

What Do Chaplains Really Do?

III. Referrals in the New York Chaplaincy Study

Lauren C. Vanderwerker, PhD

Kevin J. Flannelly, PhD

Kathleen Galek, PhD

Rev. Stephen R. Harding, STM BCC

Rev. George F. Handzo, MDiv, MA, BCC

Sister Margaret Oettinger, OP, MA, BCC

Rev. John P. Bauman, DMin, BCC

ABSTRACT. The current study examines patterns of referrals to chaplains documented in the 1994–1996 New York Chaplaincy Study. The data were collected at thirteen healthcare institutions in the

Lauren C. Vanderwerker, PhD, Union Theological Seminary, is a Research Associate at The HealthCare Chaplaincy.

Kevin J. Flannelly, PhD, is the Associate Director of Research of The HealthCare Chaplaincy.

Kathleen Galek, PhD, is a Research Associate at The HealthCare Chaplaincy.

Rev. Stephen R. Harding, STM BCC, is the Director of Pastoral Care at New York University Hospitals Center.

Rev. George F. Handzo, MDiv, MA, BCC, is the Vice President, Pastoral Care Leadership & Practice at The HealthCare Chaplaincy.

Sister Margaret Oettinger, OP, MA, BCC, is the Director of Pastoral Care for the Hospital for Special Surgery.

Rev. John P. Bauman, DMin, BCC, is the Director of Pastoral Care at The Winifred Masterson Burke Rehabilitation Hospital.

Address correspondence to Kevin J. Flannelly, 307 E. 60th Street, New York, NY 10022, USA; E-mail: kflannelly@healthcarechaplaincy.org

Journal of Health Care Chaplaincy, Vol. 14(1) 2008

Available online at <http://jhcc.haworthpress.com>

© 2008 by The Haworth Press. All rights reserved.

doi: 10.1080/08854720802053796

Greater New York City area. Of the 38,600 usable records in the sample, 18.4% were referrals, which form the sample for the current study (N = 7,094). The most common sources of referrals were nurses (27.8%) and patients themselves (22.3%), with relatively few referrals coming from physicians and social workers. The study shows the range of patient issues that are referred to chaplains, including emotional, spiritual, medical, relationship/support, and a change in diagnosis or prognosis. Although the reasons for referral varied by hospital setting and referral source, overall, patients were referred more frequently for emotional (30.0%) than for spiritual issues (19.9%). Results are discussed in relation to the need to clarify the role of the chaplain to the rest of the healthcare team, to recognize when there is a spiritual cause of emotional distress, and to establish effective referral protocols.

KEYWORDS. Chaplaincy, pastoral care, referrals, religion, spiritual care

INTRODUCTION

Spiritual needs have been defined in various ways in the medical and nursing literature. Adapting Koenig and colleagues' definition of spirituality, we would define spiritual needs as those related to "... the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent" (Koenig et al., 2001, p. 18). Spiritual needs (which include religious needs) often become more apparent and more urgent with the experience of illness and hospitalization. Patients and their family caregivers have indicated the importance of attending to spiritual needs in the context of serious illness and hospitalization in a number of recent studies (Balboni et al., 2007; Meert et al., 2005; Murray et al., 2004). Yet, these spiritual needs often go unmet by the medical system. For instance, Balboni et al. (2007) reported that 72% of patients with advanced cancer felt that their spiritual needs were not met by the healthcare system.

Healthcare chaplains are uniquely qualified and well positioned to address spiritual needs within the healthcare setting, yet Flannelly et al. (2005) estimate that only 20% of hospitalized patients are visited by a chaplain. There may be a number of possible reasons

for this low rate, including inadequate staffing of pastoral care departments (Ferrell, 2007; Fitchett et al., 2000), lack of understanding of the role of healthcare chaplains (Hamdy, 2006; McClung et al., 2006) and a low value placed on chaplains' services by other members of the healthcare team and hospital administrators (Flannelly et al., 2005; Flannelly et al., 2006; Galek et al., 2007). In spite of the fact that professional chaplaincy has evolved over recent decades to require extensive theological and clinical training, other clinicians may still view chaplains merely "as 'hand holders' or last-minute performers of religious rites" (McClung et al., 2006, p. 149). Misunderstanding or underestimation of the chaplain's competencies can result in delayed or missed opportunities to provide referrals for needed spiritual care to patients and families.

