
An Analysis of Referrals to Chaplains in a Community Hospital in New York Over a Seven Year Period*

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The study analyzed the pattern of referrals to chaplains in a suburban hospital over a 7-year period. Nurses made more than half of all the referrals to chaplains, with nursing accounting for 81.74% of referrals from staff members other than pastoral care workers and volunteers. Social workers and physicians made 11.74% and 4.08% of referrals, respectively. The number of referrals from social workers ($r = .86, p < .05$), nurses ($r = .68, p < .10$) and other staff ($r = .69, p < .10$) increased across years, with the exception of physicians. Three quarters of referrals were requests for chaplains to visit patients and one quarter were requests to visit with family or friends. A significant difference was found in the percentage of referrals made for patients and family/friends by staff members ($p < .05$), with social workers making a higher percentage of referrals for relatives and friends (34.1%), compared to nurses (26.74%) and physicians (27.27%). The most common presenting problems for which patients were referred to chaplains were anxiety, depression, and pregnancy loss. The rate of referrals for patients over the entire study period was 39.04 per 1000 patient stays.

Religion and spirituality play vital roles in the lives of people across the lifespan, especially in times of crisis.¹ A recent study suggests that the increased use of religious/spiritual coping strategies is directly related to the severity of illness.² Indeed, a number of studies have found that higher use of religion/spirituality as a coping mechanism is related to lower levels of the negative affective symptoms that are often associated with stress and illness among hospitalized patients.³ Religious and spiritual

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¹Kenneth I. Pargament, *The Psychology of Religion and Coping: Theory, Research, Practice* (New York, NY: Guilford Press, 1997).

²Harold G. Koenig, Kenneth I. Pargament, & Julie Nielsen, "Religious Coping and Health Status in Medically Ill Hospitalized Older Adults," *Journal of Nervous and Mental Disease*, 1998, Vol. 168, No. 9, pp. 519-521.

³Harold G. Koenig and Andrew J. Weaver, *Counseling Troubled Older Adults: A Handbook for Pastors and Religious Caregivers* (Nashville, TN: Abingdon Press, 1997).

beliefs offer the additional benefit of hope, particularly for people with serious illnesses.⁴ Faith invites the suffering person to search for meaning and perspective through a source greater than one's self and, in doing so, gain a sense of control over feelings of vulnerability. Ferrell and colleagues⁵ found that spiritual care was more important to oncology patients than were support groups, counseling sessions, peer support, or even the support of spouses.

Although spiritual care can be provided by any member of the health-care team, chaplains bear the primary responsibility for it. There are approximately 10,000 certified chaplains in North America who belong to one of five major professional organizations: the Association for Clinical Pastoral Education, the Association of Professional Chaplains, the Canadian Association of Pastoral Practice and Education, the National Association of Catholic Chaplains, and the National Association of Jewish Chaplains.⁶ Chaplain certification requires clinical supervision and training equivalent to the qualifications for becoming a licensed clinical social worker.⁷ Patients often place a high value on interactions with hospital chaplains, reporting that pastoral visits bring hope, make hospitalization easier, and increase their readiness to return home.⁸

While there has been some discussion of the relationship of chaplains to other health-care professionals,⁹ there are very few published findings on the number and kinds of interventions chaplains make or of the number and kinds of referrals made between chaplains and other health-care team members.^{10,11,12} As the practice of health-care chaplaincy becomes increasingly driven by JCAHO regulations and the increased use of spiritual assessments, the percentage of visits in response to referrals can be expected to rise. At the moment, there is little baseline data available to describe the relationship between chaplains and others in regard to referrals. The present study examines some of the reasons why people are referred to chaplains in a general hospital setting, what kinds of patient and family issues are referred, and whether there are differences in the number and nature of referrals made for male and female patients.

⁴Jacqueline R. Mickley, Karen Soeken, & Anne Belcher, "Spiritual Well-Being, Religiousness and Hope Among Women with Breast Cancer," *Image*, 1992, Vol. 24, No. 4, pp. 267-272.

⁵Betty R. Ferrell, Marcia M. Grant, Brandi M. Funk, Shirley A. Otis-Green, & Nellie J. Garcia, "Quality of Life in Breast Cancer Survivors: Implications for Developing Supportive Services," *Oncology Nursing Forum*, 1998, Vol. 25, No. 5, pp. 887-895.

