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# A National Survey of Health Care Administrators' Views on the Importance of Various Chaplain Roles\*

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A random sample of hospital administrators throughout the United States was surveyed about their views on the importance of eleven chaplain roles and functions. The 494 respondents fell into three categories: (1) directors of pastoral care departments (N = 132); (2) administrators of hospitals that have a pastoral care department (N = 180); and (3) administrators of hospitals that *do not* have a pastoral care department (N = 182). All three groups considered all eleven roles to be relatively important, although administrators of hospitals that *do not* have a pastoral care department gave lower ratings, overall. Meeting the emotional needs of patients and relatives were seen as chaplains most important roles, whereas performing religious rituals and conducting religious services were seen as least important by all three groups. In all but a few instances, the level of importance that administrators assigned to the various roles were positively related to their ratings of their own religiousness and spirituality ( $r$ 's = .11 to .26,  $p < .05$ ).

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**I**n recent years, several personal accounts have been published that describe chaplains' roles, functions, and the kinds of patient issues they encounter in various healthcare settings, including hospice,<sup>1</sup> long-term care,<sup>2</sup> general hospitals,<sup>3</sup> psychiatric hospitals,<sup>4</sup> out-patient clinics,<sup>5</sup> and intensive care units.<sup>6</sup> Gibbons and his colleagues<sup>7</sup> noted that the role chap-

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<sup>1</sup>Marilyn D. Harris, and Lamont R. Satterly, "The Chaplain as a Member of the Hospice Team," *Home Healthcare Nurse*, 1998, Vol. 16, No. 9, pp. 591-593.

<sup>2</sup>Lloyd A. Taylor, "Activities: From a Chaplain's Notebook," *Nursing Homes Long Term Care Management*, 1993, Vol. 42, No. 4, pp. 2, 40.

<sup>3</sup>Josei Gable Rodriguez, "Chaplains' Roles Expand in Redesign," *Health Progress*, 1996, Vol. 77, No. 5, pp. 51-53.

<sup>4</sup>Dan D. Bruce and S. Duane Bruce, "The Chaplain in a Private Psychiatric Hospital," *The Psychiatric Hospital*, 1989, Vol. 20, No. 3, pp. 125-128.

<sup>5</sup>Paul A. Mandziuk, "Is There a Chaplain in Your Clinic?" *Journal of Religion and Health*, 1996, Vol. 35, No. 1, pp. 5-9.

<sup>6</sup>Henry Byekwaso, "Becoming a Chaplain on the ICU," *Health Progress*, 2000, Vol. 81, No. 3, pp. 71-72.

<sup>7</sup>James L. Gibbons, John Thomas, Larry VandeCreek, & Arne K. Jessen, "The Value of Hospital Chaplains: Patient Perspectives," *The Journal of Pastoral Care*, 1991, Vol. 65, No. 2, pp. 117-125.

lains play on the treatment team often depends on the way chaplaincy is valued by staff from other disciplines. Related research has examined the importance of different chaplain roles and activities from patient and staff perspectives.<sup>8,9,10,11</sup>

Research suggests that support by hospital administrators is a key element in chaplains' professional satisfaction,<sup>12</sup> and that the religious faith and practice of administrators may influence their support for pastoral care in their healthcare institutions.<sup>13</sup> No previous research has been reported on how healthcare administrators view the role of chaplains. Therefore, the present study surveyed healthcare administrators about the importance they placed on various chaplain roles and functions and administrators' personal religiosity and spirituality.

## Methods

A survey of healthcare administrators was conducted using a list of the chief executive officers (CEOs) of licensed healthcare institutions throughout the United States (N = 6,650), which was purchased from American Medical Information, Inc. A total of 3,300 questionnaires were mailed to CEOs based on a random sample of roughly 50% of the sampling frame. A cover letter, signed by the second author, explained the purpose of the survey and asked the CEOs to complete the questionnaire themselves or give it to another appropriate person within the institution to complete.

### Questionnaire

The questionnaire consisted of three sections, the last of which is the focus of the current study. The first section asked questions about institutional characteristics, a detailed analysis of which is presented by Flannely, Handzo, and Weaver.<sup>14</sup> The findings from the second section, which asked how the institutions provided for the pastoral and spiritual needs of its patients are also reported in Flannely, Handzo, and Weaver.<sup>15</sup>

The third section asked a series of items about the roles of chap-

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<sup>8</sup>Cullene Bryant, "Role Clarification: A Quality Improvement Survey of Hospital Chaplain Customers," *Journal of Healthcare Quality*, 1993, Vol. 15, No. 4, pp. 18-20.

