

# What Do Chaplains Really Do?

## I. Visitation in the New York Chaplaincy Study

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**ABSTRACT.** The current study presents findings from the New York Chaplaincy Study about chaplain visits with patients and their families in 13 healthcare institutions in the Greater New York City area during 1994–1996. It documents the distribution of 34,279 clinical visits by religious affiliation, population served (patients, family and friends), and type of healthcare setting (acute care and non-acute care), and analyzes the number and duration of visits with patients by their medical status. Chaplains in acute settings tended to make less frequent but longer visits with patients than chaplains in non-acute settings. On average, chaplains spent less time with patients who were alone than they did during visits with patients whose family was present during the visit or visits with only family members. Average visit duration was positively related to the percentage of visits in each of the 13 facilities that were made in response to referrals ( $r = .65$ ,  $p < .05$ ), and the average duration of referred visits was significantly longer ( $p < .001$ ) than that of non-referred visits ( $p < .001$ ). The findings are intended to provide a general picture of what these particular chaplains did in these particular institutions over this particular time-period and are not intended to represent a standard of what chaplains should be doing.

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

## *INTRODUCTION*

The first chaplaincy department was established at Massachusetts General Hospital in Boston where Russell Dicks and Dr. Richard Cabot established a Clinical Pastoral Education (CPE) program to provide supervised education for clergy ministering to patients, family, and staff (Burton, 1992; McSherry, 1987). This event may be said to mark the beginning of what has been called “the crossroads of science, medicine and spirituality” (Burton, 1992, p.1). “Unique among health care providers, chaplains live and work at this very crossroads” (Burton, 1992, p.1).

Although spiritual care is the responsibility of all professional staff in hospitals and other healthcare settings (Handzo & Koenig, 2004; Millison & Dudley, 1992), it is the primary function of professional chaplains, who are spiritual-care specialists (Daly, 2006; Handzo & Koenig, 2004). Unlike other healthcare professionals, chaplains are

uniquely trained and sensitive to discussing spiritual and existential issues (Handzo, 1992). The basic requirements for becoming a board certified chaplain include a graduate level theological education, and 1,600 hours of Clinical Pastoral Education (Handzo, 2006).

Chaplains minister to different populations of individuals, including patients, families and staff (Flannelly et al., 2005). A national survey of pastoral care directors found that chaplains considered their ministry to all three populations as being very important (Flannelly et al., 2005). Although patients are chaplains' primary constituency in healthcare settings (Daly, 2006; Gibbons et al., 1991; Handzo & Koenig, 2004; VandeCreek & Lyon, 1997), the pastoral care they provide to patients' families is also important (Broccolo & VandeCreek, 2004; Goodell, 1992; Pargament et al., 1999; VandeCreek et al., 1994), especially since hospital staff often do not have the time to spend with them (Levine, 1998).

Over the years, various chaplains have described their ministry in critical care (Gillman et al., 1996), intensive care (Sharp, 1991), nursing homes (Phillips, 1973), and various other settings (Flannelly et al., 2005, 2006). These articles illustrate the ways in which chaplaincy is similar and ways in which it is different across healthcare settings. Some of the articles are purely narrative whereas others provide quantitative data. Sharp's study of the ministry of chaplains in a neonatal intensive care unit is particularly interesting because it documents the frequency of chaplains' interactions with parents and other family members, as well as staff, at three different hospitals. However, the sample size was relatively small, with only twelve chaplains participated in the study, which makes it difficult to generalize the findings.

VandeCreek and Lyon (1994/1995) report the findings of a much larger study that looked at the number and length of chaplain contacts with patients, families and staff at three hospitals over a two-month period. Clinical visits with patients accounted for 42 or 43% of all contacts at all three hospitals, and visits with families accounted for 29–35% of all contacts. The percent of contacts with staff was much more varied among the hospitals, ranging from 6 to 17%. Worship services and sacramental functions were counted separately. Overall, the percentage of time spent with patients was substantially higher than that spent with family members.

