
Topography of Referrals to Chaplains in the Metropolitan Chaplaincy Study

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Understanding referral patterns to chaplains is essential not only to ensure proper patient treatment, but also to assist chaplains seeking to expand the range of patient situations in which they are called to intervene. Information about more than 58,000 chaplain visits was documented during the first two years (2005-2006) of the Metropolitan Chaplaincy Study. Data from 15,655 of these visits, which were made in response to referrals (26.9% of all visits), were analyzed in the present study. Seventy-eight percent of referral requests were met within the same day, and 94.9% of requests and were met within 2 days. Nurses were the most frequent source of referrals to chaplains (45.0%), followed by self-referrals from patients or requests from their family members (30.3%), with the remainder coming from a variety of hospital disciplines. The most common reason for referrals was that patients requested to see a chaplain. Other relatively common reasons for referrals were problems or issues related to illness or treatment, and end-of-life issues, concerns about death and the death of patients, with reasons for referrals differing by referral source. The most common reason for referrals among professional staff was that patients were feeling bad or in pain, followed by medical issues, and end-of-life issues. Patient and family referrals usually involved positive patient affect, whereas staff referrals usually involved negative patient affect.

By any measure, significant changes have beset healthcare settings over the past two decades. More and more hospital departments have been pushed to reduce costs, improve the quality of services, locate new opportunities for growth, and increase productivity. Within this climate, many have emphasized that pastoral care resources need to be deployed efficiently (e.g., Fitchett, 2000), especially since institutional financial cut-backs have often led to lower chaplain-patient ratios. Handzo (2006) discusses the importance of protocol-based referral systems, in which chaplains are automatically involved in situations such as codes, organ donation, deaths, changes in prognosis, advanced directives, and disasters. Handzo further emphasizes the need for protocols assessing and diagnosing spiritual distress that would trigger referrals to chaplaincy services. Undergirding these referral systems is the capacity of hospital staff to conduct spiritual screening to discern when a referral is appropriate.

Although it is widely recognized that chaplains must rely on professionals in other disciplines to make them aware of the spiritual and religious concerns of patients (Handzo and Koenig, 2004), a recent study by Galek et al. (2007) found that chaplains view their capacities differently than do other members of the health care team. Specifically, while chaplains believe that they can contribute positively to the care of patients experiencing physical pain or struggling with a medical treatment issue, other disciplines do not make a chaplain referral under these circumstances. Additionally, the Galek et al. (2007) study revealed that while chaplains believe they are able to help patients process issues related to anger, anxiety, and depression, those in other medical fields do not seem to share that belief. In general, this and related studies have found that nurses tend to see the role of chaplains more like chaplains themselves do, whereas social workers and physicians see a more limited role for chaplains (Flannelly, Galek et al., 2005; Flannelly, Handzo et al., 2006).

Understanding referral patterns becomes essential not only to ensure proper patient treatment, but to assist chaplains seeking to expand the range of patient situations in which they are called to intervene. Galek et al. (2007) found that hospital staff members in medicine, social work and nursing are most likely to make a chaplain referral for religious and end-of-life issues. However, a variety of studies (e.g., Simsen, 1986) have demonstrated that while a minority of patients may have explicit religious concerns and needs, a majority have existential concerns of a wider nature (Mako et al., 2006). Walter (1997) argues that if only those who are religious are referred to a chaplain, this undermines the goal of holistic care. Many have argued that all individuals have a spiritual dimension that entails a search for meaning and that working with a chaplain can be beneficial, especially in the face of physical ailments and medical problems.

Finally, within the current climate of budgetary constraints, knowledge of the referral topography becomes essential for chaplains seeking both to maintain and grow their departments. As chaplains interact with hospital administrators, they need to provide evidence of the need for pastoral care. Since access to patients is so intricately tied to receiving referrals from those in other disciplines, if other hospital members do not understand the nature of chaplaincy, they of course will not provide referrals. Many patients who could benefit from pastoral care will not receive it.

Given the interdependence among hospital funding, chaplains' perceptions and patient care, the reasons and circumstances under which staff members refer to chaplains

demand attention. With this aim in mind, the current study evaluates the landscape of referral patterns within eleven metropolitan New York City hospitals.