<sup>9</sup>Raymond G. Carey, "Chaplaincy: Component of Total Patient Care?" *Hospitals*, 1973, Vol. 47, No. 14, pp. 166-172.

<sup>10</sup>Julia D. Emblen, and Lois Halsted, "Spiritual Needs and Intervention: Comparing the Views of Patients, Nurses, and Chaplains," *Clinical Nurse Specialist*, 1993, Vol. 7, No. 4, 175-182.

<sup>11</sup>Cecile G. Sharp, "Use of the Chaplaincy in the Neonatal Intensive Care Unit," *Southern Medical Journal*, 1991, Vol. 84, No. 12, pp. 1482-1486.

<sup>12</sup>Kent Crossley, "Professional Satisfaction Among U.S. Healthcare Chaplains," *The Journal of Pastoral Care & Counseling*, 2002, Vol. 56, No. 1, pp. 21-27.

<sup>13</sup>Larry VandeCreek, Karolynn Siegel, Eileen Gorey, Sharon Brown, & Rhoda Toperzer, "How Many Chaplains per 100 Inpatients? Benchmarks of Health Care Chaplaincy Departments," *The Journal of Pastoral Care*, 2001, Vol. 55, No. 3, pp. 289-301.

<sup>14</sup>Kevin J. Flannely, George F. Handzo, & Andrew J. Weaver, "Factors Affecting HealthCare Chaplaincy and the Provision of Pastoral Care in the United States," *The Journal of Pastoral Care and Counseling*, 2004, Vol. 58, Nos. 1-2, pp. 127-130.

<sup>15</sup>*Ibid.*

lains,<sup>16,17,18,19,20,21,22,23</sup> along with questions about the religiosity and spirituality of respondents. The first question of this section required participants to rate how important it is, in their opinion, that chaplains at their hospital minister to three different groups of people (or types of groups served)—*i. e.*, patients, patients' families/friends, and staff members. A rating scale of 0 through 10 was printed next to each group, with 0 labeled as "not at all important" and 10 labeled as "extremely important." The second question asked respondents to rate the importance of eleven different roles that chaplains assume in the ordinary course of their professional work (see Table 2). The same 0-10 response scale was printed next to each role. The next two questions asked participants "How religious are you?" and "How spiritual are you?" Once again, a similar rating scale was employed, but the end points of the scale were labeled "not at all" and "very." A final question asked participants to list other roles they believed were important for chaplains to exercise in their hospital-based ministry.

**TABLE 1**  
**Mean Group Ratings of How Important it is for Chaplains to Minister to Various Groups, by Type of Survey Respondent**

Type of Respondent	Type of Group Served							
	Patients		Family and Friends		Staff Members		All Groups	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Directors of Pastoral Care Departments	9.8	0.5	9.5	0.9	9.1	1.5	9.5	0.8
Administrators of Hospitals that have a Pastoral Care Department	9.6	0.9	9.2	1.3	8.3	2.0	9.0	1.2
Administrators of Hospitals that do not have a Pastoral Care Department	8.8	1.6	8.4	2.0	7.0	2.6	8.0	1.8
All Respondents	9.3	1.2	9.0	1.6	8.0	2.3	8.8	1.5

<sup>16</sup>Bruce and Bruce, 1989, *op. cit.*

<sup>17</sup>Bryant, 1993, *op. cit.*

<sup>18</sup>Carey, 1973, *op. cit.*

<sup>19</sup>Gibbons, *et al.*, 1991, *op. cit.*

<sup>20</sup>Sharp, 1991, *op. cit.*

<sup>21</sup>Mary Martha Thiel and Mary Redner Robinson, "Physicians' Collaboration with Chaplains: Difficulties and Benefits," *The Journal of Clinical Ethics*, 1997, Vol. 8, No. 1, pp. 94-103.

<sup>22</sup>Cashel Weiler, "Patients Evaluate Pastoral Care," *Hospital Progress*, 1975, Vol. 56, No. 4, pp. 34-35, 38.