⁶Larry VandeCreek and Laurel Burton, "Professional Chaplaincy: Its Role and Importance in Healthcare," *The Journal of Pastoral Care*, 2001, Vol. 55, No. 1, pp. 81-97.

⁷Lynette S. Danylchuk, "The Pastoral Counselor as Mental Health Professional: A Comparison of the Training of AAPC Fellow Pastoral Counselors and Licensed Clinical Social Workers," *The Journal of Pastoral Care*, 1992, Vol. 46, No. 4, pp. 382-391.

⁸Larry VandeCreek and Marjorie Lyon, "Ministry of Hospital Chaplains: Patient Satisfaction," *Journal of Health Care Chaplaincy*, 1997, Vol. 6, No. 2, pp. 1-61.

⁹Andrew J. Weaver, Laura T. Flannelly, Kevin J. Flannelly, Larry VandeCreek, Harold G. Koenig, & George Handzo, "A Ten Year Review of Research on Chaplains and Community Based Clergy in Three Primary Oncology Nursing Journals: 1990-1999," *Cancer Nursing*, 2001, Vol. 23, No. 5, pp. 335-340.

¹⁰Harold G. Koenig, Lucille B. Bearon, Margot Hover, & James L. Travis, "Religious Perspectives of Doctors, Nurses, Patients, and Families," *The Journal of Pastoral Care*, 1991, Vol. 45, No. 3, pp. 254-267.

¹¹Cullene Bryant, "Role Clarification: A Quality Improvement Survey of Hospital Chaplain Customers," *Journal of Healthcare Quality*, 1993, Vol. 15, No. 4, pp. 1820.

¹²Graeme Gibbons, Andrew Retzas, & Jaya Pinikahana, "Describing What Chaplains Do in Hospitals," *The Journal of Pastoral Care*, 1999, Vol. 53, No. 2, pp. 201-207.

Methods

The study was conducted at Lawrence Hospital Center in Bronxville, New York. Lawrence Hospital Center is a 280-bed, acute-care facility located in the heart of southern, suburban Westchester county. Lawrence provides emergency care to some 30,000 individuals and acute care to over 9,000 patients annually, and is recognized for its professional excellence in cardiology, obstetrics, orthopedics, and oncology.

Data on referrals to the Pastoral Care Department were collected over a seven year period, between 1994 and 2000. Throughout this time, the department staff consisted of one or two certified professional chaplains, and various student and part-time professional chaplains. The primary data for the study consist of the source, target, and reason for referrals, which were recorded whenever referrals were made to the department.

Hospital records indicated that 73,796 patients were discharged from the hospital during the course of the study: 27,265 males (36.95%) and 46,531 females (63.05%). Annual discharge data for male and female patients were used to calculate separate referral rates for each gender in terms of number of patient stays: number (*i.e.*, frequency) of referrals/number of discharges X 1000 = rate of referrals per 1000 patient stays per year. Annual referral rates were statistically analyzed by Analysis of Variance (ANOVA) and Pearson's product-moment correlation.¹³ Frequency data were analyzed by the Chi-square test.¹⁴ Comparisons between male and female patients were conducted using the Chi-square test for "goodness of fit,"¹⁵ with the expected values derived from the proportion of male and female discharges. Analyses of other data are described in the text.

Results

Sources and Targets of Referrals

Table 1 presents the frequency and percentage of requests for chaplain visits that came from various sources. As seen in the table, the nursing department made more than half of the requests. The second largest number of requests came from the pastoral care department itself. More than three quarters of these represent requests to chaplains from pastoral care volunteers, with the remainder being requests from other chaplains, including the department's director. Referrals from patients mainly reflect calls to the pastoral care department from individual patients. Excluding the pastoral care department, nursing accounted for 81.65% of requests from staff members, with social workers and physicians making 11.74% and 4.08%, respectively. In all, physicians, social workers and nursing staff comprised 97.47% of referrals to chaplains by staff. There were consistent increases over time in the number of referrals from social workers ($r = .86, p < .05$), nurses ($r = .68, p < .10$) and other staff ($r = .69, p < .10$), except physicians.

¹³Janet T. Spence, John W. Cotton, Benton J. Underwood, & Carl P. Duncan, *Elementary Statistics*. 5th Edition (Englewood Cliffs, NJ: Prentice Hall, 1990).

¹⁴Sidney Siegel and N. John Castellan, Jr. *Nonparametric Statistics for the Behavioral Sciences*. 2nd Edition (Boston, MA: McGraw Hill, 1988).