Outside of this work, there is very little in the literature that actually describes the pastoral visiting that chaplains do. There is an

untested assumption that these descriptions are not worth publishing because the numbers are going to vary so much by setting, institutional culture, and the particular practice of individual chaplains. There is even some sense within the profession that there should not be norms for pastoral care practice.

We believe it is time to open the discussion of standards for pastoral visiting and see whether there is a normative practice in such areas as average length of visits and the relative attention given to various patient populations. We fully appreciate—and will discuss here—how many variables affect the pattern of chaplaincy visits. However, we hope that this publication will encourage others to do likewise so the discussion can be public.

The present article is the first of a series of articles based on data from the New York Chaplaincy Study. It examines chaplain visits with patients, family and friends at over a dozen healthcare facilities in the Greater New York City area. Specifically, it documents the distribution of clinical visits by religious affiliation, population served (patients, family and friends), and type of healthcare setting (acute care and non-acute care), and compares the number and duration of visits with patients by their medical status. The findings are intended to provide a general picture of what these particular chaplains did in these particular institutions over this particular time-period and are not intended to represent a standard of what chaplains should be doing.

## ***METHODS***

The study was conducted at 13 healthcare institutions in the New York City area, including 10 hospitals, two nursing homes, and a rehabilitation therapy center. The data were collected by 40 professional chaplains and more than 200 Clinical Pastoral Education (CPE) students under their supervision from 1994–1996, during two-week periods each year. Some pastoral care departments had two or three data-collection periods in some years. In all, data were recorded from nearly 43,000 chaplain visits. Only 34,279 chaplain visits are included in the current analyses, after eliminating visits with outpatients (approx. 3000), staff (approx. 1000), incomplete records, and records used in previously published research (Flannelly et al., 2003, 2004).

Professional chaplains and CPE students (hereafter collectively called chaplains) documented each visit they made and recorded a number of characteristics about the visit, and the patient or other persons visited on a one-page form designed by the clinical staff of The HealthCare Chaplaincy. Pieces of information that are particularly important for the purpose of the present study are the patient's religion, who the chaplain visited, the number of the visit, the duration of each visit, and the patient's medical status. Six categories of religious affiliation were recorded: Catholic, Jewish, Islam, Protestant, other, and none. Whom the chaplain visited was divided into five categories:

- a. a patient only,
- b. a patient and family members,
- c. a patient with family or friends,
- d. family only, and
- e. friends only.

The five categories were reduced to three groups ("populations served") for analysis:

1. patient only;
2. patient and family, which combined categories b and c; and
3. family and friends, which combined categories d and e.

At the end of a visit, the chaplain estimated its duration using 5-minute intervals. The number of the visit was recorded as "1," "2," or "3." All visits beyond the third were recorded as "3." The medical status of patients was divided 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 or had coded;
5. received a checkup;
6. received a new diagnosis or prognosis;
7. was being discharged;
8. was going into surgery;
9. was in post-op, recovering from surgery;

10. was receiving rehabilitation therapy;
11. was receiving treatment other than surgery; and
12. other.

The “other” category was excluded from the analyses of medical status.

The data were grouped together for analysis by the type of healthcare settings: acute care, which included all 10 hospitals, and non-acute care, which included the two nursing homes and the rehabilitation center. Frequency data were analyzed by the chi-square test ( $\chi^2$ ). Since the number of visits recorded had a maximum value of 3, they were treated as ranked data and analyzed by the Kruskal-Wallis test for one-way analysis of variance of ranks. Two analyses were conducted on the number of visits. One examined the effect of healthcare setting and the other examined the effect of population served. Duration of visits was analyzed by a two-way ANOVA, using a 2 (healthcare setting) X 3 (population served) design. Correlation analysis was performed as explained below.

