultural Respect Framework 2016 - 2026 for Aboriginal and Torres Strait Islander Health: A National Approach to Building a Culturally Respectful Health System. 2016. Australian Health Ministers' Advisory Council. Accessed 30 July 2021. https://apo.org.au/node/256721.

Damasio, Antonio and Hanna Damasio. 2006. "Minding the Body" Daedalus 135 (3): 15-22. https://doi.org/10.1162/daed.2006.135.3.15.

de Vries, E. N., M. A. Ramrattan, S. M. Smorenburg, D. J. Gouma, and M. A. Boermeester. 2008. "The Incidence and Nature of in-Hospital Adverse Events: A Systematic Review." *Quality & Safety in Health Care* 17 (3): 216-223. https://doi.org/10.1136/qshc.2007.023622. [32]

[32] Only author initials were provided.

Dekker, Sidney W. A. and James M. Nyce. 2014. "There is Safety in Power, or Power in Safety." *Safety Science,* 67: 44-49. https://doi.org/10.1016/j.ssci.2013.10.013.

Department of Health. 2000. *An organisation with a memory: report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer*. London, UK: HM Stationery Office. Accessed 11 March 2022, https://psnet.ahrq.gov/issue/organisation-memory-report-expert-group-learning-adverse-events-nhs-chaired-chief-medical.

Department of Human Services. 2022. "Child safe environments." Government of South Australia. Accessed 24 March 2022. https://dhs.sa.gov.au/services/community-and-family-services/child-safe-environments.

Department of Justice. 2021. Fourth Annual Progress Report and Action Plan 2022. Tasmanian Government. Accessed 24 May 2022. https://www.justice.tas.gov.au/response-to-final-report.

Dictionary of Medical Terms. 2005. Bloomsbury Publishing Plc, ProQuest Ebook Central.

Donaldson, Liam, and Pauline Philip. 2004. Patient safety: a global priority. *Bulletin of the World Health Organization* 82 (12): 892. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2623103/.

Duckett, Stephen J. 1983. "Changing Hospitals: The Role of Hospital Accreditation." *Social Science & Medicine* 17 (20): 1573-1579. https://doi.org/10.1016/0277-9536(83)90102-8.

Emanuel, Linda, Don Berwick, James Conway, John Combes, Martin Hatlie, Lucian Leape, James Reason, Paul Schyve, Charles Vincent, and Merrilyn Walton. 2009. "What Exactly is Patient Safety?" *Journal of Medical Regulation* 95 (1): 13-24. https://doi.org/10.30770/2572-1852-95.1.13.

Eve, Kate and Christine Phillips. 2020. "Are the Providers of Spiritual Care in your Hospital Capable? Narrative Review of Professional Accountability in Australia." *Health and Social Care Chaplaincy* 7 (2): 241–253. https://doi.org/10.1558/hscc.37786.

Every-Palmer, Susanna, Matthew Jenkins, Philip Gendall, Janet Hoek, Ben Beaglehole, Caroline Bell, Jonathan Williman, Charlene Rapsey, and James Stanley. 2020. "Psychological Distress, Anxiety, Family Violence, Suicidality, and Wellbeing in New Zealand during the COVID-19 Lockdown: A Cross-Sectional Study." *PLoS One* 15 (11). https://doi.org/10.1371/journal.pone.0241658.

Flynn, Eleanor, Heather Tan and Vandenhoeck, A. 2021. ""We Need to Learn from What We Have Learned!": The Possible Impact of Covid-19 on the Education and Training of Chaplains." *The Journal of Pastoral Care & Counseling* 75: 37-40. https://doi.org/10.1177/1542305021996228.

Fogarty, William, Melissa Lovell, Juleigh Langenberg, and Mary-Jane Heron. 2018. *Deficit Discourse and Strengths-Based Approaches: Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing*. Carlton South, VIC: Lowitja Institute. doi:10.3316/informit.9781921889554.

Fook, Jan and Fiona Gardner. 2007. “The benefits and outcomes of critical reflection” In *Practising Critical Reflection: a Resource Handbook*, McGraw-Hill Education. ProQuest Ebook Central.

Foucault, Michel. 2003, *The birth of the clinic: an archaeology of medical perception,* Routledge, London; New York.