¹⁵*Ibid.*

TABLE 1**Percentage Distribution of the Sources of Referral Requests to Chaplains**

Source of Request	Number	Percent
Administrative and Support Staff	134	3.60
Family or Friends	195	5.22
Local Clergy	142	3.80
Nursing Department	2157	57.78
Pastoral Care Department	489	13.10
Patients	132	3.54
Physicians	108	2.89
Social Work Department	309	8.28
Other Departments	67	1.79
Total	3733	100.00

About three quarters of requests were referrals for chaplains to visit a patient (74.9%) and another quarter were requests to visit with family or friends (25.1%). A significant difference was found in the percentage of referrals made for patients and family/friends among staff members ($p < .05$), with social workers making a higher percentage of referrals for relatives and friends (34.12%), compared to nurses (26.74%) and physicians (27.27%).

Reasons for Referrals

The types of reasons that were given for making referrals to chaplains are listed in Table 2. The top row of the table indicates that 12.18% of referrals were made because a patient or relative requested to see a chaplain. The most common reason was that a patient or relative was anxious. The next most common reason was simply to provide support or pastoral care. As seen towards the bottom of the table, chaplains were sometimes asked to act as a patient advocate or help them with something, such as contacting someone. The "Other" category includes such things as crisis intervention, dealing with family issues, sharing good news, and requests from staff for the chaplain to visit hospitalized family members or friends.

TABLE 2**Number and Percentage of Reasons Given for Requesting Chaplains to Visit Patients, and Family or Friends**

Action, Problem, or Situation	Number	Percent
Asked to see a Chaplain	479	12.83
Asked for Religious Item or Ritual	68	1.82
Angry or Complaining	81	2.17
Anxiety	680	18.22
Bereavement or Loss	176	4.71
Crying or Upset	109	2.92
Depression	256	6.86
Difficult Decision	81	2.17

Dying or Terminally Ill	192	5.14
Loneliness	140	3.75
Patient Died	135	3.62
Patient in Pain	43	1.15
Pre- or Post- Operation	38	1.02
Pregnancy Loss	346	9.27
Suicidal Ideation	13	0.35
To Advocate for or Assist	46	1.23
To Provide Support/Pastoral Care	598	16.02
Other Reason or No Reason	252	6.75
Total	3733	100.00

*Anxiety and depression represent the general use of the terms, and do not refer to clinical diagnoses.

TABLE 3
Percentage of Various Reasons Given for Requesting
Chaplains to Visit Patients
(N=2796) versus Family or Friends (N=937)

Action, Problem, or Situation	Patients	Family or Friends
Asked to see a Chaplain	17.02	0.32
Asked for Religious Item or Ritual	2.36	0.21
Angry or Complaining	2.68	0.64
Anxiety	23.78	1.60
Bereavement or Loss	2.00	12.81
Crying or Upset	3.29	1.81
Depression	9.16	
Difficult Decision	0.50	7.15
Dying or Terminally Ill	6.37	1.49
Loneliness	5.01	
Patient Died		14.41
Patient in Pain	1.54	
Pre- or Post- Operation	1.36	
Pregnancy Loss	12.33	0.11
Suicidal Ideation	0.43	0.11
To Advocate for or Assist	1.65	
To Provide Support/Pastoral Care	1.65	58.91
Other Reason or No Reason	8.87	0.43
Total	100.00	100.00

Table 3 compares the reasons given for referral requests to chaplains to visit patients versus those to visit their family and friends. Patients were far more likely to ask to see a chaplain than were their family and friends. The most common presenting problems for which patients were referred to

chaplains were anxiety, depression, and pregnancy loss. The most common reasons why family and friends were referred to chaplains were bereavement/loss, having to confront difficult decisions, the patient's death, and simply being in need of support or pastoral care. All reasons listed in the table differed significantly between patients and family and friends ($p < .001$).

Referrals for Male and Female Patients

Female patients were more likely than male patients to directly contact the pastoral care department to request a chaplain visit (females = 111, males = 21, $p < .001$), and they were also more likely to be referred to chaplains (females = 2123, males = 673, $p < .001$). Female patients were more likely than male patients to be referred to chaplains for almost every reason listed in Table 4, and in more than half of the instances these differences were statistically significant. Pregnancy loss and the "None or Other" category are excluded from the table.

