

## **Selected Findings from the “New York” and the “Metropolitan” Chaplaincy Studies: A 10-Year Comparison of Chaplaincy in the New York City Area**

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*In recent years, the chaplain-to-patient ratio in U.S. hospitals has remained roughly the same while the role of the hospital chaplain has expanded. We compared data on 33,000 chaplain visits from the New York Chaplaincy Study (1994–1996) with 58,000 chaplain visits from the Metropolitan Chaplaincy Study (2005–2006), in order to explore whether changes in both the role of the healthcare chaplain and changes in the healthcare system itself have affected the amount of time that chaplains are able to spend with patients. The overall pattern of lengths of visits was stable over time, but chaplains in the Metropolitan Chaplaincy Study had proportionally fewer visits with family members and more visits with patients, more visits based on referrals, and spent more time dealing with end-of-life issues than chaplains in the earlier New York Chaplaincy Study. We discuss ways that chaplains seem to be adjusting successfully to increasing demands on their time.*

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## INTRODUCTION

A 1997 survey of U.S. hospitals with pastoral care departments found they had 1.85 chaplains per one hundred patients, with larger hospitals having closer to 1 chaplain per 100 patients (VandeCreek, Grey, Siegel, Brown, & Torperzer, 2001). A survey of a random sample of all U.S. hospitals conducted in November 2003 found larger hospitals were more likely to have pastoral care departments, but they had relatively fewer chaplains for their size (Flannelly, Handzo, & Weaver, 2004). On average, hospitals with 100–200 patients had 1 chaplain per 100 patients, with larger hospitals having .8 to .9 chaplains per 100 patients. A more recent study, using data from the American Hospital Association reported that the extent of chaplaincy services in U.S. hospitals stayed roughly the same between 1980 and 2003 (Cadge, Freese, & Christakis, 2008).

At the same time, the role of chaplains had been expanding in the U.S. and elsewhere (Ford & Tartaglia, 2006; Wright, 2001; Zock, 2008). Financial realities have forced chaplains to become a more visible and multi-functional presence in their institutions in order to highlight the value of continued funding for pastoral care. For instance, chaplains counsel staff members, conduct community outreach activities with local clergy, sit on ethics committees, and participate in medical and nursing education programs (Feldbush, 2008). Hospitals are increasingly being encouraged or even mandated to have pastoral representation on a number of committees dealing with issues such as ethics, palliative care, and cancer care. Recent national surveys confirm the wide range of roles that chaplains throughout the United States perform in their hospitals (Flannelly, Bucchino, Handzo, & Tannenbaum, 2005a; Flannelly, Weaver, Handzo, & Smith, 2005b). Given that chaplains' roles are expanding while the chaplain-to-patient ratio remains static, one would expect that chaplains would have less time to minister directly to patients.

Additionally, the expansion of chaplains' roles is occurring within a healthcare system which itself has undergone significant shifts in recent decades. Changes in reimbursement systems for inpatient care have led hospitals to strive to shorten patients' length of stay (Ottenbacher, Smith, Illig, Linn, Ostir, & Granger, 2004). With length of stay declining, the result is more rapid turnover of patients and greater acuity of illness among the inpatient population at any given time. As a consequence, professional chaplains might be expected to have fewer opportunities to follow-up with patients, fewer chances to meet with family members, and an increasing need to concentrate their clinical time on the most urgent patient needs.

However, these changes might be less likely to affect the pattern of visits of Clinical Pastoral Education (CPE) students, whose efforts are often focused on one particular unit or section of the hospital and whose time is less constrained by the competing demands of multiple roles.

This paper reports the results of a comparison between two different studies of chaplain visits, conducted almost 10 years apart, in order to explore whether changes in both the role of the healthcare chaplain and changes in the healthcare system itself have affected the amount of time that chaplains are able to spend with patients.

## METHODS

We compared data from two studies that were conducted approximately 10 years apart: the New York Chaplaincy Study (1994–1996) and the Metropolitan Chaplaincy Study (2005–2006). Each study collected data from chaplain visits at hospitals in the New York City metropolitan area. The New York Chaplaincy Study included 10 hospitals and collected information on 33,000 visits, which were conducted by 40 professional chaplains and 200 students who were enrolled in CPE through the HealthCare Chaplaincy. Data were collected on paper forms over two-week periods each year. Some pastoral care departments had two or three data-collection periods in some years.

