

# Factors Affecting HealthCare Chaplaincy and the Provision of Pastoral Care in the United States\*

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As pastoral care has begun to mature as a profession, particularly in healthcare settings, it is producing some of the basic knowledge and information which undergird and legitimize it.<sup>1</sup> To date, however, little research has been done that documents the role chaplains play in healthcare settings,<sup>2,3</sup> or the place of chaplaincy and pastoral care within the healthcare system.<sup>4</sup>

A study by VandeCreek and his colleagues<sup>5</sup> provides valuable data on the employment and deployment of chaplains in healthcare settings with pastoral care departments. Their survey of pastoral care directors found that the number of chaplains increased with hospital size in both religiously affiliated and non-affiliated hospitals, but the number of chaplain FTEs was roughly two times higher in religiously affiliated hospitals.

The present study attempted to extend the findings of VandeCreek *et al.*<sup>6</sup> by conducting a randomized survey of healthcare institutions throughout the United States (U.S.) to see how they are meeting the spiritual needs of patients. The study was designed to measure the degree to which different institutional characteristics (such as religious affiliation) affect whether they employ professional chaplains and the number of chaplains they employ.<sup>7</sup>

## Methods

A survey of healthcare facilities was conducted using a list of the chief executive officers (CEOs) of licensed healthcare institutions in the U.S. (N = 6,650), which was purchased from American Medical Information, Inc. A total of 3,300 questionnaires were mailed to CEOs based on a random sample of 50% of the sampling frame.

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

<sup>2</sup>Kevin J. Flannelly, Andrew J. Weaver, and 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.

<sup>3</sup>Sarah L. Fogg, Andrew J. Weaver, Kevin J. Flannelly, and George F. Handzo, "An Analysis of Referrals to Chaplains in a Community Hospital in New York Over a Seven Year Period," *The Journal of Pastoral Care and Counseling*, in press.

<sup>4</sup>Larry VandeCreek, Karolynn Siegel, Eileen Gorey, Sharon Brown, and Rhoda Toperzer, "How Many Chaplains per 100 Inpatients? Benchmarks of Health Care Chaplaincy Departments," *The Journal of Pastoral Care*, 2001, Vol. 55, No. 3, pp. 289-301.

<sup>5</sup>*Ibid.*

<sup>6</sup>*Ibid.*

<sup>7</sup>*Ibid.*

## Questionnaire

The questionnaire consisted of three sections, the first two of which were used in the present study. The first section obtained information about seven characteristics of the facilities (see Table 1), which were used as independent variables in the statistical analyses: (1) their average patient census; (2) the population density of the area in which they were located; (3) the region of the U.S. in which they were located; and whether they were (4) religiously affiliated, (5) a for-profit or not-for-profit institution, (6) a hospital or other type of healthcare facility, and (7) a general or specialty healthcare facility.

The second section of the questionnaire asked how the facility met the pastoral and spiritual needs of its patients. Five major dependent variables were directly measured or calculated: whether the institutions/facilities (1) employed chaplains and (2) had a pastoral care department; (3) the number of chaplains employed; (4) their full-time equivalents (FTEs); and (5) whether the chaplains were certified. The number of certified chaplains was converted into a percentage, and the number of FTEs was converted into FTEs per 100 patients for analysis purposes.

## Statistical Analyses

TABLE 1

Percentages of Healthcare Facilities that Employ Professional Chaplains and Three Measures of the Chaplains They Employ, Distributed by Seven Characteristics of Facilities

Characteristic Grouping	Percent in Each Group	Percent Employing Chaplains	Mean Number of Chaplains	Mean Percent Certified	Mean FTEs per 100 Patients
Patient Census		*	*		*
Less than 25	23.2	17.4	1.4	66.7	5.2
25 - 100	31.1	57.5	1.8	70.9	2.3
101 - 200	20.6	79.4	3.2	74.5	1.0
201 - 400	17.4	90.2	4.5	59.4	0.9
Over 400	7.7	94.4	8.1	71.4	0.8
Population Density		*	*		*
Urban	30.7	85.6	2.0	62.5	1.6
Suburban	25.0	65.3	3.4	70.6	1.6
Rural	44.3	41.9	5.0	70.8	2.2
Religious Affiliation		*	*	*	*
Affiliated	22.0	91.6	4.9	63.4	2.6
Not Affiliated	78.0	52.6	3.0	70.6	1.3
Type of Business		**			
For Profit	12.0	29.3†	3.7	79.2	1.6
Not for Profit	88.0	65.3	3.6	68.0	1.8
Hospital or Other					*
Hospital	98.0	61.1	1.7	50.0	1.8
Non-Hospital	2.0	55.6	0.5	68.2	0.8
General or Specialty					
General	81.0	61.6	3.7	65.4	1.8
Specialty	19.0	57.6	3.2	79.4	1.6
Region of U.S.		*			*
North East	21.8	69.9	3.6	66.6	1.5
Mid West	32.1	64.5	3.8	66.9	1.9
South	28.3	54.5	3.0	69.2	1.5
West	17.8	53.6	4.2	69.5	2.3

\*Significant group differences on the dependent variable in univariate analysis —  $p < .05$ .

† Significant group differences on the dependent variable in multivariate analysis —  $p < .05$ .

