A National Survey of Hospital Directors' Views about the Importance of Various Chaplain Roles: Differences among Disciplines and Types of Hospitals*

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A national random sample of hospital directors was asked to rate the importance of seven categories of chaplain roles and functions: 246 nursing directors, 267 social services directors, 307 medical directors, and 611 pastoral care directors. All four groups rated end-of-life care, prayer, and emotional support as being between very important and extremely important. Other roles, including consultation, advocacy, community outreach, and religious services and rituals were rated significantly less important. Significant differences were found across disciplines and hospital settings (general, psychiatric, *etc.*). Medical directors rated most chaplain roles lower than other directors did, and directors in psychiatric hospitals rated all roles, except religious services/rituals, lower than their counterparts in other types of hospitals. The importance that directors accorded to all the chaplain roles examined was also influenced by their own spirituality and religiosity, as well as the religious affiliation of their institution.

Numerous articles have been published over the past 30 years that describe the chaplain's role as a member of the treatment team, and many of these provide personal experiences or case studies to demonstrate the kinds of activities and functions chaplains perform in different healthcare settings.[1-6] Some older papers tend to emphasize the traditional role of chaplains in addressing the religious needs of patients, such as prayer, religious worship, services, rituals, and issues relating to death.[7,8] Recent papers tend to emphasize the importance of less traditional roles, including ethical consultation, patient advocacy, community outreach, crisis intervention, and advanced directives.[9-13] The few studies that examine chaplain roles in different settings will be discussed later.

Many articles have explicitly explored the role of the chaplain in relation to other treatment team members, especially physicians. Indeed, the

Journal of Health Care Chaplaincy devoted a special issue to this topic in 1991.[14] The articles in this issue offer specific suggestions for chaplains to foster collaborative relationships with physicians in various medical disciplines.[15-18] A key element in this process is to expand physicians' perceptions of chaplains beyond their traditional role. A recent article by Handzo and Koenig[19] discusses the relationship between chaplains and physicians in terms of a general practitioner and specialist model. This model is intended to help physicians understand the mutuality of the roles that chaplains and physicians play in the healthcare setting, and the need for each profession to have a general knowledge of the other's specialty area in order to collaborate effectively.[20]

The professional relationships between chaplains and their colleagues in social work and nursing also have been discussed to some degree. Social workers and nurses appear to be more receptive to the various roles of chaplains than are physicians.[21-29] However, it is not clear from the limited research available whether social workers and nurses accord the same kind of importance to the traditional and nontraditional roles of chaplains that chaplains themselves appear to do.[30] For example, while the nurses in Taylor and Amenta's 1994 study[31] viewed chaplains as an important source of spiritual care for patients, they did not tend to see chaplains as a source of support for staff. By contrast, chaplains place a high importance on their role of providing emotional support to patients, families and staff.[32-35] Similarly, although the nurses in Bryant's 1993 study[36] indicated it was important for chaplains to address patient issues relating to death and dying, they did not think it was important to call upon chaplains when ethical issues arose. Sharp's findings[37] also suggest that nurses and physicians are likely to place more importance on traditional rather than nontraditional chaplain roles.[38]

The present study was designed to systematically compare and contrast the opinions of various healthcare professionals regarding the importance of different chaplain roles. To this end, we conducted a national survey of randomly selected samples of medical, nursing, social service and pastoral care directors. Based on previous findings, we predicted that nurses would rate most kinds of chaplain roles as being more important than would social workers or physicians. We further hypothesized that medical, nursing, and social services directors would rate the traditional roles of chaplains as being more important than pastoral care directors would rate them.

Methods

Electronic lists were purchased from American Medical Information, Inc. containing the names and addresses of medical, nursing, social services, and pastoral care directors in healthcare institutions throughout the United States. The four lists were merged to form a master list, which was sorted and inspected to identify institutions that had a director of pastoral care and at least two of the other three types of directors. Institutions that did not meet these criteria were deleted from the master list. This list was then broken down into four separate lists for each type of director (discipline), which constituted the sampling frames for each discipline. A random sample of 1000 directors was then taken for each discipline.