The Metropolitan Chaplaincy Study included 13 hospitals and collected data on 58,000 visits, which were conducted by 25 professional chaplains and 50 CPE students. For this study, the data were collected on a daily basis throughout the two-year time-period as each hospital began to use a computerized system (Chaplaincy Counts<sup>®</sup>). Some of the hospitals were included in both studies, while others were only included in one of the studies (Table 1).

Information collected for each visit included: (a) who was visited (patient, family, staff, or other); (b) the religious affiliation of the patient; (c) whether the visit was an initial visit or a follow-up visit; (d) whether or not the visit was based on a referral, and if so, the source of the referral; (e) the duration of the visit; and (f) interventions performed by the chaplain during the visit (e.g., presence, grief support, prayer, religious ritual).

Duration of visits was recorded in 5-minute intervals. The shortest length that could be recorded was 5 minutes, while the longest was 120 minutes. For each possible visit duration, we calculated the percentage of visits of that duration. Three sets of percentages were calculated for each study: (a) total visits; (b) visits by professional chaplains; and (c) visits by CPE students. In order to detect any significant difference in the pattern of visits between professional chaplains and students, we computed the Pearson's correlation coefficient for chaplains versus students within each study. To compare the

**TABLE 1** Acute Care Hospitals in the New York Metropolitan Area that Participated in the Two Studies

New York Chaplaincy Study	Metropolitan Chaplaincy Study
Beth Israel Medical Center Hospital for Special Surgery Lawrence Hospital Center Lenox Hill Hospital Memorial Sloan Kettering Cancer Center New York Hospital Medical Center of Queens	Beth Israel Medical Center Hospital for Special Surgery Lawrence Hospital Center Lenox Hill Hospital Memorial Sloan Kettering Cancer Center New York Hospital Medical Center of Queens
New York Downtown Hospital New York Hospital Cornell Medical Center New York Hospital Westchester	Griffin Hospital North General Hospital North Shore University Hospital St. John's Riverside Hospital St. Luke's/Roosevelt Hospital Vassar Brothers Medical Center Winthrop University Hospital

patterns of visit lengths across the two studies, we computed the Pearson's correlation coefficient for the visit lengths between the total visits for each study, the professional chaplain visits for each study, and the CPE student visits for each study.

Our ability to compare the length of visits for similar issues across the two studies was limited due to the different data collection systems used. However, we identified a subset of visits from each study that had a similar counterpart in the other study. In the New York Chaplaincy Study, chaplains identified the medical status of the patient using categories including, but not limited to: in treatment, in crisis, pre-op, post-op, dying, and end-stage disease. The Metropolitan Chaplaincy Study did not include the medical status variable in the same form, but it included two variables to identify: 1) the main issue dealt with during the visit, and 2) the type of visit. Examples of responses for the main issue of the visit included, but were not limited to: advanced directive, enhanced well-being, death, loss, guilt, and ritual needs. Types of visit included: code/emergency, initial visit, follow-up, referral, pre-surgical, and other. We compared the lengths of visits in the New York Chaplaincy Study for which the patient's medical status was listed as pre-surgical with those in the Metropolitan Chaplaincy Study for which the visit type was listed as pre-surgical. We also compared visits with the patient's status coded as dying or end stage disease (New York Chaplaincy Study) with those for which the main issue of the visit was coded as death (Metropolitan Chaplaincy Study). Finally, we compared visits for which the patient's status was listed as crisis/code (New York Chaplaincy Study) with visits for which the visit type was listed as code/emergency (Metropolitan Chaplaincy Study).

**TABLE 2** Percent of Chaplain Visits with Patients, Family, Staff, and Others in the Two Studies

Population served	NYCS	MCS
Patient	81.4	91.5
Family	13.9	6.2
Staff	2.3	2.1
Other	2.4	0.2
Total	100.0	100.0

## RESULTS

The vast majority of chaplain visits were with patients, as shown in Table 2. The religious affiliation of patients who were visited in each study is presented in Table 3. The greatest percentage of patients was Catholic in each study (34.5% in the New York Chaplaincy Study and 41.0% in the Metropolitan Chaplaincy Study). In the New York Chaplaincy Study, Jewish patients were the next most commonly visited group (25.3%). However, in the Metropolitan Chaplaincy Study, the second most common religious affiliation was “other” (20.2%), which included a variety of faith traditions and affiliations (e.g., Buddhist, Hindu, Wiccan, Ethical Humanist).

In the New York Chaplaincy Study, 18.6% of visits were the result of referrals, while in the Metropolitan Chaplaincy Study, 26.9% of visits were the result of referrals. Chaplains were more likely to receive and respond to referrals than students in each study, as shown in Table 4.