TABLE 4
Percentage Distribution of Types of Referral Requests for Male and Female Patients (N = 2203)

Action, Problem, or Situation	Total Requests	Percent Males	Percent Females	$p <$
Asked to see a Chaplain	476	30.25	69.75	.01
Asked for Religious Item or Ritual	66	19.70	80.30	.01
Angry or Complaining	75	38.67	61.33	
Anxiety	665	23.46	76.54	.001
Bereavement or Loss	56	37.50	62.50	
Crying or Upset	92	25.00	75.00	.05
Depression	256	26.17	73.83	.001
Difficult Decision	14	21.43	78.57	
Dying or Terminally Ill	178	39.89	60.11	
Loneliness	140	27.14	72.86	.05
Patient in Pain	43	9.30	90.70	.001
Pre- or Post- Operation	38	15.79	84.21	.01
Suicidal Ideation	12	25.00	75.01	
To Advocate for or Assist	46	34.78	65.22	
To Provide Support/Pastoral Care	46	28.26	71.74	

Rates of Referrals for Patients

The rate of patient referrals over the entire study period was 39.04 per 1000 patient stays. Table 5 gives the mean rates of patient referrals for the first three years and the last three years of the study. ANOVA revealed a significant increase in the overall rate of patient referrals over time ($p < .001$), and a significant interaction between sex and time ($p < .01$), attributable to the differential increase in the rates of referrals for males and females. Correlation analysis indicated a linear increase in referrals for both male ($r = .52$) and female ($r = .83$) patients over time, but only the latter correlation

was statistically significant ($p < .05$) because of the small sample size (i.e., 7 years). Table 6 shows the mean rates per stay for the five most common problems for which patients were referred to chaplains. No changes were found over time except for pregnancy loss, which exhibited a linear increase in the rate of referrals over the 7-year study period ($r = .82$, $p < .05$). The higher rates for referrals for pregnancy loss reflect the concerted efforts of the nursing and pastoral care departments over the years to provide pastoral care to all patients who suffer a pregnancy loss.

TABLE 5
Rate* of Patient Referrals to Chaplains During the
First and Last Three Years of the Study

Years	Rates for Males		Rates for Females	
	Mean	SD	Mean	SD
First three	19.97	3.90	34.73	7.03
Last three	26.39	4.86	53.02	6.65

*Rate per 1000 patient stays

TABLE 6
Rates* of the Five Most Common Problems for
which Patients were Referred to Chaplains

Problem	Rates for Males		Rates for Females	
	Mean	SD	Mean	SD
Anxiety	4.47	1.80	9.84	5.17
Depression	2.01	1.70	3.92	1.80
Dying or Terminally Ill	2.65	1.63	2.41	1.38
Loneliness	1.19	1.07	1.78	1.25
Pregnancy Loss			7.93	5.63

*Rate per 1000 patient stays

Discussion

Our findings indicate that the largest proportion of referrals to chaplains came from the nursing department, which is consistent with other studies on chaplain referrals.^{16,17} This is not surprising, since nurses are the mem-

¹⁶Koenig *et al.*, 1991, *op. cit.*

¹⁷Kevin J. Flannely, Andrew J. Weaver, & George F. Handzo, "A Three-Year Study of Chaplains' Professional Activities at Memorial Sloan-Kettering Cancer Center in New York City," *Psycho-Oncology*, 2003, Vol. 12, No. 8, pp. 760-768.

bers of the health-care team who have the greatest amount of patient contact. And, at Lawrence Hospital Center, they are encouraged to consider the pastoral/spiritual needs of their patients. When admitting new patients, nurses complete a questionnaire that includes a pastoral screen, including: Does the patient have a terminal illness? Does the patient have religious/cultural practices that will be affected by hospitalization? Has the patient suffered a recent loss or bereavement? Does the patient request a chaplain or specific religious care?

The second largest number of requests came from the pastoral care department itself. More than three quarters of these referrals represent requests to chaplains from pastoral care volunteers. Here too, the nursing staff provide a valuable source of information to the pastoral care department, since pastoral care volunteers routinely ask the nurse in charge of a unit they visit if there are patients that particular day in need of pastoral care. Pastoral care volunteers refer patients and family members who need more pastoral care than they are qualified to provide to professional chaplains. Volunteers also inform patients and families of the range of pastoral care services available during their hospital stay and can make referrals for patient and family members who ask to see a chaplain. Chaplains, in turn, may refer the patient or family to another chaplain with particular expertise or to provide continuous coverage during a chaplain's absence.