Questionnaires were mailed to directors, by name, in each discipline,

accompanied by a letter from The HealthCare Chaplaincy's clinical director that explained the purpose of the study. The same letter was sent to all directors. A reminder was mailed about two weeks after the initial mailing and a second identical questionnaire was mailed two weeks after that to encourage participation.

The initial mailing yielded a comparatively low response rate for the medical directors, which prompted the authors to take a second random sample from the list for this group. The second sample of medical directors was mailed the same questionnaire with a more personalized cover letter that was signed by the research director and two prominent physicians who serve on The HealthCare Chaplaincy's board of trustees. The identical questionnaire with a similar cover letter encouraging participation was mailed two weeks later.

Questionnaire

The first section of the survey instrument obtained data on the demographic characteristics of respondents and the type of healthcare facility in which they worked. Two additional items asked participants: "How religious are you?" and "How spiritual are you?" The response categories ranged from 0 (Not at all) to 5 (Extremely).

The main section of the questionnaire asked respondents how important they thought it was for chaplains to engage in 19 different kinds of activities or roles. The list of roles was developed from previous research,[39-51] including several roles that hospital executives said they thought were important.[52]

Dependent Variables

Factor analysis was conducted on participants' ratings of the 19 role questions to see if they fell into distinct categories. Seven categories of roles were formed as a result of the factor analysis. The seven categories and the items which comprise them are: (1) *Grief and Death*—provide end of life care, be part of the palliative care team, do grief and bereavement counseling; (2) *Emotional Support*—provide emotional support to patients, provide emotional support to families, provide emotional support to staff members; (3) *Community Liaison and Outreach*—be a liaison to community clergy, be a liaison to the community at large, perform community outreach; (4) *Directives and Donations*—provide education about advanced directives, handle requests for organ and tissue donations; (5) *Religious Services/Rituals*—conduct religious services and worship, perform religious rituals; (6) *Consultation and Advocacy*—do crisis counseling and debriefing for staff, provide ethical consultation, serve as a patient's advocate, promote patient safety, help patients and families dealing with difficult decisions; and (7) *Prayer*—pray with patients or relatives.

The factor loadings for categories 1-6 ranged from .59 to .89 for all groups of participants. The Cronbach alphas for these same six measures ranged from $\alpha = .73$ to $\alpha = .91$. Prayer had low factor loadings that were distributed across all of the other six categories of roles, so it was kept as a separate category.

Independent Variables

Type of discipline and type of hospital were used as independent variables in the statistical analyses. Spirituality, religiosity, gender, and whether a hospital was religiously affiliated were all used as covariates in the analyses. Gender and religious affiliation were each dummy coded as 1 or 0.

Statistical Analyses

The seven classes of roles were used as the dependent variables in the statistical analyses. The importance ratings of the seven classes of chaplain roles were analyzed in a 4 X 4 X 7 MANCOVA, with discipline and type of hospital as between factors and the seven categories of chaplain roles as the dependent variables. Spirituality, religiosity, gender, and hospital religious affiliation were used as covariates in the analyses, as noted above. Univariate analyses were subsequently conducted on some of the variables when significant differences were found. Correlations were conducted between each of the three religion/spirituality covariates (spirituality, religiosity, and institutional religious affiliation) and the importance ratings for each of the seven role categories.

Results

Participants

A total of 1,505 questionnaires were returned from respondents. The response rate varied by discipline, with 28.9% of social services directors, 26.5% of nursing directors, and 62.3% of pastoral care directors returning the surveys. While only 10.6% of medical directors in the first sample responded, the response rate for the second sample was 23.1%. Excluding a number of questionnaires that were incomplete, 246 nursing directors, 267 social services directors, 307 medical directors, and 611 pastoral care directors participated in the study.