Gaita, Raimond. 1999. A Common Humanity: Thinking about Love & Truth & Justice. Melbourne: Text Publishing.

Gardner, Fiona. 2011. *Critical Spirituality: A Holistic Approach to Contemporary Practice*. Ashgate, Farnham; Burlington.

Geertz, Clifford. 2001. *Available Light: Anthropological Reflections on Philosophical Topics*. Princeton: Princeton University Press. ProQuest Ebook Central.

Good, Mary-Jo DelVecchio, Sarah S. Willen, Seth Donal Hannah, Ken Vickery, and Lawrence Taeseng Park, eds. 2011. *Shattering Culture: American Medicine Responds to Cultural Diversity*. New York: Russell Sage Foundation. ProQuest Ebook Central.

Graycar, A. F., and C. W. Junor. 1970. “The Anatomy of a Health Scheme.” *The Australian Quarterly* 42 (3): 48–64. https://doi.org/10.2307/20634381.

Guldenmund FW. 2010. “Understanding and exploring safety culture.” PhD diss., Oisterwijk: Delft University of Technology, Uitgeverij Boxpress. https://www.researchgate.net/publication/40901518_Understanding_and_Exploring_Safety_Culture.

Harvey, Kevin, Brian Brown, Paul Crawford, and Sally Candlin. 2008. ""Elicitation Hooks": A Discourse Analysis of Chaplain-Patient Interaction in Pastoral and Spiritual Care." *The Journal of Pastoral Care & Counseling* 62 (1-2): 43-61. https://doi.org/10.1177/154230500806200106.

Holmes, Cheryl. 2018. "Towards National Consensus: Spiritual Care in the Australian Healthcare Context." *Religions* 9 (12): 379. https://doi.org/10.3390/rel9120379.

Holmes, Cheryl. 2021. “From Chaplaincy to Spiritual Care: Turning Points for an Emerging Health Profession”. *Asia Pacific Journal of Health Management* 16 (4):54-61. https://doi.org/10.24083/apjhm.v16i4.691.

Hor, Su-yin, Natalya Godbold, Aileen Collier, Rick Iedema. 2013. “Finding the patient in patient safety.” *Health* 17 (6): 567-83. https://doi.org/10.1177/1363459312472082.

Hughes, Brian and George Handzo. 2009. *The Handbook on Best Practices for the Provision of Spiritual Care to Persons with Post Traumatic Stress Disorder and Traumatic Brain Injury*. Washington, DC: Bureau of Medicine and Surgery, United States Department of the Navy.

Hunter, Thelma A.C. 1969. "The Politics of National Health." PhD diss., Australian National University, and ANU Digital Theses. https://doi.org/10.25911/5c6e716154f9c.

Illich, Ivan. 1975. *Medical Nemesis: The Expropriation of Health*. London: Marion Boyars Publishers Ltd.

Illich, Ivan. 1999. “The Obsession with Perfect Health.” Translated by Antonio Cerella. 2017. *Journal for Cultural Research* 21 (3): 286-291. https://doi.org/10.1080/14797585.2016.1272824.

Institute of Medicine. 1999. *To Err is Human: Building a Safer Health Care System*. Edited by Linda T. Kohn, Janet M. Corrigan and Molla S. Donaldson. Washington, DC: National Academy Press. ProQuest Ebook Central.

International Nuclear Safety Advisory Group. 1992 *The Chernobyl Accident: Updating of INSAG-1*. 1992. Vienna: International Atomic Energy Agency.

Issa, Daniela. 2017. “Reification and the Human Commodity: Theorizing Modern Slavery in Brazil.” *Latin American Perspectives* 44 (6): 90-106. https://doi.org/10.1177/0094582X17727480.

Jerolmack, Colin and Shamus Khan. 2014. ‘Talk Is Cheap: Ethnography and the Attitudinal Fallacy’, *Sociological Methods & Research* 43 (2): 178–209. https://doi.org/10.1177/0049124114523396.

Johnston, Jennifer L. 2017. "When I Say … Hegemony." *Medical Education* 51 (8): 782-783. https://doi.org/10.1111/medu.13235.