The seven facility characteristics were initially analyzed by chi-square tests to examine their individual effects on (a) employing chaplains, and (b) having a pastoral care department. The seven characteristics were then tested together to determine their joint effect on each of these dependent variables, using multivariate logistic regression. Univariate (*t*-tests, and ANOVAs) and multivariate tests (least-squares multiple regression) were then conducted on the data from those institutions that employed chaplains to see if the seven facility characteristics affected (a) the number of chaplains they employed, (b) the percentage of those chaplains that were certified, and (c) the number of chaplain FTEs per 100 patients.

## Results

A total of 494 questionnaires were returned from all 50 states, Washington, D.C., Puerto Rico, and the U.S. Virgin Islands, for a return rate of 15%. Table 1 shows the percentage of facilities in each group for each of the seven independent variables, and the effects of each independent variable (*i.e.* facility characteristic) on four of the five dependent variables (percent employing chaplains, number of chaplains employed, percent of chaplains certified, and FTE per 100 patients). The percentages of facilities having pastoral care departments are not shown in the table because they closely mirror the results for facilities who employ chaplains. The percentages in the left column sum to 100% within each of the seven categories of characteristics (*i.e.*, Patient Census, Population Density, Religious Affiliation, *etc.*). Significant group differences on the dependent variables are indicated in the first row of each characteristic, directly above the column of figures (*i.e.*, percentages or means).

Univariate analyses revealed that the percentages of healthcare facilities that employed chaplains and those that had a pastoral care department were positively and significantly related to three facility characteristics (*i.e.* patient census, population density, and religious affiliation). Two other characteristics also had significant effects: region and type of business. For-profit businesses were significantly less likely to employ professional chaplains and to have pastoral care departments.

The same pattern and direction of effects were found for patient census, population density, religious affiliation, and for-profit businesses using multivariate logistic regression. Regional differences were not statistically significant when the other facility characteristics were controlled for statistically in the multivariate analyses.

Although the average patient census of the healthcare facilities in our sample was directly related to population density, population density continued to have a significant effect on whether a facility employed chaplains or had a pastoral care department, even when patient census was controlled for in the regression models. Population density effects were generally related to increased reliance on community clergy and volunteers to meet the spiritual needs of patients in suburban and, especially, rural facilities. While volunteers and community clergy were widely used among facilities in all settings, 57.9% of rural facilities relied solely on clergy and/or volunteers, with 9.8% of them saying they relied solely on volunteers. In contrast, only 14.2% of urban facilities and 31.3% of suburban facilities said they relied solely on volunteers and/or local clergy, with less than 3.5% of each saying they relied exclusively on volunteers.



Among those facilities that employed chaplains, univariate and multivariate analyses indicated that patient census and population density exerted a significant positive effect on the number of chaplains employed (see Table 1). However, univariate analyses suggested and multivariate analyses confirmed that religiously affiliated institutions employed fewer certified chaplains (63.4% of chaplains employed) than non-affiliated institutions (70.6%), on average. No other facility effects were found for either of these dependent variables.

As shown in the last column of Table 1, five out of seven facility characteristics significantly affected FTEs per 100 per patients, according to univariate tests. But only two of these (affiliation and patient census) were significant predictors of FTEs in the multiple regression analysis. FTEs per 100 patients were twice as high in religiously affiliated healthcare facilities. Although the number of chaplains increased with increasing census size, FTEs per 100 patients were inversely related to the patient census.

## Discussion

The present study uncovered a number of factors that contribute to the employment of chaplains and the provision of pastoral care in healthcare institutions throughout the U.S. Chief among these are population density, average patient census, and religious affiliation. Only business type had a clear negative effect on chaplaincy, with for-profit facilities being significantly less likely to employ chaplains or have pastoral care departments.

The findings are consistent with those of VandeCreek *et al.*<sup>8</sup> showing that religiously affiliated healthcare institutions employ more chaplains. On average, the religiously affiliated facilities in our sample employed 4.9 chaplains compared to 3.0 employed by non-affiliated facilities. Both figures are higher than those reported by VandeCreek *et al.*<sup>9</sup> for religiously affiliated ( $M = 4.0$ ) and non-affiliated hospitals ( $M = 1.5$ ). The average FTEs per 100 patients for religiously affiliated and non-affiliated facilities (see Table 1) are close to the figures presented by VandeCreek *et al.*,<sup>10</sup> (2.90 and 1.22, respectively).

Although both studies found that the number of chaplains in facilities that employ them is directly related to the size of the patient census, our study indicates that average FTEs per 100 patients decreases with census size. Another unique finding of the present study is that the percentage of certified chaplains is lower among affiliated than non-affiliated facilities employing chaplains. This effect is presumably due to the fact that religious denominations often assign or encourage their own clergy to serve as hospital chaplains regardless of their professional training.

Our finding that less urban areas rely more heavily on volunteers and local clergy to provide spiritual care to patients may be due to a number of factors, including financial considerations, a higher degree of volunteerism and sense of community obligation in rural areas, and the expectation that local clergy continue to provide for the pastoral needs of their congregation when they are hospitalized. ❧

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<sup>8</sup>*Ibid.*

<sup>9</sup>*Ibid.*