Abstract

The Shared Experience of Personalized Spiritual Care Services Between

Hospital Chaplains and Hospital-based Healthcare Providers

by Janie J. Taylor

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DEPARTMENT OF CHILD DEVELOPMENT AND FAMILY RELATIONS

The research highlighted in this dissertation offers contributions to both the implementation of and literature related to the biopsychosocial-spiritual (BPS-S) approach to healthcare, in particular as it relates to the spiritual care and support hospital-based healthcare providers (HBHPs) receive from hospital chaplains (HCs). Foundational insight into how to integrate hospital chaplaincy support and spiritual care into hospital-based healthcare delivery systems aligns well with the Institute of Medicine's 2001 mandate to defragment our ailing healthcare system and reduce deficits in patient care. Moving past a myopic and strictly biomedical viewpoint of what is included in "patient care" invited investigation about the systemic interplay between provider spiritual health and patient health outcomes. Even though HBHPs who participated in this phenomenological study appreciated the spiritual care received by hospital chaplains, and noted that they were able to provide better patient care as a result, they reported that the true value of the care did not appear to be recognized by hospital administrators. The lack of hospital chaplain inclusion on treatment teams in some units also raised questions about the need for a seamless and well-integrated hospital-based care delivery system. Implications from this study are applied to clinical, research, and educational opportunities in the area of hospital chaplaincy.

THE SHARED EXPERIENCE OF PERSONALIZED SPIRITUAL CARE SERVICES

BETWEEN

HOSPITAL CHAPLAINS AND HOSPITAL-BASED HEALTHCARE PROVIDERS

A Dissertation Presented to

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by

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DEDICATION

Without the work of several trailblazers, pioneers, and visionaries, the Medical Family Therapy Doctoral program would have never been established at East Carolina University. Dr. Cynthia E. Johnson, chair of the Department of Child Development and Family Relations, worked alongside Drs. Mel Markowski, Angela Lamson, and Jennifer Hodgson to birth the first such program in the nation. Their tireless energies were matched only by their passions, and 2005 marked the entrance of the initial group of students into the program. What a group: Dr. Ryan Anderson, Dr. Amy Blanchard, Dr. Patrick Meadors, and me! The long-winding path I traveled was made easier by a dear cheerleader, my husband, Bobby. With the completion of my work, the first group's journey passage will end. It is to the trailblazers, pioneers, visionaries, my fellow students, and my husband that this dissertation is dedicated. I offer my respect, thanks, blessings, and appreciation to you all.

ACKNOWLEDGEMENTS

Just as a tapestry represents multiple hours of weaving and varying colors of thread, sometimes even a multiplicity of textures, my doctoral work is no less than a collaborative effort. While some individuals may have played larger roles at times than others, no one who joined me in this journey is insignificant, nor is my gratitude to and for them. However, before beginning my expressions and acknowledgements, I must give praise to God. The foundation of my life, my faith not only guides me, it provides purpose and strength.

Dr. Jennifer Hodgson, my dissertation chair and major professor, has tirelessly encouraged, directed, and re-directed me and my development, especially as a researcher. I am confident there were times she wondered how to foster the fire I needed to continue this academic endeavor. In spite of my delays and trips, her perseverance appeared unshakeable, even when I broke my arm and was de-railed for a time. She helped me to see purpose in what I had begun; and I am grateful for her guidance (and persistence). Next, I would like to thank the rest of my committee: Drs. Angela Lamson, Natalia Sira, and David Musick. Dr. Angela Lamson, the director of the Medical Family Therapy Doctoral Program, understood there "was one more leaf in the yard I needed to rake up." Her curiosity helped keep me on the right track without making me feel as though I could not accomplish my goals. She and Dr. Hodgson have helped me understand each of us has the ability to accomplish some amazing things in life. Drs. Natalia Sira and David Musick offered the balanced perspective I needed from the medical community, as well as affirmation for my thoughts and work. Each of them provided direction while helping me celebrate the steps along the way. I cannot express the depth of appreciation I have for the tireless work of these four individuals. I know I would not be where I am today

without them; and I am ever mindful of the fact they were willing to lay aside part of their summer vacations to read my proposal and meet with me.

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Significant as well is the assistance I have received from Josh Fowler, a Masters-level Marriage and Family Therapy student at ECU. Josh has been my triangulated investigator and his skills and abilities have assisted me in analyzing my data, as well as reviewing my work. I recognize the important role Josh has played over the past few months, and I am quite grateful.

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would still be looking for some of the articles reviewed in Chapter Two of this work. She labored for weeks (months probably) on end and never once mentioned the fact I was not part of her job description.

I must say "thank you" to a number of cheerleaders, who have kept my spirits high and/or who have recognized I was tiring and provided needed strength. Mrs. Jodi Hudson was "present" when I first started dreaming this dream. She has prayed for me, listened, and noted down years, months, weeks, and even days until deadlines, always reminding me "I could do it." Drs. Ryan Anderson, Amy Blanchard, and Patrick Meadors embraced me as a fellow student, and together we agreed to compete with no one except ourselves, even though Patrick reminded me I would be old when I finished this endeavor. Well, Patrick, I am older, but I refuse to accept the "old" title! Katie Buck has steadfastly checked in and cheered; and Scott Lane has chided and jeered, both of which I have accepted and recognize to be his way of offering encouragement.

Last, I would like to acknowledge the important role my spouse, Dr. Bobby Taylor, has played in this journey. Never has there been a time that I have questioned his love for me, or his belief in my abilities. At times, Bobby has wanted me to accomplish this goal more than I have; and I am glad we will both see it end before long (Lord willing). He has seen my tears, heard my frustration, and watched me pace; but he has never been negative. I am thankful for his presence, and acknowledge I might have given up long ago without all he has done.

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PREFACE

When just a young girl, I often challenged my parents with questions: "Why do I have to go to school?" "Why does the sun rise in the east and set in the west?" "Why do roads have curves? Why can't they be straight?" To the best of their abilities, my parents tried to offer understanding of complex issues in a manner a young child could grasp. As I grew, I continued to ask, "Why do roads have curves? Why can't they be straight?" Again, my parents would describe land rights, ownership, bedrock, pre-existing designs, and so forth. As I reflect back over my life, I chuckle as I see that much like the country roads that thread throughout North Carolina, my personal journey rarely has taken straight courses.

Foundation of Faith

As far back as I can remember faith has played a significant role in my life and that of my family members. I was taught Christian tenets and strive to live according to biblical teachings. I learned the importance of treating others with respect and working to improve the plight of all. Desiring to help others, I accepted multiple responsibilities within the church and ministered in various capacities. While doing so, I have accompanied many individuals to medical appointments, been with countless hospitalized patients when experiencing needed protocols, provided spiritual care to patients and family members, and been with patients and families as transitions have occurred from life to death. My faith is my foundation; it is the very core of my existence.

Medical Influences

Equally significant, however, may be the many medical influences in my life. The daughter of a labor and delivery room nurse, I learned early about many health-related matters, especially that health is precious. Mom used to boast that she delivered most of the children in

town; and, it seems there may have been some validity to her story. She worked nights and my dad, who worked as a grocer, was delegated much of my care. When two general practitioners opened an office in town, Mom was hired as one of the doctors' nurse; however, I was a teenager at the time. While her new job meant more time at home, she had not been working in the practice long before she began her multiple-year struggle with cancer. Many are my memories of hospitals and medical procedures. There were times I would provide her medical care, which seems disconcerting when I think about it now. But, Mom was not the only one who dealt with medical issues. Dad had cardiac and pulmonary problems. I was no older than seven when he had his first heart attack. Mom died when I was a freshman in college; Dad passed eighteen years later.

Career Change

The doctors with whom Mom worked, and many of her friends, decided I should pursue a career in medicine. I, on the other hand, had my fill of hospitals and doctors' offices and their thoughts failed to align with my own. I did desire to enter a medical field, but it was not one my parents recognized. I wanted to work in behavioral health. The mention of such was never well received by my parents. And, being the obedient child I was at the time, I honored their advice (waiting until mid-life to begin that venture), and secured a degree in religion and philosophy. After years of working in multiple ministry positions, the desire to work within the behavioral health field grew stronger and I harkened to the siren's call.

This pursuit began with a Master's in Counseling. After that degree was earned, I desired more clinical experience. Seeing the needs of so many couples and families, I determined my next pursuit would be within the field of marriage and family therapy. East Carolina University

(ECU) was my program of choice and I was fortunate enough to be accepted in the Master's program.

By this time, I had seen many families who were encountering issues. I also observed young people who had been placed in residential settings excel until they were placed back within their family systems. Even though the youth had learned new ways to address issues and been able to do well away from their family units, the old systemic forces proved too powerful when they returned home, unless their families had developed new patterns of interaction as well. Having this insight made the concepts presented in the classroom make sense.

While pursuing this Master's, I worked as a teaching assistant. The classroom proved to be a great fit and it afforded me the opportunity to explain theories to underclassmen. In retrospect I chuckle when I think of the students with whom I interacted the day I learned of Urie Broffenbrenner's death; they failed to understand my sense of loss. Integral to the understanding of ecological systems, I saw him as an extended family member of my philosophical and practical frameworks, the very components, the structures, I had come to love and implement within my clinical work.

Medical Family Therapy Program

After I completed my Masters-level study of marriage and family therapy, I engaged in clinical work full time, working toward licensure. I worked within a residential setting and encouraged families to participate in therapy before youth returned to their familial systems. I continued to hone my clinical skills in this site until such time that I returned to Greenville to work full-time at ECU. While I enjoyed my job responsibilities, I was always awaiting news about the University's impending doctoral program in Medical Family Therapy, as I had my eyes

set on seeking a slot in the first class. Amazingly, I was accepted in the program and a new journey began.

Shortly after beginning the program, I came face-to-face with the biopsychosocial-spiritual (BPS-S) approach. Much of my thoughts and conceptualizations were there in front of me. In fact, they were penned on the first and second pages of McDaniel, Hepworth, and Doherty's 1992 text:

> …human life is a seamless cloth spun from biological, psychological, social, and cultural thread; that patients and families come with bodies as well as minds, feelings, interaction patterns, and belief systems; that there are no biological problems without psychosocial implication, and no psychosocial problems without biological implications. Like it or not, therapists are dealing with biological problems, and physicians are dealing with psychosocial problems. The only choice is whether to do integrated treatment well or do it poorly. (pp. 1-2)

At that point, everything gelled and I knew I had found a paradigm with which I resonated. Adopting a BPS-S approach was little more than allowing my systemic roots to mature.

It Comes Together

The various aspects of my life, clinical work, and training merge within this dissertation. My spiritual roots opened the way for me to be curious about spirituality within a medical setting; and, because hospital chaplains are the individuals to whom the responsibility is given to provide that care, they became part of my focus. When I widened my lens, I was able to see a system of individuals who attend to the demanding stresses of biomedical sciences day in and day out. I became even more curious: Who takes care of providers? What happens to them when they have problems? How are they able to provide care when they are tired, when their

resources are depleted, when they have nothing left to give but they have six more hours to work during a respective shift? The questions were planted and the labor has been intense, not to mention quite long. The pages that follow offer the results of that birthing process, the literature review, method, findings, and discussion.

In Conclusion

As a child I wanted roads that were straight and direct, but learned that was not always possible. As an adult, I have learned that many of my personal journeys do not always lead where I think they will or should. This path, however, has brought me to an oasis, at least for this point in time. I am not sure where the next path will lead, but it is my hope that at the least this work will provide fodder for those who not only travel with me but who will follow the same path.

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CHAPTER 1: INTRODUCTION

Religion and spirituality are critical components of one's health and well-being

(Chapman & Grossoehme, 2002), especially in times of crisis (Fogg, Weaver, Flannelly, &

Handzo, 2004). Multiple researchers have found religion and spirituality to have a significant

relationship to physical and mental health (George, Ellison, & Larson, 2002; Hill & Pargament,

2003; Koenig, McCullough, & Larson, 2001; Larson, Swyers, & McCullough, 1998; Seybold &

Hill, 2001; Thorensen, 1999; Thorensen, Harris, & Onan, 2001) and are beginning to gain insight

into how they contribute to positive coping in patients who suffer with severe, chronic, and

terminal conditions (Brady, Peterman, Fitchett, Mo, & Cella, 1999; Carey, 1985; Cotton, Larkin,

Hoopes, Cromer, & Rosenthal, 2005; Koenig, McCullough, & Larson, 2001; Post, Puchalski, &

Larson, 2000; VandeCreek, Pargament, Belavich, Crowell, & Firedell, 1999). Physicians are

being encouraged by contributors to the literature (e.g., Flannelly, Galek, Bucchino, Handzo, &

Tannenbaum, 2005; Post, Puchalski, & Larson, 2000), and by HMO administrators (VandeCreek

& Burton, 2001; Yankelovich Partners, 1997), to include spiritual care in treatment modalities.

The major spiritual issue to be addressed with patients is "how to integrate body, mind,

and spirit in the face of illnesses, traumas, losses, and life transitions" (VandeCreek & Burton,

2002, p.1). During such times, hospital chaplains help patients and their families in their search

for meaning and purpose, as they wrestle with matters which cause existential distress

(Puchalski, Lunsford, Harris, & Miller, 2006). Basic to this practice is the belief that every

individual has a spiritual dimension (McKee & Chappell, 1992; Sulmasy, 2002). However,

despite the practical significance of the hospital chaplain, there remain uncertainties about their

role, skill sets, and the place for existential support in our healthcare system. It is important that

as we move toward engaging them more as collaborators in hospital settings that we understand

their historical background, research literature, and opportunities for inclusion as members of the healthcare team.

Historical Development of Hospital Chaplaincy

Prior to the Renaissance, hospitals were religious and charitable organizations which housed the chronically ill and poor. In the years after the Renaissance, medical science and religion divided and matters of the body were separated from those of the mind and spirit (Porter, 1997). A courtship of sorts between medical science and theological training and practice began again in the 1920s, when the Reverend Anton Boisen recommended that ministerial students study patients in mental institutions to learn about the human soul. His colleague and mentor, Richard Cabot, endorsed Boisen's practice and encouraged the supervision of clinical skill development as he believed one's soul has the potential at "times of pain, sorrow, frustration, and surprise…[for] experiences that invite a new start in life" (Cabot & Dicks, 1953, p. 23). The first ministerial students entered clinical training in 1925 and various programs developed in the years that followed. It was not until 1967, however, that the various groups and training programs organized and formed the Association for Clinical Pastoral Education (ACPE) and the title, "Hospital Chaplains" was conceived. Since 2000, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has required qualified hospital chaplains to attain "education, training, experience, competence, registration, certification, licensure, law, or regulation." This training helps prepare hospital chaplains to meet the spiritual and emotional needs of patients, family members, and hospital staff, as well as assisting through a more systemic lens of patient and family centered-care.