Methods

Information about chaplain visits to patients, families and other individuals in response to referrals was collected as part of the on-going Metropolitan Chaplaincy Study. Eleven healthcare institutions in the New York City area participated in the study during 2005-2006. The data were collected by 29 professional chaplains and 60 students enrolled in Clinical Pastoral Education (CPE) through The HealthCare Chaplaincy. Hereafter, the term chaplain is used in reference to professional chaplains and CPE students unless otherwise specified. All data were collected using a proprietary electronic system (called "Chaplaincy Counts"), which was developed by The HealthCare Chaplaincy.

Data were collected on a total of 58,125 chaplain visits during the first two years of the study, of which 15,655 (26.9%) were made in response to a referral from staff or other individuals, including self-referrals from patients. The present study analyzes the data from these 15,655 referrals.

Three major categories of information were recorded about each visit: (a) who was visited by the chaplain; (b) the source of the referral; and (c) the reason for the referral. Sources of referral were classified into 15 categories, which are listed in Table 1. Reasons for making a referral were coded into 26 categories, including "Other" and "None Given," (see Table 2). It is important to note that these categories represent the reason for the referral as defined by those making the referral. The categories do not necessarily represent reasons that would be considered appropriate by the chaplains themselves.

The study participants (i.e., chaplains and students) recorded the primary affect of clients during roughly a third of their visits. Affect was classified into one of the following 15 categories: (1) anger, (2) anxiety, (3) detachment, (4) determination, (5) discouragement, (6) fear, (7) gratitude, (8) grief/sadness, (9) guilt/shame, (10) happiness/joy, (11) hopefulness, (12) hopelessness, (13) loneliness, (14) pain, and (15) relief. These 15 categories were grouped into two broader categories by the authors: "positive" and "negative" (see Table 5).

Results

As noted in the Methods section, 26.9% of all chaplain visits were the result of referrals. It is worth noting, however, that the percentage of referrals varied by hospital and professional status (i.e., CPE student or professional chaplain). The percentage of referrals to professional chaplains was 31.7% compared to 19.6% for students, and the overall rate of referrals ranged from 11.1% to 56.3% across the eleven hospitals in the study. Seventy-eight percent of referral requests were met within the same day, and 94.9% of requests were met within 2 days.

As seen in Table 1, nursing staff were the most common source of referrals to chaplains (45.0%), with the vast majority of these coming from registered nurses. The next largest source of referrals to chaplains was self-referrals from patients or requests from their family members (30.3%). The remaining 24.7% of referrals mainly came from a variety of hospital disciplines, with physicians, social workers and care coordinators accounting for 8.3% of all referrals.

There was a wide variety of reasons for making referrals to chaplains, as shown in Table 2. The 25 reasons were classified into five categories for easier interpretation. The most common reason for referrals was that the patient requested to see a chaplain. Smaller numbers of patients explicitly requested prayer or rituals. Although other religious needs or requests constituted the second most frequent reason these were either not specified by the patient or not specified by the person making the referrals. A small number of referrals were made for family and friends who needed pastoral care.

The next most common reasons for referrals were for problems related to illness or treatment (12.5%), and end-of-life issues, concerns about death and the death of patients (10.4%). Non-compliance is included in this category because it is a concern for staff members. Taken together, somewhat less than a quarter of all referrals were made for these three types of issues.

Almost another quarter of referrals to chaplains were based on the patient's emotion or pain. The emotional reasons included general distress, anxiety/agitation, depression and loneliness. Keep in mind that the emotional reasons given for a referral are not the same as the chaplain's assessment of the patient's affect, which we will discuss later.

Sixteen percent of referrals were made to chaplains according to the patient's situation or circumstances. Pre-op had the highest frequency within this category, followed by change in prognosis, decision-making, pregnancy loss, and the like. Advocacy had the highest frequency within the category labeled "Other Purposes" in the table.

Referral reasons differed significantly depending on whether the referral was originated by clients and their families or staff and other sources. Table 3 illustrates this difference, eliminating the category "Patient Requested a Chaplain," and collapsing the remaining 22 reasons into different categories.

Not surprisingly, perhaps, the most common reason that patients and family members wanted to see a chaplain was to meet religious needs, including prayer and religious rituals. The next most frequently given reasons for patient/family referrals were medical issues or concerns, including pre-op, change in prognosis, non-compliance, and illness/treatment issues from Table 2. Pain might properly be considered a medical issue, but we decided to keep it in the category of "feelings." In either case, pain accounts for less than half of one percentage point in either category (medical or feelings). Death and end-of-life issues were the fourth most frequent category of patient/family initiated referrals. This category encompasses the category of death and end of life issues from Table 2 as well as pregnancy loss and code. Other loss was put in the feelings category, along with distress, anxiety/agitation, depression, general distress, loneliness and pain.

