

Patients' Expectations of Healthcare Chaplaincy: A Cross-Sectional Study in the German Part of Switzerland

Urs Winter-Pfändler · Kevin J. Flannelly

© Springer Science+Business Media, LLC 2011

Abstract Identifying patients' expectations of and need for healthcare chaplaincy is important in terms of appropriate intervention. Therefore, a sample of 612 patients from 32 general hospitals and psychiatric clinics in the German part of Switzerland was surveyed about their expectations of chaplaincy service. A principal component factor analysis of participants' ratings found that the survey items fell into three distinct categories. These were the need for (1) emotional support, (2) help to cope with illness/disease, and (3) religious/spiritual assistance. Among the expectations, the need for emotional support was rated most important, followed by help to cope and, lastly, religious/spiritual assistance. Gender, religious denomination, general religiosity, and subjective health status significantly influenced these expectations. The results showed that fulfilling patients' expectations increases their overall satisfaction with, and the importance they accord to the chaplain's visit, as well as their confidence in the chaplain.

Keywords Healthcare chaplaincy · Patients' expectations · Research-informed chaplaincy

Introduction

Today's healthcare chaplaincy in most Western European countries is challenged by a number of social and economic changes. Among these are the increasingly multicultural nature of societies, the explosion of healthcare costs associated with increasing

U. Winter-Pfändler (✉)
Swiss Institute of Pastoral-Sociology (SPI), Gallusstrasse 24, Postfach 1926,
9001 St. Gallen, Switzerland
e-mail: u.winter@gmx.ch

K. J. Flannelly
HealthCare Chaplaincy, New York City, USA

marketization of the public health service (Giaimo 2002; Gray 2007; Harrison 2004), the decrease in membership of the two established churches (Roman Catholic as well as Protestant), since the 1970s (Pollack 1996), and the increasing individualization of society (Beck 1992).

This development can be observed in Switzerland as well. Whereas Christianity is still the predominant religion in Switzerland (82% of the total resident population), the number of people who do not belong to any religious community is growing (11% of the total population). The two major Christian denominations are the Roman Catholic Church (42% of the population) and the Swiss Reformed Church (33%). The largest minority religion is Islam (4%) (Swiss Federal Statistical Office 2003).

As a consequence of this social change, a shift from traditional religious chaplaincy to spiritual care (for believers and non-believers alike) can be observed, mainly in the context of healthcare institutions (Mitchell and Sneddon 1999; Mowat and Swinton 2007). In addition to that, the tasks of modern chaplaincy have expanded (Mitchell and Sneddon 1999; Wright 2001).

A study by Mowat and Swinton (2007) indicates that chaplaincy has been responding to these challenges. In their study, based on interviews with forty-four full-time chaplains from Scotland, the authors describe a process model of chaplaincy service. Three main tasks form the basis of modern healthcare chaplaincy: seeking spiritual need, identifying spiritual need, and responding to need.

The first task of the chaplain is to seek patients with spiritual needs that have to be addressed. To succeed in this task, the chaplain has to establish a supportive network with the other professionals in the hospital. Next, the needs of those patients have to be identified. The authors differentiate between religious/sacramental needs, existential needs (e.g. finding meaning, emotional support), theological needs (e.g. theodicy questions like “Why me?”), and practical needs (informational support). Finally, the chaplain has to respond to the identified needs by helping patients to cope with their problems and issues. The model clearly indicated how important it is to identify patients’ needs and their expectations of chaplaincy. This observation is also supported by Fitchett et al. (2000) and Galek et al. (2005).

Therefore, in the present study, we survey patients in the German part of Switzerland about their expectations of healthcare chaplaincy. In particular, the study is designed to examine the personal factors (gender, old age, religious denomination, and general religiosity) and factors relating to hospital stay (admission to hospital, subjective health status, and length of stay) that influence patients’ expectations. The study also examines the level of consistency between expectations and pastoral care experiences. Duffy and Munro (2005) assume that the amount of correspondence between patients’ needs (e.g. request for comfort or desire for prayer) and the service provided by chaplains influences patient satisfaction. Accordingly, we analyse the degree to which patients’ expectations are met and the extent to which the correspondence between patient’s expectation and the actual provision of spiritual care influences patient satisfaction.

