Review Article

The Provision of Hospital Chaplaincy in the United States: A National Overview

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Abstract: Over the past 25 years, the Joint Commission for the Accreditation of Healthcare Organizations has changed its guidelines regarding religious/spiritual care of hospitalized patients to increase attention concerning this aspect of hospital-based care. Little empirical evidence assesses the extent to which hospitals relied on hospital chaplains as care providers during these years. This study investigates (1) the extent of chaplaincy service availability in US hospitals between 1980 and 2003; (2) the predictors of having chaplaincy services in 1993 and 2003; and (3) the change in the magnitude of these predictors between years. This study examines the presence or absence of chaplaincy or pastoral care services in hospitals using the American Hospital Association Annual Survey of Hospitals (ranging from 4,946–6,353 hospitals) in 1980–1985, 1992–1993, and 2002–2003. Between 54% and 64% of hospitals had chaplaincy services between 1980 and 2003, with no systematic trend over this period. In 1993 and 2003, hospital size, location, and church affiliation were central factors influencing the presence of chaplaincy services. Smaller hospitals and those in rural areas were less likely to have chaplaincy services. Church-operated hospitals were much more likely to have chaplaincy services; but between 1993 and 2003, church-operated hospitals were more likely to drop chaplaincy services than to add them. Not-for-profit hospitals were more likely than investor-owned hospitals to add chaplaincy services. Changes to Joint Commission for the Accreditation of Healthcare Organizations policies about the religious/spiritual care of hospitalized patients between 1980 and 2003 seem to have had no discernible effect on the fraction of US hospitals that had chaplaincy services. Rather, characteristics of hospitals, their surroundings, and their religious affiliations influenced whether they provided chaplaincy services to patients.

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The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) guidelines regarding religion and spirituality have evolved since 1969, when the Commission first addressed the topic. In 2003, JCAHO stated that "patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values." Hospitals were to "demonstrate respect" for patient needs, including the need for "pastoral care and other spiritual services." Additional language about religion and spirituality was included in the guidelines about dietary options, pain concerns, resolving dilemmas about patient care issues, end-of-life issues, and the treatment and responsibilities of staff. JCAHO Associate Director of Standards Interpretation explained that the Commission "expects you to conduct a spiritual assessment of every patient in every healthcare setting [. . .] to determine how a patient's religion or spiritual outlook might affect the care he or she receives [. . .]. At minimum the spiritual assessment should determine the patient's religious denomination, beliefs, and what spiritual practices are important to the patient."[1]

Little prior research has evaluated whether the Joint Commission's recommendations have had an appreciable impact and, more importantly, whether and how hospitals have met

Key Points

- Between 54% and 64% of hospitals had chaplaincy services between 1980 and 2003, with no systematic trend over this period.
- Smaller hospitals and those in rural areas were less likely to have chaplaincy services.
- Church-operated hospitals were much more likely to have chaplaincy services.
- Between 1993 and 2003, church-operated hospitals were more likely to drop chaplaincy services than to add them.
- Not-for-profit hospitals were more likely than investor-owned hospitals to add chaplaincy services.

patients' religious and spiritual needs as outlined in these guidelines. Many hospitals have done so through the use of voluntary and employed hospital chaplains supported financially by the hospital or local religious organizations. Knowing which hospitals have chaplains is the first step in understanding whether they work collaboratively with nurses, physicians, and other healthcare professionals.[2–8]

Limited empirical data exist describing these hospital chaplains, and existing studies[9–12] (Sakurai, Unpublished Dissertation, 2005) have used nonrepresentative samples and/or surveys with low response rates. To our knowledge, this study provides the first systematic national overview of hospital chaplaincy based on a well-regarded survey, the American Hospital Association's Annual Survey of Hospitals. A question about the presence of a hospital chaplaincy service was asked in this survey intermittently from 1980 through 2003. We evaluated the overall percentage of hospitals providing chaplaincy services between 1980 and 2003. We also provide a more detailed examination of predictors of chaplaincy services in 1993, when JCAHO guidelines began to change, and in 2003, after guideline changes had been made.

Materials and Methods

This study analyzes survey data about the presence of hospital chaplaincy services collected in the American Hospital Association's Annual Survey of Hospitals in 1980–1985, 1992–1993, and 2002–2003; the included years are the only ones to date in which the survey has asked about chaplaincy services. This survey is regularly administered to a full sample of hospital facilities in the United States, and there was a consistently high response rate over the studied period. The number of hospitals surveyed in these years varied from 4,946 to 6,353.