Ethical consultation, advance directives, organ donation, and decision-making are all subsumed under the category "decisions." The reasons "discharge issues" and "advocacy" from Table 2 were placed in the "other" category in Table 3.

In contrast to patient/family initiated referrals, the most frequent reasons for referrals initiated by staff and other sources were almost evenly split between medically related problems and issues (26.9%) and feelings (25.1%). The next most frequent reasons were evenly split between religious needs (17.6%) and death and end-of-life issues (17.2%).

Table 4 shows the percentage distribution of reasons for referrals given by different types of staff. The most common reason for referrals among all four staff categories listed in Table 4 was that patients were feeling bad or in pain. The second most common

reason for making a chaplain referral was medical in nature, although physicians were less likely to make such referrals. Death and end-of-life issues was the third most frequent category of referral. These kinds of referrals were made most often by physicians and least often by nurses.

Nurses were somewhat more likely than physicians, social workers or other staff to refer patients to chaplains for religious reasons. As might be expected due to their increased involvement with patients' families and social networks, social workers were somewhat more likely to refer family members and friends to chaplains than other staff members.

Table 5 gives the percentage distribution of chaplains' assessments of the primary affect of patients, family members and friends who were referred to them. The results are broken down by positive and negative affect and the source of the referral. Referrals from clergy are not included in the table because of their relatively low frequency (n = 31).

By far, the most commonly observed emotion when patients, family members and volunteers made referrals to a chaplain was gratitude. Interestingly, this was also true for referrals from CPE students. By contrast, the predominant observed emotions in cases of staff referrals, apart from chaplains, were grief, sadness and anxiety. The positive and negative affect observed in patients referred by other chaplains was intermediate to those referred by other sources, and gratitude was observed in less than 11% of patients referred by other chaplains.

Discussion

The findings illustrate that chaplains receive referrals from a wide range of staff and other individuals, such as family members and patients themselves (see Table 1). Indeed, the second most common source of referrals was patients and families. Nursing staff was the most common source of referrals to chaplains, constituting close to half of all referrals. It is assumed that some number of these referrals were actually from patients, family members or doctors, but were recorded as being from nurses because the nurses actually called them in. Referrals from nearly a dozen other specific categories of clinical and administrative staff were recorded.

The findings further illustrate that referrals are made to chaplains for a wide variety of reasons (see Table 2). Some referrals reflected patient requests for specific religious interventions (e.g., prayer or rituals), or simply for a visit from the chaplain. Other referrals were based on patients' medical situation (e.g., pre-op, change in prognosis, discharge, etc.), or their feelings and concerns. Fogg, Weaver, Flannelly and Handzo (2004) reported a similar range and mix of reasons for referrals to chaplains in a seven-year study at a community hospital outside New York City.

Some of these results can be directly compared to those from a study conducted at many of the same hospitals in 1994-1996 (Vanderwerker et al., in press). The results of that study are similar in several respects. As in the current study, the most common referral sources were, in order, nurses, patients, families and other chaplains. Physicians and social workers in that study comprised 7.1% of all referrals, which is reasonably close to the 5.6% observed in the present study. The present study was more meticulous in documenting referrals from other kinds of staff. Flannelly, Weaver and Handzo (2003, 2004) reported somewhat lower rates of referrals to chaplains from nurses, physicians and social workers over a three-year period at a large New York City hospital. Fogg et

al. (2004), on the other hand, reported substantially higher rates of referrals to chaplains from nurses and social workers. The distinction may be due to the fact that Fogg et al. (2004) was reporting on a one-person pastoral care department where the staff were referring to one chaplain with whom they had a close, long-term relationship. Both the Flannelly and the Fogg studies found that the rate of referrals by nurses increased significantly over the study period, and Fogg found significant increases by all hospital staff, except physicians.

A major methodological difference between the two studies was that patient's medical situation formed a category that was independent of, and separate from, reasons for referrals in the Vanderwerker et al. study. So, a patient might be in pre-op, but the reason for referral might be anxiety or agitation. Another patient might be in post-op, but the reason for referral might be pain or depression. In the present study, however, medical situations were included in a list of mutually exclusive reasons for referrals that also included patient feelings among the reasons. Thus, a person making a referral in the present study might give the patient's medical situation as the reason for the referral when the patient was feeling anxious or depressed. This would tend to increase the percentage of referrals based on patients' medical situations and decrease the percentage of referrals based on patients' feelings. This may partially explain why the percentages of referrals based on patients' medical situations were somewhat higher and the percentages of referrals based on patients' feelings were lower in the present study compared to the Vanderwerker et al. study.