The Biopsychosocial-spiritual Approach

The biopsychosocial-spiritual (BPS-S) approach adds understanding to the complexity of healthcare provision. Engel (1977, 1980), who valued systems theory, offered an alternative to biomedical care provision by expanding the framework to aspects of patient care not addressed by the prevailing scientific approach. He noted, "Nothing exists in isolation…[as] every system is influenced by the configuration of the systems of which each is a part" (1980, p. 537). Engel thus expanded the medical lens with his recognition that every "cell, organ, person, family…indicate[s] a level of complex integrated organization" (1980, p. 536). Failing to acknowledge the systemic interplay of components serves to reduce medical care to a preoccupation of disease and the human body. Even the doctor-patient encounter involves relationship.

An internist, Engel (1977, 1980) considered individuals' affective and psychological states, as well as their interpersonal relationships when treating a biomedical disorder. Engel thus expanded the medical lens. In doing so, the focus changed from symptoms and their causes to a framework wherein illness was seen to have social, psychological, and behavioral dimensions. In fact, Engel explained that a physician operating from a systems perspective understands "the probability that the course of [an] illness and the care of the patient may be importantly influenced at the psychological and interpersonal levels of organization" (1980, p. 538). Thus, the patient is best seen with a whole person lens instead of a limited focus being directed on a diseased body. Adding the spiritual dimension is often credited to Wright, Watson, and Bell (1996), as they noted that the human illness experience includes the beliefs and meanings ascribed to it by the patient and family.

In 2001, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) mandated medical teams be more attentive to patient "cultural and religious beliefs" (VandeCreek & Burton, 2001, p. 83). In 2003, the IOM (2003) called for patient- and family-centered care which included mandates to help "make healthcare safe, effective, patient-centered, timely, efficient, and equitable" (p. 6) and for medical team members to "respect [each patient's] values, preferences, and expressed needs" (p. 48). As a result, the psychological, social, and spiritual dimensions of the illness experience were beginning to be seen as complementary to the biological ones. This conclusion was not novel for those who were already attending to issues of spirituality and health. However, it has lent new meaning to the importance of effectively translating the research of spirituality into clinical practice and documenting clinical practice effectiveness by tracking measurable outcomes.

Need for the Study

Over the last decade, the number of certified chaplains in the United States has risen to over 10,000 (Fogg, Weaver, Flannelly, & Weaver, 2004). Chaplains are present in hospitals because they embrace their religious and spiritual orientations and bring their respective perspectives, skills, and authority to patients, families, and staff members (Norwood, 2006). For many patients, referrals to a hospital chaplain are seen as critical to good healthcare, as board-certified chaplains are able "to address all aspects of spirituality in the healthcare system at the patient, staff, and system levels" (McClung, Grossoehme, & Jacobson, 2006, p. 151). However, McClung et al. also recommended that chaplains intervene with fellow hospital employees because "caregivers need to receive care as well as offer it" (p. 151).

The medical profession puts healthcare workers on the front lines where "regardless of specialty area…[they] witness and try to support patients suffering and dying, families coping

with uncertainty and grief, and colleagues making difficult decisions" (McClung et al., 2006, p. 151). Multiple researchers have focused on the grief nurses experience at the death of a patient (e.g., Kaplan, 2000; Lally, 2005; Morita, Miyashita, Kimura, Adachi, & Shima, 2004; Papadatou, Ballali, Papazoglou, & Petraki, 2002); in fact, it has been called "the most stressful experience of nurses" (Shinbara & Olson, 2010, p. 32). Ewing and Carter (2004), however, reported that "grief, loss, and bereavement" (p. 471) are the major stressors of all hospital staff. A caring and healing environment can preserve "human dignity, wholeness, and integrity" (Green, McArdle, & Robichaux, 2009, p. 299). A culture of care, which hospital chaplains are trained to nurture, can foster a healthier work environment where hospital-based healthcare providers can work optimally and attention is paid to the whole person and not just one part.

While there is recognition that addressing the spiritual needs of providers and staff is important, much of the research at present has been written to help readers understand the role of chaplains and their impact on patient well-being (e.g., Handzo, Flannelly, Kudler et al., 2008; Flannelly, Weaver, & Handzo, 2003; Montonye & Calderone, 2010; Piderman et al., 2008; Sharp, 1991; VandeCreek & Lyon, 1991). The work performed by HCs has been recognized though by many professionals within the medical community such as: nurses (e.g., Carey, 1973; Chapman & Grossoehme, 2002; Galek, Silton et al., 2009; Taylor & Amenta, 1994; Weinberger-Litman, Muncie, Flannelly, & Flannelly, 2010; Vanderwerker, Flannelly et al., 2008), physicians (e.g., Carey, 1973; Daaleman & Frey, 1998; Galek, Vanderwerker et al., 2009; Vanderwerker, Flannelly et al., 2008), social workers (Galek, Vanderwerker et al., 2009), case workers (Galek, Vanderwerker et al., 2009), and hospital administrators (Galek, Vanderwerker et al., 2009). In spite of these findings, it appears many healthcare professionals do not see the link between biomedical and social, emotional, and spiritual issues (e.g., Daaleman & Frey, 1998; Flannelly &

Galek, 2006; Flannelly, Weaver, & Handzo, 2003; Koenig, Bearon, Hover, & Travis, 1991). Marginalization (Norwood, 2006), stereotypes relative to chaplaincy services (Koenig, Bearon, Hover, & Travis, 1991; Norwood, 2006), and professional role conflicts (Wittenburg-Lyles et al., 2008) may limit integration of hospital chaplains into integrated treatment teams (Taylor et al., 2012). Lack of referral protocols (e.g., Galek, Flannelly et al., 2007; Vanderwerker, Flannelly et al., 2008), limited understanding of availability, and knowledge of how to access chaplain services could contribute to lack of referrals and team inclusion (Taylor et al., 2012). All of these factors may also impair those within the medical system from seeking care from hospital providers when they experience personal and spiritual needs. To date, however, none of these researchers have addressed the experience of providers who have accessed hospital chaplains for personal care and how this interaction detracts from or adds to their personal health and patient-family healthcare outcomes.

Overview of Chapters

Given that chaplains attend to the spiritual dimension of patients, families, and staff members, the first article, found in Chapter Two, is a review of the research-based literature covering the roles and activities of hospital chaplains and measurable effects of their service on health outcomes. The purpose of this article was to systematically review the research literature covering the roles and activities of hospital chaplains and their measurable effects on health outcomes. Sixty-eight articles met the inclusion criteria and five distinct themes emerged from the analysis process: spiritual care provision, chaplain activities and interventions, satisfaction with chaplain interventions, interdisciplinary team work and collaboration, and referral patterns. The following operational definitions were used to guide the literature review process:

- "Chaplains" are ministers who provide spiritual care and who are employed by healthcare organizations or are contracted by hospitals for such services (Snorton, 2006). These ministers serve as spiritual care specialists on healthcare teams (Handzo & Koenig, 2004). Certified chaplains complete a minimum of 1,600 hours of supervised clinical training with individual and group supervision, case study, and theological review (Snorton, 2006). This training helps chaplains provide effective spiritual interventions.

- "Chaplaincy intervention" includes the various ways in which chaplains offer spiritual comfort and provide spiritual and/or religious care to patients, family members, and health care team members. This care often includes prayers, conducting of religious services, listening to an individual or family's illness story, and being available to individuals as a spiritual/religious resource during times of illness, crisis, and/or trauma (Pargament, 1997).

- "Spirituality" encompasses a broader focus than "religion" (Astrow, Puchalski, & Sulmasy, 2001). The term refers to life principles that pervade and animate an individual or group's entire being (Dombeck & Karl, 1987). These foundational beliefs are developed throughout the lifespan and serve to provide structure as well as purpose and meaning to daily activities and interpretation of morals, faith, love, suffering, God, or higher power (Beusher & Beck, 2008).

- "Religion" is a set a organized beliefs, practices, rituals, and/or language that is characteristic of a community searching for transcendent meaning, generally relative to belief in a deity, or that which is existential (Koenig et al., 2001; Sulmasy, 2002).

- Hospital-based healthcare providers are individuals who are responsible for providing healthcare services for patients. Those who work in hospital settings include physicians, surgeons, physician assistants, nurse practitioners, nurses, mental health providers, rehabilitation specialists, and/or technicians.

The findings from the systematic review revealed that spiritual care provision has a positive effect on health outcomes and patient satisfaction with medical care. They found that hospital chaplain interventions expedited the healing process (e.g., Bay, Beckman, Trippi, Gunderman, & Terry, 2008; Florell, 1973; Iler, Obenshain, & Camac, 2001), decreased nursing time with the patient and family (e.g., Florell, 1973; Iler, Obenshain, & Camac, 2001), and shortened the length of hospital stays (e.g., Iler, Obenshain, & Camac, 2001). Of all providers, nurses referred patients for hospital chaplain services more often (e.g., Chapman & Grossoehme, 2002; Galek, Vanderwerker et al., 2009; Vanderwerker, Flannelly, et al., 2008), and a paucity of evidence- based referral protocols exist for helping hospital based healthcare providers to know how, when, and under what reasons, they should access hospital chaplain support (Taylor & Amenta, 1994). Chaplains also reported that they would like to be more active members on interdisciplinary treatment teams (e.g., Norwood, 2006; Wittenberg-Lyles, Oliver, Demiris, Baldwin, & Regehr, 2008). Chapter Three includes a detailed description of the study's methodology. A phenomenological investigation (Husserl, 1901 as cited in Smith, 2006) was designed to elucidate the hospital-based healthcare providers (HBHPs) experiences receiving care from hospital chaplains (HCs). It was designed to answer the following research questions: "What are the experiences of hospital-based healthcare providers as recipients of spiritual care from a hospital chaplain?", and "What are the experiences of hospital chaplains who provide spiritual care to hospital-based healthcare providers?" Phenomenology was chosen as the more

appropriate design method as it is often used when one is seeking to understand the "essence or underlying meaning of a phenomenon or experience" (Creswell, 2007, p. 51) that several individuals share. Data collection consisted of the researcher conducting in-depth interviews which were audio-taped and transcribed. Responses were categorized according to thematic patterns (Colaizzi, 1978). Verification strategies outlined by Lincoln and Guba (1985), which included a triangulated investigator, peer debriefer, reflexive journal, and audit trail were used to increase credibility, transferability, dependability, and confirmability for the study. These methods are designed to help increase the trustworthiness of the findings which is critical in qualitative studies.

Chapter Four contains the second dissertation article which was written to present findings from a phenomenological study on the shared experience of spiritual care between hospital chaplains and hospital-based healthcare providers. Findings that reinforce the need to integrate hospital chaplaincy support and spiritual care into hospital-based healthcare delivery systems, as well as the merits of caring for the provider are described. Distinct themes emerged when meaning statements were collapsed into the following six thematic clusters: Awareness of chaplain availability, chaplains focus on building relationships with providers and staff, chaplains are integrated in varying degrees on certain hospital units, chaplains meet providers' personal and professional needs, providers appreciate chaplains, and barriers to expanding hospital chaplains' services. Notably, even though the HBHPs appreciated the care received and were able to provide better patient care as a result, the true value of the care provided may not be recognized by administrators. The lack of inclusion on treatment teams in some areas also caused questions to be raised about the lack of education and research available to encourage hospitals to implement a more widespread and seamless care delivery system. Implications from

this study are applied to clinical, research, and educational opportunities in the area of hospital chaplaincy.

The concluding chapter of this dissertation is the platform in which findings of a phenomenological investigation of the lived experience of HBHPs who have received emotional and spiritual support from HCs are reviewed. While the benefits HBHPs received as a result of chaplaincy care were highlighted, questions were raised and implications extended toward the adaptation of an integrated care hospital-based delivery model. The chapter also included a summation of the previous chapters, as well as a place to discuss implications from articles one and two.

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CHAPTER 2: REVIEW OF LITERATURE:

A SYSTEMIC REVIEW OF LITERATURE ON HOSPITAL CHAPLAINCY

National and international regulatory and accrediting bodies recognize how important it is to meet patients' spiritual needs. In 1999, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) mandated that "medical care team[s] respect the [patients'] cultural and religious beliefs" (VandeCreek & Burton, 2001, p. 83). Their anticipated outcome was that the beliefs, practices, and spiritual needs of patients, as well as the caregivers and medical care team members would all be considered a part of the healthcare experience (VandeCreek & Burton, 2001).

In 2003, The Institute of Medicine (IOM) proposed multiple recommendations, all of which serve to "make healthcare safe, effective, patient-centered, timely, efficient, and equitable" (p. 6). They endorsed that while a patient-centered care model is used to assure the physical comfort of the patient, medical team members should work to "respect [each patient's] values, preferences, and expressed needs" (IOM, 2003, p. 48). For example, emotional support is provided to help eliminate both fear and anxiety in the patient and this help extends to their family members and friends as well. The IOM model for healing environments also promotes the bridging of interdisciplinary collaboration through the use of healthcare models that are biological, psychological, social, and spiritual in nature.

Spirituality as a part of healthcare is the least explored of those domains but according to VandeCreek and Burton (2001), everyone has deep existential needs and concerns. At times of crisis or when an individual or family experiences sickness, "profound experiences of transcendence, wonder, awe, joy, and connection to nature, self, and others have been found among individuals who turn toward their faith as well as those who may not believe in or

practice within traditional religious structures" (p. 82). Questions about one's purpose (meaning of life), the dualism between good and evil (the need to find meaning in good and bad events), as well as the patient's ultimate fate (prognosis and beliefs about death and eternity) may surface and demand consideration. In fact, between 33% and 94% of patients want their spiritual concerns addressed by medical care team members (Carey, 1985; Daaleman & Nease, 1994; Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999; King & Bushwick, 1994; Fitchett, Meyer, & Burton, 2000; Koenig, McCullough, & Larson, 2001).

While medical professionals focus on a patient's biomedical condition, DeVries, Berlinger, and Cadge (2008) explained that "chaplains seek to read the whole person, asking questions about what people's lives are like outside the hospital, what they care about most, and where they find joy and support in the world" (p. 9). Many patients and family members see those in hospital chaplaincy to be "an incarnational symbol of all things, mysterious, ultimate, and transcendental" (Hall, 1992, p. 5); some within the hospital-based medical community also recognize the important role hospital chaplains (HCs) embody (e.g., Koenig, McCullough, & Larson, 2001; McClung, Grossoehme, & Jacobson, 2006; Weinberger-Litman, Muncie, Flannelly, & Flannelly, 2010). Despite the fact that hospitals all across the United States employ chaplains to meet the spirituals needs of their patients, authors have been advocating since 1991 for empirical studies designed to capture the effects of chaplaincy on patient health outcomes (Gibbons, Thomas, VandeCreek, & Jessen, 1991; Hover, Travis, Koenig, & Bearon, 1992; Koenig, Bearon, Hover, & Travis, 1991; Koenig, McCullough, & Larson, 2001; The Hastings Center, 2008). This article presents a systematic review of the research literature covering the role and activities of hospital chaplains and their measurable effects on health outcomes.

