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# How Satisfied Are Patients with the Ministry of Chaplains?

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The author describes the importance of chaplaincy departments conducting periodic patient satisfaction studies and provides quantitative results from 1440 patients discharged from one of 14 U.S. general hospitals. Patients expressed the most satisfaction in response to the item, "The chaplain seemed to be a person of spiritual sensitivity." The results also suggest the characteristics of patients who appear most responsive to this ministry.

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Chaplains and healthcare administrators seldom ask the question in the title of this article; more immediate concerns demand their attention. Patient satisfaction with the ministry of chaplains, however, merits more attention than it currently receives. Press<sup>1</sup> begins his discussion of patient satisfaction studies with the question, "Why bother?" At least four reasons exist for "bothering" to conduct periodic chaplaincy satisfaction studies.

First, patients take their spiritual and religious interests with them into the hospital. These interests are further stimulated by current cultural emphases that encourage patients to use spiritual interventions (*e.g.*, prayer) to promote recovery and healing. Many patients regard spirituality as extremely important, but their satisfaction with the spiritual ministry of chaplains is an ongoing relevant question.

Second, the spiritual interests of patients notwithstanding, at least some administrators tend to ignore the role and contribution of chaplains. This ministry is not essential to institutional operations in the same sense as the services of physicians and nurses. Administrators may assume, therefore, that chaplains are marginal to the institution's mission. At the same time, this neglect among administrators implies that chaplains are merely guests in the institution and not part of the treatment effort. This dynamic can demoralize chaplains and undermine their professionalism. Attention to patient satisfaction can underscore that chaplains are integrated into the hospital's mission and can identify their contribution.

Third, when chaplains seek to provide ministry to patients, they risk offending them. Despite all the interest in spirituality during illness, some patients want nothing to do with spirituality or religion. They can be

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<sup>1</sup>D.A. Dillman, *Mail and Telephone Surveys: The Total Design Method* (New York, NY: John Wiley and Sons, 1978).

offended that a chaplain even stopped to talk with them. Some patients and their family members assume that chaplains cannot be helpful to them when they are emotionally vulnerable. Patient satisfaction scores can indicate whether chaplains helpfully manage such situations.

Finally, in contrast to the medical and nursing professions, chaplaincy lacks best practices standards. The helpfulness of this ministry, therefore, is grounded in the personal/professional relationship styles of individual chaplains and the skills learned in their specialized education. Chaplains vary among themselves in their helpfulness, and periodic patient satisfaction studies provide valuable feedback.

As these considerations demonstrate, the ministry of chaplains involves both potential benefits and risks. "Bothering" to conduct periodic chaplaincy satisfaction studies increases the awareness of administrators and chaplains concerning how patients respond to this ministry.

## How Can Meaningful Results Be Created?

Some commercial satisfaction questionnaires do not gather information concerning the ministry of chaplains. Others include a general item that inquires about responses of professional staff members to spiritual needs. Such items generally create vague, unhelpful results. As Leebov and Scott<sup>2</sup> suggests, general inquiries yield only general information of limited value; more specific inquiries provide more helpful information. They suggest the periodic use of department-specific questionnaires. The use of a custom questionnaire that gathers information concerning specific chaplaincy activities seems appropriate and results from its periodic use could also become the basis for chaplaincy quality improvement efforts.

## What Literature Exists?

The literature contains four publications that describe results from a comprehensive study of patient satisfaction with chaplaincy services. One publication<sup>3</sup> describes the Patient Satisfaction Instrument-Chaplaincy (PSI-C) and initial results from the chaplaincy department in one general hospital. It also invited chaplaincy departments in other hospitals to use the questionnaire and to send completed surveys to the authors for analysis. A second publication<sup>4</sup> describes results from 508 patients discharged from one of 14 Canadian hospitals. A third publication<sup>5</sup> reports the results from 2000 patients discharged from one of 32 hospitals. A recent Irish study<sup>6</sup> builds a theological foundation for conducting patient satisfaction studies and reports results from the PSI-C. These four publications describe results from the original PSI-C with 40 clinical items, each with a Likert-type scale (1 = strongly disagree; 4 = strongly agree) and a "not applicable" category.