Excluding the pastoral care department, nursing accounted for 81.65% of requests from staff members, with social workers and physicians making 11.74% and 4.08%, respectively. Although every effort is made to correctly identify the sources of all referrals, the percentage of referrals from physicians may appear to be lower than it actually is because physician referrals are usually made through staff nurses or unit clerks, and therefore may not be directly attributed to the physician who initiated the referral. Nevertheless, the low percentage of referrals from physicians found here is similar to the findings of Flannelly *et al.*¹⁸ and Koenig *et al.*¹⁹

Unlike physicians and nurses, social workers at Lawrence Hospital Center, as in many other acute health care settings, connect with patients and families primarily in making patient discharge plans. Hence, we would not expect as many referrals from social workers as we would from nurses. However, since their dealings with patients often involve significant changes in the patient's and the family's lifestyle (*i.e.*, transfer to hospice, short- or long-term rehabilitation, permanent nursing home placement), social workers may find it advisable to refer the patient or family members to pastoral care for additional spiritual and emotional support. It also follows from the nature of their relationship with patients and families that social workers made more referrals for relatives and friends (34.12%), compared to nurses (26.74%).

The results show that the number of referrals increased over the course of the study, particularly among nurses and social workers, who made 93.4% of the referrals from staff members. This increase may be attributable to an increasing awareness of the importance of spiritual care among all the hospital's employees, and, perhaps, an increasing recognition of the value of chaplain interventions. Or it could reflect a rising interest in spirituality among staff members, generally. In any case, employees

¹⁸*Ibid.*

¹⁹Koenig *et al.*, 1991, *op. cit.*

are encouraged to treat patients and families as "whole persons," made of body, mind, and spirit. Every new employee and every employee undergoing the annual review of hospital policies and procedures learns, or is reminded, how essential it is to treat patients and families this way, and that all employees should be sensitive to these three components of care. During orientation, employees receive a brochure from the pastoral care department and basic training for how to make pastoral care referrals.

Referrals to chaplains from local clergy to see patients were fairly low (3.8%)—around the range reported by Flannelly *et al.*²⁰ (2.2%) in a study conducted at Memorial Sloan-Kettering Cancer Center (Memorial) in New York City. In that study we speculated that because many of the patients at Memorial are from outside the New York area, their clergy may not know how, or whom to contact to make a referral. When we looked at the reasons clergy made referrals to chaplains we found that about one quarter were for the chaplain to substitute for the clergyperson, who was unable to visit a patient. Most of the other reasons that were given imply that clergy visited the patient and wanted the chaplain to make a follow-up visit because of the patient's emotional state (*e.g.*, anxious, depressed, lonely). These data show that local clergy rely on chaplains to provide the continuity of spiritual care they are unable to provide to their congregants, reflecting a sense of collaboration between chaplains and community clergy. A recent study of community clergy found that clergy were more likely to refer patients to seek medical treatment at hospitals that have pastoral care departments.²¹

Patients, friends, and family members were referred for a variety of reasons. For family and friends the most common reason for the chaplain referral was simply to provide pastoral care and support. Referrals for visits to friends and family members over the course of the study period amounted to a quarter of all referrals. By contrast, our study at Memorial hospital found that more than 40% of referrals to chaplains were for interventions with family and friends without the patient present. We suspect the higher rate of referrals in the Memorial study is due to the fact that it has a large population of patients from outside the New York area. Family members who travel to New York therefore have few local resources to assist them during the hospital stay of their loved ones. Recognizing this, staff enlist the hospital's chaplains to provide support. Since Lawrence is a community hospital, family have more resources available, including local clergy, and they are less likely to need support from chaplaincy staff.

The reasons for referring patients to chaplains were usually quite specific, the most common being anxiety, depression, other signs of emotional distress, and the loss of a pregnancy. Just over 17% of the referrals were made because patients specifically asked to see the chaplain. Again, it should be noted that the terms anxiety and depression reflect general usage and do not refer to clinical diagnoses, which chaplains are not professionally trained or qualified to deal with.