The potential for missed opportunities is particularly relevant in situations where chaplains must rely on referrals from other members of the medical team, or requests from patients themselves, in order to identify individuals who are in need of a pastoral care intervention (Handzo, 2006). Although some hospitals may have a well-staffed, proactive pastoral care department that is able to provide a visit to each newly admitted patient, the reality rarely meets this ideal (Fitchett et al., 2000). Thus, in a time of limited resources, referrals become an important tool for alerting chaplains to patients who are in need and helping them to prioritize their schedule of visits. Although the data examined in the present study are from the late 1990's, referrals are even more important today as a key component of chaplains' practice (Handzo, 2006; Handzo & Koenig, 2004).

The relatively few studies that have examined referral patterns to chaplains have looked at only a few, selected hospitals (Flannelly et al., 2003, Fogg et al., 2004, Koenig et al., 1991). All three of these studies found that referrals to chaplains were far more likely to be made by nurses than other hospital staff, such as social workers or physicians. Two of the studies were observational studies in which data about referrals were recorded by the chaplains themselves as the referrals came in. These studies show that patients are as likely to be referred to chaplains for non-religious issues, especially emotional distress, as they are for religious or spiritual issues.

The purpose of the present study is to expand upon these findings by examining referral data collected in different types of healthcare settings, including the sources of and reasons for referrals, both to

describe these patterns and to determine whether they differ by healthcare setting.

METHODS

The study collected information about chaplain visits to patients, families, and friends in response to referrals. Thirteen healthcare institutions in the New York City area participated in the study during 1994–1996. The 13 institutions included eight general hospitals, two nursing homes, a cancer center, a rehabilitation center, and a hospital that specializes in orthopedic surgery. Data were collected during two-week periods each year, but some institutions had two or more data-collection periods in some years. In all, data were collected on 42,990 chaplain visits. After excluding visits with outpatients, incomplete records, and records used in previously published research (Flannelly et al., 2003; 2004), the database contained about 38,600 records of chaplain visits. Of these, 7,094 visits (18.4%) were made in response to referrals from staff or other individuals, including self-referrals from patients. The present study analyzes the data from these 7,094 referrals.

The information recorded about each visit included, among other things:

- a. who was referred to the chaplain;
- b. the source of the referral;
- c. the reason for the referral;
- d. the patient's medical status; and
- e. the patient's religious affiliation.

The religious affiliations of the patients were Catholic (39.5%), Jewish (28.2%), Protestant (21.1%), and Islamic (3.0%), with the remainder identifying as either 'none' or 'other.'

The individual(s) referred to the chaplain were classified into five general categories - patients, family members, friends, staff, and other. Source of referrals were recorded into 11 categories:

1. patient;
2. family;

3. friends;
4. volunteer;
5. another chaplain;
6. community clergy;
7. nurse;
8. physician;
9. social worker;
10. other staff; and
11. other.

The primary reason for the referral was classified into 14 categories:

1. the patient made a request;
2. the patient died;
3. the patient was being discharged;
4. the patient received a new diagnosis or prognosis;
5. the patient was non-compliant with treatment;
6. a difficult decision had to be made;
7. anxiety or agitation;
8. hostility;
9. grief;
10. pain or depression;
11. spiritual distress;
12. relationship/support issues;
13. other reason; and
14. no reason given.

For most of the analyses, we excluded those referrals for which no reason was given, and we combined certain reasons for referrals into broader categories. Four items (anxiety/agitation, pain/depression, grief, and hostility) were combined to create the category we called ‘emotional issues,’ and two items (spiritual distress and requests for religious items or rituals) were combined to create a category called ‘spiritual issues.’ Difficult decision and non-compliance with treatment were combined to create a category of ‘medical issues.’ Change in a patient’s diagnosis or prognosis was kept as its own separate category because it was considered an important event with potentially distinct spiritual implications for patients. Since referrals for patients being discharged were relatively infrequent and did not

seem to fit within these three new categories, we included it in the category 'other.'