## **RESULTS**

### ***Visits by Religious Affiliation of Patients***

Table 1 presents the percent of patients of all religious affiliations who were visited by chaplains in acute and non-acute settings. Catholics comprised roughly 40% of both acute and non-acute care patient visits. Chaplain visits to Jewish patients comprised around a quarter of the sample in both settings, with Protestants comprising roughly a fifth to a quarter of the samples in each setting. Islamic patients made up less than 5% of the patient visits in each setting. It is important to note that all the visits reported were done by multi-faith professional chaplains or CPE students. Visits done by clergy from the community visiting people of their denomination were not included.

Hospital census data on patients' religion were available for two hospitals. The census reports included the percentages of Catholics, Jews and Protestants at both hospitals and the report of one hospital included Islamic patients. Approximately 35–50% of patients were Catholic, 19–24% were Jewish, and 14–20% were Protestant at both

TABLE 1. Percentage of Patients of Various Faiths who were Visited by Chaplains during the Course of the Study at Acute and Non-Acute Healthcare Settings

Religious Affiliation	Type of Healthcare Setting	
	Acute	Non-Acute
Catholic	38.9	41.2
Jewish	27.0	23.6
Protestant	19.0	24.9
Islam	4.7	4.5
Other	4.9	4.8
None	5.5	1.0

of these hospitals, and 1% were Islamic at the second hospital. Chi-square goodness-of-fit tests were conducted on each of the four religious denominations listed in the table, separately for each hospital, to see if chaplain visits with patients of each denomination were proportionate to the census data on religious denomination. No significant differences were found between the observed and expected proportions of visits for Catholic or Protestant patients in the first hospital, but visits with Jewish patients were significantly higher than expected ( $\chi^2(1) = 7.6, p < .01$ ). No significant differences were found for Catholic, Jewish, or Protestant patients at the second hospital, but chaplain visits with Islamic patients was higher than expected ( $\chi^2(1) = 490.0, p < .001$ ). Although the data are limited, they suggest that distribution of chaplain visits tends to mirror the distribution of the religious denominations of patients. The exceptions, however, may be noteworthy, because the hospital with a greater than expected percentage of visits to Islamic patients had a part-time Imam on staff, and the hospital with a greater than expected number of visits to Jewish patients had a chaplaincy resident who is a Rabbi.

### *Visits by Populations Served*

The percentages of all 34,279 chaplain visits that were with each population served in acute and non-acute settings are presented in Table 2. The distribution of visits within the three categories of people served by chaplains differed significantly between the two

TABLE 2. Percent of Chaplain Visits with Patients, Family and Friends at Acute and Non-Acute Healthcare Settings

Population Served	Type of Healthcare Setting	
	Acute	Non-acute
Patient only	63.9	87.2
Patient and family	22.3	2.9
Family and friends	13.8	9.9

settings ( $\chi^2(2) = 277.3 p < .001$ ), with chaplains in non-acute settings (rehabilitation facilities and nursing homes) being far more likely to visit just patients (i.e., Patient Only). It is noteworthy that the percentage of visits that included patients is roughly the same across the settings. The difference is in the number of visits where family or friends were also present.

Percentage of visits that were with family members at the ten hospitals in the study varied widely. On the one hand, some hospitals had very little common space where families could spend time outside a patient's room while, on the other hand, some had private rooms in which family members could stay overnight if they chose. Chaplain visits with family and friends were 10% or less at both the nursing homes and the rehabilitation center. At the nursing homes, family visits were more common on weekends when, depending on the patient's condition, the family might take the patient out for lunch or some other outside activity. The chaplain was most likely to spend a lot of time with family members when the death of the patient was apparently near or there was a danger of death. The rehabilitation center encouraged families to visit patients after therapy sessions are over for the day, after the chaplain's usual daytime work hours.

Friends were present during 5% of the visits in the Patient and Family category. Approximately one quarter of the visits in the Family and Friends category are visits with "friends only" and three quarters are visits with "family only."