Aims of Literature Review

This review aims to: (1) analyze research conducted on the role and activities of hospital chaplains in spiritual care provision, (2) analyze hospital chaplains affect on health outcomes, and (3) organize the literature to identify themes and gaps in knowledge. The results will be used to target areas for future research.

Methodology for Review of Literature

A two-phase process was used to extract the critical literature for this review. Phase one included a search for published research-based literature using the following databases: ONESEARCH, CINAHL, EBM Reviews (all including Cochrane and MEDLINE), PubMed, and Google Scholar. The following key words formed the list of search terms used to identify the relevant literature: 'hospital chaplain' [or] 'pastoral care' [or] 'spiritual care' [and] 'hospital', 'doctors', 'nurses', 'medical care providers' [or]'patients.' This initial search resulted in a total of 215 articles. Application of the inclusion criteria reduced the number of articles for review to 57. A second investigator verified the articles identified for inclusion by replicating the search process. The inclusion criteria were research studies: (1) published in English, (2) published in peer-reviewed journals, (3) conducted in inpatient hospital sites in the United States, and (4) included one or more combination of selected search terms. Studies not conducted in U.S. hospital settings were excluded from this review. The second phase involved reviewing reference lists of articles that met the inclusion criteria. A total of 11 articles met the inclusion criteria from this phase. Overall, both phases combined resulted in 68 articles that were admitted for review. The span of years covered in this review is from 1973-2011, with the dates being dictated by the first article published that met the inclusion criteria and up to the present. The 68 studies that met the inclusion criteria are briefly summarized in Table 1.

Results

The studies included in this literature review have been organized into five thematic categories: (1) spiritual care provision, (2) chaplain activities and interventions, (3) satisfaction with chaplaincy intervention, (4) interdisciplinary team work and collaboration, and (5) referral patterns. Even though a few articles spanned across one or more thematic categories due to their robustness and the divergent nature of the outcomes, each study was included only once in the category in which it fits most appropriately.

Spiritual Care Provision

The 14 studies that are represented under this theme offer understanding and an overview into various aspects relative to the general ways HCs care for patients' spiritual needs and values in an inpatient medical setting. The theme also includes studies on hospital types and sizes which often include Pastoral Care Departments, and an overview of the patient issues often addressed. Specific interventions and activities used are addressed in the second thematic category.

To provide optimal care, it is helpful for HCs to have an understanding of the more frequently noted patient characteristics and needs. Fitchett, Meyer, and Burton (2000) found that those who requested spiritual care tended to be older, non-White, and female. Over half of the patients who requested care from HCs desired sacraments and prayer, and wanted someone with whom they could talk. Another team of researchers found patients expected a hospital chaplain to visit every few days and reported chaplains offered reminders of both God's presence and care (Piderman et al., 2008). Flannelly, Galek, and Flannelly (2006) surveyed HCs and learned they perceived patients to desire spiritual care that helped them achieve meaning and purpose, love and belonging, death/resolution, and understanding of the Divine.

Researchers have also noted that similarities between patients and chaplains' spiritual beliefs and gender appeared to improve care provision and reception. Galek, Silton, Vanderwerker et al. (2009) found that HCs reported praying more when patients held similar beliefs. Protestant chaplains were found to be 50% more likely to pray with Protestant patients, while Catholic chaplains were 20% more likely to pray with Catholic patients. They also reported chaplains were more likely to pray with patients of their same gender. Silton, Asekoff, Taylor, and Silton's (2010) study reinforced these results and added instructions on how to minister to Jewish patients specifically.

Cultural traditions, norms, beliefs, and biases may be understood more broadly than one's race, ethnic origin, or religious affiliation when it comes to spiritual care. Cultural barriers may also exist as some individuals see needing care and accessing assistance as signs of weakness. For example, spiritual care provision to active duty military veterans can be challenging as a veteran may find it difficult to admit his or her need (Fletcher, Ronis, Hetzel, & Lowery, 2010) in a system where it is important to be seen strong physically and spiritually. The provision of care to a diverse population within and outside of the military may be challenging as different cultural groups and communities may embrace the provision of spiritual care as more or less intrusive or essential to the overall healthcare experience.

Pastoral care departments, while possible, are often not included in all hospital facilities even though chaplaincy intervention has been found to be a component of total patient care, according to patients, nurses, physicians, and chaplains (Carey, 1973). Variables such as patient census, population density, religion-affiliation, and type of business were found by Flannelly, Handzo, and Weaver (2004) to impact the establishment of pastoral care departments. For example, urban hospitals tended to have pastoral care departments more often than rural ones.

Cadge, Freese, and Christakis (2008) affirmed their findings and noted that hospital size, location, and church-affiliation were the most important determinants of hospital chaplaincy service availability. While the number of chaplains within a medical center were also found to be directly related to census size, religious-affiliated hospital-based institutions tended to employ 4.9 chaplains per 100 inpatients; whereas, non-religious healthcare institutions hired 3 chaplains per 100 inpatients (VandeCreek, Siegel, Gorey, Brown, & Toperzer, 2001). VandeCreek and Gibson (1997) sought to determine the availability of spiritual support during hospitalizations as provided by local clergy and HCs. They found that less than one-fourth (22%) of the patients were visited by a religious caregiver from their community. HCs were responsible for 35% of the total number of visits.

While collaboration (which appears to increase HC usage and patient referrals) between HCs and other healthcare professionals appears to be increasing, HCs indicated nurses also have the ability to provide spiritual care (Cavendish et al., 2007). It is unclear from the findings of this study if only certain nurses or nurses on certain units, provided the spiritual care patients desired and/or needed, or if a universal skill set was shared by all nurses. In a study with registered nurses, they indicated that addressing patient spiritual care needs was essential (Scott, Grzybowski, & Webb, 1994).

Chaplain Activities and Interventions

The 26 studies included under this theme helped to form a better understanding of the specific hospital chaplain activities and interventions used to meet the spiritual needs of patients, family members, and staff.

Chaplain activities. According to several researchers, multiple chaplain activities can be considered "spiritual care." In 2008, Hummel, Galek, Murphy, Tannenbaum, and Flannelly

performed a content analysis on peer-reviewed spiritual care literature and uncovered 250

spiritual care interventions (not limited to hospital settings). When these interventions were

categorized, only 2 out of the 10 categories were explicitly religious: religion and spirituality; the

remaining categories were: counseling, emotional support, advocacy, present, respect,

communication, adjunct therapy, and other care.

As noted earlier, spiritual care provision can include a comprehensive list of

responsibilities. A review of the 1994-96 data from 30,995 hospital-based chaplain visits in New

York City expanded Hummel et al.'s 2008 findings. Handzo et al. (2008) studied chaplaincy

interventions with a wide range of patients across multiple healthcare inpatient settings and

recorded 17 activity types, more than the 10 recorded by Hummel et al's team in 2008. Nine of

the 17 interventions were religious in nature (hearing confessionals, faith affirmations,

theological development, the performance of rites/rituals, providing religious items, offering

blessings, praying, meditations, other spiritual support); the balance was characterized as being

non-religious (crisis intervention, emotional enabling, ethical consultation, life review, patient

advocacy, bereavement work, counseling, empathetic listening). Handzo, Flannelly, Kudler et

al. (2008) also provided more clarity of activities in both categories. These results served to

expand VandeCreek and Smith's (1992) work, which identified that chaplains mainly helped

patients and family members search for meaning and purpose in suffering. Likewise, Montonye

and Calderone (2010) found that addressing matters of faith, life review, prayer, and performing

rites and sacraments were items listed as being involved in spiritual care provision. Significant

to HCs' activities and interventions are themes of respect and dignity (Flannelly, Galek,

Tannenbaum, & Handzo, 2007). Chaplains desired not only to be treated with respect, they

sought the same from and for those with whom they collaborated and provided spiritual care.

For example, Galek, Flannelly, Jacobs, and Barone (2008) found female spiritual care providers reported personally experiencing five emotional and/or spiritual constructs more than their male counterparts (belonging, meaning, hope, beauty, and acceptance of death). Awareness of their own experiences served to remind chaplains that their individual needs might be different than those of the patients they serve.

Care for patients, family members, and hospital staff. Among the various responsibilities of HCs is making contacts with patients, family members, and hospital staff. VandeCreek and Lyon (1994) reported chaplains logged nearly 40,000 contacts with patients, families, and staff in three hospitals over a two-month period. Years later, Handzo, Flannelly, Murphy et al. (2008) studied the New York Chaplaincy Study data of 1994-96 and reported a total of 43,000 chaplain visits across 13 healthcare facilities; data was collected for two-week periods each year. When Vanderwerker, Handzo, Fogg, and Overwold (2008) compared the data from the New York Chaplaincy Study of 1994-96 and the Metropolitan Chaplaincy Study (conducted over 10 years later), they discovered the chaplain-to-patient ratio and overall pattern of visit length remained the same. The proportion of chaplain visits to family members decreased over the 10 years between the two investigations, as did the length of stay of the patients. Chaplains did increase the number of visits with patients, with more of them being the result of referrals from other hospital personnel.

Integration of HCs. Researchers found the integration of HCs into various medical settings improved patient care and satisfaction. Chaplains were new to the study hospital healthcare teams when Sharp (1991) studied chaplaincy logs from three Dallas/Fort Worth area hospitals to learn how chaplains were used in neonatal intensive care units. During the 6-month period under investigation, chaplains recorded their interactions with patients and families, and

noted the source and type of consultation, with whom the interaction occurred, and the source of the request. Researchers found chaplains initiated 43% of the chaplain-family interactions, with nurses (31%), parents (15%), physicians (8%), and other family members (3%) being responsible for other chaplain contacts. Chaplain team inclusion provided support for patients and families, when performance of spiritual rituals (such as baptisms and end-of-life ceremonies, as well as prayer, emotional support, and grief and bereavement work) was added as a component of care (Cadge, Calles, & Dillinger, 2011).

Researchers have concluded that chaplain interventions improve patient care across diverse hospital settings and health conditions. Chaplain interventions have been effective with patients diagnosed with chronic conditions, such as chronic obstructive pulmonary disease (COPD), leading patients to report lower levels of anxiety, shorter hospitalizations, and higher levels of satisfaction with care (Iler, Obenshain, & Camac, 2001). A reduction in anxiety and depression was also experienced with coronary artery bypass graft (CABG) recipients (Bay, Beckman, Trippi, Gunderman, & Terry, 2008). Furthermore, HCs also provide beneficial assistance to surgical patients. Florell (1973) found that chaplains offered crisis intervention with surgical patients and were found to impact patient healing processes significantly. Sheehan and Wathen (1982) confirmed their findings and reported chaplains directed teams in their efforts to address emotional issues experienced by patients with hand injuries.

Perhaps more complex, HCs are often called to intervene with patients who are experiencing terminal illnesses. Piderman and Johnson (2009) studied chaplain involvement in a randomized controlled multidisciplinary trial involving patients with life expectancies of five years or less. Patients expressed a need for spiritual care, especially prayers, sacraments, and time with chaplains. Balboni et al. (2009) reported chaplain visits and spiritual support from

medical care team members has been found to be associated with a higher quality of life and greater use of hospice service by patients near end of life. Davies, Control, Larson, and Wedger (2010) confirmed their findings and showed the importance Mexican-American and Chinese-American families placed on receiving information from healthcare providers when their children were receiving pediatric palliative care.

  Perceptions of HC interventions. Because of a desire for more insight into the role of spiritual care provision by HCs, members of the Department of Pastoral Services at Duke University Medical Center conducted research on various aspects of their work. The process that followed is outlined in the 1992 case study by Hover, Travis, Koenig, and Bearon. The researchers found a disparity relative to the spiritual care chaplains provided and the perceptions of nurses, physicians, patients, and family members. Nurses (92%) and physicians (74%) reported believing the spiritual care offered by HCs to be helpful to patients and families; 33% of the patients and families felt they had been helped.

  The unique function of HCs may not be recognized by all hospital personnel, including administrators. In 2005, Flannelly, Weaver, Handzo, and Smith found CEOs of hospitals without a pastoral care department assigned lower ratings to the importance of all chaplain roles and functions than did administrators of facilities with pastoral care departments. According to Flannelly, Galek, Bucchino, Handzo, and Tannenbaum (2005), a healthcare facility administrator's role, as well as the size of the hospital, may impact the importance ascribed to the chaplains' roles. The researchers reported that nursing, physician, social worker, and chaplaincy administrators identified grief and death work, prayer, and emotional support to be the three most important chaplain roles for patients and their family members.

HC assistance with ethical matters. Another aspect of chaplaincy care includes providing ethical consultation to medical teams, patients, and family members. Fox, Myers, and Pearlman (2007) reported that 81% of general hospitals with over 400 beds offered ethical consultations, with physicians, nurses, social workers, and chaplains all being placed in the consultant role. DeLong (1990) studied chaplains and found that they assisted families with their decisions relative to organ donations about 50% of the time. They provided support and information as family members weighed ethical and spiritual concerns. Two additional research teams provided insight into a unique ethical matter sometimes encountered by Oregon chaplains: physician-assisted suicides (PAS). Over half of the PAS requests in Oregon have also involved chaplains, with patient conversations focusing on the reasons patients make the request, the role of faith, and how family members may be impacted (Carlson, Simopolous, Jackson, & Ganzini, 2005). Another study done by Goy, Carlson, Simopolous, Jackson, and Ganzini (2006) found the chaplain views on PAS are associated with their individual beliefs about suicide.

Satisfaction with Chaplaincy Interventions

Twelve studies reflected satisfaction with chaplaincy intervention from the perspectives of patients (Flannelly, Oettinger, Galek, Braun-Storck, & Kreger, 2009; Gibbons, Thomas, VandeCreek, & Jessen, 1991; Parkum, 1985; Johnson & Spilka, 1991; VandeCreek, 2004; VandeCreek, Thomas et al., 1991; VandeCreek & Connell, 1991); the patient's family (Broccolo & VandeCreek, 2004), colleagues' (Fitchett, Rasinski, Cadge, & Curlin, 2009), and hospital administrators' (Clark, Drain, & Malone, 2003; Manns, 1990; Yankelovich Partners, 1997).