The medical status of patients was broken into twelve categories. These were, that the patient:

1. died;
2. was in the process of dying;
3. was in the end-stage of a disease;
4. was in crisis;
5. received a check-up;
6. received a new diagnosis or prognosis;
7. was being discharged;
8. was going into surgery—pre-op;
9. was post-op;
10. was receiving rehabilitation;
11. was receiving treatment; and
12. other.

The 13 institutions' data were grouped together to form 5 types of healthcare settings for some of the analyses: nursing home, rehabilitation center, general hospital, cancer center, and orthopedic surgery hospital.

The original twelve categories of medical status were recoded to form seven categories for the data presentation. The categories of 'died,' 'was in the process of dying,' and 'end-stage of disease' were combined to create the category of 'dying/end-stage' The categories of 'was in crisis,' 'check up' and 'discharged,' which were infrequently endorsed and did not fit into any other category, were combined with 'other.' Although we acknowledge that the latter three categories would raise different spiritual issues, they were not endorsed often enough to allow for separate analyses.

Most of the analyses focus on chaplain referrals to patients, as noted below. Those analyses exclude the 17.7% of referrals to family and friends without the patient, the 1.9% that were for staff, and the 2.9% who were unspecified, leaving 5,508 chaplain visits to patients, with or without family and friends being present. The frequency counts vary in the tables because of missing data and the elimination of certain categories of variables in some of the tables.

RESULTS

As mentioned in the Methods section, the 7,094 visits included in current study represent all the visits made in response to referrals from a dataset containing 38,600 records of chaplain visits. As such, referrals accounted for 18.4% of all chaplain visits.

The percentage of referrals varied by healthcare setting, with referrals accounting for about one fifth of the chaplain visits in the cancer center (20.5%) and general hospitals (19.3%), about one tenth of the visits in the rehabilitation center (9.4%) and nursing homes (10.3%), and over three quarters of the visits at the orthopedic surgery hospital (77.0%). The percentage of visits that were the result of referrals in most of the general hospitals ranged between 16% and 22%, but two of the ten had percentages of 30% or more.

Sources of Referrals

Table 1 presents the complete distribution of the sources of all referrals to chaplains. Nurses were the most common sources of referrals (27.8%), followed by patients themselves (22.3%). Together, nurses and patients accounted for about half of all requests for chaplain visits. Family members (12.7%) and other chaplains (11.4%) were the next most common sources of referrals. Relatively few referrals came from physicians (2.7%).

TABLE 1. Source of Referrals to Chaplains

Source of Referral	Number	Percent
Nurse	1970	27.8
Patient	1579	22.3
Family	903	12.7
Other Chaplain	812	11.4
Other Staff	459	6.5
Volunteer	412	5.8
Social Worker	311	4.4
Physician	191	2.7
Community Clergy	119	1.7
Friend	112	1.6
Other	226	3.2
Total	7094	100.0

Among staff, 67.2% of referrals came from nurses, 10.6% from social workers, 6.5% from physicians, and 15.7% from other staff. Referrals from nurses comprised approximately 58.7% of all staff referrals at the orthopedic surgery hospital, 70.6% of all staff referrals at the general hospitals, and 80.2% of all staff referrals at the cancer center. Referrals from social workers were most common at the orthopedic surgery hospital and the rehabilitation center, where they made up 19.0% and 38.6% of all staff referrals, respectively.

Since we had collected identical data from an independent sample of referrals during the same years at the cancer center (Flannelly et al., 2003; 2004), we decided to see if the results for the two samples were comparable, using the chi-square goodness-of-fit test. Chi-square tests conducted on all the sources listed in Table 1 (except "Other") found no difference between the observed and expected percentages for any of the sources except patients and nurses. Patient self-referrals in the current study were significantly higher ($\chi^2(1) = 55.5, p < .001$) and referrals from nurses were significantly lower ($\chi^2(1) = 10.4, p < .01$) in the present study than in the earlier study. To put those findings in perspective, the percentage of staff referrals that came from nurses in the earlier study was 82.3% compared to the 80.2% in the present study.