### ***Number and Duration of Visits by Setting and Population Served***

The number of chaplain visits and the duration of chaplain visits were each analyzed by nonparametric and parametric statistics,

respectively, as described above. The results of these analyses are presented in Tables 3 and 4.

### *Number of Visits*

Table 3 gives the percentage of the number of chaplain visits with each population served by type of setting. Of the total chaplain visits included in the study, 41.5% were initial visits with patients, with or without family and friends being present.

The Kruskal-Wallis test found a significant effect of healthcare setting with chaplains in acute care settings being much more likely to make only one visit with each population, and chaplains in non-acute settings being much more likely to make three or more visits with each population during the two-week data collection periods. Although the median number of visits across all ten hospitals in the study was 1, three of the ten hospitals had medians higher than 1. The median number of visits was 3 for both nursing homes and 2 for the rehabilitation center. Any visit to the same patient or family beyond the third was recorded as 3, so we do not know the actual number of visits to those patients or families and are unable to calculate the mean number of visits.

The number of visits is affected by length of stay (LOS) which tends to be much longer at the non-acute facilities. This study was conducted before both nursing homes in the study converted some beds to rehabilitation, and the length of stay at the rehabilitation center at the time of the study was approximately 23 days, with some patients staying longer than four weeks.

TABLE 3. Percentage Distribution of Number of Visits by Chaplains with Patients, Family and Friends in Different Healthcare Settings

Population Served	Type of Healthcare Setting					
	Acute			Non-Acute		
	1	2	3 or more	1	2	3 or more
Patient only	54.0	18.9	27.1	13.7	6.7	79.6
Patient and family	55.1	15.0	29.9	17.0	7.8	75.2
Family and friends	52.8	15.8	31.4	21.2	8.5	70.3

Main effect of healthcare setting:  $\chi^2(1) = 64.9, p < .001$ .

TABLE 4. Average Duration (in minutes) of Chaplain Visits with Patients, Family and Friends in Different Healthcare Settings

Population Served	Type of Healthcare Setting					
	Acute			Non-Acute		
	<i>Md</i>	<i>M</i>	<i>SD</i>	<i>Md</i>	<i>M</i>	<i>SD</i>
Patient only	10	14.1	12.3	5	8.3	7.4
Patient and family	10	15.0	14.1	5	10.3	8.7
Family and friends	10	15.5	15.2	10	9.9	8.1

Main effect of healthcare setting:  $F(1, 34278) = 185.9, p < .001$ .

Main effect of population served:  $F(2, 34278) = 14.6, p < .001$ .

### *Duration of Visits*

The length of visits ranged from five minutes to almost three hours, with the average visit duration being 13.6 minutes ( $SD = 12.6$ ). The median visit duration across all healthcare institutions in the study was 10 minutes, with the median at acute and non-acute facilities being 10 minutes and 5 minutes, respectively.

Table 4 presents the median and mean duration of chaplain visits to each of the populations served in each healthcare setting. The mean duration of visits differed significantly between healthcare settings ( $p < .001$ ), with the mean for acute settings ( $M = 14.5, SD = 13.1$ ) being substantially higher than the mean for non-acute settings ( $M = 8.5, SD = 7.5$ ). This result was heavily influenced by the single chaplain at one of the nursing homes who made a large number of visits whose average length was less than 6 minutes.

It is also worth noting that there was considerable variation among the means of the ten hospitals: 12.5–19.0 minutes. Such differences are, no doubt, due to a number of factors, including patient characteristics, staffing levels, individual styles, and the criteria for making visits. Analysis revealed that average visit duration was positively related to the percentage of visits in each of the 13 facilities that were made in response to referrals ( $r(11) = .65, p < .05$ ), and that the average duration of referred visits ( $M = 19.4$  minutes,  $SD = 18.8$ ) was significantly longer ( $t(38,613) = 37.6, p < .001$ ) than that of non-referred visits ( $M = 12.5, SD = 11.4$ ).