In general, the percentage of referrals was disproportionately higher for female than male patients. Females were more likely to ask for a chaplain or a religious item or ritual, and they were referred to chaplains more often

²⁰Flannelly *et al.*, 2003, *op. cit.*

²¹Michael Moran, Kevin J. Flannelly, Andrew J. Weaver, John A. Overvold, Winnifred Hess, & Jo Clare Wilson, "A Study of Pastoral Care, Referral, and Consultation Practices Among Clergy in Four Settings in the New York City Area," *Pastoral Psychology*, in press.

for certain reasons, including crying, pain, depression, loneliness and anxiety. These findings might be biased by the fact that the chaplains at the hospital were both females. A number of studies have examined the religious activity and attitudes of hospitalized patients, but most of them have not looked at gender differences.^{22,25,34,35} Yet, the higher proportion of referrals for female patients is consistent with scientific research and national polls that indicate that females in the United States tend to be more religious than males, across age groups.^{26,27,38,39}

A study by Fitchett, Meyer, and Burton³⁰ is particularly relevant because it asked hospital patients if they wanted "spiritual care," during an interview about their religious and spiritual life. Of the 471 patients admitted during the course of the study, 202 were interviewed. Of these 202 patients (the majority of which were Catholic or Protestant), 70 (34.7%) requested a visit from a chaplain when the option was offered to them. Females were consistently, but not significantly more likely to request that the chaplain talk to them, pray with them, and give them the sacrament of communion.

The average rate of patient referrals throughout the study was 39.04 per 1000 patient stays. The rate of referrals increased over time, especially for females, and for female patients who lost a pregnancy. While our attempt to calculate rates of referrals is intended to provide a benchmark, the rate measure we used was developed after the fact, and it is rather crude. Ideally, one would calculate rates in terms of patient days, not patient stays as we do here. Hence, gender differences in rates per patient stay could occur because women had longer hospital stays than men, although we have no reason to believe this was the case.

We believe the high rates for referrals for pregnancy loss reflect the results of the coordinated efforts of the nursing and pastoral care departments to address the spiritual needs of pregnancy loss patients. The professional staff of Lawrence Hospital Center is especially concerned for patients and families going through the loss of a child at any time during pregnancy or just after birth. Although some religious and social institu-

²²Harold G. Koenig, "Religious Attitudes and Practices of Hospitalized Medically Ill Older Adults," *International Journal of Geriatric Psychiatry*, 1998, Vol. 13, No. 4, pp. 213-224.

²⁵Harold G. Koenig, Lindo K. George, & Ilene C. Siegler, "The Use of Religion and Other Emotion-Regulating Coping Strategies Among Older Adults," *The Gerontologist*, 1988, Vol. 28, pp. 303-310.

²⁶Harold G. Koenig and David B. Larson, "Use of Hospital Services, Religious Attendance, and Religious Affiliation," *Southern Medical Journal*, 1998, Vol. 91, No. 10, pp. 925-932.

²⁷Harold G. Koenig, David O. Moberg, & James N. Kvale, "Religious Activities and Attitudes of Older Adults in a Geriatric Assessment Clinic," *Journal of the American Geriatrics Society*, 1988, Vol. 36, pp. 362-374.

³⁴George H. Gallup, and D. Michael Lindsay, *Surveying the Religious Landscape: Trends in U.S. Beliefs* (Harrisburg, PA: Morehouse Publishing, 1999).

³⁵Jeffery S. Levin, Robert J. Taylor, & Lindo M. Chatters, "Race and Gender Differences in Religiosity Among Older Adults: Findings from Four National Surveys," *Journals of Gerontology*, 1994, Vol. 49, No. 3, S137-S145.

³⁸Alan S. Miller and John P. Hoffman, "Risk and Religion: An Explanation of Gender Differences in Religiosity," *Journal for the Scientific Study of Religion*, 1995, Vol. 34, No. 1, pp. 63-75.

³⁹Christian Smith, Melinda L. Denton, Robert Faris and Mark Regnerus, "Mapping American Adolescent Religious Participation," *Journal for the Scientific Study of Religion*, 2002, Vol. 41, No. 4, p. 597-612.

³⁰George Fitchett, Peter M. Meyer and Laurel A. Burton, "Spiritual Care in the Hospital: Who Requests It? Who Needs It?" *The Journal of Pastoral Care*, 2000, Vol. 54, No. 2, pp. 178-185.

tions, and health care facilities, have begun to recognize pregnancy loss as significant, many do not. Nursing and pastoral care staff developed a protocol to provide a standard of care to all pregnancy loss patients that helps them through the first hours and days of their loss. The protocol includes an automatic referral to the pastoral care department. ✻

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