By investigating these questions, we hoped to take a major step toward making chaplaincy a research-informed profession (Fitchett 2002) and improving the quality of healthcare chaplaincy service. To achieve these ends, the study was initiated by the Swiss Catholic and Protestant Chaplaincy associations. Chaplaincy services are offered only by the official churches (Roman Catholic and Protestant) in Switzerland. Whereas professional chaplains work in large hospitals and clinics, local parish ministers offer pastoral and spiritual care in smaller regional hospitals and nursing homes.

Methods

Study Procedure

The study was designed as a cross-sectional investigation. Hospital and clinic patients from the German part of Switzerland were asked to complete a questionnaire regarding their experience with chaplaincy services during their hospitalization. The survey was distributed to patients from 32 general hospitals and psychiatric clinics, including 15 district or regional hospitals, seven province hospitals, three university hospitals, three private hospitals, two psychiatric clinics, and two other institutions. All patients who had been visited by a chaplain for more than ten minutes received a questionnaire. Patients who were not able to fill out the form, due to their medical condition, intellectual state or linguistic skills were excluded. A total of 679 questionnaires were returned. The response rate was 30.12%. In order to increase the homogeneity of the study population, 67 long-term inpatients were excluded from the study and only discharged patients were included in all further analyses.

The study protocol had first been reviewed and accepted by the responsible committee of the Catholic and Protestant Chaplaincy Associations of the German part of Switzerland and the Chair for pastoral care and pastoral psychology at the University of Berne, Switzerland. The study protocol and the questionnaire were then submitted to the federal ethics committees of the provinces of Basel and Lucerne, which are official reviewing committees for empirical research, and were accepted.

Study Sample

A total of 612 patients participated in the study, ranging from 18 to 94 years of age ($M = 62.06$ years, $SD = 15.76$). Of these, 327 (53.69%) were women and 282 (46.31%) were men (missing: $N = 3$). Nearly half of the patients were Roman Catholic ($N = 300$, 49.10%), and roughly four out of ten were Protestant ($N = 242$, 39.61%). The remaining respondents either did not belong to a religious denomination ($N = 38$, 6.21%) or were connected to another religion or denomination (primarily to evangelical free churches) ($N = 31$, 5.07%) (Missing: $N = 1$). The average duration of hospital stay was 22.79 days ($SD = 32.58$ days). Table 1 provides further details about the sample.

Measures

Patients' Expectations of Healthcare Chaplaincy

Items for measuring patients' expectations of chaplaincy service were adapted by reviewing previous work in this field (Lublewski-Zienau et al. 2005; Flannelly et al. 2007). A team of four chaplains oversaw the development of the screening tool, in order to guarantee enculturation and feasibility in the Swiss-German context. In the end, eleven items were created to assess patients' expectations. These items could be answered on a four-point Likert scale, ranging from 1 "Strongly disagree" to 4 "Strongly agree".

A principal component exploratory factor analysis (with Varimax rotation) was performed. Factor analysis of patients' expectations yielded three factors (Eigenvalue >1) that

Table 1 Demographic characteristics of respondents

	<i>N</i>	Percent
<i>Marital status</i> (Missing: <i>N</i> = 3)		
Married	341	55.99
Unmarried	99	16.26
Widowed	82	13.46
Divorced or separated	87	14.29
<i>Admission to hospital</i> (Missing: <i>N</i> = 18)		
Unexpected	302	50.84
Expected	292	49.16
<i>Patients' reason for stay</i> (Missing: <i>N</i> = 6).		
Disease	387	63.86
Emergency	86	14.19
Accidental injury	76	12.54
Diagnostic assessment	30	4.95
Ongoing treatment	20	3.30
Childbirth	7	1.16
<i>Patients were at following institutions</i> (Missing: <i>N</i> = 13)		
Province hospital	207	34.56
District/regional hospital	142	23.71
University hospital	118	19.70
Private hospital	84	14.02
Psychiatric clinic	38	6.34
Other institutions	10	1.67

N = number of respondents

Table 2 Factor loadings and reliability (alpha) of the patients' expectations for chaplaincy