Our findings should be considered in light of national surveys that have explored the attitudes of chaplains and other healthcare professions about the role of hospital chaplains. As noted above, all staff uniformly made referrals to chaplains to deal with patients' feelings. This finding is consistent with survey research reporting that medical, nursing, social work and other hospital administrators, as well as hospital executives, and chaplains themselves see emotional support to patients and families as one of the most important roles chaplains perform in hospital settings (Flannelly, Weaver, Handzo & Smith, 2005; Flannelly, Galek, Bucchino, et al., 2005; Flannelly, Galek, Handzo, et al., 2006). These surveys have found that the chaplain's role in dealing with death and end-of-life issues are regarded as even more important by physicians, social workers, and nurses, although nurses made proportionately fewer referrals for these reasons in the present study. This proportionality is likely accounted for by the fact that death is a relatively infrequent occurrence in virtually all hospitals.

On the other hand, Galek et al. (2007) found that physicians and social workers were less likely to make referrals to chaplains for treatment issues, which is consistent with the current findings. In a similar vein, other surveys have found that physicians and social workers tend to see consultation as a less important role for chaplains (Flannelly, Galek et al., 2005; Flannelly, Handzo et al., 2006), which is probably reflected in low rate of referrals for decisions in the present study.

With the exception of nurses, most staff made relatively few referrals for patients' religious needs, which is also consistent with staff attitudes expressed in national surveys. Although most of the healthcare professionals we have surveyed consider it very important for chaplains to pray with patients, they rate other forms of religious interventions, such as religious rituals and services to be much less important. Chaplains themselves tend to share these opinions about the rituals and services. Indeed, in one

survey, pastoral care directors across the nation ranked religious services last and religious rituals next to last in terms of the importance they accorded to a list of 11 chaplain activities (Flannelly, Weaver, Handzo & Smith, 2005). By comparison, praying with patients and family members was ranked second by chaplains.

Chaplains' attitudes about these matters seem to differ somewhat from the desires of patients and family members, as represented by their reasons for referrals. The referral records, however, did not fully document the nature of religious requests made by patients and families. Many patients and family members may not understand the full range of spiritual and emotional services that a professional chaplain is trained to provide. In any case, CPE students should be prepared to meet the religious needs of patients as well as they are prepared to meet their emotional and spiritual needs.

On the other hand, the disparity between chaplains and patients/families in terms of the care they expect to give and receive, respectively, may not be as great it seems. Handzo (2006), Fitchett et al. (2000), and other chaplains have argued the point that it is critical to differentiate between patients' desires or wishes and their actual needs. They have recommended that religious requests by those not in distress should be handled by specially trained volunteers or other clergy who can serve the denominational needs of patients and families (Fitchett et al., 2000; Handzo, 1998, 2006). Handzo and his colleagues (Handzo, 2006; Handzo & Wintz, 2006) go a step further in recommending that specific protocols be established that determine what type of incidents or events should trigger referrals to chaplains, such as deaths, codes, and radical changes in prognosis. The affect of patients referred by students was more in keeping with that observed in patients who self-referred or were referred by families or volunteers, implying that students based their referrals on the patient's desire more than the patient's need. The affect observed for patients referred by professional chaplains, on the other hand, was more often negative than positive, implying that professional chaplains, like other staff, were more likely to base their referrals on their perception of the patient's need. This distinction between CPE students and professional chaplains merits further investigation.

A national survey by Galek et al. (2007) provides information about the types of patient issues, if not the specific events, which different healthcare professionals believe should trigger referrals to chaplains. Four broad categories of issues were derived from 14 specific issues: (a) meaning, loss, and death; (b) treatment issues; (c) pain and depression; and (d) anxiety and anger. Generally consistent with the present findings (see Table 4), nurses, social workers, physicians in that study said it was important to refer chaplains to patients having issues around meaning, loss, and death. On the other hand, though referrals for anxiety and anger are relatively common in this and other studies of referrals, the healthcare professionals surveyed by Galek et al. indicated that referring patients for these feelings was much less important. The importance of referring patients to chaplains for pain and depression or treatment issues was seen as falling between these two extremes (i.e., meaning, loss and death versus anxiety and anger). Such attitudes among physicians and social workers in the present study might be reflected more by their low rate of referrals than by the proportion of referrals they made for different reasons.