The patterns of referrals by source differed somewhat by healthcare setting, as shown in Table 2. Professional staff provided the majority of referrals to chaplains in each healthcare setting. The percentage of patient self-referrals to chaplains ranged from 4.7% in the nursing homes to 39.1% in the rehabilitation center. Family and friends made 17.7% of requests for chaplain visits at the cancer

TABLE 2. Referral Source by Healthcare Setting

Source of Referral	Type of Healthcare Setting				
	General Hospitals (n = 3062)	Cancer Center (n = 1290)	Orthopedic Hospital (n = 425)	Nursing Homes (n = 320)	Rehabilitation Center (n = 87)
Patient	28.3	22.8	34.3	4.7	39.1
Family/Friends	12.2	17.7	6.3	3.7	0.0
Hospital Staff	39.8	25.5	44.7	79.1	52.9
Clergy/Chaplain	12.8	16.4	7.8	8.7	8.1
Other	6.9	17.6	6.8	3.7	0.0

TABLE 3. Medical Status of Patients Referred to Chaplains*

Medical Status	Number	Percent
Treatment	2253	45.3
Post-Operation	858	7.3
Pre-Operation	477	9.6
Dying/End-Stage	328	6.6
Rehabilitation	352	7.1
New Diagnosis/Prognosis	246	4.9
Other	458	9.2
Total	4972	100.0

*The total number of patients referred to chaplains was 5508. The total for the table is lower because the medical status of some patients was not recorded.

hospital but none at the rehabilitation center. It is worth noting in this regard that family members were rarely around during the day at the rehabilitation center, whereas the cancer center had facilities to accommodate families, including private rooms.

Patient Medical Status

The remainder of the analyses focuses on visits with patients, whether or not their friends and family were present. Table 3 shows the medical status of the patients in the sample. Almost half of the referrals to chaplains (45.3%) were for patients who were hospitalized for some type of treatment other than surgery. Another 16.9% of referrals were for patients who were pre- or post-operative. Fewer than 10% of patients fell into each of the following categories: dying/end-stage, rehabilitation, diagnosis/prognosis, and other.

Reasons for Referrals

Table 4 presents the reasons that were given for making a referral. Among those who gave a reason, the most frequent reason was that the person had relationship or support issues (16.6%). The next most common reasons were spiritual distress (12.2%), anxiety/agitation (10.8%), and pain/depression (10.8%). Unfortunately, no rationale was given for making the referral to the chaplain in 14.4% of the cases.

TABLE 4. Reasons for Referrals to Chaplains

Reason for Referral	Number	Percent
Relationship/Support Issues	914	16.6
Spiritual Distress	674	12.2
New Diagnosis/Prognosis	419	7.6
Anxiety/Agitation	593	10.8
Pain/Depression	594	10.8
Request for Religious Item/Ritual	424	7.7
Difficult Decision	204	3.7
Grief	134	2.4
Hostility	79	1.4
Patient Being Discharged	86	1.6
Non-Compliance with Treatment	58	1.1
Other	534	9.7
None	795	14.4
Total	5508	100.0

Table 5 presents the reasons for referral in each of the healthcare settings, combining the reasons into six categories as described in the Methods section. Slightly more than half (52.1%) of chaplain referrals at the nursing homes and slightly less than half (45.9%) of chaplain referrals at the rehabilitation center were for emotional issues, whereas only 10.7% of referrals from the cancer hospital were for emotional issues. Across healthcare settings, 30.0% of all referrals were for patient emotional issues, whereas 19.9% were for spiritual issues.

TABLE 5. Reasons for Referrals by Healthcare Setting

Reason for Referral	Type of Healthcare Setting				
	General Hospitals (n = 2591)	Cancer Center (n = 1160)	Orthopedic Hospital (n = 338)	Nursing Homes (n = 307)	Rehabilitation Center (n = 62)
Emotional Issues	34.9	10.7	28.1	52.1	45.9
Spiritual Issues	23.7	22.8	17.7	27.7	32.8
Relationship/Support	18.5	27.7	16.6	8.8	9.8
New Diagnosis/Prognosis	8.8	8.3	14.5	2.9	6.5
Medical Issues	6.6	1.3	15.7	1.6	1.6
Other	7.9	29.3	7.4	6.8	3.3