Factor/item	Factor 1	Factor 2	Factor 3
<i>Expectations related to coping with illness/disease</i> ($\alpha = .80$)			
The chaplain should help me to make decisions.	.70	.27	.28
The chaplain should help me to cope with my illness/disease.	.64	.37	.30
The chaplain should help me with the question "Why me?"	.71	.31	.12
The chaplain should help to settle my thoughts and feelings.	.63	.28	.38
The chaplain should entertain or distract me.	.70	-.04	-.06
<i>Expectations related to religion/spirituality</i> ($\alpha = .85$)			
The chaplain should pray with me or read from the Bible.	.15	.85	.15
The chaplain should administer a sacrament or give me a blessing.	.13	.88	.14
The chaplain should meditate or be in silence with me.	.36	.76	.07
<i>Expectations related to emotional support</i> ($\alpha = .72$)			
The chaplain should treat me with dignity and respect.	-.02	.09	.80
The chaplain should listen to me and have time for me.	.24	.01	.80
The chaplain should strengthen my hope and comfort me.	.27	.35	.68

encompassed all eleven items (see Table 2). The three factors included expectations related to the following: (1) *Coping with illness/disease*—help to make decisions, to cope, to answer the question, "Why me?", cope with negative emotions/thoughts as well as

distraction; (2) *Religion/spirituality*—prayer, blessing, sacraments, reading from the Bible; and (3) *Emotional support*—showing dignity and respect, listening and providing hope and comfort. All items loaded on the main factor >0.60 and showed factor loadings <0.40 on the other factors. The items, factor loadings and Cronbach's alphas are reported in Table 2.

Differences Between Expectations and Chaplaincy Service Experiences

After the patients' expectations were assessed, the patients were asked to describe their experience of the chaplain's visit and what the chaplain did during his/her visit (in terms of expectations). Differences between expectations and experience were calculated.

Overall Satisfaction with Chaplain's Visit: General Satisfaction, Importance of Pastoral Conversation, and Trust in the Minister

These three constructs were each measured with a single item. The general satisfaction with the chaplain's visit was assessed with the item "On the whole, I was satisfied with the chaplain's visit" and the importance of the conversation with the item "The chaplain's visit was important to me". The possible answers for these two items ranged from 1 "Not at all true" to 8 "Very true". Finally, patients were asked whether they had confidence in the chaplain. The possible answers to this question were 1 "No, I had no confidence" to 4 "Yes, I had great confidence".

Religion

General religiosity was measured by two items. The first was created according to Frick et al. (2005): "In the broadest sense of the term, I would describe myself as a believing/spiritual/religious person". The second item pertained to church involvement: "I regularly attend the religious life of my religious denomination (e.g. service attendance)". This item was created by the authors. Both items could be answered on a Likert scale with answers ranging from 1 "strongly disagree" to 4 "completely agree". Internal consistency (Cronbach's α) for the religiosity scale was $\alpha = 0.70$.

Patients were also asked to specify their own religious denomination. Two variables were created based on patients' religious affiliation: Protestant (Protestant = 1 and all others = 0) and Catholic (Catholic = 1 and all others = 0).

Hospital Stay

Respondents were asked why they had to stay at the hospital and whether this was an expected or unexpected hospitalization. In addition, patients were asked how long they had to stay in the hospital and in which type of healthcare institution they had been.

Subjective Health Status

Health status was measured using a single self-assessment item from Bührle et al. (2005): "How would you describe your current health status?" Response options concerning actual subjective health status ranged from 1 "very good" to 6 "very bad".

Demographic Data

Demographic data concerning gender, age, religious denomination, and marital status were collected in the last section of the questionnaire. Marital status was coded as 1 = currently married and all others = 0.

Statistical Analyses

Statistical Package for the Social Sciences (SPSS) version 14 was used to analyze the data. Principal component factor analysis was conducted as described earlier. Ordinary least squares multiple regression was used to test the hypotheses about the relationship between the independent and dependent variables. The regression models for each dependent variable included gender, age, marital status, religious affiliation, general religiosity, admission to hospital (1 = unexpected admission, 0 = expected admission), length of stay, and subjective health status. To examine the assumption of autocorrelation in the residuals, Durbin–Watson tests were conducted. Values between 1.98 and 2.09 indicated no violation of the assumption.

The difference between patients' expectations of and their experiences with chaplains was calculated as described earlier. Pearson's correlation coefficient (two tailed) was performed to test the influence of this difference on general patient satisfaction, the importance of the chaplain's visit, and confidence in the chaplain.