In 1981, the survey distinguished between hospital-based/staffed and hospital-based/contracted services, but the two categories are combined here for consistency with other years. The 2003 survey distinguished between hospital-based/staffed chaplaincy/pastoral care and care provided through the hospital's health system affiliation, integrated delivery network affiliation, or joint venture arrangement; these categories are also combined in the analysis. Other analyses that disaggregated these categories did not yield different results (data not shown).

Hypotheses

Independent variables used in this study are summarized in Table 1. Based on the existing literature and 10 interviews we conducted with professional chaplaincy leaders, we had six hypotheses about the relationship between these variables and the presence of chaplaincy services:

1. We expected that larger hospitals (as measured by adjusted average daily census) would be more likely to have hospital chaplains.
2. We expected that hospitals in larger metropolitan areas would be more likely to have chaplains.

Table 1. Percentages and means for selected variables, 1993 and 2003 American Hospital Association Annual Survey

	1993	2003
Region		
Northeast	15.8	13.5
South	38.7	39.3
Midwest	28.9	29.2
West	16.6	18.1
Metropolitan statistical area		
Rural—nonmetro areas	39.5	42.0
Small (0–250,000)	9.5	9.2
Medium (250,001–1,000,000)	18.4	18.5
Large (larger than 1,000,000)	32.7	30.3
Average daily census (adjusted)		
0–50	30.2	26.3
51–100	20.8	20.1
101–150	12.9	11.6
151–200	8.7	10.2
200	27.5	31.8
Control		
Church-operated	10.8	10.7
Nongovernment, not-for-profit	45.3	47.7
Government, nonfederal	28.1	24.4
Investor-owned	15.8	17.3
Other operating characteristics		
Member, council of teaching hospitals	5.6	6.2
Church-operated	10.8	10.7
Patient characteristics		
Mean % of patients on Medicare (SD)	43.3 (21.9)	46.8 (23.6)
Mean % of patients on Medicaid (SD)	18.4 (18.0)	19.5 (19.7)
Services and technologies		
Oncology specialists at hospital or subsidiary	40.8	52.2
Occupational health services	44.7	61.7
N	5587	4793

Cases excluded are missing values for the dependent variable or membership in the Council of Teaching Hospitals and/or have their regions coded as other (ie, "associated areas").

3–4. In addition to expecting that church-operated hospitals would be much more likely to have chaplains than other hospitals, we hypothesized that—as chaplains do not directly contribute to hospital revenues—investor-owned hospitals would be less likely to have chaplains than either government (nonfederal) or (nongovernment and non-church-operated) not-for-profit hospitals. In our analyses, we exclude hospitals in the Veterans Administration, as they have all had chaplains since the Veterans Administration Chaplaincy was established in 1945.

5. We expected that teaching hospitals would be more likely to have chaplains, which we measured by whether they belonged to the Council of Teaching Hospitals.

6. Several chaplaincy leaders we interviewed discussed the special value of chaplains in providing religious/spiritual care for oncology patients. Therefore, we hypothesized that hospitals with oncology services would be more likely to have chaplains. Because we worried that the observed effects of having an oncology service could merely reflect the hospital size, we also included in our model whether hospitals had an occupational health service; we did this because such a presence was roughly as common as that of an oncology service in the American Hospital Association data, and there would be no reason to expect a special relationship between occupational health services and the presence of chaplaincy services.

As additional covariates, we included the mean number of patients on Medicare and Medicaid to avoid confounding by these aspects of a hospital's client population.

We first present descriptive statistics about hospital chaplaincy between 1980 and 2003 and then examine logistic regression models predicting the presence of chaplaincy in 1993 and 2003. We also compare results from these models to assess changes in the predictors of chaplaincy services between these 2 years. Additional analyses of change between 1993 and 2003 as a single model did not yield substantially different results (data not shown).

Results

As described in Table 2, between 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. Approximately 59% of hospitals had chaplains in both 1993 and 2003.

Table 2. Chaplaincy service in US hospitals

Year	Total hospitals	Reporting hospitals	Hospitals reporting chaplaincy service	Percentage of reporting hospitals with chaplaincy
1980	6,965	6,277	3,643	58.0
1981[a]	6,933	6,276	3,371	53.7
1982	6,915	6,277	3,499	55.7
1983	6,888	6,353	3,670	57.8
1984	6,872	6,302	3,817	60.6
1985	6,872	6,304	4,000	63.5
1992	6,539	5,916	3,175	53.7
1993	—	5,789	3,398	58.7
2002	5,794	4,876	2,581	52.9
2003[a]	—	4,946	2,934	59.3

Data sources: AHA Annual Survey, Health Forum, LLC, a subsidiary of the American Hospital Association. Fiscal years 1980–1985, 1992 and 2002; and AHA Hospital Statistics, 1993 and 2003.