TABLE 6. Reasons for Referrals by Referral Source

Reason for Referral	Referral Source				
	Patient (n = 1038)	Family or Friends (n = 635)	Hospital Staff (n = 2056)	Clergy or Chaplain (n = 579)	Other (n = 405)
Emotional Issues	30.3	22.2	38.7	14.8	15.8
Spiritual Issues	31.1	24.4	19.3	22.5	23.0
Relationship/Support	25.7	29.3	12.3	24.7	16.3
New Diagnosis/ Prognosis	5.8	10.7	9.8	10.0	7.6
Medical Issues	2.7	6.5	6.4	5.0	8.2
Other	4.4	6.9	13.6	23.0	29.1

Reasons for Referrals by Source

The reasons for referral by referral source are presented in Table 6. Roughly 6 out of 10 self-referrals by patients were for spiritual issues or emotional issues, with patients being almost equally likely to request a chaplain visit for emotional issues as they were for spiritual issues. A quarter of patient requests were for relationship/support. Looking at referrals from family and friends, relationship/support was the most common reason to request a chaplain to visit a patient (29.3%), followed by spiritual issues (24.4%) and emotional issues (22.2%). Among referrals from hospital staff, more than one-third (38.7%) were for emotional issues. Requests for chaplains to help the patient deal with a new diagnosis were almost twice as common from family and friends, hospital staff, and other clergy/chaplains as they were from patients themselves. A similar pattern was seen for referrals to deal with other medical issues. Referral requests for explicitly spiritual issues only accounted for between one-fifth and one-third of all requests made by any source.

Table 7 shows the reasons for referral by specific categories of hospital staff. Nurses, social workers, and other staff primarily referred patients to chaplains because of emotional issues. Physicians, on the other hand, most often referred patients to the chaplain to address medical issues (26.3%). This percentage rises to 45.8% if we include change in diagnosis or prognosis as a medical issue, which it clearly is. Other staff made almost as many referrals to chaplains as physicians and social workers combined, and did so most often for

TABLE 7. Reasons for Referral by Staff Members

Reason for Referral	Staff Member			
	Nurse (n = 1399)	Physician (n = 118)	Social Worker (n = 232)	Other Staff (n = 307)
Emotional Issues	40.5	24.6	34.9	38.8
Spiritual Issues	17.3	13.6	15.9	33.2
Relationship/Support	12.2	10.2	9.9	15.0
New Diagnosis/Prognosis	9.4	19.5	13.4	5.2
Medical Issues	4.8	26.3	12.9	1.0
Other	15.8	5.9	12.9	6.8

emotional issues and spiritual issues. They were almost twice as likely to make referrals for spiritual issues, as were nurses, social workers, and physicians. Unfortunately, we do not have information as to the specific functions or disciplines of the staff members who were included in this category, but we know they included the full spectrum of staff, from patient representatives to activity therapists, to ward clerks, to the housekeeping staff.

DISCUSSION

Overall, 19.3% of all chaplain visits in the ten general hospitals were the result of referrals but at two of the ten hospitals 30% or more visits resulted from referrals, and the percentage was 77% at the orthopedic surgery hospital. The latter is because all patients at the orthopedic hospital were asked on admission if they wanted to see a chaplain, and all those that said they did were referred to the pastoral care department.

Nurses were the source of 67.2% of all staff referrals across the five settings, with the highest percentage of nursing referrals observed at the cancer center (80.2%). This percentage is comparable to the figure reported by Flannelly et al. (2003) for the same institution (82.6%) based on an independent set of observations. Referrals from social workers were more common at the rehabilitation center and the orthopedic surgery hospital than they were at most hospitals. The differences observed across healthcare settings are probably

due in part to the differences in the procedures for making referrals in the different settings.

It is possible, and even likely, in some circumstances that referrals that were attributed to nurses during the data collection were actually initiated by physicians and carried out by nurses. We do not know to what extent this occurred, but a recent survey of nurses, social workers and physicians found that nurses were the most likely to believe it was important refer patients to chaplains for various reasons, whereas physicians were the least likely to believe it was important to refer patients to chaplains (Galek et al., 2007). The observed pattern of referrals from staff is also consistent with Koenig et al.'s (1991) findings on the importance accorded by nurses, social workers and physicians to referring patients to chaplains for various reasons. Both Koenig et al. (1991) and Galek et al. (2007) report a connection between physicians' tendency to be less religious than the general population and their relatively low level of referrals to chaplains. Interestingly, we found that "other staff" made more referrals to chaplains than both physicians and social workers combined. The individuals who fell into the category of "other staff" were in such jobs as ward clerk and house-keeping staff. It is possible that these individuals' own level of religiosity was more in line with that of patients and nurses, rather than physicians, which could have contributed to their higher level of chaplain referrals. However, we do not have the data to test this hypothesis.