<sup>23</sup>Larry VandeCreek and Laurel Burton, "Professional Chaplaincy: Its Role and Importance in Healthcare," *The Journal of Pastoral Care*, 2001, Vol. 55, No. 1, pp. 81-97.

**TABLE 2**  
**Mean Ratings of the Three Types of Participants about the**  
**Importance of Eleven Chaplain Roles, Grouped by Factor**

Chaplain Roles	Factor	Administrators								
		Pastoral Care Directors			with Pastoral Care Departments			without Pastoral Care Departments		
		<i>M</i>	<i>SD</i>	<i>Rank</i>	<i>M</i>	<i>SD</i>	<i>Rank</i>	<i>M</i>	<i>SD</i>	<i>Rank</i>
Provide End-of-Life Care	1	9.7	0.7	1	9.2	1.5	2	8.9	2.1	3
Provide Emotional Support to Patients	1	9.6	0.8	2	9.4	1.0	1	9.0	1.4	1
Provide Emotional Support to Family/Friends	1	9.5	0.9	3	9.1	1.2	3	8.7	1.5	4
Provide Emotional Support to Staff	2	9.4	1.3	4	8.6	1.9	7	7.6	2.2	5
Be the Point-Person for Integrating Spirituality into Overall Institutional Care	2	9.4	1.3	5	8.6	2.0	6	7.1	2.6	9
Pray with Patients or Relatives	2	9.2	1.2	6	9.1	1.3	4	8.9	1.5	2
Provide Ethical Consultation	2	9.1	1.3	7	8.3	2.0	8	7.3	2.6	7
Serve as a Liaison to Local Clergy	2	8.8	1.6	8	8.7	1.7	5	7.5	2.8	6
Serve as the Patient's Advocate	2	8.5	1.9	9	8.1	2.1	9	7.3	2.7	8
Perform Religious Rituals	3	8.4	1.9	10	7.6	2.4	10	6.9	2.1	10
Conduct Religious Services/Worship	3	7.5	2.5	11	7.2	2.7	11	6.1	3.1	11

### Measures and Analyses

The importance ratings were used as the dependent variables in the statistical analyses. Responses to the first question were analyzed in a mixed (within and between) analysis of variance (ANOVA) design, with type of group served (patients, patients' families/friends, and staff members) as the within factor and type of respondent as the between factor. Respondents were classified into three separate categories or types: (1) directors of pastoral care departments (N = 132); (2) administrators of hospitals that have a pastoral care department (N = 180); and (3) administrators of hospitals that *do not* have a pastoral care department (N = 182). The ratings of the eleven chaplain roles were analyzed by one-way ANOVA's, with type of respondent as the between-group factor.

Factor analysis was conducted on the ratings to see to what degree the respondents tended to group the various roles together with respect to their importance. Correlation analyses were used to examine the relationship between religiosity and spirituality and their relationships with participants' importance ratings.

## Results

A total of 494 questionnaires were completed, with a return rate of 15%. Completed questionnaires were received from all 50 states, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands. One hundred and eighty one questionnaires were completed by CEOs, vice presidents or chief operating officers, 132 were completed by pastoral care directors, and the remainder was completed by other administrators. Since more than 98% of the questionnaires received came from hospitals, for simplicity, we use the term hospital to include other types of healthcare institutions (*i.e.*, long-term care facilities, rehabilitation centers, hospices, *etc.*).

### Overall Importance of Ministering to Various Groups

Table 1 gives the average ratings that the three types of respondents assigned to the importance of ministering to different groups. The far right column of the table shows a significant main effect of type of respondent, collapsed across the three types of groups served [ $F(2,491) = 49.9$ ,  $p < .0001$ ]. Planned comparisons showed that pastoral care directors gave significantly higher ratings than hospital administrators [ $F(1,491) = 50.1$ ,  $p < .0001$ ], and that hospital administrators with pastoral care departments gave higher ratings than those without pastoral care departments [ $F(1,491) = 49.5$ ,  $p < .0001$ ].

The bottom row of the table shows the main effect of the type of group served, collapsed across type of respondent [ $F(2,982) = 152.1$ ,  $p < .0001$ ]. A significant linear trend was found across groups served, with service to patients rated the most important and service to staff rated the least important [ $F(1,982) = 215.6$ ,  $p < .0001$ ]. A significant interaction effect of respondents and groups was also found [ $F(4,982) = 11.4$ ,  $p < .001$ ], which is mainly attributable to the relatively low importance that hospital administrators without a pastoral care department accorded to ministering to staff members.