[a]*See Discussion in text of differences in the survey item for these 2 years.*

Table 3 presents logistic regression results for 1993 and 2003. A comparison of the models for the 2 years shows that the factors that led hospitals to have chaplaincy services were relatively consistent in 1993 and 2003. As predicted, hospital 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. The largest hospitals were more likely to be teaching hospitals, and our results show that, consistent with our predictions, teaching hospitals were more likely to have chaplains, which is not surprising, given that even net of size that teaching hospitals typically have larger than average nonmedical staffs.

Church-operated hospitals were much more likely to have chaplains than other kinds of (non-Veterans Administration) hospitals. Holding other variables at their mean, church-owned hospitals had a 0.86 predicted probability of having a chaplain in 2003, compared with only 0.48 for government-owned hospitals. In comparison with investor-owned hospitals, nongovernment or church-operated not-for-profit hospitals were also more likely to have chaplains. There was no significant difference between government-owned and investor-owned hospitals.

Hospitals in rural areas were much less likely than those in large urban areas to have hospital chaplaincy in both 1993 and 2003. The difference in 2003 corresponds to a change in predicted probabilities from 0.58 for rural hospitals to 0.71 for hospitals in large urban areas. We observed no other effect of locality other than this difference.

We did find a positive relationship between having an oncology service and chaplains, which might otherwise support the suggestion from the chaplains interviewed that the provision of chaplaincy services was particularly responsive to the needs of cancer patients. However, we can see that when an occupational health service is also included, it has effects as large or larger than having an oncology service.

Given the lack of change in the overall percentage of chaplains between 1993 and 2003, comparisons in coefficients between 1993 and 2003 also provided an analysis of whether the variables were associated with any changes in which hospitals had chaplains. To confirm, we also conducted a multinominal logistic regression analysis of the four-category outcome implied by the absence of chaplaincy services in 1993 and 2003 (results not shown) and obtained results consistent with those discussed here. The only significant differences were for types of hospitals. The coefficient for church-operated hospitals was larger in 1993 than 2003, suggesting that, compared with other types of hospitals, church-operated hospitals were relatively more likely to have dropped

Table 3. Coefficient for logistic regressions of presence of chaplaincy, 1993 and 2003. American Hospital Association Annual Survey of Hospitals

	1993		2003	
	Model 1	**Model 2**	**Model 1**	**Model 2**
Northeast	0.03 (0.12)	0.12 (0.12)	0.02 (0.14)	0.09 (0.14)
South	0.06 (0.09)	0.17 (0.10)	0.19 (0.10)	0.27[b] (0.10)
Midwest	0.23 (0.10)[b]	0.24[b] (0.10)	0.28[d] (0.11)	0.13 (0.11)
Rural	0.43 (0.08)[c]	0.33[c] (0.10)	0.47[c] (0.10)	0.61[c] (0.10)
Small MSA	0.13 (0.12)	0.12 (0.13)	0.04 (0.14)	0.08 (0.15)
Medium MSA	0.05 (0.01)	0.02 (0.10)	0.13 (0.11)	0.13 (0.11)
Average census 1–50	2.26 (0.11)[c]	1.88[c] (0.12)	2.18[c] (0.12)	1.40[c] (0.13)
Average census 51–100	1.43 (0.11)[c]	1.19[c] (0.12)	1.35[c] (0.11)	0.88[c] (0.12)
Average census 101–150	1.23 (0.12)[c]	1.08[c] (0.12)	1.01[c] (0.13)	0.73[c] (0.13)
Average census 151–200	0.75 (0.14)[c]	0.71[c] (0.14)	0.74[c] (0.13)	0.62[c] (0.14)
Teaching hospital	1.53 (0.31)[c]	1.42[c] (0.31)	1.58[c] (0.31)	1.23[c] (0.31)
Church-operated	2.56 (0.21)[c]	2.57[c] (0.21)	2.00[c] (0.16)	1.91[c] (0.17)
Other not-for-profit	0.36 (0.10)[c]	0.34[c] (0.10)	0.97[c] (0.10)	0.89[c] (0.10)
Government, nonfederal	0.18 (0.10)	0.24[b] (0.10)	0.41[c] (0.11)	0.40[c] (0.12)
% Medicaid	0.007 (0.002)[c]	0.008[c] (0.002)	0.01[c] (0.002)	0.01[c] (0.002)
% Medicare	0.011 (0.002)[c]	0.007[c] (0.002)	0.01[c] (0.002)	0.01[c] (0.002)
Oncology service		0.18[b] (0.09)		0.76[c] (0.08)
Occupational health		0.64[c] (0.07)		0.75[c] (0.08)
Intercept	1.18 (0.16)	0.69 (0.18)	0.58 (0.17)	0.13 (0.18)
2 Log likelihood	5912.2	5824.3	5009.93	4777.99
N	5587	5587	4793	4793

[a]*MSA, Metropolitan Statistical Area;* [b]*P 0.010;* [c]*P 0.05;* [d]*P 0.01.*

Standard errors are given in parentheses. Reference categories are west (region), large MSA (area size), average census 201 (hospital size), and investor-owner (institutional type).

chaplains in the intervening period than to have added them. Not-for-profit hospitals were more likely than investor-owned hospitals to have added hospitals in the intervening period than to have dropped them.