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<sup>2</sup>W. Leebov and G. Scott, *Service Quality Improvement: The Customer Satisfaction Strategy for Health Care* (Chicago, IL: American Hospital Association, 1994).

<sup>3</sup>I. Press, *Satisfaction: Defining, Measuring and Improving the Experience of Care* (Chicago, IL: Health Administration Press, 2002).

<sup>4</sup>L. VandeCreek and M. Lyon, "Preliminary Results from a Patient Satisfaction Instrument for Pastoral Care," *The Caregiver Journal*, 1992, Vol. 9, No.1, pp. 42-49.

<sup>5</sup>L. VandeCreek, M. Lyon, & J. DeVries, "Canadian Hospital Patients Evaluate Their Chaplain's Ministry," *Pastoral Sciences*, 1995, Vol. 14, pp.133-145.

<sup>6</sup>L. VandeCreek and M. Lyon, *Ministry of Health Care Chaplains: Patient Satisfaction* (New York, NY: Haworth Press, 1997).

No other published literature that quantified comprehensive patient satisfaction with this ministry was found. The study reported here describes results from a shortened version of the PSI-C.

## The Present Study

### The Patients

Chaplaincy departments of 14 U.S. general hospitals who arranged with the author to use the questionnaire carried out the selection of patients and mailed questionnaires to them. These hospitals were located in the upper Midwest and eastern section of the U.S.—from Massachusetts to South Dakota, from Missouri to Delaware, and ranged in size from 50 to 500 beds. Eight hospitals were religiously affiliated and six were unaffiliated. All patients selected by the departments had received at least one chaplaincy visit during their hospitalization and their characteristics are described in Table 1.

TABLE 1  
Patient Characteristics

Gender (females)	56%
Age (mean years)	57.2
Education level completed (hs/college experience/college graduate)	52%/26%/22%
Caucasian race	91%
Married or in a committed relationship	61%
Religious heritage (Protestant/Catholic/"Other")	59%/30%/11%
Worship attendance patterns (weekly/holidays only/rarely or never)	47%/34%/19%
Attended a hospital worship service during admission	13%
Seriousness of illness when admitted (not very/somewhat/extremely)	13%/22%/65%
Length of hospital stay (1 wk or less/2-4 wks/more than 4 wks)	45%/38%/17%
Distance from home to hospital 50 miles or less	73%
Received family/friends as visitors almost every day	74%
Visited by personal clergy/ official denominational representative	61%
Visits from chaplains (1 to 2 visits/3 to 6 visits/7 or more visits)	52%/35%/13%
Patients overall satisfaction with their hospital experience (extremely satisfied/somewhat satisfied/ neutral or dissatisfied)	65%/24%/11%

N = 1440

### **The Questionnaire**

Shortly after publication of PSI-C results, further analyses suggested that some highly correlated items could be removed. This shortened the questionnaire (PSI-C-R) to 23 clinical statements (Table 2) with 16 items in a demographic section. The questionnaire asked about many aspects of this ministry and included three outcome-oriented items (*i.e.*, "The chaplain's visit made the hospitalization easier," "contributed to my readiness to return home," and "contributed to a faster recovery." As in the original version, a Likert-type scale (1 = strongly disagree; 4 = strongly agree) followed each item with a "not applicable" option. Patients were instructed to select this option when an item pertained to services they did not receive.