Chaplains often speak of nurses as their natural allies. Nursing has long recognized the importance of spirituality in caring for patients (Flannelly et al., 2002; Weaver et al., 1998, 2001), and nurses place great importance on the role chaplains play in different healthcare settings (Flannelly et al., 2005, 2006). The current findings, as well as similar findings from previous studies (Flannelly et al., 2003, Fogg et al., 2004), clearly show that nurses foster the work of chaplains by referring patients and family members in need of pastoral care to them. Survey studies suggest that social workers tend to see the chaplain's role as being somewhat less important than nurses do (Flannelly et al., 2005, 2006), and perhaps, are less sure about what the chaplains role should be (Galek et al., 2007). This may account for the relatively low rate of referrals from social workers in most of the institutions in the study. Yet some institutions, such as the orthopedic surgery hospital and rehabilitation center, had relatively high rates of referrals from social workers, possibly because the social workers there had come to know the chaplains themselves very well.

Our results are consistent with those of Flannelly et al. (2003, 2004) and Fogg et al. (2004) in showing that chaplains are referred to patients for a variety of reasons other than just religious or spiritual needs. Emotional issues were some of the most common reasons for patients to be referred to chaplains—more common than spiritual issues or concerns in some settings. Overall, 30.0% of patients were referred for emotional issues, compared with 19.9% of referrals for spiritual issues. While chaplains are well trained to deal with patients' emotional problems, they also recognize that emotional conflict can sometimes reflect an underlying spiritual conflict. Their ability to address the often-overlapping realms of emotion and spirituality makes them uniquely qualified to deal with many of the non-medical issues that arise for patients and their families in the healthcare setting. More than half of all referrals from patients and family members, as well as nurses were for either emotional issues or relationship/support, whereas about one-third of referrals from physicians and social workers were for those reasons, suggesting that physicians and social workers may be underestimating the scope of the chaplain's role in dealing with issues beyond those that are explicitly religious.

Whereas almost half of all referrals in both the rehabilitation and nursing home settings were related to the emotional realm, in the cancer care setting, just over ten percent of the referrals involved emotional issues. We surmise that this low rate of referrals for emotional issues at the cancer center is due to the presence of a psycho-oncology department that receives the overwhelming majority of referrals for emotional distress. By contrast, the relatively high rate of referrals to chaplains for emotional issues in nursing homes may reflect the low availability of psychological services at those institutions. While psychological distress is undoubtedly more effectively addressed in institutions that are well staffed with psychologists and other counselors, psychological symptoms are often the manifest indicators of underlying deeper spiritual issues. Thus, it becomes imperative to fine-tune the assessment process in order to discern the psychological from the spiritual so that distress rooted in spiritual issues can be effectively addressed.

Although the healthcare chaplain plays a crucial role in providing religious support to patients, our results confirm that the role they play extends far beyond prayer and religious rituals. Chaplains are sought for help to address a wide range of emotional and relationship

issues with both patients and families. Physicians and social workers are least likely to make referrals, whether because they are less religious themselves or because of uncertainty as to the scope of the chaplain's role and when it is appropriate to make a referral. Between HIPAA regulations that restrict community clergy's access to patients, and research suggesting that patients with the fewest spiritual resources may be least likely to request a chaplain visit (Fitchett et al., 2000), appropriate referrals to the healthcare chaplain become increasingly important. These results indicate the importance of clarifying the role of the chaplain to both patients and hospital staff, as well as developing a standardized protocol for chaplaincy referrals so that each member of the healthcare team can identify situations that call for pastoral care and make the appropriate referral to the chaplain.

ACKNOWLEDGEMENTS

The authors wish to acknowledge the assistance of Research Librarian Helen P. Tannenbaum and Research Assistant Kathryn M. Murphy with the preparation of this manuscript. We also thank the many the professional chaplains and CPE students who participated in the New York Chaplaincy Study. The preparation of this article was funded in part by a grants from the Henry Luce Foundation, the John Templeton Foundation, and the Arthur Vining Davis Foundations.