A small but statistically significant difference was found in the mean duration of visits to the three categories of people listen in Table 4: patients, family etc. ( $p < .001$ ). On average, chaplains spent less time with patients who were alone than they did with just family and friends or with patients whose family was present during the visit.

### ***Visits to Patients, Family, and Friends and Patient Medical Status in Acute Settings***

Table 5 examines the context (i.e. patient medical status) in which chaplains visited different individuals in acute care settings. Here, we compare all visits with patients (with or without family and friends present) to visits with only family and friends. Medical status is listed in descending order based on the percentage of visits made to family and friends (without the patient present) in acute care settings. Most visits with either category were in the context of some type of medical treatment other than surgery, which is to be expected since this category encompasses a wide range of medical care received in most hospitals. The second most common context for visits in both categories is after a patient had surgery. The next most frequent reasons for visits to family and friends was the patient was in the end stage of a disease, the patient was in the process of dying and the patient's death.

Patients were somewhat more likely to be visited than were family and friends before the patient went into surgery and while the patient

TABLE 5. Percentage of Visits with Family and Friends or Patients Visited (with or without others present) by Patient Medical Status in Acute Settings

Medical Status	Family and Friends	Patients
Treatment	43.0	51.8
Post-op	17.4	15.3
End Stage	9.7	3.3
Dying	8.2	1.3
Deceased	5.6	0.0
Pre-op	4.8	11.1
Diagnosis/prognosis	3.7	5.4
Crisis/code	3.0	0.8
Being discharged	2.4	2.6
Rehabilitation	2.0	8.2
Checkup	0.2	0.2

was in the hospital to receive treatment or rehabilitation therapy. Visits with families and friends exceed those with patients in those categories where one might expect the patient to be unavailable for a visit (i.e., end stage, dying, deceased, crisis/code). This may also be the reason post-op families were more commonly seen than were the patients themselves.

### *Number and Duration of Visits to Patients by Medical Status*

Table 6 shows the percentage distribution of number of visits to patients and the mean durations of these visits by the medical status of patients in the ten hospitals in the study. Medical status is listed in descending order with respect to the relative frequency of visits in each category shown. The column heading label “3+” stands for “3 or more” visits. Checkups are excluded from Table 6 because their frequency was too low to provide meaningful results.

The most common circumstances in which chaplains visited patients were when patients were hospitalized for treatment, rehabilitation therapy, and surgery. There were no figures available to compare these percentages to the percentage of these patients in the overall population of the hospitals. Both pre-op visits and post-op may be over-represented because one of the chaplains in one hospital was assigned to visit every patient before their surgery and another hospital emphasized making post-op visits with patients.

Table 6. Percentage Distribution of Number Visits and Mean Duration of Visits to Patients (with or without others present) in Acute Care by Their Medical Status

Medical Status	Number of Visits			Duration in Minutes		
	1	2	3+	<i>Md</i>	<i>M</i>	<i>SD</i>
Treatment	45.9	19.0	35.1	10	14.1	11.5
Post-op	57.7	24.1	18.2	10	14.4	13.5
Pre-op	89.9	6.1	4.0	10	11.9	13.2
Rehabilitation	44.7	12.9	42.4	10	12.7	12.0
Diagnosis/prognosis	81.9	11.5	6.6	10	15.4	12.2
End stage	16.3	20.7	63.0	15	19.7	18.9
Being discharged	24.7	26.0	49.3	10	14.6	10.4
Dying	33.3	17.0	49.7	15	19.9	22.0
Crisis/code	55.1	13.0	31.9	15	22.0	19.9

In several categories (treatment, rehabilitation, dying, crisis/code), the chaplain tended to see the patients either once or three or more times. End-stage patients clearly draw a lot of pastoral care attention and command multiple visits in a short period. On the other hand, change in diagnosis or prognosis and being pre-op seem to represent singular, time-bound events, which chaplains are able to address in a single visit largely.