### **The Process**

Chaplaincy departments who wished to conduct a satisfaction study of their ministry received the PSI-C-R from the author along with guidelines adapted from Dillman<sup>7</sup> that would maximize return rates. These instructions encouraged departments to select a random sample of discharged patients who had received at least one chaplaincy visit during their hospitalization. They cautioned against creating a biased sample and encouraged mailing questionnaires within 10 days of discharge during one or two months until they received as many completed questionnaires as practicable. Emphasis was placed on creating professional appearing materials. The instructions to each department included a sample cover letter and suggested that the questionnaires be coded so that reminders could be sent to non-responders. After the chaplaincy director signed each cover letter, the department mailed it with the PSI-C-R and a postage free return envelope to the patient address listed in the medical chart. The instructions suggested sending a postcard after two weeks, thanking those who had responded and urging non-responders to complete the questionnaire. Two weeks after sending the postcard, departments were instructed to identify responders by using the questionnaire code and to send non-responders a new cover letter, another questionnaire, and a postage free return envelope. The participating departments collected the completed returns and mailed them to the author for statistical analysis. They gave permission to enter their patient responses into the PSI-C-R computer file and received a report that compared their scores to other participating departments.

## **Study Results**

An analysis of the 1440 completed questionnaires identified three subscales and an independent item as reported in Table 2. The alpha scores described acceptable levels of subscale reliabilities (stronger reliability is indicated by alphas closer to .99). The first subscale contained 13 items and described how chaplains helped patients cope with the hospitalization, creating a subscale mean of 3.41 on the one-to-four scale. Four of its items reflected explicit religious aspects of this ministry, four items described help with personal anxieties, and five items pertained to cooperation with hospital personnel or outcomes related to hospitalization. Patients gave the highest mean score (3.66) to the item, "The chaplain helped me realize that God cares for me."

TABLE 2

## Satisfaction Scores for the Ministry of Chaplains and Item Correlations to a General Satisfaction Score

Questionnaire Items by Subscales	Mean	Std.	%	Corr.
<b>Subscale 1: Ministry that Promotes Coping (Alpha = .96)</b>	3.41	—	—	.25***
The chaplain helped me to realize God cares for me.	3.66	.62	83	.22***
The chaplain's visits made the hospitalization easier.	3.60	.61	86	.21***
The chaplain helped me use my faith/beliefs/values to cope.	3.60	.64	78	.16***
The chaplain helped me feel more hopeful.	3.56	.63	81	.22***
The chaplain's visits gave me strength to go on.	3.49	.68	78	.21***
The chaplain's visits aided my spiritual growth.	3.48	.67	77	.23***
The chaplain helped me face difficult issues.	3.47	.72	68	.25***
The chaplain helped me overcome my fears.	3.40	.74	68	.22***
The chaplain helped me adjust to my medical condition.	3.34	.75	67	.19***
The chaplain's visits contributed to my readiness to return home.	3.29	.81	62	.24***
The chaplain's visits contributed to a faster recovery.	3.23	.80	64	.22***
The chaplain helped the clergy of my congregation understand my situation.	3.13	1.00	26	.26***
The chaplain helped me cooperate with the doctors and nurses.	3.06	.94	46	.16***
<b>Subscale 2: The Supportive Ministry of Chaplains (Alpha = .87)</b>	3.70	—	—	.22***
The chaplain's prayer was a comfort to me.	3.79	.48	82	.14***
The chaplain gave the impression s/he was really listening to me.	3.75	.54	88	.13***
The chaplain seemed to know what s/he was doing during the visit.	3.74	.56	88	.18***
The religious worship service met my needs.	3.68	.58	38	.22***
My need for the sacraments was fulfilled.	3.65	.63	51	.20***
After talking with the chaplain, I felt better about my problems.	3.60	.61	79	.20***
<b>Subscale 3: Acceptance of the Chaplain(s) Ministry (Alpha = .74)</b>	1.25	—	—	.12***
The chaplain's visits scared me.	1.19	.58	78	.12***
The chaplain talked too much.	1.24	.59	83	.14***
The chaplain's visits made me too tired.	1.32	.71	75	.10**
<b>Independent Item</b>				
The chaplain seemed to be a person of spiritual sensitivity	3.81	.49	93	.14***

Notes: The questionnaire items are arranged into three subscales plus an independent item as determined by factor analyses (available from the author). The "Mean" is the arithmetic average of the scores between 1 (strongly disagree) and 4 (strongly agree). The % column indicates the percentage of respondents who used the Likert-type scale to respond to the item. The remaining percentage selected "Not Applicable," indicating that they could not respond to the item. The column titled "Corr" reports the correlation to an item in the demographic section that read, "Tell us how satisfied you were with your overall hospital stay."