REFERENCES

- Balboni, T. A., Vanderwerker, L. C., Block, S. D., Paulk, M. E., Lathan, C. S., Petet, J. R., & Prigerson, H. G. (2007). Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life. *Journal of Clinical Oncology*, 25(5), 555–560.
- Ferrell, B. (2007). Meeting spiritual needs: What is an oncologist to do? *Journal of Clinical Oncology*, 25(5), 467–468.
- 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., Bucchino, J., Handzo, G. F., & Tannenbaum, H. P. (2005). Department directors' perceptions of the roles and functions of hospital

- chaplains: A national survey. *Hospital Topics: Research and Perspectives on Healthcare*, 83(4), 19–27.
- Flannelly, L. T., Flannelly, K. J., & Weaver, A. J. (2002). Religious and spiritual variables in three major oncology nursing journals: 1990–1999. *Oncology Nursing Forum*, 29(4), 679–685.
- Flannelly, K. J., Galek, K., & Handzo, G. F. (2005). To what extent are the spiritual needs of hospital patients being met? *International Journal of Psychiatry in Medicine*, 35(3), 319–323.
- Flannelly, K. J., Handzo, G. F., Galek, K., Weaver, A. J., & Overvold, J. A. (2006). A national survey of hospital directors' views about the importance of various chaplain roles: differences among disciplines and types of hospitals. *Journal of Pastoral Care & Counseling*, 60(3), 213–225.
- Flannelly, K. J., Weaver, A. J., & Handzo, G. F. (2003). A three-year study of chaplains' professional activities at Memorial Sloan-Kettering Cancer Center in New York City. *Psycho-Oncology*, 12(8), 760–768.
- Flannelly, K. J., Weaver, A. J., & Handzo, G. F. (2004). A three-year study of chaplains' professional activities at Memorial Sloan-Kettering Cancer Center in New York City. *Chaplaincy Today*, 20(2), 3–12.
- Fogg, S. L., Weaver, A. J., Flannelly, K. J., & Handzo, G. F. (2004). An analysis of referrals to chaplains in a community hospital in New York over a seven year period. *Journal of Pastoral Care & Counseling*, 58(3), 225–235.
- Galek, K., Flannelly, K. J., Koenig, H. G., & Fogg, S. L. (2007). Referrals to chaplains: The role of religion and spirituality in healthcare settings. *Mental Health, Religion & Culture*, 10(4), 363–377.
- Hamdy, R. C. (2006). Chaplains, the hidden assets. *Southern Medical Journal*, 99(6), 638.
- Koenig, H. G., Bearon, L. B., Hover, M., & Travis, J. L. (1991). Religious perspectives of doctors, nurses, patients, and families. *Journal of Pastoral Care*, 45(3), 254–267.
- Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. New York: Oxford University Press.
- Handzo, G. F. (2006). Best practices in professional pastoral care. *Southern Medical Journal*, 99(6), 663–664.
- Handzo, G. & Koenig, H. G. (2004). Spiritual care: Whose job is it anyway? *Southern Medical Journal*, 97(12), 1242–1244.
- McClung, E., Grosseohme, D. H., & Jacobson, A. F. (2006). Collaborating with chaplains to meet spiritual needs. *MEDSURG Nursing*, 15(3), 147–156.
- Meert, K. L., Thurston, C. S., & Briller, S. H. (2005). The spiritual needs of parents at the time of their child's death in the pediatric intensive care unit and during bereavement: a qualitative study. *Pediatric Critical Care Medicine*, 6(4), 420–427.
- Murray, S. A., Kendall, M., Boyd, K., Worth, A., & Benton, T. F. (2004). Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their carers. *Palliative Medicine*, 18(1), 39–45.

- Weaver, A. J., Flannelly, L. T., & Flannelly, K. J. (2001). A review of research on religious and spiritual variables in two primary gerontological nursing journals 1991 to 1997. *Journal of Gerontological Nursing, 27*(9), 47–54.
- Weaver, A. J., Flannelly, L. T., Flannelly, K. J., Koenig, H. G., & Larson, D. B. (1998). An analysis of research on religious and spiritual variables in three major mental health nursing journals, 1991–1995. *Issues in Mental Health Nursing, 19*(3), 263–276.