Missing Data

Missing data were treated with expectation-maximization (EM) imputation technique. EM technique produces less biased parameters than other imputation techniques when data are missing at random (MAR) or systematic (Acock 1997; Fox-Wasylyshyn and El-Masri 2005).

Results

Descriptive Results

Table 3 shows the results for expectations of chaplaincy as well as subjective health status and general religiosity. Most important was emotional support, followed by help to cope

Table 3 Descriptive results of expectations for healthcare chaplaincy, subjective health status, and general religiosity

Scale	<i>N</i>	<i>M</i>	<i>SD</i>	Range
Expectations related to coping with illness/disease	612	2.73	0.77	1–4
Expectations related to religion/spirituality	612	2.36	1.01	1–4
Expectations related to emotional support	612	3.65	0.50	1–4
Subjective health status	612	2.98	1.11	1–6
General religiosity	612	2.94	0.86	1–4

N = number of respondents; *M* = mean; *SD* = standard deviation

with the illness or disease. Religious or spiritual needs were lowest. On average, participants are highly religious and reported that their health status is “satisfactory”.

Factors Influencing Expectations

Table 4 shows the results of the regression analyses on expectations related to emotional support, coping with illness, and religion/spirituality. Patients’ religiosity was positively associated with all three expectation variables. Religious/spiritual needs were also influenced by patients’ denomination, with Catholic patients reporting significantly more religious/spiritual needs and Protestants reporting significantly less religious/spiritual needs than the other patients.

Women rated emotional needs as more important than men did. Finally, patients reporting lower health scores perceived more religious/spiritual issues and interventions by the chaplain than healthier patients.

Difference Between Patients’ Expectations and Experience on General Patient Satisfaction, the Importance of the Chaplain’s Visit and Confidence in the Chaplain

Differences between patients’ expectations of and their experience with chaplains showed significant associations with all three outcome variables: general patient satisfaction with the chaplain’s visit was $r = -0.16^{**}$, the association with importance of the chaplain’s visit was $r = -0.19^{**}$ and with confidence in the chaplain $r = -0.12^{**}$. The analyses correlations indicate that the better the patients’ needs were fulfilled, the higher the patients’ satisfaction, the importance of the chaplain’s visit, and the confidence in the chaplain were. However, the observed associations only explain a small amounts of variance of all three measures ($R^2 = .01$ to $.04$).

Table 4 Summary of multiple linear regression analyses for variables predicting expectations for health-care chaplaincy

Variable	Expectations related to coping with illness/disease			Expectations related to religion/spirituality			Expectations related to emotional support		
	B	SE B	β	B	SE B	β	B	SE B	β
Constant	2.16	.19		.43	.21		3.40	.12	
Gender (1 = male, 0 = female)	.01	.07	.01	-.07	.07	-.03	-.13	.04	-.13**
Age	.00	.00	.02	.00	.00	.06	.00	.00	-.05
Marital status (1 = married, 0 = others)	-.04	.07	-.02	-.08	.07	-.04	-.01	.04	-.01
Catholic patients (vs. others)	.19	.11	.12	.24	.12	.12*	-.09	.07	-.08
Protestant patients (vs. others)	.09	.11	.06	-.24	.12	-.12*	-.03	.07	-.03
Patients’ religiosity	.13	.04	.14**	.53	.04	.45**	.14	.03	.25**
Hospital admission	-.11	.06	-.07	-.13	.07	-.06	.03	.04	.03
Length of stay	.00	.00	.06	.00	.00	.06	.00	.00	.05
Health status	.01	.03	.02	.07	.03	.08*	.00	.02	.01
R^2 (adjusted)	.03			.31			.06		

* $p < .05$, ** $p < .01$; β = standardized coefficient; R^2 = explained variance

Discussion

The patients' expectations can be categorized as need for emotional support, religious/spiritual needs and need for help to cope with illness or disease. The present study showed that patients primarily want a chaplain to listen to them, strengthen their hope, comfort them, and treat them with dignity and respect. The second highest rated needs were related to coping with their health situation, a difficult decision and the question, "Why me?" Traditional religious interventions like prayers, blessings, or sacraments were mentioned least. The results are similar to the findings of Wright (2001). The author reported in his survey of chaplains that patients expressed other than religious needs related to ministry:

The data suggest that patients have a wide range of non-religious requirements, these include wanting someone to listen to them and someone to 'be there' for them. Patients frequently wish to address non-religious issues—concern for a relative, suffering, and death and dying. (p. 240)

The findings of a study by Lublewski-Zienau et al. (2003) are also consistent with the present results. Over 80% of the 362 interviewed patients in that study wanted the chaplain to listen to them, and 71% wanted the chaplain to comfort them or help them cope with problems.