\*  $p = .05$ ; \*\*  $p = .00$ ; \*\*\*  $p = .000$

The six items of the second subscale concerned how this ministry provided support; the item with the highest score reflected comfort provided by the chaplain's prayers (3.79). Patients gave an acceptable score to the worship services in the hospital although only 38 percent acknowledged that they attended such a service by responding on the Likert-type scale. They were very satisfied with the professional demeanor of chaplains ("seemed to know what s/he was doing during the visit") and reported that they "felt better about problems" after the visit(s). Taken together, these items created a higher subscale mean score (3.70) than the first subscale (3.41).

The three items in the third subscale concerned whether patients accepted this ministry, exploring whether chaplains scared patients by visiting or imposed themselves in fragile clinical situations. These items were worded negatively and their mean scores was 1.25, suggesting that patients accepted this ministry with few concerns.

The analysis (Table 2) also identified an item independent of the three subscales, (i.e., "The chaplain seemed to be a person of spiritual sensitivity"). More patients used the Likert-type scale to respond to it than any other item (93%) and created the highest mean score (3.81).

One item in the demographic section asked, "How satisfied were you with your overall hospital stay?" with five response categories (1 = extremely satisfied; 5 = extremely dissatisfied). The correlation of each clinical questionnaire item to this global assessment of satisfaction is reported in Table 2. These moderate but statistically significant correlations suggested the relationship between satisfaction with this ministry and patients' satisfaction with the total hospital experience.

Chaplains and healthcare administrators not only wish to obtain satisfaction scores but also want strategies concerning how scores can be raised. Additional analysis of the satisfaction scores identified patient characteristics of those who were particularly responsive to this ministry (Table 3). These patients included those who were visited more frequently by chaplains, those who did not attend the hospital's worship services, those with less formal education, those who more frequently attended community worship services when not ill, those who were older, more ill when admitted, and those with shorter hospital stays. Additional, tailored pastoral attention to such patients may increase their satisfaction.

TABLE 3  
Variables That Predict 7 Patient Satisfaction Scores

Variables	Beta	Std.E.	t
How many times did the chaplain visit you?	.160	.01	4.79***
Did you attend a worship service while in the hospital?	-.132	.04	-4.37***
Highest education level completed	-.105	.02	-3.51***
How frequently do you usually attend worship services when you are not ill?	-.087	.02	-2.94**
What is your age?	.070	.01	2.32*
How ill were you when you arrived at the hospital?	.086	.01	2.80**
How long were you in the hospital?	-.091	.02	-2.64**

Notes: The analysis determined that the following patient characteristics did not significantly influence the satisfaction scores: gender, race, marital status, and patient religious heritage, the distance they lived from the hospital, the frequency with which they received visitors, and whether their congregational clergy (or another official representative) visited them. Standardized betas are quoted from a stepwise regression analysis. Std.E. = Standard Error.

\*  $p = .05$ ; \*\*  $p = .00$ ; \*\*\*  $p = .000$

Were patients equally satisfied with chaplaincy services in the 14 participating hospitals? Analysis revealed a significant difference across departments (Oneway Analysis of Variance:  $F = 5.86$ ;  $p = .000$ ), demonstrating that patients were more satisfied with the ministry of the chaplaincy department in some hospitals than in others.

## Discussion of the Study and Its Results

Commercial satisfaction questionnaires tend to ignore chaplaincy or to gather global, unhelpful information. Results from this chaplaincy-specific survey suggest that more helpful information can be obtained and point out how and to what extent chaplaincy services are appreciated in the participating hospitals.

Many persons stereotype chaplains as clergy who simply perform religious services and rituals. These results demonstrate that chaplains respond to diverse patient concerns (as demonstrated by item contents) in a sensitive manner (the item concerning "spiritual sensitivity" received the highest mean score) with considerable patient satisfaction.

