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July 2008 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Cadge, W., Freese, J. and Christakis, N. A. "**The provision of hospital chaplaincy in the United States: a national overview**." *Southern Medical Journal* 101, no. 6 (June 2008): 626-630.

SUMMARY and COMMENT: Wendy Cadge, Jeremy Freese, and Nicholas Christakis -- three sociologists (and Dr. Christakis is also a physician) from Brandeis University, Northwestern University, and Harvard University, respectively -- offer an empirical analysis of the provision of chaplaincy services in hospitals between 1980 and 2003. They use three data sets from the American Hospital Association's Annual Survey of Hospitals: 1980-1985, 1992-1993, and 2002-2003; for this "first systematic national overview of hospital chaplaincy based on a well-regarded survey" [p. 627]. However, it should be noted at the outset that the analysis of the "presence or absence of hospital chaplaincy services" works from "a very broad measure" [p. 630] that does not take into account the particular makeup of such services.

The article's considerable strength lies in the authors' empirical insights for an important twenty-three-year period. While the data here is already five-years old, that may turn out not to be too problematic, due to consistency in findings for that period. Key results of the analysis are:

- "[B]etween 54% and 64% of hospitals had chaplaincy services between 1980 and 2003. *No trends are evident in the fraction of hospitals that had chaplaincy services during these years* [emphasis added]. Approximately 59% of hospitals had chaplains in both 1993 and 2003." [p. 628]
- "[H]ospital size, location, and church affiliation were the central factors influencing the presence of chaplaincy services." [p. 629]
- "[H]ospital size was strongly associated with having a chaplain; hospitals with a smaller average daily census were less likely than those with more patients to have chaplains. Holding other variables constant at their mean, the predicted probability of having a chaplaincy service in 2003 was 0.48 for hospitals with an average daily census of 50 or less, compared with 0.79 for hospitals of 200 or more." [p. 628]
- "[T]eaching hospitals were more likely to have chaplains…." [p. 628]
- "Hospitals in rural areas were much less likely than those in large urban areas to have hospital chaplaincy in both 1993 and 2003." [p. 628]
- "Church-operated hospitals were much more likely to have chaplains than other kinds of (non-Veterans Administration) hospitals." [p. 628]

- "[C]ompared with other types of hospitals, church-operated hospitals were relatively more likely to have dropped chaplains [between 1993-2003] than to have added them." [pp. 628-629]
- "Not-for-profit hospitals were more likely than investor-owned hospitals to have added [chaplains between 1993-2003] than to have dropped them." [p. 629, and see also p. 630 --NOTE: There is evidently a typographical error in the original text on p. 629, which reads, "…to have added hospitals…," and the point seems to be reiterated on p. 630, which reads, "…to have added chaplains…."]
- "We did find a positive relationship between having an oncology service and chaplains…. However, … when an occupational health service is also included, it has effects as large or larger than having an oncology service." [p. 628]
- "[A]lthough positive changes in JCAHO [Joint Commission for the Accreditation of Healthcare Organizations] guidelines concerning religion and spirituality occurred between the early 1980s and early 2000s, there is not yet evidence that they had any effect on the fraction of hospitals with hospital chaplaincy services between 1993 and 2003." [p. 629]

The authors discuss JCAHO requirements at several points, commenting on how those "guidelines regarding religion and spirituality have evolved" [p. 626], but there is no mention of significant changes in JCAHO standards that were implemented in 2004-2005, which, it is possible to argue, came to place *less* emphasis on religion and spirituality. [*During 2003-2005, JCAHO radically altered its survey practice and revised its manual of Standards. For more on this, see the Related Items of Interest section, below.*] While these changes obviously do not affect the analysis of the data from 2003 and before, they may speak to the context for interpreting the current significance of some of the results. Nevertheless, the authors indicate that "[l]eaders in hospital chaplaincy" [p. 630] who they interviewed emphasized the value they perceived in the JCAHO standards, such as their being "a powerful tool for advocating for pastoral care" [p. 630].

Chaplain researchers may be especially interested in the data presented in three tables: Percentages and Means for Selected Variables, 1993 and 2003 American Hospital Association Annual Survey [p. 627], Chaplaincy Service in US Hospitals [p. 628], and Coefficient for Logistic Regressions of Presence of Chaplaincy, 1993 and 2003 [p. 629].

This article establishes a good baseline, if a general one, for further studies on trends in the provision of chaplaincy. The authors suggest: "Additional, more detailed data collection is needed to assess variations, specifically in how hospitals have and continue to provide chaplaincy services, what impact JCAHO policy changes may have had on that provision, and what influence (if any) chaplaincy services have on patient satisfaction and other relevant outcomes" [p. 630]. An exploration of how hospitals with chaplaincy services may have adjusted the number and function of chaplains during the last quarter century would be especially illuminating.