Keenan, Paul. 2017. “Being and Feeling Spiritually Safe When Receiving Health and Social Care.” *Catholic Medical Quarterly* 67 (2). http://cmq.org.uk/CMQ/2017/contents_may_2017.html

Keenan, Paul. 2017. "Spiritual Vulnerability, Spiritual Risk and Spiritual Safety—In Answer to a Question: ‘Why is Spirituality Important within Health and Social Care?’ at the ‘Second International Spirituality in Healthcare Conference 2016—Nurturing the Spirit.’ Trinity College Dublin, the University of Dublin." *Religions* 8 (3): 38. https://doi.org/10.3390/rel8030038

Kelly, Ewan. 2012. “Competences in Spiritual Care Education and Training.” In *Oxford Textbook of Spirituality in Healthcare* edited by Mark Cobb, Christina Puchalski and Bruce Rumbold. Oxford: Oxford University Press.

Lave, Jean. 1991. "Situating Learning in Communities of Practice." In *Perspectives on Socially Shared Cognition*, edited by Stephanie D. Teasley, Lauren B. Resnick and John M. Levine, 63-82. Washington; US; DC; American Psychological Association. https://doi.org/10.1037/10096-003.

Lukács, György. 2013. *The Culture of People's Democracy: Hungarian Essays on Literature, Art, and Democratic Transition, 1945-1948*. Translated by Tyrus Miller. Leiden: BRILL. Accessed 10 February 2022. ProQuest Ebook Central.

MacKay, Joel. 2021.“Cambodia in the midst of COVID-19 humanitarian crisis; Australia must support.” Amnesty International Australia. Accessed 4 April 2022. https://www.amnesty.org.au/cambodia-in-the-midst-of-covid-19-humanitarian-crisis-australia-must-support/.

Mackean, Tamara, Matthew Fisher, Sharon Friel, and Frances Baum. 2020. "A Framework to Assess Cultural Safety in Australian Public Policy." *Health Promotion International* 35 (2): 340-351. https://doi.org/10.1093/heapro/daz011.

Maher, Frances A. and Mary Kay Tetreault. 1993. "Frames of Positionality: Constructing Meaningful Dialogues about Gender and Race." *Anthropological Quarterly* 66 (3): 118-126. https://doi.org/10.2307/3317515.

Marino, Elizabeth K. and Albert J. Faas. 2020. "Is Vulnerability an Outdated Concept? After Subjects and Spaces." *Annals of Anthropological Practice* 44 (1): 33-46. https://doi.org/10.1111/napa.12132.

Mattingly, Cheryl. 1998 "In Search of the Good: Narrative Reasoning in Clinical Practice" *Medical anthropology quarterly* 12 (3): 273-297.

Mercy Health. 2022. "Celebrating 100 years of Mercy healthcare." Accessed 9 March 2022. https://www.mercyhealth100years.com.au/

Meyerowitz-Katz, Gideon, Samir Bhatt, Oliver Ratmann, Jan Markus Brauner, Seth Flaxman, Swapnil Mishra, Mrinank Sharma, Sören Mindermann, Valerie Bradley, Michaela Vollmer, Lea Merone, and Gavin Yamey, 2021. "Is the Cure really Worse than the Disease? the Health Impacts of Lockdowns during COVID-19." *BMJ Global Health* 6 (8). https://doi.org/10.1136/bmjgh-2021-006653.

Mitchell, Alice G, Suzanne Belton, Vanessa Johnston, Wopurruwuy Gondarra and Anna P. Ralph. 2019. ""That Heart Sickness": Young Aboriginal People's Understanding of Rheumatic Fever", *Medical Anthropology* 38 (1): 1-14. https://doi.org/10.1080/01459740.2018.1482549.

National Health Practitioner Ombudsman, website. Accessed 8 August 2021. https://www.nhpo.gov.au/legislation.

Nussbaum, Martha,1994, *The therapy of desire: Theory and practice in Hellenistic ethics*. Princeton, NJ: Princeton University Press.

O'Neill, Arthur. 1994. "Danger and safety in medicines." *Social Science & Medicine* 38 (4): 497-507. https://doi.org/10.1016/0277-9536(94)90246-1.

Office of the Children's Guardian. 2022. "Who the Child Safe Standards apply to". Accessed 24 March 2022. https://ocg.nsw.gov.au/child-safe-scheme/implementing-child-safe-standards/who-child-safe-standards-apply.