The mean duration of most visits falls within a fairly tight range across the different status categories. The standard deviations tends to be large in relationship to the means, indicating that there is significant variation in the length of pastoral care contacts irrespective of the patient's medical condition. The crisis and end of life visits tend to be longer, but the variation is greater as well.

## *DISCUSSION*

The present study provides a systematic description of pastoral visits to patients, families and friends by chaplains working in a variety of different healthcare settings. Before discussing the results, however, we should heed the words of VandeCreek and Lyon (1994/1995), who noted the limitation of using number and length of visits as measures of what chaplains do. What such numbers do not do tell us about is the chaplain's responsiveness to the individual needs of patients and families and the kinds of problems they have that dictate the amount of time that chaplains spend with them. In short, they do not tell us about the content, quality, or outcomes of pastoral visits.

The current study found that 63.9% of chaplain visits in acute care settings were with patients only, and another 22.3% were with patients with family or friends present. In sum, 86.2% of all chaplain visits in acute-care settings included patients. This figure is substantially higher than the 57% figure reported by VandeCreek and Lyon (1994/1995). If one assumes that the sacramental functions recorded by the chaplains in that study were performed with patients, the percentage of patient contacts rises to about 59%.

The difference between the findings of the two studies could be methodological. VandeCreek and Lyon (1994/1995) mention that some pastoral care departments counted visits differently than others, and that is probably true to some extent in the present study. Moreover, since so many chaplain visits at the acute-care facilities

in our own study involved patients and family members (22.3%), it is difficult to imagine how one would record those visits as being either with patients or with families. The differences between the two studies could also be real, since the percentage of patient visits observed by VandeCreek and Lyon is within the range found among the different hospitals in our study. Patient only visits in the present study ranged from a low of 45% to 75% among the ten hospitals in our study.

Two other differences between the two studies are worth mentioning. First, VandeCreek and Lyon's (1994/1995) results indicate that chaplains spent more time per visit with patients than they did with family members, but our findings indicate that chaplain visits are somewhat longer with family and friends than they are with only patients. Here too, the differences may be real or methodological artifacts. Some anecdotal information from chaplains in our study indicates that they tend to see families more often around end-of-life issues and the nature of these visits may be responsible for the increased time chaplains spent alone with families. This was particularly true in one nursing home. Second, VandeCreek and Lyon included staff contacts in their results. We did not do so here because staff visits accounted for only 2% or so of all visits. Pastoral care to staff is a very important part of the chaplain's ministry and merits independent attention.

### ***Results Versus Expectation***

While there are no accepted standards of practice for health care chaplaincy, there are expectations for results such as these based on what is anecdotally known about general pastoral care practice in these settings. The results of this survey generally conform to those expectations.

### ***Visits to Different Religious Groups***

We would expect that, all else being equal, the percentage of visits to patients of each religious group would be roughly proportional to their representation in the patient population of the healthcare institutions. Indeed that seems to be the case in this sample, although the comparative data are limited and there appear to be some exceptions. Because few priests or rabbis were part of the pastoral care staff, their ministry to patients is not well documented by the current findings. It would be useful to do so in future research. Given the large

proportions of Catholic and Jewish patients at many of the health-care institutions participating in the study, they would seem to be excellent sites for studying what these community clergy do and how their ministry compares to that of the professional chaplains.

### *Medical Setting and Population*

While the percentage of visits where patients were present was roughly the same in non-acute and acute settings during the two-week data collection periods used in the study, family and friends were present less frequently in the non-acute settings. Some of this appears to be due to institutional culture. For example, the rehabilitation center discouraged family from visiting during daytime therapy hours. This distinction could also be a result of the overall acuity level of the patient. One would expect family to be present more often when the patient is sicker, as in a hospital. This explanation is also supported by the proportionately larger number of visits reported with family when the patient was in crisis or at the end of life.