The percentage of patients who used the Likert-type scale to respond to individual items varied widely from 93 percent to 26 percent (Table 2). This variation is not surprising because, while specific questionnaire items generate specific information, their specificity makes them irrelevant to the spiritual care of some patients. This reflects the diverse clinical and religious situations chaplains encounter. Sometimes the patient wishes the chaplain to pray; sometimes prayer is inappropriate. Sometimes the patient discusses difficult issues; sometimes no difficult issues exist because the patient is very happy (e.g., "no cancer was found during my surgery"). Sometimes the patient wishes the sacrament of the Eucharist; sometimes the patient professes no religious faith. The satisfaction scores demonstrate that this ministry is diverse and not limited to religious patients.

The correlations reported in Table 2 link each clinical questionnaire item to the patient's evaluation of their overall hospital experience. The clinical interpretation of these correlations must consider the percentage of patients who used the Likert-type scale to create the mean score—and thus its correlation to global satisfaction. For example, 83 percent used the scale to respond to the item, "The chaplain helped me to realize that God cares for me," creating a correlation of .22 to the global satisfaction score. In contrast, 26 percent used the scale to respond to the item, "The chaplain helped the clergy of my congregation understand my situation," creating a correlation of .26. The correlation produced by the first example reflects the perception of many more patients than the second example, impacting the interpretation of clinical significance. Note, however, that the difference between the two examples does not mean that one is more important than the other to the patients involved.

The correlations of the three outcome items to global satisfaction are especially interesting because they relate to economic factors. The correlations are:

- .24 "The chaplain's visits contributed to my readiness to return home."
- .22 "The chaplain's visits contributed to a faster recovery."
- .21 "The chaplain's visits made the hospitalization easier."

These moderate but significance correlations demonstrate that, in the view of patients, chaplaincy visits helped them with important issues of medical, nursing, and administrative interest.

The results in Table 3 identify patient characteristics more strongly associated with chaplaincy satisfaction and suggest how this ministry might raise the scores. For example, those who received an increased number of chaplaincy visits were more satisfied. Repeated visits positively influence patient satisfaction.

Those who did not attend a worship service in the hospital created higher satisfaction scores for chaplaincy. Perhaps these patients were too ill to attend and chaplaincy visits functioned as a proxy for the worship service, thus accounting for the significant association. Additionally, those who attend worship services more regularly in the community when they are not ill create higher scores. These results suggest that the religiously active patients are more satisfied with the chaplain's visits. The less educated, the older patients, those who are more seriously ill upon admission and those with shorter hospital stays also create higher scores. Many of the findings reported in Table 3 are similar to those identified in previous publications, increasing confidence in the results.

We compared the mean scores across the 14 chaplaincy departments and found significant differences in the satisfaction scores. This suggests that the PSI-C-R can detect differences in satisfaction. These differences must be interpreted carefully, however, because they may be explained at least in part by the differing patient characteristics across the departments.

Assessment of these results must consider at least two limitations and suggests that much work remains. First, although participating departments received instructions concerning how to select their patient sample and how to maximize the return rate, the demand of clinical duties and limited departmental personnel support sometimes compromised these procedures. Some were unable to keep adequate records concerning how many patients received questionnaires and some may not have sent the reminder postcard or the second questionnaire. Consequently, information concerning patient response rates is unavailable. Chaplaincy departments were also unable to determine if the respondents were representative of the patients they visited or the total inpatient hospital population.

Second, nothing is known about the chaplains who provided the evaluated services except that they were administratively responsible to the chaplaincy departments within their respective hospitals. Their age, race, gender, religious affiliation, or academic and clinical education for this ministry may influence the scores.

In conclusion, these results suggest an answer to the question posed in the title at least for the participating hospitals. The mean scores reported in Table 2 suggest that patients are generally satisfied with the ministry of chaplains. The satisfaction scores, however, did differ across participating institutions and this suggests the need for individual departments to determine patient responses to their ministry. Administrators and chaplains can know more clearly how satisfied patients are with this ministry by conducting their own periodic studies. ♣

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