The sources of referrals are displayed in Table 5. The majority of referrals came from either patients and families or nursing staff in each study; however, patients and families referred more frequently than nurses in the New York Chaplaincy Study (44.5% vs. 35.3%) and less frequently in the Metropolitan Chaplaincy Study (30.4% vs. 45.0%).

Table 6 displays the percentage of chaplain and student visits collapsed into 10-minute intervals. In both studies, 5- and 10-minute visits were the most common, equaling 57.7% of the total visits in the New York Chaplaincy

**TABLE 3** Percent of Chaplains Visits to Patients of Various Faiths in the Two Studies

Religious affiliation	NYCS	MCS
Catholic	34.5	41.0
Jewish	25.3	16.5
Protestant	18.7	17.3
Muslim	4.0	1.9
Other	12.8	20.2
None	4.7	3.1
Total	100.0	100.0

**TABLE 4** Percent of Visits Resulting from Referrals in the Two Studies

	NYCS	MCS
Referrals to chaplains	25.4	31.7
Referrals to students	13.9	19.6
Total referrals	18.6	26.9

Study and 51.1% of the total visits in the Metropolitan Chaplaincy Study. The next most common was 15- and 20-minute visits, occurring in 26.7% of New York Chaplaincy Study visits and 32.2% of Metropolitan Chaplaincy Study visits. This pattern held true for both chaplains and students. Visits longer than 30 minutes were relatively rare, accounting for only 6.1% and 6.2% of total visits for the respective studies. The mean visit durations in minutes for chaplains and students in the New York Chaplaincy Study were 14.5 ( $SD=14.6$ ) and 14.8 ( $SD=13.8$ ), respectively. For the Metropolitan Chaplaincy Study, the mean visit duration was 15.5 ( $SD=13.5$ ) for chaplains and 15.6 ( $SD=11.5$ ) for students.

The distribution of the duration of visits remained stable for chaplains and students across both studies, as indicated by the fact that the percentages of visits of each duration were highly correlated between the two studies ( $r=.96$ ,  $p<.001$ ). The percentages of visit durations also were highly correlated between the two studies for chaplain ( $r=.95$ ,  $p<.001$ ) and student visits ( $r=.96$ ,  $p<.001$ ). The pattern for chaplain and student visits were also highly correlated within each study, with  $r=.99$  ( $p<.001$ ) in the New York Chaplaincy Study, and  $r=.97$  ( $p<.001$ ) in the Metropolitan Chaplaincy Study.

Initial visits were slightly more common than follow-up visits in the New York Chaplaincy Study (54.8% vs. 45.2%, respectively) than in the Metropolitan Chaplaincy Study (52.4% vs. 47.6%, respectively). However, the average duration of initial visits was slightly shorter than that of follow-up visits for both the New York Chaplaincy Study ( $M=13.1$ ,  $SD=12.0$  vs  $M=16.6$ ,  $SD=15.6$ ) and the Metropolitan Chaplaincy Study ( $M=14.1$ ,  $SD=10.5$  vs.  $M=15.9$ ,  $SD=1.6$ ). Mean durations of initial versus follow-up visits and referred versus non-referred visits calculated separately for chaplains and

**TABLE 5** Sources of Referrals in the Two Studies

Source	NYCS	MCS
Patients/Family	44.5	30.4
Nursing	35.3	45.0
Social work	5.6	2.5
Physicians	3.4	3.1
Other	11.2	19.0
Total	100.0	100.0

**TABLE 6** Percentage Distribution of Visit Duration for Chaplains and Students in the Two Studies

Minutes	NYCS			MCS		
	Chaplains	Students	Total	Chaplains	Students	Total
5–10	59.4	57.0	57.6	53.3	47.6	51.1
15–20	26.4	27.1	26.7	31.2	34.3	32.4
25–30	8.9	9.7	9.7	8.6	13.0	10.3
35–40	1.6	2.5	2.2	2.7	2.4	2.6
45–50	1.4	1.5	1.5	1.8	1.3	1.6
55–60	1.3	1.2	1.3	1.0	0.8	0.9
65–70	0.2	0.3	0.3	0.4	0.2	0.3
75–80	0.1	0.2	0.2	0.2	0.2	0.2
85–90	0.1	0.2	0.2	0.3	0.2	0.2
95–100	0.1	0.1	0.1	0.1	0.0	0.1
105–110	0.0	0.0	0.0	0.1	0.0	0.0
115–120	0.5	0.3	0.3	0.4	0.1	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0

students are presented in Table 7. As seen in the table, the means of chaplains and students are very similar within studies, and they do not vary much across studies either.