The sample consisted of 52.8% women and 47.2% men, but the percent of men and women varied widely across disciplines. Women comprised 92.6% of nursing and 86.9% of social services directors, but only 37.8% of pastoral care and 16.5% of medical directors. Age ranged from 26 to 78 years, with the mean age of men and women being, respectively, 55.1 and 52.4 years. Across disciplines, the mean age ranged from 50.2 to 56.0. With the exception of physicians, the majority of directors held master's degrees: social services (72.1%); pastoral care (70.1%); and nursing (61.7%).

Most of the participants worked in general hospitals (73.6%) or hospitals that included specialized care, which we designated "mixed" (13.4%). Of the remaining participants, 6.0% worked in psychiatric institutions and 7.0% worked in other kinds of specialized healthcare facilities.

Role Effects

The MANCOVA conducted on the importance ratings of the seven categories of chaplain roles found main effects of discipline and type of hospital ($p<.001$). As expected, a significant interaction effect of category by discipline was found, indicating that the importance of different roles was rated differently by different types of directors ($p<.001$). A significant interaction effect of category and hospital type was also found ($p<.001$), although we had not made any prediction about this happening. Self-reported ratings of spirituality and religiosity had significant effects on the importance ratings for most of the categories, as did the religious affiliation of the hospitals.

The importance ratings accorded to the seven chaplain roles were also found to differ significantly, regardless of discipline or hospital type. Overall, the first three roles listed in Tables 1 and 2 (*i.e., Grief and Death, Prayer,*

Emotional Support), were rated as being significantly more important than the other roles listed in the table ($p<.001$), with the first three roles rated between very important and extremely important. By contrast, the next three chaplain roles listed in both tables were rated between moderately and very important, on average. Handling advanced directives and organ donations were rated significantly less important than the other six chaplain roles, across discipline and hospital type ($p<.001$).

Effects of Discipline

Table 1 shows the average importance rating accorded to each chaplain role by the disciplines of the directors. All four groups of directors said it was very important, at least, for chaplains to deal with issues related to grief and death, although there was some variation among groups. Prayer was also considered to be very important, although medical directors rated prayer significantly lower than did the other directors. Providing emotional support was considered somewhat less important by social services and medical directors.

TABLE 1

Mean (S.D.) Importance Ratings Given by Different Disciplines to Each of the Seven Categories of Chaplain Roles

	Pastoral Care	Nursing	Social Services	Medicine
*Grief and Death***	4.46 (0.71)	4.38 (0.73)	4.27 (0.88)	4.34 (0.82)
*Prayer***	4.51 (0.76)	4.37 (0.83)	4.46 (0.87)	4.09 (1.04)
Emotional Support†	4.53 (0.67)	4.34 (0.75)	3.96 (1.00)	4.07 (0.90)
*Community Liaison and Outreach***	3.63 (0.97)	3.79 (0.91)	3.64 (0.97)	3.44 (1.13)
Consultation and Advocacy†	3.93 (0.80)	3.78 (0.86)	3.33 (1.05)	3.28 (1.02)
Religious Services/Rituals	3.65 (1.16)	3.53 (1.21)	3.78 (1.16)	3.52 (1.21)
*Directives and Donations***	2.58 (1.31)	2.00 (1.39)	2.06 (1.44)	2.20 (1.42)

** $p<.01$
† $p<.001$

All four groups tended to agree on the importance of performing religious services and rituals, but they rated this category lower than the first three categories listed in the table. Community liaison and outreach work were rated about the same as religious services/rituals, but medical directors rated it significantly lower than did the other three groups. A closer

examination of the items that composed this construct revealed being a liaison to local clergy was rated significantly higher, within and across disciplines, than community outreach or being a liaison to the community at large.

Consultation and advocacy was given higher ratings by pastoral care and nursing directors, but it was regarded as significantly less important by social services and medical directors. Because of their diversity, univariate analyses were also conducted on the individual items comprising this construct. Both within and across the disciplines, the relative importance given to the five items was, from highest to lowest: (a) helping families make difficult decisions; (b) providing ethical consultation; (c) conducting crisis counseling and debriefings; (d) serving as a patient advocate; and (e) promoting patient safety.

As seen in Table 1, handling advanced directives and organ donations was rated the lowest of the seven categories. Chaplains, however, tended to see these functions as being more important than the other three groups.