### Importance of Various Chaplain Roles

Table 2 gives the mean importance ratings of the eleven chaplain roles for each of the three types of respondents. The means were ranked within respondent type for presentation and discussion purposes. The means are listed in descending order in Table 2 according to their ranking among pastoral care directors. The ranks are shown solely to facilitate comparisons among the types of respondents and were not used in the analyses.

Factor analysis showed that respondents' tended to group the eleven roles into three factors (see Table 2). Factor 1 and Factor 3 are the easily categorized; respectively, as care and emotional support to patients and families (Factor 1) and religious services and rituals (Factor 3). Factor 2 is mainly composed of different institutional roles that chaplains play.

ANOVA revealed significant differences in respondents' ratings of all eleven roles, with  $F$ 's ranging from a low of 3.06 for praying with patients and relatives, ( $p < .05$ ) to 46.97 ( $p < .0001$ ) for being the institution's point person for integrating spirituality. Pastoral care directors rated every role except praying with patients or relatives significantly higher than hospital administrators did [ $F$ 's = 9.69 to 47.50,  $p < .01$  to  $p < .0001$ ]. Administrators with pastoral care departments rated all eleven roles significantly higher than administrators without pastoral care departments [ $F$ 's = 4.88 to 46.20,  $p < .05$  to  $p < .0001$ ]. If we set the alpha level for the experiment-wise error rate to  $p < .001$  to correct for the multiple analyses, the omnibus  $F$ 's would

still yield significant differences across respondent types for ratings of all the roles, except praying with patients or relatives.

As seen in Table 2, providing end-of-life care, praying with patients and relatives, and providing emotional support to patients and family and friends were rated highly by all three types of respondents. Performing religious rituals and conducting religious services were consistently rated the lowest in importance among all survey respondents. Patient advocacy was also ranked fairly low in terms of its importance among the three types of respondents.

Hospital administrators with pastoral care departments were the most likely participants to suggest other roles that they thought were important for chaplains to perform, including such functions as drug counseling, fund raising, and teaching cultural sensitivity. The most common suggestions were: (1) community liaison and outreach (N = 24); (2) crisis counseling and debriefing for staff (N = 23); (3) grief and bereavement counseling (N = 21); (4) advanced directives education for patients and families (N = 12); (5) being part of the palliative care team (N = 5); and (6) handling request for organ and tissue donations (N = 4). Five of these six roles were mentioned by pastoral care directors 2-6 times. No pastoral care director suggested that chaplains should make organ donation requests. Administrators who do not have pastoral care departments only mentioned crisis counseling and community outreach.

### **Religiosity, Spirituality, and Administrators' Ratings**

The correlation between religiosity and spirituality was high for all participants [ $r(492) = .56, p < .001$ ], and it was nearly the same when pastoral care directors were excluded from the analysis [ $r(492) = .57, p < .001$ ]. The correlations between religiosity, spirituality, and the importance of ministering to different groups were also fairly high among hospital administrators, with values of  $r$  ranging between .20 and .24. There were no significant differences among the correlations for the three types of groups, or their respective correlations with religiosity or spirituality.

Administrators' religiosity and spirituality were also related to the degree of importance they assigned to various chaplain roles. This was particularly true for spirituality, with spirituality being significantly and positively correlated [ $r$ 's = .11 to .26,  $p < .05$ ] with all eleven roles except end-of-life care and clergy liaison. Religiosity was positively and significantly correlated with hospital administrators' importance ratings of six of the eleven chaplain roles. These included emotional support of family/friends and staff [ $r = .12$  and  $.13, p < .05$ ], ethical consultation [ $r = .14, p < .05$ ], praying with patients/relatives [ $r = .23, p < .01$ ] and performing religious rituals and services [ $r$ 's = .14,  $p < .05$ ].