Table 8 shows the percentage of visits of various durations for three types of visits: pre-surgical visits, visits where the main issue addressed was death, and visits in response to a code/emergency. For the latter two categories, we excluded one hospital that participated in the Metropolitan Chaplaincy Study, as we explain later. The pattern for pre-surgical visits is nearly identical across the two studies. However, the percentage of 5–15 minute visits for death/end of life issues was nearly twice as high in the New York Chaplaincy Study (61.2%) as in the Metropolitan Chaplaincy Study (35.3%). Similarly, the percentage of 5–15 minute visits dealing with a code/emergency was 59.6% in the New York Chaplaincy Study and 33.3% in the Metropolitan Chaplaincy Study. Although the majority of visits for these issues were 30 minutes or less for both studies, the percentages of visits of 35 minutes or longer were higher in the Metropolitan Chaplaincy Study

**TABLE 7** Mean Duration (in minutes) of Different Types of Visits by Chaplains and Students in the Two Studies

	NYCS				MCS			
	Chaplains		Students		Chaplains		Students	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Initial visit	12.8	12.4	13.4	12.2	14.0	10.7	14.1	10.2
Follow-up	16.8	16.9	16.4	15.3	15.8	12.4	16.1	10.3
Referral	20.0	19.1	20.4	20.3	18.2	17.2	19.2	15.2
Non-referral	12.6	12.1	13.9	12.2	14.3	11.1	14.7	10.2

**TABLE 8** Duration of Visits in the Two Studies for Comparable Issues

Minutes	Pre-surgical visit		Dying/End of life		Code/Emergency	
	NYCS	MCS	NYCS	MCS*	NYCS	MCS*
5–15	85.4	86.4	61.2	35.3	59.6	33.3
20–30	11.0	11.6	25.5	36.2	23.1	27.3
35–45	1.8	1.4	5.3	11.7	6.2	12.1
50–60	0.8	0.4	4.1	6.8	6.2	9.7
65–75	0.3	0.1	2.0	2.7	0.6	4.8
80–90	0.4	0.1	0.6	2.9	1.0	4.2
95–105	0.0	0.0	0.2	0.5	0.0	0.6
110 or more	0.3	0.0	1.1	3.8	3.3	7.9

\*Excluding visits from one suburban teaching hospital (see explanation in Results section).

(28.4% for death, 39.3% for code/emergency) than in the New York Chaplaincy Study (13.3% for death, 17.3% for code/emergency).

The hospital that was excluded from the results for dying/end of life and code/emergency visits shown in Table 8 is a suburban teaching hospital that has a protocol in which chaplains are part of both the code team and the trauma team. The chaplain is paged at the onset of a code or trauma situation, and stays with the patient and family until the situation is resolved. Because of its designation as a regional trauma center, this hospital has a high frequency of code and trauma situations, which require a chaplain's extended presence. These factors result in an unusually high percentage of chaplain visits of long duration (e.g., two hours or more). When we include chaplain visits at this hospital in our results for dying/end of life and code/emergency situations in the Metropolitan Chaplaincy Study, the percentages of visits lasting 110 minutes or more jump to 7.3% and 14.6%, respectively.

## DISCUSSION

As we had hypothesized, the proportion of visits with family members decreased over the 10-year interval between studies, while the proportion of visits with patients increased. This may indicate that, as patients have shorter lengths of stay, chaplains have fewer opportunities to interact with visiting family members. The greater proportion of visits with patients may reflect the higher number of patients who pass through the hospital as a result of higher turnover.

The finding that referrals increased overall suggests that chaplains are indeed making themselves more visible within their respective institutions. Although the rate of referrals is still relatively low, the upward trend is encouraging. As we have pointed out in previous publications (Vanderwerker, Flannelly, Galek, Harding, Handzo, Oettinger, & Bauman, 2008; Galek,

Vanderwerker, Flannelly, Handzo, Kyle, Ross, & Fogg, in press), the establishment of effective referral protocols will help chaplains use their time most efficiently by identifying the patients most in need of their care. This improved efficiency will be necessary as chaplains face increasing demands on their time without corresponding increases in staffing.