Effects of Hospital Type

The effects of hospital type are shown in Table 2. The importance of prayer and issues of grief and death were rated about equally by directors in general, specialty and mixed hospitals, but they were rated significantly lower by directors in psychiatric hospitals. Emotional support was rated slightly less important, with directors from psychiatric hospitals giving the lowest ratings once again.

TABLE 2

Mean (S.D.) Importance Ratings Given by Directors in Different Types of Hospitals to Each of the Seven Categories of Chaplain Roles

	General	Specialty	Mixed	Psychiatric
Grief and Death†	4.43 (0.71)	4.41 (0.78)	4.38 (0.84)	3.81 (1.12)
*Prayer***	4.41 (0.83)	4.36 (0.84)	4.43 (0.89)	4.05 (1.13)
Emotional Support†	4.33 (0.79)	4.40 (0.83)	4.27 (0.88)	3.74 (1.12)
*Community Liaison and Outreach**	3.66 (0.96)	3.62 (1.05)	3.58 (1.08)	3.23 (1.14)
Consultation and Advocacy†	3.68 (0.91)	3.69 (1.01)	3.65 (0.99)	3.09 (1.18)
Religious Services/Rituals†	3.54 (1.20)	3.77 (1.09)	3.86 (1.15)	4.00 (1.00)
Directives and Donations†	2.26 (1.36)	2.27 (1.50)	2.38 (1.41)	1.37 (1.34)

* $p < .05$
** $p < .01$
† $p < .001$

None of the other chaplain roles were rated as being very important. Community work, consultation and advocacy, and religious services/rituals were rated roughly the same in all healthcare settings except psychiatry. Directors working in psychiatric hospitals differed significantly from their colleagues, saying that community work ($p<.05$) and consultation/advocacy ($p<.001$) were less important, and religious services/worship ($p<.01$) were more important than directors in other settings. None of the groups gave much importance to handling of directives/donations, but directors in psychiatric hospitals rated it the lowest.

Chaplains and nurses in psychiatric institutions rated emotional support ($p<.05$) and prayer ($p<.01$) significantly higher than did social workers and physicians in psychiatric settings. All disciplines working in psychiatric settings rated the importance of community work, religious services, and consultation and advocacy roughly the same.

Effects of Religion and Spirituality

Spirituality, religiosity, and institutional religious affiliation had significant effects as covariates. Correlation analyses revealed that all three variables were positively correlated with the importance ratings of each of the roles ($p<.001$). The correlations between each chaplain role and spirituality (r's = .13 to .30), religiosity (r's = .11 to .26), and institutional religious affiliation (r's = .07 to .23) all exhibited low to moderate levels of association.

Discussion

The results of this survey give substantial quantitative support to many prevalent assumptions regarding perceptions of professional pastoral care among various health care professionals, including chaplains themselves. It also challenges several long held assumptions and raises numerous questions for further exploration.

Differences among Types of Roles

Six of the seven roles we examined were, by and large, rated by most participants as being moderately to extremely important. While there were some differences in terms of how specific disciplines rated particular roles, there was substantial agreement across disciplines as to the relative high importance accorded to prayer, emotional support, and dealing with issues relating to grief and death. The latter was rated most important by all groups, indicating that end of life and bereavement care are universally seen as the most important task of pastoral care givers. These findings are consistent with those from an earlier survey we conducted, which asked chief executives officers about the roles they thought chaplains should perform.[53]

Among health care professionals, chaplains are the ones who take the lead in accompanying the dying and consoling those who survive, and they are commonly called upon to do so by other staff.[54-56] This finding both reinforces a traditional role of chaplains and other clergy and likely reflects the recent increase in attention to end-of-life issues in health-care.[57-58]

Given the importance accorded to addressing end-of-life issues, one may find it inconsistent that the roles subsumed under Consultation and Advocacy and especially Directives and Donations were rated as low as they were, since they often involve work with persons at the end of life and their families. On the one hand, it would seem that these tasks are part and parcel

of end of life and palliative care. On the other hand, however, some chaplains believe that these tasks can involve advice giving and other forms of directive intervention which is antithetical to the traditional non-directive stance of professional pastoral care. Other disciplines may still be concerned that chaplains will insert or impose their own religious beliefs into these discussions rather than allowing patients and families to exercise their own will.