## **Discussion**

Results of this study indicate that administrators strongly endorse the primary role of professional chaplains in attending to the spiritual needs of patients, families, and staff. Although significant differences were found among the three classes of administrators in terms of the importance they accorded to the pastoral care of these constituent groups, nonetheless, the importance ratings they assigned were generally quite high. A recent British survey of 151 hospices and 194 hospitals found that almost all chap-

lain job descriptions specifically stated that chaplains were responsible for providing spiritual care to patients, relatives, and staff.<sup>24</sup>

Administrators in our sample whose institutions sponsor professional pastoral care departments clearly affirmed the importance of the chaplain's role in serving all three constituencies, although they placed somewhat less importance on pastoral outreach and support to staff. Providing emotional support to patients and family members were ranked among the top four chaplain roles by all three cohorts of respondents.

It is to be expected that the hospital administrators without pastoral care departments might rank these functions differently from their counterparts who support professional pastoral care services in their institutions. The former group may not have direct experiential knowledge of the resources professional chaplains provide or be able to distinguish between professional chaplains and community-based clergy who provide occasional religious and spiritual support to their hospitalized congregants.<sup>25</sup> Nevertheless, the relatively high importance ratings assigned by administrators without pastoral care departments suggests that the absence of spiritual care professionals in their hospitals cannot be linked to a lack of appreciation for the value of the pastoral care provided by chaplains. The deficiency in providing this valued service has to be attributed to some other cause. The most probable explanation is budgetary restraints.

It does not, therefore, appear that the biggest problem facing professional chaplaincy, *vis-à-vis* healthcare administrative decisions makers, is demonstrating the value of pastoral care. Apart from economic factors, why do some hospitals elect not to have professional pastoral care departments? It may be that administrators recognize the importance of pastoral care, but are not convinced that such care must be provided by board-certified, professionally-trained chaplains.

End-of-life care was rated as very important by all three types of respondents and it was rated the most important chaplain role by pastoral care directors. Research indicates that staff members frequently call upon chaplains to help patients and their families deal with death.<sup>26,27,28</sup> Hence, it would be worthwhile for chaplains to enhance their skills in this area and to make this type of care an educational and professional priority. This finding also suggests that chaplains should be well integrated into palliative care services.

It was not surprising to find that administrators judged pastoral ministry to staff to be less important than the chaplain's direct spiritual care for patients and families, since this is not something administrators often appreciate until they see its results in action. Vance<sup>29</sup> reported that coun-

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<sup>24</sup>Michael C. Wright, "Chaplaincy in Hospice and Hospital: Findings from a Survey in England and Wales," *Palliative Medicine*, 2001, Vol. 15, pp. 229-242.

<sup>25</sup>Russel E. Vance, "The Role of the Chaplain," *Nursing Homes Long Term Care Management*, 1997, Vol. 46, No. 8, pp. 59.

<sup>26</sup>Bryant, 1993, *op. cit.*

<sup>27</sup>Kevin J. Flannelly, Andrew J. Weaver, & George F. Handzo, "A Three-Year Study of Chaplains' Professional Activities at Memorial Sloan-Kettering Cancer Center in New York City," *Psycho-Oncology*, 2003, Vol. 12, No. 8, pp. 760-768.

<sup>28</sup>Sarah L. Fogg, Andrew J. Weaver, Kevin J. Flannelly, & George F. Handzo, "An Analysis of Referrals to Chaplains in a Community Hospital in New York Over a Seven Year Period," *The Journal of Pastoral Care and Counseling*, 2004, Vol. 58, No. 3, pp. 225-235.

<sup>29</sup>Vance, *et al.*, 1997, *op. cit.*

seling staff was an important part of his work and that such counseling contributed to staff retention at the long-term care facility where he worked. This contention is supported by evidence indicating that staff members' sense of their own religiosity is positively related to their ability to empathize and negatively related to emotional burnout.<sup>30</sup> A study demonstrating a connection between staff ministry (support groups for instance) and improved staff retention would be valuable. However, a chaplain who spends a significant amount of time organizing and facilitating support groups for staff and less time in direct patient care might possibly generate a conflict with their administrative supervisor.