Nurses were a consistently reliable source of referrals across both studies, but they contributed an even higher proportion of referrals in the second study, with a corresponding decrease in requests coming directly from patients and families. Once again, this suggests that chaplaincy services are becoming better known and valued by nurses, who are the front-line health-care workers most likely to become aware of patients' spiritual distress. An increasing number of referrals also came from "other" staff, which included such individuals as rehabilitation therapists, unit secretaries, and care coordinators/case managers. This suggests that chaplains are being acknowledged and utilized as a resource by a variety of staff members beyond nurses, doctors and social workers, further supporting the idea that chaplains are making themselves increasingly visible throughout the hospital. This increasing visibility is likely due to their effectiveness not only in patient visits but also as members of the interdisciplinary care team.

Interestingly, the patterns of lengths of visits with patients were nearly identical across the two studies. This finding suggests that the changes in the healthcare system (e.g., decreased in-patient length of stay and the role of chaplaincy [increasing outreach and educational roles]) have not significantly decreased the amount of time that chaplains are able to spend with patients. Chaplains seem to be adjusting to these increased demands by improving their screening processes and referral protocols through staff members and, in some cases, pastorally-trained volunteers, so that they can use their time efficiently by focusing their attentions on those patients with the greatest need. The increased rate of referrals in the more recent Metropolitan Chaplaincy Study, combined with the finding that visits due to referrals were longer than those not prompted by referrals, further supports this claim.

While we had hypothesized that the pattern for CPE students would be less likely to change than that of professional chaplains, in fact, the patterns for CPE students and professional chaplains were remarkably similar and equally stable across time. It is important to note that we were not able to compare the quality of visits, nor would we expect CPE students to be able to provide the same quality of care as board certified chaplains. Nevertheless, in terms of the proportion of time spent in longer and shorter visits, CPE students' visiting patterns mirrored those of chaplains. The stability of those patterns over time for CPE students is less surprising than it is for chaplains, since expectations of students and demands on their clinical time probably have not changed in the way that they have for professional chaplains.

It is not surprising to see that initial visits were slightly more common than follow-up visits in both studies, as some patients do not require further pastoral care beyond the initial visit. Also, chaplains are routinely called for deaths, which rarely involve follow-up visits once the family has left the hospital. It is also not surprising that follow-up visits tended to be longer than initial visits. Follow-up visits often occur because initial screening has identified a pastoral need, and the initial visit has contributed to building rapport. Patients are often ready to spend more time dealing with in-depth issues in the follow-up visit. Additionally, patients staying long enough in the hospital to receive a follow-up visit have often learned new and disquieting information and need pastoral support.

Although we were unable to compare lengths of visits for a wide range of issues, our comparison of visits that dealt with death and code/emergency situations indicated that chaplains are devoting more time to these issues. Whereas the duration of pre-surgical visits remained essentially the same, the percentage of longer visits dealing with death/end-of-life issues and codes/emergencies increased. This is so, even when we excluded visits from one suburban teaching hospital which tends to have more frequent and longer visits for those issues (see explanation in the Results section). End-of-life and medical crises are often associated with particularly intense levels of distress; thus, they often merit an extended amount of the chaplain's time and attentive presence. In the case of end-of-life issues, members of the medical team are increasingly recognizing the value of chaplain involvement earlier in the process, by making referrals to them for support (a) to deal with decisions about discontinuing treatments, (b) to identify health care proxies, and (c) to make choices regarding the use of "extraordinary measures" such as ventilation, dialysis, and artificial nutrition and hydration. The increased amount of time spent on these issues, along with the fact that the overall pattern of time spent with patients has remained the same, adds further weight to the assertion that chaplains are adjusting to increased time demands by developing effective ways to identify patients with the most distress and prioritizing their clinical time accordingly.

There are some important limitations to note when considering these results. Unfortunately, the two studies used different coding systems to record the issues dealt with during visits. Although we were able to compare three subgroups of visits that we judged to be reasonably comparable, it will be preferable in the future to be able to use data that are coded using the same data collection system. As we continue to collect more data using the Chaplaincy Counts<sup>®</sup> system, we will be able to compare lengths of visits for different types of issues. For instance, do chaplains spend more time dealing with distressing issues such as anxiety and grief, in contexts other than death and codes/emergencies? Do they have less time available for faith affirmation in less distressed patients? These are important questions

that remain to be answered in future studies. Additionally, we wish to emphasize the fact that data such as we have reported are not able to give us the full picture of how well the chaplain responded to the particular situation and individual encountered in each visit (VandeCreek & Lyon, 1994/1995). In other words, they tell us about the quantity of time spent, but not its quality.

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