Within a hospital context, patients receive care from a variety of professionals who are not medical providers. Parkum's 1985 study of the impact of chaplaincy services found that patients see chaplains to be the most helpful of all non-medical support services. VandeCreek,

Thomas, Jessen, Gibbons, and Strasser (1991) reinforced Parkum's findings and reported that chaplain visits were rated by patients and families to be satisfactory and important, and more frequent than visits from other non-medical personnel. VandeCreek and Connell (1991) added that Catholic general medical patients saw chaplain visits to be more important than did Protestant general medical patients.

Receiving spiritual care from HCs was also found to increase patient satisfaction with medical treatment. In particular, patient satisfaction with chaplaincy services appeared to be associated with spiritual sensitivity (VandeCreek, 2001). Satisfaction scores were related to the extent patients felt their spiritual and emotional needs were met (Flannelly, Oettinger, Galek, Braun-Storck, & Kreger, 2009). When patients are satisfied with chaplain interventions, they reported an easier hospitalization, one that is characterized as being more comfortable and possibly even relaxing (VandeCreek, 2004). Years earlier, breast cancer patients reported similar findings in Johnson and Spilka's 1991 study. The 103 female patients reported higher levels of satisfaction with spiritual care provided by HCs than local clergy, and noted the number of visits, use of prayer and Scripture, and counsel the chaplains offered as being helpful.

Not only did patients express satisfaction with chaplaincy services, family members did as well. Broccolo and VandeCreek (2004) reported that bereaved family members interviewed by staff of the Catholic Health Initiative reported receiving both comfort and support from HCs. They not only saw the chaplains to be surrogate family members while they were not available, but they were also recognized for the spiritual support they extended to family members and their dying loved ones.

Even though HCs were valued by patients and their families, the various professionals with whom they work in the system may not always value them as much. While it would appear

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physicians were slow to refer to HCs as a result of a lack of training, as well as their own

religious and spiritual beliefs, physicians indicated they were satisfied or very satisfied with the

spiritual care provided by HCs to their patients (Fitchett, Rasinski, Cadge, & Curlin, 2009).

When for-profit and not-for-profit hospital administrators were surveyed by Manns (1990) in an

attempt to discover the value they placed on hospital chaplaincy services, no significant

differences were found between groups on the value of pastoral care services.

Not only can satisfaction with hospital chaplaincy care benefit patients and family

members, medical facilities can benefit as well. Clark, Drain, and Malone (2003) reported that

when hospital patients were satisfied with the emotional and spiritual care provided by HCs, a

moderately positive relationship with profitability was exhibited. HMO executives surveyed by

Yankelovich Partners (1997) found they placed faith in the power of spirituality to complement

medical practices. They also found a patient's well-being increased if his or her spiritual needs

were met. It was thereby speculated that chaplaincy intervention would impact medical care cost

containment.

Interdisciplinary Team Work and Collaboration

In their attempts to meet the medical needs of their patients, providers often engage in

integrated or collaborative care. According to Singer et al (2001), integrated care is…

> patient care that is coordinated across professionals, facilities, and support systems;
>
> continuous over time and between visits; tailored to the patients' needs and preferences;
>
> and based on shared responsibility between patient and caregivers for optimizing health.
>
> (p. 113)

In hospital settings where there is a broad spectrum of potential collaborators with varying levels

of power and influence, hospital chaplains have reported struggles with access and inclusion.

This has led to the realization that when all team members do not hold the same level of importance for spirituality (Clark et al., 2007), role conflict can occur (Harr, Openshaw, & Moore, 2009; Wittenberg-Lyles et al., 2008), and perceptions relative to a lack of respect and inclusion can result in feelings of marginalization (Norwood, 2006). Four studies described below highlighted interdisciplinary team member dynamics, expectations, and experiences with HCs.

Interdisciplinary teams are comprised of all of the medical care professionals who are involved with a respective patient's medical treatment. However, chaplains are not the only team members who consider themselves to be religious or spiritual. In 2006, Flannelly and Galek found chaplains, nurses, and social workers attributed higher levels of significance to personal spirituality than did physicians. Clark et al. (2007) found interdisciplinary team members working in hospice settings reported higher levels of job satisfaction when they were able to integrate their spirituality into the care they offered.

Competent and effective care delivery requires chaplains to interface with other healthcare professionals in a cooperative manner. However, the integration process is not always seamless. Norwood (2006) reported chaplains often feel marginalized. The perceived presence of alternative paradigms requires chaplains to negotiate with other healthcare professionals and to embrace structures and ideologies in order to survive within the system. The language, structure, and ideologies present were reported barriers to the interns and limited patient access to them. While Norwood reported on marginalization, Wittenberg-Lyles, Oliver, Demiris, Baldwin, and Regehr (2008) found chaplains often reported professional role conflicts (especially with social workers), ambiguous responsibilities that blurred task assignments, and lack of clarity about their role occurred across all levels of the hospital system. In spite of these

issues, many chaplains perceived their relationship with social workers to be positive (Harr, Openshaw, & Moore, 2009).

Referral Patterns

HCs often rely on referrals from other medical professionals to link them to those desiring and in need of spiritual intervention. The 12 studies reviewed in this section highlighted referral patterns of hospital personnel and patients to HCs.

The volume of spiritual care that HCs provide is dependent upon hospital-based healthcare providers' spiritual awareness, spiritual skill set, and willingness to refer. In their 1991 study of the religious perspectives of doctors, nurses, patients, and families, Koenig, Bearon, Hover, and Travis found that among their participants, physicians (93.5%), nurses (100%), and patients (100%) described themselves as being spiritual and/or religious. Koenig et al. (1991) also found patients (81.3%) and family members (91.2%) embraced faith as a factor that helped them cope. An examination of the spirituality and religiosity of physicians, nurses, social workers, and chaplains led researchers to find that the chaplains rated themselves higher in both religiosity and spirituality than the other healthcare professionals who participated in the study; physicians rated themselves the lowest in these areas across all four groups of professionals (Flannelly & Galek, 2006).

Referral patterns to HCs offer insight into how much various healthcare team members value spiritual and emotional support for patients. The 2009 work of Galek et al. provided information that nurses made the highest number of patient referrals to HCs (45%), with patient self-referrals or requests from family members (30%) being next. The balance of referrals was made by members of other healthcare disciplines (chaplains, 6%; physicians, 3%; case coordinators, 2.7%; social workers, 2.5%; volunteers, 2%). Their findings confirmed the earlier

work of Vanderwerker et al. (2008), who found that nurses were the most common referral source (27.8%) of all hospital staff. Flannelly, Weaver, and Handzo (2003) reviewed chaplain interventions for three years at Memorial Sloan-Kettering Cancer Center. The researchers found that nurses made nearly one-fourth of all referrals, and that the proportion of referrals they made rose annually. In another study of the interactions between nurses and chaplains, Taylor and Amenta (1994) surveyed members of the Oncology Nursing Society randomly. Respondents reported they consulted with HCs about patients diagnosed with cancer and noted an overall favorable impression of their encounters, even though chaplains were sometimes overworked, not available, or refused to come when called. Fogg, Flannelly, Weaver, and Handzo (2001) found similar results and noted that while referrals from nurses, social workers, and other hospital staff increased over time; physician referrals did not. Even though physicians do not appear to refer patients to HCs as often as do nurses, Daaleman and Frey (1998) found 30% of the physicians in their study referred patients to HCs more than 10 times a year.

It is important to understand the reasons why patients are referred to HCs. Vanderwerker et al. (2008) reported that patient issues leading to referral requests ranged from emotional, spiritual, medical, and relationship issues, to support for a change in patient diagnosis or prognosis. Galek, Flannelly, Koenig, and Fogg (2007) studied the responses from directors from four disciplines (medicine, nursing, social services, and pastoral care) and learned that patients are often referred when encountering difficulties with pain/depression, anxiety/anger, treatment issues, and their individual searches relative to loss, death, and/or meaning. The patient's emotional state (both the need for emotional support and feelings being expressed by patients and/or family members) is what appeared to prompt nurse referrals (Weinberger-Litman, Muncie, Flannelly, & Flannelly, 2010). Weinberger-Litman et al. (2010) also found nurses were

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more likely to make referrals for discharge issues than allied medical staff (social workers, case coordinators, volunteers, etc.). Adolescent psychiatric patients self-referred for pastoral care more than patients in medical and surgical situations.

Interested in seeking what would happen when chaplain staff reductions occurred, Gartner, Lyons, Larson, Sekland, and Peyrot (1990) conducted an investigation of referrals patterns. In one hospital setting, healthcare pastoral care staff members were reduced from 13.5 to 4.5 full-time chaplains. When the number of chaplains was reduced, medical team members absorbed more responsibility for spiritual care provision.

Discussion

Patient- and family-centered care (IOM, 2003) is used to endorse a healing environment in which strong interdisciplinary collaboration is implemented, and a BPS-S treatment approach is embraced. Spiritual well-being, a value and expressed need of patients (Koenig, McCullough, & Larson, 2001), has been found to help patients moderate difficult illness-related emotions such as depression (e.g., Bay et al., 2008) and anxiety (e.g., Bay et al., 2008; Scott, Grzybowski, & Webb, 1994), and has been linked to patient satisfaction (e.g., Chapman & Grossoehme, 2002; Hausmann, 2004; VandeCreek, 2004) and cost containment (Clark, Drain, & Malone, 2001; Yankelovich Partners, 1997). Researchers have shown how religiosity and spirituality offered patients a higher quality of life (Balboni et al., 2009), better adjustment to their respective physical illnesses (Florell, 1973; Sheehan & Wathen, 1982), and shorter hospitalizations (Iler, Obenshain, & Camac, 2001). Even though spiritual care provision has been found to have a positive effect on emotional well-being and patient satisfaction with care, there are also many gaps in the literature. There needs to be more focus on the outcomes of spiritual care provided in the hospital setting and who should provide that care to get the most patient, family, and provider

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benefit. A few researchers have pointed to the importance of the hospital chaplain in that role

(e.g., Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005; VandeCreek, 2004; Chapman

& Grossoehme, 2002; Clark, Drain, & Malone, 2001), but more research is needed to fill in the

empirical gaps.

After a critical review of available research, two recommendations for future research are

suggested. These recommendations involve further study on: (1) biopsychosocial and spiritual

outcomes when including a hospital chaplain as a member of the healthcare team; and (2) the

protocol for referrals to HCs for spiritual care.

BPS-S Outcomes of Including a Hospital Chaplain.

Much of the available research has been written to understand and describe the role of

HCs and their impact on patient well-being (e.g., Handzo, Flannelly, Kudler et al., 2008;

Flannelly, Weaver, & Handzo, 2003; Montonye & Calderone, 2010; Piderman et al., 2008;

Sharp, 1991; VandeCreek & Lyon, 1991). To date, there are no published studies on to the

impact of integrating HCs into interdisciplinary treatment teams. The majority of the available

research about HCs is about referrals, activities, or interventions and involves qualitative or

quantitative designs that are not inclusive of the input and influence of the multidisciplinary

healthcare team. Research invoking qualitative methods such as grounded theory or action

research, as well as efficacy and effectiveness studies (e.g., randomized control trials,

biopsychosocial and spiritual data chart audits, patient recidivism or provider/staff retention

studies) would add to the knowledgebase of biopsychosocial and spiritual outcomes found when

HCs are integrated onto the healthcare team. .

Researchers have recorded multiple activities and/or interventions used by HCs with

patients (e.g., Hummel, Galek, Tannenbaum, & Flannelly, 2008; Handzo, Flannelly, Kudler et

al., 2008; Handzo, Flannelly, Murphy et al., 2008). Even though studies have been conducted

with patients and families, no known research exists detailing the lived experience of hospital-

based healthcare providers who have received support or spiritual care from chaplains while on

duty.   A qualitative study, followed up by a more expansive mixed method one, exploring

hospital-based healthcare providers' experience of receiving spiritual care and support from HCs

would serve to enhance the literature and build an argument for broadening the role of the HC

beyond referral-driven patient and family care. Researchers may want to ask questions such as,

"Can hospital-based healthcare providers provide better care when their spiritual and emotional

needs are met?" and "Do the families of providers who access HC services personally before the

end of a shift notice a difference in how their loved one transitions home versus those who do

not?"

Protocol for Referring to HCs.

Several researchers have found that patients want to talk with HCs (Chapman &

Grossoehme, 2002) as they think chaplains are the most spiritually sensitive of all healthcare

team members (VandeCreek, 2004). VandeCreek and Gibson (1997) noted that patients often

desired hospital chaplain visits; Johnson and Spilka (1991) likewise reported patients see the

spiritual care provided by HCs to be most helpful, especially with cancer patients. The work

performed by HCs is also seen as relevant by many professionals within the medical community.

In particular, nurses (e.g., Carey, 1973; Chapman & Grossoehme, 2002; Fogg, Flannelly,

Weaver, & Handzo, 2001; Galek, Silton et al., 2009; Taylor & Amenta, 1994; Weinberger-

Litman, Muncie, Flannelly, & Flannelly, 2010; Vanderwerker, Flannelly et al., 2008), physicians

(e.g., Carey, 1973; Daaleman & Frey, 1998; Fogg, Flannelly, Weaver, & Handzo, 2001; Galek,

Vanderwerker et al., 2009; Vanderwerker, Flannelly et al., 2008), social workers (Fogg,

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Flannelly, Weaver, & Handzo, 2001; Galek, Vanderwerker et al., 2009), case workers (Galek, Vanderwerker et al., 2009), and hospital administrators (Fogg, Flannelly, Weaver, & Handzo, 2001; Galek, Vanderwerker et al., 2009). In spite of these findings, it appears many healthcare professionals do not see the link between biomedical and social, emotional, and spiritual issues, as HCs are underutilized (e.g., Flannelly, Weaver, & Handzo, 2003; Fogg, Flannelly, et al., 2001; Galek, 2009), even though healthcare professionals have experienced favorable results when interacting with HCs. Alternative paradigms (Norwood, 2006) and professional role conflicts (Wittenberg-Lyles et al., 2008) may impair seamless integration of HCs into treatment teams, contributing to the lack of understanding many healthcare professionals have of the role of chaplaincy in medical settings. This lack of understanding may contribute to the failure of many professionals to have standardized protocols for chaplain referrals (e.g., Flannelly, Weaver, & Handzo, 2003; Fogg, Flannelly, et al., 2001; Taylor & Amenta, 1994). An ethnographic study would help elucidate what is known about the culture in which successful referral protocols and spiritual care interventions are available. This information may help transform systems toward building functional integrated care teams inclusive of HC members.