Both groups of hospital administrators rated praying with patients as relatively important, as did pastoral care directors, but it ranked relatively lower in terms of the directors' ratings of the various roles. This divergence underscores cultural and religious differences. Some religious traditions place a high premium on the pastoral prayer; others do not. Clinical pastoral education places a high premium on the foundational skills of listening and responding appropriately. In some cases, formal prayer may be the last thing a patient needs or desires. However, recent studies indicate that most patients who desire spiritual care tend to see prayer as important.<sup>31,32</sup> In a similar way, the data of this survey support the notion that many administrators favor a traditional role of chaplains praying with patients. Whether prayer is or is not an indispensable component of a pastoral visit is not the issue. Managing patients' and administrators' expectations of the chaplain's role is important. Education about the place of prayer in the pastoral visit and why it is sometimes contra-indicated may be useful.

Hospital administrators rated ethical consultation fairly low and it ranked seventh or eighth in terms of its average rating within these two groups (see Table 2). While many administrators think it is very important for chaplains to deal with end-of-life issues, they may not realize that in most institutions, end-of-life issues make up a very large percentage of chaplains' ethical consultations. Ethical issues also arise in the development and implementation of treatment plans. Some chaplains consider ethical training an essential component of their professional formation.<sup>33</sup> A 1997 article in *The Journal of Clinical Ethics*<sup>34</sup> documents examples of ethical consultations between chaplains and physicians, and discusses ways in which chaplains serve as useful allies in helping patients to accept treatment plans proposed by the medical team, thus minimizing conflict between physicians and their patients, as well as the patient's relatives. These cross-disciplinary consultations are particularly useful when pro-

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<sup>30</sup>Kathryn M. Kash, Jimmie C. Holland, William Breitbart, James Dougherty, Suzanne Ouellette-Kobasa, & Lynna Lesko, "Stress and Burnout in Oncology," *Oncology*, 2000, Vol. 14, No. 11, pp. 1621-1637.

<sup>31</sup>George Fitchett, Laurel Arthur Burton, & Abigail B. Sivan, "The Religious Needs and Resources of Psychiatric Patients," *The Journal of Nervous and Mental Disease*, 1997, Vol. 185, No. 5, pp. 320-326.

<sup>32</sup>George Fitchett, Peter M. Meyer, & Laurel Arthur Burton, "Spiritual Care in the Hospital: Who Needs It? Who Gets it?" *The Journal of Pastoral Care and Counseling*, 2000, Vol. 54, No. 2, pp. 173-186.

<sup>33</sup>Michele le Doux Sakurai, "The Challenge and Heart of Chaplaincy. Recent Decades have Brought a Host of Changes to the Health Care Chaplain's Role," *Health Progress*, 2003, Vol. 84, No. 1, pp. 26-28, 56.

<sup>34</sup>Mary M. Thiel and Mary R. Robinson, "Physicians' Collaboration with Chaplains: Difficulties and Benefits," *The Journal of Clinical Ethics*, 1997, Vol. 8, No. 1, pp. 94-103.



posed plans may appear to conflict with patients' religious beliefs. Despite all these advantages, a 1993 survey of staff at a Canadian hospital found that nurses seldom (37%) or never (35%) called a chaplain when they had ethical concerns about patient care.<sup>35</sup>

Patient advocacy was rated quite low by all three groups, with a relative ranking of 8 or 9 out of 11 (see Table 2). Chaplains appear to safeguard neutrality in the patient-staff relationship and to leave advocacy to patient advocates. Yet, some writers note a trend among chaplains to become patient advocates and intermediaries between staff and patients and families.<sup>36</sup>

The chaplain's role as liaison to local clergy ranked roughly in the middle in terms of its mean importance to hospital administrators, and it ranked somewhat lower among chaplains (see Table 2). Wright<sup>37</sup> found that chaplains were responsible for liaison with local clergy in 85% of the hospices and 98% of the hospitals he surveyed in Britain. Many patients would like a visit from their local clergy, but often clergy are not notified of their hospitalization,<sup>38</sup> and federal regulations under the Health Insurance Portability and Accountability Act now make it more difficult to make such notification. By serving in this liaison role, chaplains help to ensure that clergy are informed when a parishioner of theirs is hospitalized. Community can feel confident that hospital chaplains will serve as their surrogates when they are unable to make a patient visit.<sup>39</sup> In this way and others, chaplains serve as a resource as well as a liaison to local clergy.<sup>40</sup> Perhaps, for this reason, clergy are more likely to refer patients to hospitals that have established pastoral care departments staffed by certified chaplains.<sup>41</sup>