Limitations

A major limitation of our findings is that so many referrals fell into the category “Patient Requested a Chaplain,” which did not require the referral source to specifically state why the patient wanted to see a chaplain. Similarly, referrals for emotional reasons did not provide information about why the patient was emotional. What, for instance, were patients angry about when they were referred for anger? A related problem is that the present study did not collect data on the patient’s particular circumstances (e.g., treatment, pre-op, post-op, discharge) as a separate category. These were included, instead, in the category of reasons for referral. Thus, we cannot examine to what degree, if any, different emotions are associated with different circumstances. It also undermines the consistency with which the reason categories are applied, since patients who are in pre-op, for example, might be referred for their affect, treatment issues, or for simply being in pre-op.

Conclusions and Suggestions for Future Research

The importance of understanding the chaplain referral process cannot be underestimated. Chaplains provide a vital instrumental service within the healthcare system that is now beginning to be documented. The deleterious effects of spiritual struggle in the context of illness have been demonstrated (Pargament et al., 2001; 2004), as has been the connection between spiritual struggle and an array of mental health symptoms (McConnell et al., 2006). The invaluable service provided by chaplains can not only ease the emotional and spiritual distress of patients, but can have ripple effects throughout the staff, lowering the burden of staff members to address specific patient needs.

The present results highlight a potential problem in the provision of chaplaincy services. While patients overtly experiencing distress receive chaplaincy services, as do those who expressly request a chaplain referral, the question remains as to whether the spiritual needs are being met among those who neither manifest overt symptoms nor self-refer to the chaplaincy department. The findings of Fitchett et al. (2000) indicate that patients in spiritual distress are less likely to request spiritual care than those who are coping well. These findings emphasize the importance of fine-tuning the assessment process to ensure detection of subtle spiritual issues that need to be addressed.

These findings also raise some interesting questions about how pastoral care staffing is configured in a given facility. The large number of referrals from nursing and others to cover referrals for emotional/spiritual distress and other areas of demonstrated need would argue for professional board certified chaplains designated to respond preferentially to these patients. Efficiency and financial prudence would argue for another staffing level to account for all the requests based on patient desire and issues such as gratitude and hopefulness. This staffing could be volunteer community clergy or CPE students. It is also clear from these results how important it is to understand the demography of referrals so that appropriate levels of staffing can be provided.

As with all studies, the current study raises significant ideas and concerns for future research. Future research is certainly needed to address the limitations of the present study mentioned above, such as what patients actually need or desire when they request a chaplain visit, and what do referrals for each emotion truly signify? In general, more research is needed on the emotional concerns and needs of patients and the relationship between these needs and their spiritual needs and issues. We particularly need to know

what emotional, spiritual and religious issues generate referrals in different medical situations. This research will help differentiate those patients who should be referred to pastoral care and those who should be referred to other mental health providers.

Other questions that should be pursued are why patients and families do not refer to chaplains for emotional needs, and why there is such an apparent split in the primary affect of those patients who self-refer or are referred by families or volunteers, versus professional staff. It would also be valuable to understand why CPE students fall in line with the former group in this context. Finally, we need to know what staff expects when they make referrals to chaplains for various reasons. For example, what services are physicians expecting when they refer to chaplains for end-of-life needs? What do they expect when they make that relatively rare referral of a patient for medical issues? A better understanding of these expectations will facilitate communication between chaplains and other staff members and lead to more efficient and effective referral systems.

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TABLES FOLLOW BELOW

Table 1. Sources of Referrals to Chaplains

Source of Referral	Number	Percent
Nursing Staff	7,039	45.0
Patient Self-Referral or Family Member	4,748	30.3
Other Chaplains	947	6.0
Physicians	490	3.1
Care Coordinators	420	2.7
Social Worker	393	2.5
Volunteers	305	2.0
Unit Secretaries	237	1.5
Administrators	193	1.2
Community Clergy	95	0.6
Client Relations	63	0.4
Physician Assistants	61	0.4
Rehabilitation Therapists	48	0.3
Quality Managers	9	0.1
Other	607	3.9
Total	15,655	100.0