Conclusion

Spiritual care is used to help patients report a higher quality of life, as well as moderate illness-related emotions and shorter hospital stays. Little is known about why some medical providers (e.g., physicians) refer less often than other providers, and what is needed to promote the inclusion of chaplains in integrated care teams. This review is used to highlight where additional studies are needed that will help to expedite the IOMs push for patient-centered care; care and recognition that suffering "encompasses significant emotional and spiritual dimensions" (IOM, 2003, p. 49)

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Table 1

Studies Reviewed by Thematic Categories

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
				Spiritual Care Provision		
Cadge, Freese, & Christ-akis (2008)	Quan-titative	Various	n= 6,353	Chaplains	Secondary data from hospital chaplaincy records	• Hospital size, location, and religious-affiliation are central factors in hiring of chaplains. • Religiously-affiliated hospitals more likely to drop chaplains if finances an issue; not-for-profit hospitals more likely to hire chaplains when finances become problematic. • No change in percentage of hospitals w/chaplaincy services.
Carey (1973)	Quan-titative	Lutheran General Hospital, Park Ridge, IL	n=236	Physicians (n=122), nurses (n=99), chaplains (n=26) and patients (n=189)	Questionnaire developed by author	• Physicians and nurses reported valuable to have chaplains available at all times (nurses, 87%; physicians 76%); 40% of patients saw availability as significant. • Religious affiliation not found to be statistically significant to value ascribed to chaplain availability. • Attending physicians placed greater value on chaplains than physicians not on attending staff. • Physicians, nurses, and patients all placed value on chaplains being available to offer comfort at times of serious illness/death, to help patients face death with dignity and a calm spirit; and administer sacraments.
Caven-dish et al., (2007)	Qual-itative: Focus Group	Various	n=8	Chaplains: Catholics (n=5), Protestants (n=2), Jewish (n=1); 61+ years old (n=5), 50-60 y/o (n=2), 41-50 y/o (n=1); males (n=5), females (n=3)	Structured interview guide	• Reported collaboration with nurses. • Reported believing nurses can provide spiritual care.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
Fitchett, Meyer, & Burton (2000)	Quan-titative	A mid-Western tertiary care unit.	n=202	General medical and surgical patients	A multi-dimensional Initial Spiritual Assessment Inventory (one question adapted from Blumenthal and colleagues' social support scale)	• 1/3 of patients requested spiritual care. • 60% of patients desired sacraments. • 50% of patients desired prayer. • 50% of patients wanted someone w/whom to talk. • Those who desired/requested spiritual care tended to be older, non-White, and female.
Flannel-ly, Galek, & Flannel-ly (2006)	Quan-titative	Various	n=683	Chaplains	Questionnaire developed by authors	• Four most common spiritual needs of patients: meaning and purpose, love and belonging, death/resolution, the Divine.
Flannel-ly, Handzo, & Weaver (2004)	Quan-titative	Various	n=494	Hospital CEOs	Questionnaire developed by authors	• Religiously-affiliated hospitals employ more chaplains (4.9 as compared to 3.0 of non-affiliated facilities). • A direct relationship exists between the number of chaplains employed and patient census. • More rural facilities rely more on volunteers to provide spiritual care.
Fletch-er, Ronis, Hetzel, & Lowery (2010)	Quan-titative	Mid-western Veter-an's Affair Medical Center	n=39	Veterans admitted to medical/ surgical (n=34) and extended care (n=5) units	Brief Multidimensional Measure of Religiousness/ Spirituality (BMMRS), Herth Hope Index	• Veterans are reluctant to seek/request spiritual care; seen as a weakness. • Christians more interested in seeing chaplains than non-Christians. • 33% of respondents somewhat interested in seeing a chaplain.
Galek, Silton et al., (2009)	Quan-titative (Meta-analy-sis)	Various	n=82	Catholic, Jewish, and Protestant chaplains (53 CPE students, 29 professional chaplains)	Secondary data from computerized data system	• Higher rates of prayer with patients of similar religious/faith backgrounds and with patients of same sex. • Protestant chaplains are 50% more likely to pray with Protestant patients; Catholic chaplains are 20% more likely to pray with Catholic patients.
Pider-man et al., (2008)	Quan-titative	Mayo Clinics: Ro-chester, MN	n= 15,000	Medical and surgical patients 18 yrs and older. Most were mid-Western	Questionnaire developed by authors	• Patients desired/expected chaplain visits at least every few days. • Chaplain visits desired as patients were "reminded of God's presence and care." • Patients desired to participate in religious rituals, prayer, and have

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
				Catholics and Lutherans		pastoral support.
Scott, Grzy-bowski, & Webb (1994)	Quan-titative	Henry Ford Hospital	n=280	Registered nurses	Questionnaire designed by authors	• Nurses believe acknowledging patient spiritual need essential for best care. • 50% of nurses reported patients, patient families, or both could benefit from spiritual care from chaplains. • Nurses reported most often consult with chaplains in death and emergency situations, when patients request bedside rites, and when seeking assistance with fearful and/or anxious patients.
Silton, Ase-koff, Taylor, & Silton (2010)	Qual-itative: Focus group	New York	n=7	Chaplains from Reform, Conserva-tive, and Orthodox back-grounds	Structured interview guide	• Chaplains identified 8 issues to be considered when providing care to Jewish patients: Chaplain identity, the role of chaplain within medical setting, practices of chaplain, Jewish chaplaincy prayers, ways to provide care to patients experiencing chronic and acute care, patient reactions to chaplain's gender, general spiritual interventions, challenges chaplain may encounter.
Vande-Creek & Gibson (1997)	Quan-titative	A universi-ty-based medical center in the Midwest	n=500	Patients	Questionnaire developed by authors	• 60% had notified community spiritual care providers of hospitalization. • Less than one-fourth of respondents were visited by community spiritual care providers. • 22% desired visit from clergy. • 21% expected visit from clergy.
Vande-Creek & Smith (1992)	Quan-titative	Ohio	n=159	General hospital patients, family members, and community members; males, 71; female, 89; Protestant, 145; Catholic, 13	Purpose in Life Test (PIL), The Seeking of Noetic Goals Test (SONG), The Spiritual Well-Being Scale (SWS), The Crowne-Marlowe Social Desirability Scale (CNSDS)	• Family members were found more involved in spiritual care requests than were patients. • Family members expressed a search for meaning of their loved ones' suffering. • Only 2 interventions recorded: worship services and sacramental functions.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
Vande-Creek, Siegel, Gorey, Brown, & Toper-zer (2001)	Quan-titative	Various	n=370	Chaplaincy department directors who are members of the Nat'l Assoc. of Catholic Chaplains; 25%, Eastern; 25%, Southern; Midwest-ern, 36%; Western, 14%	Questionnaire developed by authors	• Employment of hospital chaplains directly related to census size. • Religiously-affiliated hospitals hire fewer certified chaplains. • Religiously-affiliated hospitals hire 4.9 chaplains per 100 patients. • Hospitals not religiously-affiliated hire 3 chaplains per 100 patients.
Chaplain Activities and Interventions						
Balboni et al., (2009)	Quan-titative	Various	Flannel-ly, Galek, Buc-chino, Handzo, & Tannen-baum (2005)	Patients with advanced stages of cancer	Questionnaire developed by authors	• Spiritual support and chaplain visits were associated w/higher QOL in patients. • Meeting spiritual needs of patients was associated with patients using hospice services more. • Patients with high religious coping were more likely to use hospice services but did not access more aggressive care.
Bay, Beck-man, Trippi, Gun-derman, & Terry (2008)	Quan-titative	Indian-apolis coronary medical center	n=166	Coronary artery bypass graft patients	Hospital Anxiety and Depression Scale (HADS), Herth Hope Index, Brief RCOPE, Religious Problem Solving Scale	• Chaplain involvement lessened patient anxiety and depression; increased patient hope, religious coping, and religious problem-solving. • A moderate number of visits found to lessen patient symptoms..
Cadge, Calles, & Dillin-ger (2011)	Qual-itative	Various	n=52	Physicians (n=30) and chaplains (n=22)	Structured interview guide	• Physicians reported chaplains were part of interdisciplinary medical teams; in particular, they recognized chaplains' role of performing religious rituals. • Chaplains saw their participation to embrace themes of wholeness, presence, and healing.
Carlson, Simopo-lous, Goy, Jackson,	Quan-titative	Various	n=50	Hospice chaplains	Questionnaire developed by authors	• 42% opposed ODDA; 40% supported. • Over 50% had patients who requested PAS (in last 3 years). • Chaplains addressed faith and