Papps, Elaine and Irihapeti Ramsden. 1996. "Cultural safety in nursing: The New Zealand experience." *International Journal for Quality in Health Care* 8 (5): 491-497. https://doi.org/10.1093/intqhc/8.5.491.

Porta, Miquel. 2018. "iatrogenesis." In *A Dictionary of Public Health*, edited by John M. Last. Oxford University Press, https://www-oxfordreference-com.virtual.anu.edu.au/view/10.1093/acref/9780191844386.001.0001/acref-9780191844386-e-5071.

Puchalski, Christina M., Robert Vitillo, Sharon K. Hull and Nancy Reller. 2014. "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus." *Journal of Palliative Medicine* 17 (6): 642-656.

Queensland Government. 2022. "Individuals requiring a blue card to work or volunteer with children." Accessed 24 March 2022. https://www.qld.gov.au/law/laws-regulated-industries-and-accountability/queensland-laws-and-regulations/regulated-industries-and-licensing/blue-card/required/individuals#religious.

Reason, James. 1997. Managing the risks of organizational accidents. Aldershot, England: Ashgate.

Reason, James. 2000. “Human Error: Models and Management.” *British Medical Journal* 320 (7237): 768–770. https://doi.org/10.1136/ewjm.172.6.393.

Reason, James. 2012. “James Reason: Patient Safety, Human Error, and Swiss cheese.” Interview by Karolina Peltomaa and Duncan Neuhauser. *Quality Management in Health Care* 21 (1): 59-63. https://doi.org/10.1097/QMH.0b013e3182418294.

Rhodes, L. A. 1990. “Studying Biomedicine as a Cultural System”. In *Medical Anthropology, Contemporary Theory and Method*, edited by Thomas M. Johnson and Carolyn F. Sargent, 159-173. New York: Praeger.

Robinson, Kate and Robin Kearns and Isabel Dyck. 1996. “Cultural safety, biculturalism and nursing education in Aotearoa/New Zealand”. *Health & Social Care in the Community* 4 (6): 371-380. https://doi.org/10.1111/j.1365-2524.1996.tb00084.x.

Rogers, Carl R. 1967. *On becoming a person: a therapist's view of psychotherapy,* Constable, London.

Rogers, Carl R. 2007. “The Necessary and Sufficient Conditions of Therapeutic Personality Change”. *Psychotherapy: Theory, Research, Practice, Training*, 44 (3), 240-248. https://doi.org/10.1037/0033-3204.44.3.240.

Rodseth, Lars. 2018. "Hegemonic Concepts of Culture: The Checkered History of Dark Anthropology: Hegemonic Concepts of Culture." *American Anthropologist* 120 (3): 398-411. https://doi-org.virtual.anu.edu.au/10.1111/ aman.13057

Runciman, William B. 2002. "Lessons from the Australian Patient Safety Foundation: Setting Up a National Patient Safety Surveillance System: is this the Right Model?" *Quality & Safety in Health Care* 11 (3): 246 -251, https://doi.org/10.1136/qhc.11.3.246.

Safe Work Australia. “Who we are and what we do.” Accessed 25 August 2021. https://www.safeworkaustralia.gov.au/about-us/who-we-are-and-what-we-do.

Safe Work Australia. 2021b). “Psychosocial hazards.” Accessed 25 August 2021. https://www.safeworkaustralia.gov.au/psychosocial-hazards.

Safe Work Australia. 2021c). Homepage. Accessed 25August 2021. www.safeworkaustralia.gov.au.

Safe Work Australia. 2021d). “Cost of injury and illness by type.” Accessed 25 August 2021. https://www.safeworkaustralia.gov.au/data-and-research/work-related-injuries/cost-injury-and-illness-type.

Safe Work Australia. 2021e. “Australian Workers’ Compensation Statistics 2019-2020.” Accessed 25 August 2021 from https://www.safeworkaustralia.gov.au/doc/australian-workers-compensation-statistics-2019-20.

Safe Work Australia. 2022. “Volunteers – Overview”. Accessed 24 March 2022. https://www.safeworkaustralia.gov.au/safety-topic/managing-health-and-safety/volunteers/overview.