The fairly strong endorsement given to the Emotional Support categories, especially for patients and families, suggests a more general role for chaplains. This finding is also consistent with our past research on hospital executives and pastoral care directors.[59]

All four disciplines surveyed in the present study seem to support a role for chaplains with all patients across the spectrum without regard to diagnosis, prognosis, and religiosity. The ratings also give implicit recognition to the premise that emotional support is an important function of the health care team. Indeed, our anecdotal experience in several institutions strongly suggests that patient satisfaction scores related to meeting emotional needs rise significantly after professional pastoral care is introduced.

The relatively low ratings given to Religious Services/Worship are surprising, in a sense, given the place of these tasks in traditional pastoral care. But they are consistent with the findings of our earlier survey on the attitudes of healthcare executives and administrators.[60] One might speculate that they reflect a reduction in formal worship in healthcare institutions as inpatients become sicker and lengths of stay decline. Nevertheless, all four disciplines gave comparable ratings. This may be because all groups recognize that these tasks may be performed by either chaplains or community clergy, although chaplains are trained to respond to the particular individual receiving care. On the other hand, this level of agreement might indicate that chaplains have been able to interpret for healthcare workers what their role is and how it differs from the training of clergy in general. In any case, it is significant to note here that prayer did not load on this category, but was spread across all of the role categories. This suggests that prayer is perceived as a universal function of pastoral care that pervades everything else the chaplain does.

The lower ratings for Community Liaison and Outreach downplay the importance of the work that chaplains often do in the local community.[61,62] However, the highest rated item among the three items comprising this construct was the chaplain's role as a liaison to local clergy. This function appears to be more important than most directors may realize. There is now research that suggests that community clergy refer parishioners preferentially to institutions with pastoral care departments.[63] These findings would support allocating some of the chaplain's time to community outreach with the goal of improving the institution's image and actually impacting income.

Consultation and Advocacy was rated about the same as Community Liaison and Outreach, with nurses and chaplains placing more importance on this role than physicians or social workers. Helping families make difficult decisions and providing ethical consultation were the highest rated items within this category. The former may be seen as an extension of providing emotional support to families. The role of the chaplain as ethical consultant is accepted to some degree, but it is not rated equally important by all disciplines. Patient advocacy and patient safety were the lowest rated

items in this category. Our survey of hospital executives and other administrators likewise found that they did not believe this was an important role for chaplains to perform.[64] Even pastoral care directors did not see this as a very important role, although some chaplains clearly feel it is essential.[65]

We included a question about patient safety in the survey based on an article in this journal that encouraged chaplains to become more involved in promoting patient safety.[66] The findings indicate that many directors, including chaplains themselves, do not see this as a very important role. Most administrators would say something like "patient safety is everyone's job." But if this is so, it seems that "everyone" does not include chaplains, suggesting that, at some level, they are not yet fully integrated into the team.

Differences among Types of Disciplines

When the disciplines are looked at separately across roles, it is not surprising that pastoral care directors generally gave the highest importance ratings, although there were a couple notable exceptions. The high ratings of nurses would be expected since they are generally viewed as the chaplain's closest ally and most consistent supporter.[67-68] Their failure to see the connection between the chaplain's role in supporting advanced directives and end-of-life care would be surprising except for the fact that chaplains have not promoted this role for themselves. It is possible that other disciplines interpreted some of the items about end-of-life care in a stricter clinical sense—pain relief, hygiene, physical comfort. For the patient who is no longer alert, end-of-life care is offered to significant others and perhaps this was not taken into consideration by the other disciplines when answering this question.

The importance ratings of nursing directors were generally aligned with those of the chaplains themselves. Since nursing is responsible for the patient twenty-four hours, seven days per week, they are best attuned to the sometime subtle changes in the patient's condition. As such, nursing is the discipline that is mainly responsible for assessing the patient's needs and calling in the appropriate service. The findings validate professional experience that there tends to be a strong working relationship between nursing and pastoral care.