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
& Ganzini, (2005)						• spirituality of patient, reasons for desiring PAS, and concerns of family members and possible reactions. • Chaplains did not feel comments had impact on patient decisions.
Davies, Contro, Larson, & Widger (2010)	Qual- itative	Various	n=36	Family members of 28 Mexican- American and Chinese- American children involved w/ pediatric palliative care	Questionnaire developed by authors	• Information-sharing focused on patients' and parents' daily lives at hospitals and patients' deaths. • Four patterns of information-sharing: (1) no information, (2) basic information, (3) basic information w/ implications, (4) basic information w/ implications plus attention to parents' questions, concerns, and emotional needs. • Less than optimal patterns of information-sharing resulted in parents/family members feeling frustration, anger, and sadness. • Chaplains assisted w/positive narrative development for families, as well as with bridging the gaps between parents and medical professionals.
DeLong (1990)	Quan- titative	Various	n=110	Members of College of Chaplaincy	Questionnaire developed by authors	• About 50% reported involvement/organ donor process w/brain dead individuals. • Involved when families or staff desired consultation. • Identify w/emotional aspects of donors (esp. with grief and emotional trauma of families). • A second issue: explaining concept of "brain dead" to families. • See themselves as advocates for families.
Flannel- ly, Galek, Tannen- baum, & Handzo (2007)	Quan- titative	Various	n=40	Chaplains	Questionnaire developed by authors	• Chaplains worked to help improve effectiveness in meeting needs of family members of hospitalized patients. • Preliminary scale developed to assess effectiveness of services.
Flannel- ly, Weaver, Handzo, & Smith (2005)	Quan- titative	Various	n=494	Hospital administra- tors: CEOs of licensed healthcare facilities	Questionnaire developed by authors	• 11 roles seen as important to CEOs of hospitals w/o pastoral care departments; rated chaplain roles lower than administrators of hospitals w/ pastoral care departments.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
				throughout the United States: directors of pastoral care departments (n=132), CEOs of hospitals with pastoral care departments (n=180), CEOs of hospitals without pastoral care departments (n=182)		• Religiosity and spirituality of administrators positively related to importance assigned various functions.
Florell (1973)	Quan-titative	IL	n=150	Orthopedic surgery patients	Secondary data from patient charts	• Chaplains effective in crisis intervention w/surgical patients. • Interventions made significant impact in patients' healing processes: patients required less medication, had lower respiration and pulse rates, and had fewer lines of nursing notes in patient charts.
Fox, Myers, & Pearl-man (2007)	Quan-titative	Various	n=519	Hospital-appointed participants in 1998 Annual Survey of Hospitals by American Hospital Association	Questionnaire developed by authors	• 81% involved w/ethics consultation services. • Median number of ethical consultations in year prior to survey: 3. • Ethical consultations performed by physicians (34%), nurses (31%), social workers (11%), chaplains (10%). • Only 41 of respondents had formal supervised training in ethics consultation.
Galek, Flannel-ly, Jacobs, & Barone (2008)	Quan-titative	Various	n=188	Profession-al chaplains, males (n = 85); females (n = 103)	Questionnaire developed by authors	• Female chaplains report 5 spiritual constructs more than males: (1) belonging, (2) meaning, (3) hope, (4) beauty, (5) acceptance of death.
Goy, Carlson, Simopou-los, Jackson, & Ganzini (2006)	Quan-titative	Various	n=50	Hospice chaplains	Questionnaire developed by authors	• Chaplain views on PAS associated w/view on suicide. • Moral and theological beliefs most important influences in views. • Those opposed felt God alone may take life, see life as an absolute good, all have divine purpose.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
						• Those who support place emphasis on self-determination and quality of life.
Handzo, Flannel-ly, Kudler et al. (2008)	Quan-titative	Various sites in NYC	n= 30,995	Chaplains	Secondary data from New York Chaplaincy Study	• 17 types of chaplaincy intervention recorded. • 8 general in nature (crisis intervention, emotional enabling, ethical consultation, life review, patient advocacy, counseling, bereavement, empathetic listening). • 9 described as religious/spiritual (hearing confessions, faith affirmations, theological development, professional development, performance of religious rite or ritual, offering a blessing. • Interventions varied by patient status; patterns of intervention similar across faith groups and medical status.
Handzo, Flannel-ly, Murphy et al. (2008)	Quan-titative	Various sites in NYC	n=240	Hospital chaplains (n=40), CPE students (n=240)	Secondary data from New York Chaplaincy Study	• Visits tended to be shorter if patients alone. • Fewer but longer visits in acute settings. • Visits made as a result of referrals were longer.
Hauss-man (2004)	Quan-titative	Behavioral treatment center in Detroit area	n=828	Delinquent adolescent patients	Secondary data from program's database, questionnaire developed by author	• Patients who spent more time with chaplains had improved outcomes and in a less-restricted environment one year after discharge. • Chaplaincy involvement was cost effective and helped reduce recidivism.
Hover, Travis, Koenig, & Bearon (1992)	Case Study	Duke University Medical Center	n=413	Physicians and nurses	Questionnaire developed by authors	• 74% of nurses, 47% of physicians learned about chaplains directly from chaplains or from their peers. • Information about pastoral care services covered in orientation training. • Nurses and physicians saw chaplains as greater part of medical work than patients and families; disparity present. • Surgical, ob-gyn, and internal medicine physicians make more referrals to chaplains than pediatricians, psychiatrists, and neurologists.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
Hummel, Galek, Murphy, Tannen-baum, & Flannelly (2008)	Quantit ative (Meta-analy-sis)	Various	2 studies (n= 129)	Hospital chaplains	Secondary data from Medline	• 18 interventions recorded, can be divided into 3 categories: Religious support and resources; Prayer, God, and commitment; Unrelated items (religious witnessing, discussing beliefs and values w/patients, consoling patients).
Iler, Oben-shain, & Camac (2001)	Quan-titative	Hospital special-izing in coronar y treat-ment	n=50	Chronic obstructive pulmonary disease patients	Beck Anxiety Inventory	• Daily chaplain visits associated w/lower patient anxiety, shorter hospitalizations, and higher levels of satisfaction w/medical treatment.
Mon-tonye & Cald-erone (2010)	Quan-titative	Bayside Medical Center, Massac husetts	n=9 (30,70 0 visits)	Chaplains	Secondary data from an online database	• Chaplains recorded an average of 42 visits a day. • The majority of chaplain visits were to address questions about patients' relationship/understanding of their personal faith, life review, and requests for prayer.
Piderman & Johnson (2009)	Quan-titative	Mayo Clinic	NK	Patients with advanced stages of cancer	FACIT-SP-12, LASA	• Chaplaincy intervention increases patient well-being. • Patient well-being increased over time.
Sharp (1991)	Quan-titative	3 Dallas-area hospital s	n=89 (logs)	Family of NICU patients, NICU nurses and staff	Secondary data from Pastoral Care Department logbooks	• Medical and nursing staff described chaplain role as both traditional and non-traditional.
Sheehan & Wathen (1982)	Quan-titative	Ortho-pedic hospital	n=65	Hand injury patients	Questionnaire developed by authors	• Majority expressed need for emotional support by hand surgery team. • Chaplains directed team in addressing patient emotional needs.
Vande-Creek & Lyon (1994)	Quan-titative	3 Pastoral Care Depart-ments within North-western univer-sity general hospital s	n=55	Chaplains	Questionnaire developed by authors	• 40,000 visits recorded w/patients, families, and staff members. • The cost of providing pastoral care services was far less than other healthcare expenses, making it one of the most efficient services in the participating hospitals. • Researchers developed a model for integrated pastoral care units within hospitals. • Intervention types not recorded.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
Vande-Creek & Smith (1992)	Quan-titative	Ohio Hospital	n=87	Cancer (n=31), coronary (n-21) and problem pregnancy (n=43) patients	Purpose in Life Test (PIL), The Seeking of Noetic Goals Test (SONG), The Spiritual Well-being Scale (SWS), and The Crowne-Marlowe Social Desirability Scale (CNSDS)	• Family members of patients are concerned about patient suffering and search for the meaning of the suffering.
Vander-werker, Handzo, Fogg, & Over-wold (2008)	Quan-titative	Various sites in NYC	n=2 studies (91,000 visits)	Chaplains	Secondary data from NY Chaplaincy Study and Metropolitan Chaplaincy Study (MCS)	• Chaplain-to-patient ratio remained the same. • Proportion of chaplain visits to family members decreased over 10 years between studies. • Shorter patient hospital stay. • Chaplains had more visits w/patients, with more being the results of referrals. • Chaplains dealt with more end-of-life issues in MCS.
Satisfaction with Chaplaincy Interventions						
Brocco-lo & Vande-Creek (2004)	Mixed	Various	n=130	Next-of-kin whose family members had died while hospitalized	Structured interview guide	• Chaplains called helpful: (1) provided comfort and support, (2) helped w/details before, during, and after patient's death, (3) available until other family members arrived, (4) available when family not present, (5) described as a "spiritual figure" at time patient was dying.
Clark, Drain, & Malone (2001)	Quantitative (Meta-analy-sis)	Various	n=1.7 million	Patients	Secondary data from Press Ganey Associates' 2001 National Inpatient Database	• Patient satisfaction markedly higher when emotional and spiritual needs met. • Findings correlate w/overall satisfaction of services and spiritual care received.
Fitchett, Rasinski, Cadge, & Curlin (2009)	Quan-titative	Various	n= 1,144	Physicians who were members of the American Medical Association	Questionnaire developed by authors	• 89% had experience working w/chaplains. • 90% were satisfied or very satisfied w/spiritual care provided by hospital chaplains. • Physicians w/experience w/chaplains had training in importance of religiosity/spiritu-ality in healthcare delivery. • Physicians from the NE were less satisfied w/work of chaplains.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
Flannelly, Oettinger, Galek, Braun-Storck, & Kreger (2009)	Quan-titative	150-bed hospital in NY	n=250	Patients	Questionnaire developed by authors	• Over 80% said chaplains did very well meeting emotional and spiritual needs. • Patients indicated chaplains spent sufficient time with them, seemed to care, provided a level of privacy, and often followed-up with earlier conversations.
Gibbons, Thomas, Vande-Creek, & Jessen (1991)	Quan-titative	Various	n= 2,480	Patients	Questionnaire developed by authors	• Chaplains visits made more often and considered more important than those other professional. • Patients reported higher level of expectations being met.
Johnson & Spilka (1991)	Quan-titative	Various	n=103	Breast cancer patients	Allport-Ross version of Intrinsic-extrinsic Scale, questionnaire developed by authors	• 88% reported religion most important possession. • 85% explained religion helped them cope. • Very pleased w/chaplain interventions; preferred female chaplains because of dx.
Manns (1990)	Quan-titative	Various	n=600	For-profit and non-profit hospital administra-tors	Questionnaire developed by author	• No significant difference found between groups of value placed on pastoral care. • Expressed concern about how to quantify aspects of spiritual care.
Parkum (1985)	Quan-titative	6 Penn-sylvania hospitals	n=432	Patients	Questionnaire developed by author	• Pastoral services more helpful than visits by social workers, patient representatives, and hospital volunteers. • Chaplains more likely to meet expressive needs. • Chaplains fill important role not met by other hospital personnel.
Vande-Creek (2004)	Quan-titative	14 general hospitals in upper Midwest and Eastern US	n= 1,440	Patients	Patient Satisfaction Instrument-Chaplaincy (PSI-C)	• Chaplains more spiritually sensitive than other members of team. • Patient characteristics associated w/levels of satisfaction w/spiritual care received.
Vande-Creek & Connell (1991)	Quan-titative	Various	n=445	Catholic and Protestant patients and family members	Questionnaire developed by authors	• Patients who received sacraments reported greater satisfaction than those who did not. • Catholics reported higher levels of satisfaction w/chaplaincy interventions, counsel provided than did Protestants; also reported family members had a greater need for prayer and sacraments.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
Vande-Creek, Thomas, Jessen, Gibbons, & Strasser (1991)	Quan-titative	Various	n= 2,480	Recently released hospital patients	Questionnaire developed by members of the American Protestant Health Association	• Patients receive more visits from hospital chaplains than from social workers and patient representatives. • When patients and family members believe their spiritual needs are met, they choose the medical facility again when care is needed.
Yankel-ovich (1997)	Quan-titative	Annual meeting of the Ameri-can Associa-tion of Health Plans	n=300	HMO executives	Questionnaire developed by authors	• 75% reported patient well-being impacted positively if spiritual needs met (as expressed through prayer, meditation, and other spiritual/religious practices).
Interdisciplinary Team Work and Collaboration						
Clark, Leedy, McDon-ald, Muller, Lamb, & Widger (2010)	Quan-titative	Various	n=215	Hospice interdisci-plinary team members	Jarel Spiritual Well-being Scale, the Chamiec-Case Spirituality Integration, 5-item Integration Scale, and Job Satisfaction Scales	• 98% saw selves as spiritually well. • Respondents reported high spiritual belief and self-actualization. • Most reported integration of spirituality into job. • Those who reported integration had highest job satisfaction scores.
Harr, Open-shaw, & Moore (2009)	Mixed	Various	n=403	Profes-sional healthcare team members	Questionnaire developed by authors; structured interview guide	• Chaplains reported having an overly positive perception about relationships w/social workers, even though role conflicts often reported w/social workers, especially when trying to collaborate.
Nor-wood (2006)	Qual-itative: Ethnog-raphy	A univer-sity teaching hospital	n=14	Chaplains, chaplain interns, director of chaplains	Structured interview guide	• Chaplains had to learn new language and skills to integrate within medical setting. • Chaplains felt "biomedical professionals" more respected. • Stereotypes held by staff, patients, and family members of patients.
Witten-berg-Lyles, Oliver, Demir-is, Bald-win, & Regehr (2008)	Quan-titative	Various	n=100	Hospice chaplains	Questionnaire developed by authors	• Chaplains reported professional role conflict, especially w/social workers. • See themselves as being spiritual care advisors and conflict managers when involved w/interdisciplinary teams. • Chaplains also called upon to communicate w/individuals and groups outside hospital setting.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
					Referral Patterns	
Chapman & Grossoehme (2002)	Quantitative	A 253-bed tertiary-care care facility	n=73	Adolescent medical-surgical and psychiatric patients	Secondary data from pastoral care department logbook	• Nurses most frequently referred patients during times of crisis. • The patients asked to talk w/chaplains when they desired someone w/whom to pray, or they were experiencing anger, anxiety, fear, and/or guilt.
Daaleman & Frey (1998)	Quantitative	Various	n=438	Family	Questionnaire developed by authors	• 80% refer/recommend patients to pastoral care or chaplain services. • 30% make >10 referrals a year. • Report referrals: end-of-life, 75.5%; marital, 72.8%; mood disorders, 38.7%; substances, 19%. • Physicians in practice >15 years more likely to refer. • Those w/greater degrees of religiosity more likely to refer to chaplains.
Flannelly & Galek (2006)	Quantitative	Various	n= 5,000	Hospital chaplains, nurses, social workers, and physicians	Questionnaire developed by authors	• Referrals to hospital chaplains often associated with healthcare providers' level of religiosity and/or spirituality. • Hospital chaplains rated themselves higher in self-perceived religiosity than all others; physicians rated themselves lowest. • All respondents described themselves as more spiritual than religious. • Female respondents described themselves as more spiritual than did male respondents.
Flannelly, Weaver, & Handzo (2003)	Quantitative	Sloan-Kettering Cancer Center	n= 3,570 visits	Chaplains and chaplain residents	Questionnaire developed by authors	• Majority of referrals from nurses, w/nurse referrals increasing. • More than 1/3 of visits made to family and/or friends of patients without patients present. • Chaplain visits shorter when patients not present. • Visit length differed according to patient status. • Chaplain interventions differed according to patient religious affiliation.
Fogg, Flannelly, Weaver,	Quantitative	Lawrence Hospital Center,	n= 3,733	Referrals made to chaplains in Lawrence	Secondary data from logbook of Pastoral Care Department	• 81.7% of referrals made by nurses; 11.75%, social workers; 4.08%, physicians. • 75% of requests for patient care;

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
& Handzo (2004)		Bronx-ville, NY		Hospital Center, Bronxville, NY		25% for care for family members and friends. • Seen to impact cost containment.
Galek, Flannel-ly, Koenig, & Fogg (2007)	Quan-titative	Various	n= 1,207	Nurses (n=230), social workers (n=229), physicians (n=278), chaplains (470)	Questionnaire developed by authors	• Referrals to chaplains differed according to hospital type, participant's professional discipline, the hospital's religious affiliation, and participant's self-assessment of spirituality.
Galek, Vander-werker et al. (2009)	Quan-titative	Various sites in NYC	n= 58,000 visits	Chaplains	Secondary data from MCS	• 78% of referrals handled same day; 94.9% w/in two days of referral. • Nurses source of majority of referrals (45%), followed by self-referrals of patients and family requests (30%); remainder of referrals made by other healthcare professionals. • Major reasons for referrals: patient requests, issues related to illness and/or treatment, end-of-life issues. • Staff referred most because of patient pain, patients experiencing medical issues, and end-of-life issues.
Gartner, Lyons, Larson, Serk-land, & Peyrot (1990)	Quan-titative	North-westerrn Memorial Hospital	n=1 pro-gram	Patients and staff	Secondary data from Pastoral Care Department logbook	• Elimination in chaplaincy services resulted in more demands on nursing and medical staff. • Elimination of services highlighted patient need of and desire for spiritual care.
Koenig, Bearon, Hover, & Travis (1991)	Quan-titative	Duke Univer-sity Medical Center	n=306	Physicians (n=130), nurses (n=39), patients (n=77), and family members (n=60)	Questionnaire developed by authors	• Large number of patients and family members reported religiosity the most important factor that helped to enable coping; physicians did not report similar findings. • 100% of nurses, patients, and family members, and 93.5% of physicians reported believing in a Higher Power. • Report religiosity being their most important possession: nurses, 25.6%; patients, 43.8%; family members, 56.1%; physicians, 8.7%.

Authors / Date	Design	Setting	Sample		Instruments	Outcomes
Taylor & Amenta (1994)	Quan-titative	Various	n=700	Members of Oncology Nursing Society; respondents tended to be married, middle-aged, Caucasian staff nurses	Questionnaire developed by authors	• Nurses report overall favorable impression of chaplains and the spiritual care they provide. • Nurses reported chaplains often overworked, sometimes not available when called, and some even refused to come when contacted. • 99% assessed patient religious background; 47% followed up in written care plan; 73% made referrals.
Vander-werker, Flannel-ly, et al. (2008)	Quan-titative	Various sites in NYC	n= 38,600 visits	Chaplains	Secondary data from NY Chaplaincy Study	• 18.4% of records were referrals. • Nurses referred most often (27.8%), followed by patients (22.3%). • Sources of referrals: cancer centers, 20.5%; general hospitals, 17.3%; rehabilitation hospitals, 9.4%; nursing home units, 10.3%; orthopedic surgical hospitals, 77%.
Weinber-ger-Litman, Muncie, Flannel-ly, & Flannel-ly (2010)	Quan-titative	St. Luke's Hospi-tal, NYC	n=133	RN/BSNs (n=94), CNAs (n=11), unit secretaries (n=10), nurse managers (n=3), LPNs (n=3), student nurses (n=2), unit coordinator (n=1); females (n=111)	Questionnaire developed by authors	• Nurses were found to refer for family issues and less likely when patients were experiencing illness or treatment issues.

CHAPTER 3: METHODOLOGY

Creswell (2007) likens qualitative research to "an intricate fabric composed of minute threads, many colors, different textures, and various blends of materials" (p. 35). It is the research paradigm of choice when one wishes to "understand the meanings people have constructed about their world and their experiences" (Merriam, 2002, p. 4), allowing researchers to explore the participant's world and offer "rich descriptive" (p. 5) findings. When little or no research has been conducted in a certain area of the literature, qualitative methodology, particularly phenomenology, can be useful and provide new information (Colaizzi, 1978; Lincoln & Guba, 1985). Phenomenology was used to capture hospital-based healthcare providers' experiences receiving spiritual care and support from hospital chaplain services, as well as, hospital chaplains' experiences providing spiritual care and support to hospital-based healthcare providers.

Design

Phenomenology, which is reflective in nature, reveals the essence of human consciousness (Husserl, 1901 as cited in Smith, 2006). Colaizzi (1978) explained that phenomenology offers an additional benefit in the research process as it enables an investigator to generate a large quantity of in-depth data from a relatively small sample size. Phenomenology is exploratory in nature. As a result, knowledge can be gained in the absence of a predetermined hypothesis. An open-ended approach can be employed to generate in-depth information which can lead to the emergence of themes and, ultimately, the essence of a phenomenon. Unlike reductionist studies, in qualitative methods of inquiry, the human experience is written from a first-person perspective. This acknowledges the fact that the investigator is an active and involved participant in the data collection and analysis process.