### *Number of Visit by Population Served and Medical Status*

It is again important to emphasize here that all visits over the third were recorded as “3,” so it is not possible to know how often many of the patients were actually visited during this period. In addition, because of staffing patterns in some of the acute care institutions, it is likely that different chaplains visited the same patient so that more than one initial visit was recorded for the same patient. This would be particularly likely for patients who were initially pre-op where they were seen by the designated pre-op chaplain but then followed post-op by the chaplain assigned to their nursing unit. In addition, while the percentage of visits to each medical group would seem roughly to conform to the percentage in the hospital population, we do not have a way to confirm that.

In the acute setting, all populations were visited only once more than half of the time, reinforcing the perception that acute-care ministry was already by this time very limited in duration. Conversely, all populations in the non-acute setting received three or more visits almost three-quarters of the time. Declining LOS has almost certainly changed this disparity but it likely still exists. A very interesting result is that chaplains seem to visit patients either once or multiple times. They are less likely to visit a patient twice. This result

seems to hold across settings and, for the most part, across medical status. The exceptions are medical situations that are time limited like pre-ops, or end of life situations. This finding bears further investigation.

Since most chaplains in acute care make ministry to those at the end of life a priority, it is not surprising to find that those groups are visited much more often. This general result is particularly supported by the very high percentage of patients receiving three or more visits who are in the "End Stage" category, which is the most attenuated of this group of patients.

### *Duration of Visits*

An overall finding is that there was substantial variation in the duration of visits compared to average duration, indicating that these chaplains tended to have many very short visits and many long visits. This result certainly matches normally reported clinical experience. The average across medical status was relatively consistent with the exception of crisis or end-of-life visits, which tended to be longer, as would be expected. Chaplains tended to visit patients who were at the end-stage of disease or in the process of dying more often and for longer amounts of time than they did other patients.

### *Intervening Variables*

Despite the consistencies reported above, it is also evident that individual situations significantly influence the results. At one hospital, which specialized in orthopedic surgery, 14% of all patient visits were pre-op and 46% were post-op. At another hospital in which a chaplain was dedicated to visiting every patient before surgery, 35% of all chaplain visits with patients were pre-op and another 14% were post-op. The duration of pre-op visits was shorter, on average, than other visits with patients, partly because there were often a large number to visit in a very short time before they left the pre-op area for the operating rooms.

The religion of the chaplain themselves also seems to influence the results. As reported, visits to Jewish or Islamic patients were over-represented when a rabbi or Imam was on staff, even though these were CPE trained chaplains who were not specifically assigned to concentrate on members of their own faith group.

The general visiting plan of the particular chaplain sometimes had a major influence. One of the nursing home chaplains supported

the philosophy of pastoral care espoused by Phillips (1973, 1978) for ministering to nursing home residents. In keeping with Philips advice, the chaplain attempted to maximize contacts with residents including informal conversations about their interests and other aspects of their lives. As Phillips notes, "Listening to people's joys and sorrows or just their everyday concerns is very therapeutic" (Phillips, 1973, p. 76). This visiting pattern resulted in a very large number of short visits.

The chaplain at the rehabilitation center often intended to allow a week between visits in order to gain a sense of the patient's progress over time, which helps to explain why patients at the center were visited a median of two times during the two-week data periods of the study. Those patients requiring visits more frequently, however, were visited as often as every other day. Since the chaplain worked every other day, this made it possible for patients to be visited on a regular basis by the same chaplain.

### ***CONCLUDING REMARKS***

This report is part of a series we hope to publish on this database and more recent data we are collecting on an on-going basis. We believe that it begins to show what may be some patterns in the delivery of pastoral care to patients, families, and friends by health care chaplains in various settings. Despite the size of this database, we do not believe it justifies anything but the most preliminary judgments on what these patterns might be. While the data were collected in thirteen unique institutions, it is important to point out that all of the chaplains involved worked for the same organization. The current report also highlights some of the intervening variables that might cause practice to vary.

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