Patients in the present study who were more religious or spiritual were more likely to report a need for chaplaincy services. These results correspond with a number of studies demonstrating that religious and spiritual resources are recruited to provide a framework for finding meaning and comfort when individuals confront adverse experiences. Furthermore, highly religious people use their religious beliefs more than less religious people to cope with critical life events (McIntosh et al. 1993; Pargament et al. 2001; Park 2005).

Protestants in the present study reported significantly lower levels of religious/spiritual expectations than other patients, whereas Catholics reported significantly higher levels of religious/spiritual needs than other patients. This effect can be explained by the differing religious traditions of the two official Churches in the German-speaking part of Europe. The Catholic Church, on one hand, has a great legacy of religious rituals and rites, meditation forms and blessings. The Protestant Churches, on the other, have been critical of rites and rituals for a long time (Wohlleben 2004). Similar findings with reference to gender and religious denomination were reported by Piderman et al. (2008). In that study, which investigated the expectations of 535 patients about hospital chaplaincy, Catholic patients significantly, and more likely, want a chaplain to administer religious ritual or sacrament than did Lutheran or other patients.

Furthermore, the patients who had more serious illnesses expressed more religious/spiritual needs than other patients. These findings are consistent with other research indicating that religion and spirituality tend to become more important for individuals facing threatening and deleterious situations, and religious coping is more common among people confronted with stressful life events, including illness (Pargament et al. 1998; Bjorck and Thurman 2007). This may help to explain why, in the present study, clinical condition showed a significant influence. The similar result was also found by Piderman et al. (2008). Patients who were hospitalized for a week or more expressed a significantly greater need for "pray and read scripture" than those who were hospitalized for 4–6 days.

Finally, the present study supports the model of Duffy and Munro (2005). The more the patients' expectations are fulfilled by the chaplain, the more patients are satisfied with the chaplain's visit; the more they evaluate the visit as important, the more they feel confident in the chaplain. Therefore, it is important that chaplains identify patients' expectations

effectively and conscientiously in order to react and intervene appropriately. If this is achieved, patients will experience chaplaincy service as helpful and important.

The present study was a cross-sectional investigation in the German part of Switzerland. All patients were surveyed after hospital discharge. Therefore, an important part of chaplaincy service, work with dying or comatose patients and their needs, was not assessed. Furthermore, most participants in this study are Christians. Therefore, future research on expectations should include patients from non-Christian religious traditions as well as screen the needs and wants of families of dying people. Additionally, a weakness of the present study is the low response rate. Results should be interpreted with this limitation in mind. The study, finally, took place in Switzerland. It would be interesting to do the same study in other European or overseas countries in order to compare the results.

Despite these limitations, the present study contributes to an optimization of chaplaincy service. This might increase the effectiveness of pastoral work in terms of the well-being of patients, their families, and hospital staff.

Acknowledgments The authors gratefully acknowledge the financial support of the Catholic and the Protestant Chaplaincy Associations of the German part of Switzerland.