Although this method of qualitative inquiry is well known and-respected, I addressed several issues common to applying a phenomenological approach. The first relates to the nature of the approach itself. Because phenomenology is descriptive, a dynamic interplay occurs between the participant and researcher as the essential themes reflecting what constitutes the nature of participant's lived experiences begin to surface (Colaizzi, 1978). Therefore, I engaged in reflexivity and bracketed my assumptions, beliefs, ideas, and so forth relative to the spiritual care hospital chaplains (HCs) provide to hospital-based healthcare providers (HBHPs). I sought to suspend my understanding of the shared experience of personalized spiritual care services between hospital chaplains and hospital-based healthcare providers in an effort to be more fully present to participants' perspectives and experiences.

Second, semi-structured interview questions were used to collect rich information about HBHPs' experience of receiving spiritual care from HCs. The questions were "open-ended, evolving, and nondirectional" (Creswell, 1998, p. 99). The first question asked was a main overarching question and was followed by several sub or probing questions written to add depth and detail to the experience being studied. The overarching query was the broadest question I could ask my respective participants about hospital chaplaincy and spiritual care. Sub questions were used to explore the structural meaning of the experience, underlying themes and contexts, and/or universal structures that precipitate feelings and thoughts. Although my intention was to develop an overarching question that elicited an in-depth description naturally, I wanted to make sure that participants have the opportunity to relate a rich complex narrative. See Appendix B for a list of the questions used in this study.

Third, I collected data from individuals who have experienced receiving spiritual care from hospital chaplains by means of in-depth interviews. In this study it was HCs, as well as,

HBHPs (e.g., physicians, surgeons, nurses, mental health providers, and/or technicians). I chose to interview both chaplains and providers because current literature records the roles and responsibilities of HCs as well as the benefits of spirituality for patients encountering health issues and/or their family members (e.g., Hummel, Galek, Tannenbaum, & Flannelly, 2008; Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005; VandeCreek, Pargament, Belavich, Cowell, & Firedell, 1999). There is no known research, however, on the possible benefits of spiritual care provision to healthcare providers. No known research exists either on how spiritual care provision might impact a provider's ability to work within his or her respective job environment. A search of the literature yielded no studies relative to HCs providing spiritual care to HBHPs. It was believed that by interviewing both HCs and HBHPs insight could be gained into the providers' perceptions of the care received and the impact of that care. It was believed that additional understanding of how the HCs felt he or she might have assisted the HBHP and what he or she did to provide care could also be acquired. Questions were broad, general, and open-ended in order to elicit textual and structural descriptions. Ultimately, participants' descriptions elucidated the common and perhaps uncommon experiences (Colaizzi, 1978) noted by providers seeking the support of HC's services for spiritual care

The fourth issue common to phenomenological studies related to the data analysis process. Colaizzi (1978) explained that the phenomenological protocol would call for me to go through the data and highlight significant statements, sentences, and words which provided understanding of how participants experience the phenomenon. Accordingly, the statements were divided into clusters or themes. Significant statements were then used to write a description of participant experiences, as well as the context thereof. Lastly, the phenomenon was reported with the goal of developing an essential, invariant structure of the experience. An

essential, invariant structure, or cohesive narrative, presented an overall picture of the experience grounded only in the perspective of those being studied. My intent was to gain insight into the role of the HCs in the provision of spiritual care to HBHPs through solicitation and analysis of the experiences shared by both HCs and HBHPs.

The Role of the Researcher

Consistent with a phenomenological approach, I tried to "bracket" my understanding of the phenomenological event in order to submerge myself in the participants' experiences (Husserl, 1901; Smith, 2006). These bracketed thoughts, which comprise my personal epoche (see Appendix A), were used in a process called reflexivity (Colaizzi, 1978). According to Colaizzi, the researcher is inescapably engaged and influential in the process and therefore becomes part of the phenomenon under investigation. For this reason, all investigators associated with this study recorded their bias statements prior to the data collection phase. I also engaged in several verification strategies (Lincoln & Guba, 1985), listed later in this chapter, to further increase confidence in the study's outcomes.

Setting

The setting for the research study was a southeastern regional academic medical center comprised of 861 patient beds, a large staff of over 1,700 staff and healthcare providers, and a pastoral care department staff of 5 full-time hospital clergy, 6 chaplain residents, as well as 6 individuals who serve in the pool of supply chaplains. The medical center, which moved to its present location in 1977, primarily serves the citizens of the 29 eastern counties of North Carolina. The pastoral care department was established in 1983. As employees of the facility, the chaplains provide pastoral care to patients, families, and hospital staff Monday through Friday from 8:30 a.m. to 5 p.m.; however, at least one chaplain is on call at nights and on

weekends to provide care for deaths, critical situations, and when spiritual care needs are urgent in nature. The staff chaplains, chaplain residents, and pool of supply chaplains network to assure all areas of the hospital are covered (e.g., medicine, surgery, oncology, behavioral health, rehabilitation). Inpatient hospice employs its own chaplains and is not covered by the medical center staff. Data collection occurred at a private confidential setting agreed upon by the researcher and each respective participant. The setting was convenient and easily accessed by the participant and the researcher.

Participants

Potential participants included all HCs employed at the proposed hospital and HBHPs who have used the hospital chaplaincy service for personal and professional spiritual care and support. The number of individuals which should be interviewed in phenomenological studies can actually range from as few as 1 (Dukes, 1984) to as many as 325 (Polkinghorne, 1989). Dukes (1984) recommended researchers study between 3 and 10 participants; however, Polkinghorne (1989) recommended that researchers who engage in phenomenology should interview between 5 and 25 individuals. Colaizzi (1978) believed that data collection should continue until saturation is reached or no new information is being obtained through the data collection process. The investigator attempted to recruit an equal number of participants from both the HC and HBHPs' perspectives to gain a balanced understanding of the phenomenon under investigation.

The inclusion criteria for eligible participants included: (a) 18 or older, (b) fluent in English, (c) HCs or HBHPs with hospital privileges, and (d) HBHP who have used a HC for personal and/or professional reasons. HBHPs, for the purposes of this study, included those

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persons who are responsible for providing health care services for any physical or mental health need for patients being cared for within the hospital system.

Recruitment

A purposive sample (Colaizzi, 1978) was used in this study. This sampling method allowed me to select participants who I believed would be informative and who could provide information that may not be available elsewhere. Colaizzi recommended purposeful selection when limits exist relative to the number of sites, participants, and settings.   In particular, a criterion sampling strategy was used, as all individuals included in the study had received spiritual care from a HC. Colaizzi noted that criterion sampling is an appropriate choice when all of the participants have experienced the phenomenon being studied.

Subsequent to receiving Office of Human Research Integrity (OHRI) approval, participant recruitment of HCs was made via email and then a follow-up phone call to confirm receipt of the email if no response was received within seven business days. Regardless of interest to consent to the study, HCs were provided with an informational email (see Appendix C) detailing the purpose of the study and asked to approach providers that they knew who had accessed their services for personal and/or professional support and who they thought would be open to discussing their experience with this investigator. No potential participant names or contact information were accepted or requested from the HCs. The information sheet for HBHPs (Appendix D) included instructions on how interested participants could contact the investigator for more information about the study. Copies of the informational sheets were also distributed to all HCs so they could give them to potential HBHP participants. Once contacted, I offered a verbal explanation of the study, and addressed potential risks and benefits associated with participation. If the provider agreed to participate, a time and place was scheduled for the

interview to occur. Prior to beginning the interview process, the consent document was

explained to each prospective participant and he or she was given an opportunity to ask questions

relative to the research prior to signing it.

Procedures

After each participant gave his or her informed consent (see Appendix E), he or she was

asked to complete a brief demographic survey (see Appendix F for hospital chaplain's

questionnaire; Appendix G, hospital-based healthcare provider questionnaire). Once completed,

the interview phase began with all interviews following the outline listed in Appendix B for

either a HC or HBHP.

I conducted in-depth, open-ended interviews which were estimated to last approximately

45 minutes to an hour. The interview outline was followed to ensure that the open-ended

questions which related to the lived experience of providing or accessing hospital chaplaincy

services for personal or professional spiritual care was posed to all participants. The interview

process, however, involved multiple phases. I began with pre-determined queries; for example, I

asked a HBHP, "On a typical day, what types of scenarios might lead you to interact with a

HC?" I then used detail-oriented and elaboration probes to get additional details and as a way to

encourage participants to tell me more. If, for example, a HBHP said he called a HC when a

natural disaster, such as a tornado, occurred and multiple individuals are in the emergency

department after sustaining injuries as well as the loss of all of their possessions, I asked, "What

might a HC do that would be helpful at such a time? Why would you call a HC?" I employed

clarification probes when I was unsure of what was being said and as a way to make certain I

understood what the interviewee was saying (Patton, 2002). These questions were used to drill

down to the main focus of the study, the times when HBHPs used HC services for their own personal use.

A digital audiorecorder was used to capture each interview. All interviews were transcribed verbatim. In the transcripts, all names and potential identifying demographic information were removed and replaced with pseudonyms. All computer files with study content were password protected. When not in use, the digital recorder, all hard copies of transcripts, notes, informed consents, and study materials containing confidential information, were stored in a locked filing cabinet in the investigator's office.

I used N-Vivo 9, a qualitative data analysis computer program, as an aid to data analysis. The software is designed to work with rich text-based data and utilizes a hierarchical structure. I identified and coded segments of information which were then classified, sorted, categorized, and retrieved according to code.

Analysis

Colaizzi (1978) described qualitative data analysis as being the process whereby data are organized into themes. This process often involves the application and collapsing of codes, categories, and themes into figures, and tables, and would call for me to "get to know [my] data" (Knight, 2007, p. 1), so as to understand the experience of soliciting and receiving the spiritual support of a HC. The analytical process is not a linear process. The process required me to immerse myself in the data multiple times, as the research design and analytical process entailed coding, grouping, and forming clusters of themes from participants' responses. I examined the data statement by statement and ponder an underlying query: "What is this about?" I labeled, or coded, each section as I described the section, noted the topic(s) found therein, and/or analyzed the themes which emerged and were found therein. Each of these steps required the researcher

to examine responses and the interpretations thereof (Knight, 2007). My deep involvement with my data was time-consuming but resulted in an invariant description of the phenomenological experience that is grounded in the actual data.

Colaizzi's (1978) phenomenological method of analysis was utilized to conceptualize the participants' experiences of providing or receiving hospital chaplaincy services. The steps noted within the approach were as follows:

(1) My triangulated investigator and I read participant responses in one sitting so that we could develop an "overview" of their experiences. We noted our initial reactions about possible codes separately. This allowed us to track our biases throughout the study and double check that the final results were actually grounded in the data and not just in our initial impressions of it. My triangulated investigator and I reviewed our work together throughout the entire data analysis process. If there were times we are not in agreement, I consulted with my peer debriefer for additional input and her perceptions.

(2) My triangulated investigator and I extracted significant statements, meaning key words and phrases relative to hospital chaplaincy from participants' transcripts. We did not code tangential and repetitive statements.

(3) My triangulated investigator and I grouped significant statements into meaning statements to help consolidate the findings into a more manageable form that was easier to interpret.

(4) My triangulated investigator and I created thematic clusters by combining similar meaning statements.

(5) I drafted an exhaustive description, or summative narrative, of the participants' lived experiences of the phenomenon under investigation. The triangulated investigator

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verified how accurately I have represented the raw data, using his own narrative for comparison. He reviewed his thoughts about participant responses and noted similarities and differences between his or her conceptualization and my own.

(6) I applied verification strategies to help increase the trustworthiness of research findings. I noted the strategies which were applied to the analysis process below. I discontinued data collection when thematic saturation had occurred. The triangulated investigator and I determined when thematic saturation had occurred. The peer debriefer verified that our decisions were grounded in the actual data.

Verification Strategies

Polit and Beck (2006) pointed out qualitative researchers are concerned that their data reflect the truth. As a result, qualitative researchers seek to enhance the trustworthiness of their results. I focused on four constructs to evaluate and verify the trustworthiness of the data generated (Lincoln & Guba, 1985). Trustworthiness relates to the level of confidence a qualitative researcher has in his or her data; it is measured using four criteria: credibility, dependability, confirmability, and transferability. Credibility refers to the correctness or truth of the data, while dependability refers to the stability of the data over both time and conditions. Polit and Beck (2006) suggested that "credibility is to validity (in quantitative studies) what dependability is to reliability" (p. 335). The term confirmability refers to the likelihood that two or more independent individuals would interpret data in a similar manner. Transferability refers to the degree to which findings can be transferred to other groups and settings; it is similar to the concept of generalizability in quantitative research. In particular, I was concerned with the credibility, dependability, confirmability, and transferability of my data, research interpretations, and conclusions (Polit & Beck).

Credibility. Credibility offers evaluation of how well the desired subject area has been identified, as well as how richly and fully it is described in the research process (Lincoln & Guba, 1985). My triangulated investigator helped verify findings. My respective experiences and immerging impressions were discussed with him, as he read and coded participant responses, coded significant statements, and created thematic clusters independently. He used his draft to review mine in order to verify how accurately I had represented the raw data. My triangulated investigator was engaged with me through the narrative drafting and review processes.

In order to increase the credibility of this study, I engaged in peer debriefing. I used periodical peer debriefings to discuss my experiences and emerging impressions of the phenomenon under study. The peer debriefer is an objective individual who reviews the various aspects of the research data and offers his or her own questions and perceptions. The peer debriefer either has experience in the subject being studied, qualitative research, or both (Polit & Beck, 2006). She reviewed my narratives as well as my findings to assure they were founded in the raw data. It should be noted that to increase trustworthiness of the findings the peer debriefer and I bracketed our personal beliefs, assumptions, and biases in a written statement prior to the start of the research project (Lincoln & Guba). This verification method also facilitated establishment of the confirmability, dependability, and transferability of the data which are described below.

Dependability. Dependability refers to data stabilization over time and its consistency (Lincoln & Guba, 1985). While the dynamic nature of settings can make dependability challenging, an audit trail was used to record the conditions that surround the phenomenon, and any changes in the phenomenon that occur in the setting, and/or among the participants during the course of the research (Knight, 2008; Lincoln & Guba).

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Among the components of this audit trail were my research log, wherein all the activities and decision points relative to the research were dated and noted; handwritten dated field notes; analyses and interpretation memos, which included my writings relative to thoughts about how I was analyzing and interpreting the data; my code book, which was the place where codes were listed, as are the descriptions used throughout the research process (Knight, 2008; Lincoln & Guba, 1985); and the drafts of research findings, as they show how the investigator's thoughts evolved through the course of the research process (Knight). The researcher's reflexive journal and her bracketed assumptions as well as the epoche of the peer debriefer were also components of my audit trail.