Salter, Erica. 2015, "The Re-contextualization of the Patient: What Home Health Care Can Teach Us About Medical Decision-Making", *HEC forum* 27 (2):143-156. https://doi.org/10.1007/s10730-015-9268-6.

Siegler, Miriam, and Humphry Osmond.1973. “Aesculapian Authority.” *The Hastings Center Studies* 1 (2): 41–52. https://doi.org/10.2307/3527512.

Singer, Merrill. 1995. “Beyond the Ivory Tower: Critical Praxis in Medical Anthropology.” *Medical Anthropology Quarterly* 9 (1): 80–106. https://doi.org/10.1525/maq.1995.9.1.02a00060.

Snider, Erin, Ayse Erenay, Thomas St. James O’Connor, Colleen Dotzert, Stephanie Hong, Ruth Smith, Lisa Dolson and Michael P. Foulger. 2019. "Evidence-Based Spiritual Care Practice in the Canadian Context: Twenty Years Later." The Journal of Pastoral Care and Counseling 73 (2): 88-95. https://doi.org/10.1177/1542305019843239.

Spiritual Care Australia. 2014. *Standards of Practice*. Accessed 8 August 2021. https://www.spiritualcareaustralia.org.au/about-us/standards-and-policies.

Spiritual Care Australia. 2017. *Code of Conduct*. Accessed 8 August 2021. https://www.spiritualcareaustralia.org.au/about-us/standards-and-policies.

Spiritual Health Association. 2019. *Spiritual Care in Medical Records: A Guide to Reporting and Documenting Spiritual Care in Health Services*. Melbourne.

Spiritual Health Association. 2020. *Guidelines for Quality Spiritual Care in Health*. Melbourne.

Spiritual Health Association. 2020b. *Capability Framework - For Spiritual Care Practitioners in Health*. Accessed 8 August 2021. https://www.spiritualhealth.org.au/standards.

Spiritual Health Association. 2020c. *Telehealth Guidelines*. Melbourne.

St John of God Health Care. 2022. “History.” Accessed 9 March 2022. https://www.sjog.org.au/about-us/history

Stonington, Scott and Diana Coffa. 2019. "Structural Iatrogenesis - A 43-Year-Old Man with “Opioid Misuse”." *The New England Journal of Medicine* 380 (8): 701-704. https://doi.org/10.1056/NEJMp1811473.

St Vincent’s Health Australia. 2022. “Our heritage”. Accessed 9 March 2022. https://www.svha.org.au/about-us/our-heritage.

Taussig, Michael T. 1980. "Reification and the Consciousness of the Patient." *Social Science & Medicine. Part B: Medical Anthropology* 14 (1): 3-13. https://doi.org/10.1016/0160-7987(80)90035-6.

Taylor, Kerry and Pauline Thompson Guerin. 2019. *Health Care and Indigenous Australians: Cultural Safety in Practice*. 3rd Ed. London: Bloomsbury Publishing Plc. Accessed September 8, 2021. ProQuest Ebook Central.

Team, Victoria and Lenore Manderson. 2020. “How COVID-19 Reveals Structures of Vulnerability”, *Medical Anthropology* 39 (8): 671-674. https://doi.org/10.1080/01459740.2020.1830281.

The Independent Hospital Pricing Authority. 2019. “*Reference to Changes for ICD-10AM/ACHI/ACS*” 11th Ed. Darlinghurst, NSW.

Turner, Christopher. 2021. "Self and Dignity: The Spirituality of Survival" *Religions* 12 (4): 233. https://doi.org/10.3390/rel12040233.

Turner, Christopher. 2021b. “Critical Self Reflection: Adopting Standardised Education for Reflective Practice”. *Roads Less Travelled*, Spiritual Care Australia National Conference 21-23 June 2021, online.

van Schie, Tejo and David Seedhouse. 1997. "The Importance of Care." *Health Care Analysis* 5 (4): 283-291. https://doi.org/10.1007/BF02678526.

Waterson, Patrick. 2014. *Patient Safety Culture: Theory, Methods and Application*, edited by Patrick Waterson. ProQuest Ebook Central.

World Health Organisation, 2021, “Patient Safety.” Accessed 8 August 2021. https://www.who.int/health-topics/patient-safety#tab=tab_1.