References

- Acock, A. (1997). Working with missing data. *Family Science Review*, *1*, 76–102.
- Beck, U. (1992). *Risk society. Towards a new modernity*. London: Sage.
- Bjorck, J. P., & Thurman, J. W. (2007). Negative life events, patterns of positive and negative religious coping, and psychological functioning. *Journal for the Scientific Study of Religion*, *46*(2), 159–167.
- Bührlen, B., Gerdes, N., & Jäckel, W. H. P. (2005). Entwicklung und psychometrische Testung eines Patientenfragebogens für die medizinische Rehabilitation (IRES-3). *Rehabilitation*, *44*, 63–74.
- Duffy, J., & Munro, G. (2005). Measuring the effectiveness of chaplaincy: What to audit. *Scottish Journal of Healthcare Chaplaincy*, *8*(2), 9–13.
- Fitchett, G. (2002). Health care chaplaincy as a research-informed profession: How we get there. *Journal of Health Care Chaplaincy*, *12*, 67–72.
- Fitchett, G., Meyer, P. M., & Burton, L. A. (2000). Spiritual care in the hospital: Who requests it? Who needs it? *Journal of Pastoral Care*, *54*(2), 173–186.
- Flannelly, K. J., Galek, K., Tannenbaum, H. P., & Handzo, G. F. (2007). A preliminary proposal for a scale to measure the effectiveness of pastoral care with family members of hospitalized patients. *The Journal of Pastoral Care & Counseling*, *61*(1–2), 19–29.
- Fox-Wasylyshyn, S. M., & El-Masri, M. M. (2005). Handling missing data in self-report measures. *Research in Nursing and Health*, *28*, 488–495.
- Frick, E., Riedner, C., Fegg, M. J., Hauf, S., & Borasio, G. D. (2005). A clinical interview assessing patients' spiritual needs and preferences. *European Journal of Cancer Care*, *15*, 238–243.
- Galek, K., Flannelly, K. J., Vane, A., & Galek, R. M. (2005). Assessing a patient's spiritual needs: A comprehensive instrument. *Holistic Nursing Practice*, *19*(2), 62–69.
- Giaimo, S. (2002). *Markets and medicine: The politics of health care reform in Britain, Germany and the United States*. Ann Arbor: The University of Michigan Press.
- Gray, A. M. (2007). European health care costs. *Social Policy and Administration*, *18*(3), 213–228.
- Harrison, M. (2004). *Implementing change in health systems. Market reforms in the United Kingdom, Sweden and the Netherlands*. London: Sage.
- Lublewski-Zienau, A., Kittel, J., & Karoff, M. (2003). Was erwarten Patientinnen und Patienten von der Klinikseelsorge?—Eine Studie in der kardiologischen Rehabilitation. *Wege zum Menschen*, *55*(7), 463–478.
- Lublewski-Zienau, A., Kittel, J., & Karoff, M. (2005). Religiosität, Klinikseelsorge und Krankheitsbewältigung. *Wege zum Menschen*, *57*(4), 283–295.
- McIntosh, D. N., Silver, R. C., & Wortman, C. B. (1993). Religion's role in adjustment to negative life event: Coping with the loss of a child. *Journal of Personality and Social Psychology*, *65*, 812–821.
- Mitchell, D., & Sneddon, M. (1999). Spiritual care: Informing the debate: Chaplaincy and spiritual care in Scotland. *International Journal of Palliative Nursing*, *5*(6), 275–280.

- Mowat, H., & Swinton, H. (2007). *What do chaplains do?. The role of the chaplain in meeting the spiritual needs of patients. Report No. CSHD/MR001*. Aberdeen: Mowat Research Limited.
- Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37(4), 710–724.
- Pargament, K. I., Tarakeshwar, N., Ellison, C. G., & Wulff, K. M. (2001). Religious coping among the religious: The relationships between religious coping and well-being in a national sample of Presbyterian clergy, elders, and members. *Journal for the Scientific Study of Religion*, 40, 497–513.
- Park, C. L. (2005). Religion as a meaning-making framework in coping with life stress. *Journal of Social Issues*, 61, 707–724.
- Piderman, K. M., Marek, D. V., Jenkins, S. M., Johnson, M. E., Buryska, J. F., & Mueller, P. S. (2008). Patients' expectations of hospital chaplains. *Mayo Clinical Proceedings*, 83(1), 58–65.
- Pollack, D. (1996). Zur religiös-kirchlichen Lage in Deutschland nach der Wiedervereinigung. Eine religionssoziologische analyse. *Zeitschrift für Theologie und Kirche*, 93, 586–615.
- Swiss Federal Statistical Office. (2003). Schweizer Religionslandschaft im Umbruch. Eidgenössische Volkszählung 2000. Retrieved from http://www.bfs.admin.ch/bfs/portal/de/index/infothek/lexikon/bienvenue___login/blank/zugang_lexikon.topic.1.html.
- Wohlleben, E. (2004). *Die Kirchen und die Religionen. Perspektiven einer ökumenischen Religionstheologie*. Göttingen: Vandenhoeck & Ruprecht.
- Wright, M. C. (2001). Chaplaincy in hospice and hospital: Findings from England and Wales. *Palliative Medicine*, 15, 229–242.