While chaplains often work closely with social workers and consider them supportive in the same way as nursing, this assumption did not prove to be true since their ratings were generally closer to the doctors than to the nurses. The role they seem to see for chaplains is also the most traditional, giving their highest rating for Prayer and the highest rating of all four disciplines for Religious Services. The low rating for Emotional Support is also noteworthy. Since both chaplains and social workers are able to provide social support, the low ratings by social workers may partially reflect a turf dispute between the two disciplines. Indeed, the functions of chaplains and social workers often overlap. If these two disciplines have not clarified their roles within a hospital, one might imagine that the lines of responsibility may become blurred and the team might not function as effectively. It may be well worth the time and effort for pastoral care directors to enter into a meaningful dialogue with social workers to explore how their roles overlap and compliment one another.

It is interesting that chaplains thought it was more important than other disciplines that they be involved in handling requests for organ donations

and providing education about advanced directives. However, most hospitals have other mechanisms for these functions and do not need to turn to the chaplains. Perhaps the chaplains feel they have skills in these areas that are not being adequately utilized in their work setting.

The doctors had the lowest ratings of the four disciplines in four of the seven categories. Their relatively low rating for prayer is especially notable and may represent the persistence of the old stereotype in which clergy support patient denial with "false hope." These low ratings should be troubling for those who want to further integrate pastoral care and work in institutions whose governance is dominated by physicians. While some useful articles have been written about improving collaboration among chaplains and physicians,[69-70] the heart of the matter seems to be that chaplains must be able to convince physicians that chaplains are able to perform a variety of roles outside of what many physicians see as their traditional roles.[71]

Despite the differences among the disciplines, it is important to note that all four disciplines subscribe substantial importance to most of the potential pastoral care roles they were asked about. This finding further supports the claim that professional chaplains have become a widely accepted member of the health-care team. Nevertheless, different disciplines place different importance on various chaplain roles.

Differences among Types of Institutions

Some striking differences were found among types of institutions, especially psychiatric hospitals. Some of these differences are easily explained. Since patients rarely die in psychiatric facilities, we would expect less importance would be placed on the importance of addressing grief and death issues. Following the same reasoning, we would expect that psychiatric facilities would be less concerned with advanced directives and organ donations.

On the other hand, religious worship is still a significant part of pastoral care practice in these facilities where patients often stay for extended periods and are able to attend. Indeed, the performance of religious services and rituals was the only role that garnered higher importance ratings among directors in psychiatric hospitals than those in other types of institutions. We are aware of only two articles that discuss psychiatric chaplaincy, both of which emphasize the religious role of chaplains.[72-73] Since both of these are rather old, they do not give us the current perspective of chaplains working in psychiatric settings. The current findings indicate that chaplains in psychiatric hospitals place more importance on emotional support, prayer, and other religious activities than some of their colleagues—notably social workers and physicians. But they agree with their colleagues that community work and consultation/advocacy are less important roles for chaplains in psychiatric settings. Sivan, Fitchett and Burton[74] in a study of psychiatric patients suggested that "psychiatrists have particular difficulty considering religion as a therapeutic resource" (p. 18). The present results tend to bear that out.

Conclusions

This study marks the first systematic sampling of health-care managers in the United States on this subject matter. The four disciplines we studied generally agreed that prayer, emotional support, and dealing with issues

relating to grief and death were very important chaplain roles. Conducting religious services, performing community outreach, consultation and advocacy were viewed as moderately to very important, but the degree of importance accorded to these roles varied considerably by discipline and hospital type. In addition to these effects, the importance directors placed on all the chaplain roles we examined, was influenced by their own spirituality and religiosity, as well as the religious affiliation of their institution. Overall, it appears that chaplains are seen as being principally devoted to the care of individual patients, family members and to a lesser degree staff, but they are not seen as major players in supporting some of the broader goals of the institution itself.

Endnotes

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