Table 2. Reasons for Referrals to Chaplains

Reason for Referral	Number	Percent
<i>Requests and Needs</i>		
Patient Requested a Chaplain	1,996	15.6
Prayer	322	2.5
Religious Ritual	332	2.6
Other Religious Need or Request	1,714	13.4
Family and Friends	372	2.9
<i>Issues</i>		
Illness/Treatment Issues	1,598	12.5
Death and End of Life Issues	1,336	10.5
Non-Compliance	29	0.2
<i>Feelings</i>		
Anxiety/Agitation	887	7.0
Distress	701	5.5
Depression	570	4.5
Loneliness	195	1.2
Pain	61	0.5
<i>Situations</i>		
Pre Op	752	5.9
Change of Prognosis	458	3.6
Decision-Making	263	2.1
Pregnancy Loss	191	1.5
Other Loss	124	1.0
Discharge	122	1.0
Code	96	0.8
Organ Donation	18	0.1
<i>Other Purposes</i>		
Advocacy	163	1.3
Advance Directives	68	0.5
Ethics Consult	20	0.2
Other	399	3.1

Excludes "None Given" (n = 2,868)

Table 3. Reasons for Referral Given by Patients/Families and Other Sources (%)

Reason	Referral Source	
	Patients and Families (n=2,055)	Staff and Other Sources (n = 8,736)
Religious Needs	40.5	17.6
Medical Issues	23.8	26.9
Feelings	16.9	25.1
Death and End of Life	5.9	17.2
Family/Friends Care	2.8	3.6
Decisions	2.7	3.6
Other	7.4	6.1

Excludes “Patient Requested a Chaplain” (n = 1,996) and “None Given” (n = 2,868)

Table 4. Reasons for Referrals by Hospital Staff (%)

Reason	Hospital Staff Referral Sources			
	Nurses (n = 5,502)	Physicians (n = 465)	Social Workers (n = 367)	Other Staff (n = 925)
Feelings	27.3	23.9	22.1	22.4
Medical Issues	15.7	6.5	7.1	5.1
Death and End of Life	17.4	33.6	21.6	25.4
Religious Needs	17.9	11.0	11.2	12.8
Decisions	3.2	7.8	7.7	3.9
Family/Friends Care	3.3	5.2	7.1	3.8
Other	22.6	13.7	24.9	29.4

Excludes “Patient Requested a Chaplain” (n = 1,996) and “None Given” (n = 2,868)

Table 5. Chaplains' Assessments of the Primary Affect of Patients, Family and Friends Referred to Them by Various Sources (%)

Patients & Family Primary Affect	Volunteers & Other (n = 1,156)	CPE Students (n = 404)	Professional Chaplains (n = 172)	Nurses (n = 174)	Physicians (n = 2,186)	Social Workers (n = 203)	Other Staff (n = 220)	(n = 435)
Positive Affect	67.6	64.1	69.4	47.5	29.5	21.7	33.2	27.4
Gratitude	53.1	50.2	56.5	10.9	9.7	6.9	4.6	8.0
Hopefulness	8.5	8.2	7.1	18.3	10.5	5.4	15.0	10.3
Determination	3.6	4.7	3.3	12.9	6.8	6.9	10.9	8.0
Happiness/Joy	1.6	1.0	1.9	3.4	1.8	0.5	1.4	1.0
Relief	0.8	0.0	0.6	2.0	0.7	2.0	2.0	0.0
Negative Affect	32.4	35.9	30.6	52.4	70.5	78.3	66.8	72.6
Anxiety	12.1	7.7	6.5	14.3	18.9	13.8	20.5	19.3
Grief/Sadness	7.0	7.4	6.5	10.9	21.8	26.9	16.8	26.9
Discouragement	3.9	6.7	4.6	4.8	8.8	8.4	11.8	6.2
Fear	3.5	4.7	2.6	4.8	5.8	6.9	5.0	7.6
Anger	1.8	2.5	2.6	2.0	3.6	3.9	3.6	3.9
Detachment	1.1	3.2	3.3	2.0	5.1	8.0	3.2	3.3
Pain	1.1	1.0	3.3	7.5	3.2	3.9	1.8	2.5
Guilt/Shame	0.4	1.2	0.6	2.0	0.9	0.5	0.5	1.2
Hopelessness	0.7	0.5	0.6	2.7	1.5	3.0	2.3	0.7
Loneliness	0.7	1.0	0.0	1.4	1.5	1.5	1.4	1.2