Suggestions for the Use of the Article for Discussion in CPE:

This month's article should be of great interest to students looking into careers in health care chaplaincy, and thus it may be most suited to those in second-year residencies and in supervisory education. Still, it is very readable for any student and could be used to begin or supplement a discussion with first-year residents and interns about chaplaincy as a profession. From a research perspective, the article is a nice illustration of the value of analyzing data that *others* have already gathered, and students first embarking on research projects might be asked to think of how they could utilize data already being gathered at their centers. Moreover, the article may be an invitation for students or staff chaplains to think about particular trends in their own institutions. Readers should keep in mind that descriptions of JCAHO's Standards apply only to the period addressed in the article.

Related Items of Interest:

I. JCAHO, the Joint Commission for the Accreditation of Healthcare Organizations significantly altered its method for surveying hospitals between 2003 and 2005. Under the old method, compliance was based upon a general assessment of Standards that were lined out in the official JCAHO *Comprehensive Accreditation Manual for Hospitals* (CAMH), which gave emphasis to statements about the *intent* of Standards and offered *examples* of compliance. In 2002, issues of spirituality and religion figured explicitly in ten Standards for acute care hospitals, and the CAMH went into some detail about how pastoral care services might be provided and about the potential role of chaplains. However, under the revised method for hospital surveys (which has been fully in place since 2005), compliance is scored by a fairly complex system based upon individual "Elements of Performance" for each Standard. Religious and spiritual issues have since become part of eight "Elements of Performance" under seven Standards. Examples of compliance through the use chaplains no longer appear, and the word *chaplain* occurs only once in the 544 pages of the 2008 manual: under a glossary definition of *qualified individuals*. To compare issues of religion/spirituality in the old and new JCAHO manuals, see summaries for the **2002** CAMH and the **2008** CAMH. JCAHO accredits a range of health care institutions and uses different sets of standards for the different settings.

II. Among the references in this month's article are two sociological studies of chaplains that have been featured as previous Articles of the Month:

> Lee, S. J. C. "**In a Secular Spirit: Strategies of Clinical Pastoral Education**." *Health Care Analysis* 10, no. 4 (December 2002): 339-356. [See the October 2003 Article of the Month.]
>
> Norwood, F. "**The ambivalent chaplain: negotiating structural and ideological difference on the margins of modern-day hospital medicine**." *Medical Anthropology* 25, no. 1 (January-March 2006): 1-29. [See the April 2006 Article of the Month.]

Note, though, that the article by Norwood drew some critical response from members of the Research Network, whose comments (and the author's reply) appeared in our Spring 2006 Newsletter [§2].

III. The authors of this month's article note the importance of further research on the impact of chaplaincy services on patient satisfaction [p. 630]. For more on this topic, see the October 2004 Article of the Month.

IV. One means of assessing the provision of chaplaincy is by looking at chaplain-to-patient bed ratios. This month's article includes references to Larry VandeCreek's "**How many chaplains per 100 inpatients? Benchmarks of health care chaplaincy departments**" [*Journal of Pastoral Care* 55, no. 3 (Fall 2001): 289-301] and to Kevin Flannelly, George Handzo, and Andrew Weaver's extension of VandeCreek's 2001 study in their "**Factors affecting healthcare chaplaincy and the provision of pastoral care in the United States**" [*Journal of Pastoral Care and Counseling* 58, nos. 1–2 (Spring-Summer 2004): 127-130 (--NOTE: the bibliographic citation is listed *incorrectly* in our featured article)]. However, see also our Spring-Summer 2007 Newsletter [§3], which points to an unpublished survey of chaplain-to-bed ratios mentioned in Mary Whitmer and Susan Hurst's "**Innovative solutions: a plurality of vision. Integrating the chaplain into the Critical Care Unit**" [*Dimensions of Critical Care Nursing* 26, no. 3 (May-June 2007): 91-95]:

> In 2003, a staff chaplain at Banner Good Samaritan Medical Center (BGSMC) contacted the Pastoral Care Department at each facility that had attained Magnet status as of that date to inquire about chaplain staffing to bed ratios (FTEs and Average Daily Census were used to determine these 2 numbers). Of 108 Magnet facilities when the survey was conducted, 101 were ultimately contacted by telephone. The unpublished result of that survey yielded a ratio of 1:153. This ratio can be used as a benchmark to determine staffing needs for a pastoral care department. [p. 92]

If you have suggestions about the form and/or content of the site, e-mail Chaplain John Ehman (Network Convener) at john.ehman@uphs.upenn.edu .

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