Discussion and Conclusion

Our findings suggest three main conclusions: first, these results show that whether hospitals had chaplains in 1993 and 2003 was strongly predicted by general demographic and institutional characteristics of the hospitals. As in previous analyses[10] of smaller datasets, hospital size, location, and church affiliation were the central factors influencing the presence of chaplaincy services. Smaller hospitals and those in rural areas were less likely to have chaplaincy services than larger hospitals and those in more urban areas in 1993 and 2003, likely reflecting differences in financial and religious leadership resources in these areas. Smaller and/or rural hospitals might not have resources available to hire chaplains and/or there may be less need because local religious leaders are more readily available.

Church-affiliated hospitals were also much more likely than others to have chaplaincy services, potentially indicating different value commitments around religious/spiritual care and/or greater ease of finding and financially supporting chaplains. Additional information about the religious affiliations of hospitals and their chaplains would enable further consideration. In comparison with investor-owned hospitals, nongovernment, or church-operated not-for-profit hospitals were also more likely to have chaplains, perhaps indicating different value commitments or financial management priorities.

Second, although positive changes in JCAHO 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. Though the Joint Commission first considered religion and spirituality in 1969, the guidelines were significantly revised in the 1990s when the religious/spiritual care of patients was framed as a "right," addressed under the heading of "Patient Rights." In the 1990s, there was also a transition in the standards about what the religious/spiritual care of patients should be called and who specifically might provide it. In 1996, the Joint Commission stated that hospitals were to demonstrate respect for "pastoral

counseling," a phrase replaced with "pastoral care and other spiritual services" in 1999 after chaplaincy leaders argued that this phrase better reflected their jobs. Although the Joint Commission has not established specific guidelines or licensing requirements that mandate who can provide religious/spiritual care, in their 1999 guidelines they mentioned pastoral services departments and pastoral personnel from outside of the facility as possibilities.

Leaders in hospital chaplaincy described the changes the Commission has made as overwhelmingly positive. "Ten years ago the Joint Commission didn't ask about spiritual care," one chaplain explained. "Today it's one of the first things they ask about." Another leader explained, "Anytime you get standards like that, whether it's JCAHO or HIPAA [Health Insurance Portability and Accountability Act] or anything else, you know it certainly becomes a powerful tool for advocating for pastoral care." Although changes in JCAHO policies in the 1990s may have influenced the number and visibility of chaplains at individual hospitals, they have not increased the fraction of hospitals that have chaplains.

Third, the only changes evident in the fraction of hospitals that had chaplains in 1993 and 2003 were related to whether the hospital was church-operated or not-for-profit. Compared with other types of hospitals, church-operated hospitals were relatively more likely to have dropped chaplains between 1993 and 2003 than to have added them. This could reflect greater financial pressures on church-operated hospitals in these years. If so, however, these pressures did not extend to not-for-profit hospitals, as these hospitals were actually more likely than investor-owned hospitals to have added chaplains in the intervening period than dropped them. These findings require additional study. Not only did the percentage of hospitals with chaplaincy services not change between 1993 and 2003, but the magnitude of different predictors of chaplaincy services changed little.

This study presents the first national overview of hospital chaplaincy, but it is limited in several ways. Primarily, it examines only the presence or absence of hospital chaplaincy services, a very broad measure of the presence and work of hospital chaplains. It is certainly possible that the structure and functioning of chaplaincy departments changed based on changes in healthcare financing, the professionalization of hospital chaplaincy, the strategic work of professional chaplaincy organizations, etc. 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.

Rather than being an impetus for change in hospital chaplaincy services, our findings begin to suggest that changes to JCAHO guidelines around religion/spirituality may be largely symbolic, reflecting changes already being made in hospitals. These findings[2,13] suggest that the increased attention to religion/spirituality in JCAHO guidelines, some hospitals, and the medical literature, may not be related to the changing presence of hospital chaplains but to increased attention to religion and spirituality among other healthcare providers. Physicians and nurses currently occupy some of the most prominent places in related medical and societal discourse about religion/spirituality and are contributing to broader trends in medicine around spiritual and ethical concerns.[14]

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Please see Dr. Martin Feldbush's editorial on page 580 of this issue.