All three types of respondents rated religious rituals and services lowest among the eleven chaplain roles. An early study of patients' evaluations of chaplains' roles conducted at St. Mary's Hospital in Rochester, New York yielded somewhat comparable findings.<sup>42</sup> Over 600 patients from eight Christian denominations were asked to rank seven chaplain roles in terms of their importance. The seven categories were: (1) friendly visits, (2) visits before surgery, (3) bringing the sacraments, (4) chapel services, (5) support for relatives, and providing (6) counseling and (7) comfort. Friendly visits ranked the highest, followed by providing comfort and visits before surgery. Overall, chapel services were ranked the lowest and bringing sacraments was close to the bottom, except for Catholics and Lutherans, who ranked it first and third, respectively. Another early study by Carey<sup>43</sup> asked patients and staff at Lutheran General Hospital in Park Ridge Illinois to rate the importance of 20 chaplain roles but its findings are not presented

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<sup>35</sup>Bryant, 1993, *op. cit.*

<sup>36</sup>Sakurai, 2003, *op. cit.*

<sup>37</sup>Wright, 2001, *op. cit.*

<sup>38</sup>Larry VandeCreek and Stephanie Gibson, "Religious Support from Parish Clergy for Hospitalized Parishioners: Availability, Evaluation, Implications," *The Journal of Pastoral Care*, 1997, Vol. 51, No. 4, pp. 403-414.

<sup>39</sup>Fogg, *et al.*, 2004, *op. cit.*

<sup>40</sup>Sakurai, 2003, *op. cit.*

<sup>41</sup>Michael Moran, Kevin J. Flannelly, Andrew J. Weaver, Jon A. Overvold, Winifred Hess, & Jo Clare Wilson, "A Study of Pastoral Care, Referral, and Consultation Practices Among Clergy in Four Settings in the New York City Area," *Pastoral Psychology*, 2005, Vol. 53, No. 3, pp. 253-264.

<sup>42</sup>Wieler, *et al.*, 1975, *op. cit.*


<sup>43</sup>Carey, 1973, *op. cit.*

in detail. Here too, "Catholics and Lutherans put a much higher value on administering the Sacraments and providing chapel services. . . ." <sup>44</sup> While some recent studies have attempted to examine patients' perspectives about the kinds of chaplain services they desire, <sup>45,46</sup> more studies of this nature would be invaluable for the profession. These findings again reflect more about differences directly interpreted by religious diversity than by the inherent worth of ritualized religious practice.

According to Carey, <sup>47</sup> "A large majority of the chaplains put a high value to caring for relatives (ranked first by patients) and patients at the time of serious illness or death (ranked second by patients)." These findings are in keeping with the relative rankings of the hospital administrators currently surveyed. Consistent with the current findings, the chaplains Carey <sup>48</sup> surveyed ranked their religious role functions rather low. They ranked their sacramental role tenth, and leading chapel services sixteenth out of twenty.

Administrators' spirituality appears directly related to the importance they assign to all eleven chaplain roles; their religiosity directly relates to the importance they assigned to six of the chaplain roles. Hospital characteristics also influenced the importance administrators accorded to different roles, to varying degrees.

As evidence mounts for the significant influence of religion and spirituality on health, it becomes clearer that health care institutions should attend to the religious and spiritual needs of their patients, families, and staff and that the best way to provide this service is by employing professional chaplains. To find the best role for these chaplains and fully integrate them into the health care team requires input from all members of that team and from institutional administration. The present study provides some valuable new information for this ongoing discussion.

Although this is a national study with a substantial number of participants, it requires replication to confirm and extend these findings. While these results do much to specify what chaplain roles hospital administrators think are important, we do not know what factors contribute to their opinions aside from their own religiosity and spirituality. Since the correlation coefficients between importance and personal religiosity and spirituality are relatively small, a number of unknown factors may come into play in determining why administrators consider each role important. Finally, the question of why so many hospitals do not have chaplains on staff when their administrators apparently value what they do remains an important one to investigate. 

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<sup>44</sup>Carey, 1973, *op. cit.*, p. 170.

<sup>45</sup>Fitchett, *et al.*, 1997, *op. cit.*

<sup>46</sup>Fitchett, *et al.*, 2000, *op. cit.*

<sup>47</sup>Carey, 1973, *op. cit.*, p. 170.

<sup>48</sup>Carey, 1973, *op. cit.*