Confirmability. Confirmability helps to verify dependability and relates to the objectivity or neutrality of the data (Polit & Beck, 2006). I employed multiple methods to increase the rigor of the data, increase confidence in its findings, as well as assist with confirmability. First, I kept a dated reflexive journal (Lincoln & Guba, 1985), in which I recorded my impressions, personal reactions, assumptions, and biases, and other thoughts and feelings throughout the process of data collection and analysis. Secondly, the audit trail (Knight, 2008; Lincoln & Guba), detailing my process of coding, recoding, and consolidation (which has been mentioned previously), assist with confirmability.

Transferability. Transferability is the final construct on which I will focus (Lincoln & Guba, 1985). While it is impossible for full transferability to occur, I will strive to have rich data, data that provides a thorough description of the phenomenon with detail. Maxwell (2005) indicated rich data often requires verbatim transcripts of interviews. Notations relative to statements felt to be significant are not sufficient. In order to achieve this goal, I continued to conduct interviews until saturation was achieved and no new information was being gained. This

called for me to continue the interview process until such time that no new insight was offered (Creswell, 2005). My reflexive journal also assisted in achieving transferability, as a description of my research setting, my research process, and interview interactions were detailed there. This information offered sufficient data for one to determine applicability to other settings (Polit & Beck, 2006).

Presentation of Findings

Study findings are presented in a manuscript format. My research report provides insight into the procedures used to collect data, as well as how I moved from the raw data to my description of the lived experience of providers who accessed HCs for personal or professional spiritual support.

Findings were organized according to the themes which emerged during analysis. Excerpts of participants' responses were used to support my work. Quotes which support the various thematic clusters give a rich description of participants' experiences. The phenomenological experience was conceptualized and presented by means of the overarching essence which highlights the shared experience of all participants. I discussed the findings of my research, noting both implications and applications for HCs and for HBHPs.

Polkinghorne (1989) explained that qualitative researchers should "produce a research report that gives an accurate, clear, and articulate description of an experience" (p. 46). When achieved, "the reader of the report should come away with the feeling that 'I understand better what it is like to experience that'" (Polkinghorne, 1989, p. 46). Therein was my goal: To present the essence of the lived experience of HBHPs who have received spiritual care from HCs in such a way that we understand said phenomenon better.

Dissemination Plan

      I plan to disseminate the results using professional peer-reviewed outlets, as well as outlets for the healthcare provider with the intention to reach a multi-disciplinary audience. I will present the results at national conferences as well as professional meetings attended by HBHPs and/or HCs and their potential collaborators. Venues such as the annual conferences of Pastoral Counselors, American Association of Marriage and Family Therapists, Collaborative Family Healthcare Association, and North Carolina Association of Marriage and Family Therapists conferences offer opportunities for presentation. As recommended by Richards and Morse (2007), and most important to me, the results will also be disseminated to all consenting and interested participants within one year of this study's conclusion.

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CHAPTER 4: THE SHARED EXPERIENCE OF SPIRITUAL CARE SERVICES BETWEEN

HOSPITAL CHAPLAINS AND

HOSPITAL-BASED HEALTHCARE PROVIDERS

It has been less than 100 years since medical science and religion have entered into a working alliance (Porter, 1997). In order to appreciate where the field of hospital chaplaincy is today, it is important to understand how it evolved. In the 1920s, serious discussions about integrating medical science, theological training, and practice took place when the Reverend Anton Boisen urged students of the ministry to interact with individuals residing in mental institutions; he felt by doing so, the students would learn more about the human soul. Dr. Richard Cabot agreed with Boisen, as he felt "times of pain, sorrow, frustration, and surprise…[offer] experiences that invite a new start in life" (Cabot & Dicks, 1953). Cabot mentored Boisen and suggested clinical skill development be supervised; the first hospital chaplain students entered clinical training in 1925. Even though multiple programs were developed in the years that followed, it was not until 1967 that the various groups and training programs formed the Association for Clinical Pastoral Education (ACPE).

The Commission on Ministry in Specialized Settings (COMISS) was created in 1979, as the spirit of collaboration between medical science and religion continued to grow. COMISS offered individuals from different clinical groups, professional bodies, and boards (e.g., professional certification and accreditation organizations, religious endorsing bodies, professional pastoral care organizations, and chaplain and pastoral care employing organizations) to combine their efforts and develop a means by which pastoral services could be evaluated. The COMISS and Commission on the Accreditation of Pastoral Services (CCAPS, formerly "JCAPS") engaged in dialogue with the Joint Commission on the Accreditation of Healthcare

Organizations (JCAHO) to strengthen the definition of qualified spiritual care professionals. In 1998, JCAHO began requiring hospital chaplains (HCs) to attain a level of "education, training, experience, competence, registration, certification, licensure, law, or regulation" (JCAHO, 1998, p. 466), which helps prepare chaplains to meet the spiritual and emotional needs of patients, family members, and hospital staff.   As of 2004, nearly 10,000 board-certified hospital chaplains work within United States hospitals (Fogg, Weaver, Flannelly, & Handzo, 2004)

Multiple researchers have recorded activities and/or interventions utilized by hospital chaplains for patient care purposes (e.g., Hummel, Galek, Murphy, Tannenbaum, & Flannelly, 2008; Handzo, Flannelly, Kudler et al., 2008, 2008; Handzo, Flannelly, Murphy et al., 2008); however, no known research exists detailing the lived experience of hospital-based healthcare providers who have personally received spiritual support from chaplains while on duty and the difference it makes on their ability to care for patients and families.

The purpose of this study was to use a phenomenological design to study the shared experience of personalized spiritual care services between hospital chaplains and hospital-based healthcare providers and answer the following research questions: (a) "What is the nature or essence of the experience of a hospital chaplain providing spiritual support to the providers of this healthcare system?" and (b) "What is the nature or essence of the experience of a hospital based healthcare provider receiving spiritual support from the hospital chaplaincy service?" This two-pronged approach allows for a richer understanding of this dyadic experience that will help expand the science and better capture outcomes not traditionally reported in the literature.

Spiritual Component to Healthcare

The biomedical model often identifies the elements of illnesses without examining psychological and social factors which may be present. Internist George Engel (1977, 1980)

believed patients to be more than mere cells and organ systems and developed the biopsychosocial (BPS) model. He proposed existential system connectivity, thereby broadening diagnostic lenses to include micro and macro level systems. Such connectivity would suggest that a patient's disease or illness would affect him or her as well as those within his or her emotional and social network. The BPS was expanded by Bell, Wright, and Watson (1992) and Wright, Watson, and Bell (1996) to include spirituality as a stand-alone dimension, as an individual's belief system can impact biomedical, psychological, and social outcomes. According to VandeCreek and Burton (2001) everyone has needs and concerns which are existential. Hodgson, Lamson, and Reese (2007) reinforced the importance of incorporating the spiritual component in the healthcare experience and offered practitioners a means to assess patients' BPS and spiritual needs.

While the biopsychosocial and spiritual aspects of a hospitalized patient are recognized widely in the literature, it is not surprising to learn that between 33% and 94% of patients want their spiritual concerns addressed by medical care team members (e.g., Carey, 1985; Daaleman & Nease, 1994; Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999; King & Bushwick, 1994; Fitchett, Meyer, & Burton, 2000; Koenig, McCullough, & Larson, 2001). These findings help to reinforce the recognition that a patient's spiritual dimension is a part of their illness experience (McKee & Chappell, 1992; Sulmasy, 2002) with the major spiritual concern for many patients and families being "how to integrate body, mind, and spirit in the face of illnesses, traumas, losses, and life transitions" (VandeCreek & Burton, 2001).

Interventions of Hospital Chaplains

Hospital chaplains (HCs) are able "to address all aspects of spirituality in the healthcare system at the patient, staff, and system levels" (McClung, Grossoehme, & Jacobson, 2006). In

order to do so, Hummel, Galek, Murphy, Tannenbaum, and Flannelly (2008) explained that HCs

need to address a comprehensive list of tasks (e.g., religious and spiritual intervention delivery,

counseling, emotional support, and advocacy). In addition to making contact with patients and

families (e.g., Carey, 1973; Fitchett, Meyer, & Burton, 2000; Flannelly, Galek, Tannenbaum, &

Handzo, 2007; Piderman et al., 2008), integration of spiritual care from hospital chaplains has

been found to improve patient and family satisfaction with medical care (Cadge, Calles, &

Dillinger, 2011). Researchers have found patients want to talk with hospital chaplains (Chapman

& Grossoehme, 2002), as they find chaplains are the most spiritually sensitive of all healthcare

team members (VandeCreek, 2004; VandeCreek & Gibson, 1997). Chaplain interventions have

been effective with individuals diagnosed with illnesses such as COPD (Iler, Obenshain, &

Camac, 2001) and cancer (Balboni et al., 2009; Davies, Contro, Larson, & Widger, 2010;

Johnson & Spilka, 1991). Broader populations such as parents with children in the neonatal

intensive care unit (Sharp, 1991) and surgical patients (Florell, 1973; Sheehan & Wathen, 1982)

have also reported receiving comfort. For example, inpatient coronary artery bypass graft

patients were found to experience reductions in anxiety and depression (Bay et al., 2008) and

better coping (Bay et al., 2008; Iler, Obenshain, & Camac, 2001) with hospital chaplaincy

involvement. Lastly, participants across several studies reported that hospital chaplains

intervened and assisted patients and families in making difficult ethical decisions (Carlson,

Simopolous, Goy, Jackson, & Ganzini, 2005; Delong, 1990; Fox, Myers, & Pearlman, 2007;

Goy, Carlson, Simopolous, Jackson, & Ganzini, 2006). Often, hospital chaplains learn of patient

needs and desires for spiritual care as a result of referrals, which makes chaplains reliant on other

healthcare providers to recognize the importance of spiritual care provision for patients.

Referral to Chaplains

   HCs often rely on referrals from other medical professionals to link them to those desiring and in need of spiritual intervention. Taylor, Hodgson, Lamson, Sira, & Musick (unpublished doctoral article, 2012) found that the volume of spiritual care that HCs provide is dependent upon hospital-based healthcare providers' spiritual awareness, skill set, and willingness to refer. Nurses often make the highest number of patient referrals (Flannelly, Weaver, & Handzo, 2003; Fogg, Flannelly, Weaver, & Handzo, 2004; Galek et al., 2009; Vanderwerker et al., 2008), and are the most common referral source of all hospital staff for chaplaincy services. Patient issues leading to referral requests ranged from emotional, spiritual, medical, and relationship issues, to support for a change in patient diagnosis or prognosis (Vanderwerker et al., 2008), as well as when encountering difficulties with pain/depression, anxiety/anger, treatment issues, and their individual searches relative to loss, death, and/or meaning (Galek, Flannelly, Koenig, & Fogg, 2007). The patient's emotional state (both the need for emotional support and feelings being expressed by patients and/or family members) is what appeared to prompt nurse referrals (Weinberger-Litman, Muncie, Flannelly, & Flannelly, 2010). Adolescent psychiatric patients self-referred for pastoral care more than patients in medical and surgical situations (Weinberger-Litman et al., 2010).

   Even though researchers have validated the importance of spiritual care provided by HCs, a systematic review of the literature by Taylor et al. (unpublished doctoral article, 2012), revealed that while some healthcare professionals may value HC services, many do not make the link between biomedical and social, emotional, and spiritual issues or incorporate the necessary personnel to address them. As a result, HC services often remain compartmentalized and HCs

are not fully integrated into the various hospital units, keeping referrals more common among those who make the connection (Koenig, Bearon, Hover, & Travis, 1991).

Method

Research Design

Phenomenology reveals the essence of human consciousness (Husserl, 1901, as cited in Smith, 2006). While yielding a large quantity of rich data from a small sample size (Colaizzi, 1978), this open-ended approach generates in-depth knowledge about a specific phenomenon, which in this research was the spiritual care and support extended by HCs to hospital-based healthcare providers (HBHPs) from the experience of both parties. Phenomenology is often used when one desires an understanding of the "essence or underlying meaning of a phenomenon or experience" (Creswell, 2007, p. 51) shared by several individuals. Because phenomenology is descriptive, a dynamic interplay occurs between the participant and researcher as the essential themes reflecting what constitutes the nature of participant's lived experiences begins to surface (Colaizzi, 1978). When little or no research has been conducted on a certain topic, qualitative studies, especially phenomenology, can be both useful and appropriate (Colaizzi, 1978; Lincoln & Guba, 1985). As no known research exists on the experience of HCs providing spiritual care to HBHPs, phenomenology is thus the best method of qualitative inquiry for this study. Using this design, participants will provide new information about their world and experiences, as well as the meanings they ascribe to them (Colaizzi, 1978). This research study was IRB approved in August, 2011.

The Role of the Researcher

The researcher who uses a phenomenological approach is an active and involved participant in the data collection and analysis processes. Therefore, according to Colaizzi

(1978), researchers are inescapably engaged and influential in the process and therefore become part of the phenomenon under investigation. For this purpose, each of the three researchers associated with this study recorded his or her epoche (i.e., thoughts, opinions, and beliefs about the selected topic, i.e., hospital chaplaincy) (Husserl, 1901; Smith, 2006), on the shared experience of personalized spiritual care services between HCs and HBHPs and "bracketed" areas of potential bias. This process was designed to help submerge the researchers into the participants' experiences more fully (Husserl, 1901; Smith, 2006).

Setting

The setting for this study was a southeastern regional academic medical center comprised of 861 patient beds, a large staff of over 1,700 staff and healthcare providers, and a pastoral care department of five full-time hospital clergy, six hospital chaplain residents, and a pool of six supplemental chaplains. The medical center opened this location in 1977 and primarily serves the 29 eastern counties of North Carolina, all of which are rural. The pastoral care department was established in 1983 and its staff is charged with the responsibility of providing pastoral care to patients, families, and hospital employees.

Participants

The inclusion criteria for eligible participants were: (a) 18 or older, (b) fluent in English, and (c) HCs or HBHPs with hospital privileges. HBHPs, for the purposes of this study, included those persons who are responsible for providing healthcare services for any physical or mental health need for patients being cared for within the hospital system.

A purposive sample of five hospital chaplains (HCs) and seven hospital-based healthcare providers (HBHPs) participated in this phenomenological study. Research continued with both HCs and HBHPS until thematic saturation had occurred. While it may seem the number of

HBHPs was low when one considers the number of employees in the facility, it must be noted that participants were individuals who had received spiritual care from HCs. It is not known how many hospital employees have received care from HCs; however, those who participated were contacted by HCs, and these individuals contacted the researcher.

Hospital chaplains. Of the HCs who participated in the study, 40% were Black (n=2), 40% were White (n=2), and 20% selected "other" (n=1). Majority of the HCs were male (60%; n=3). Participants' ages ranged from 33-65 (*M*=52). Length of employment ranged from less than 1 to 20 years (x=5). Majority of the HCs were female (60%; n=3).

Hospital-based healthcare providers. Of the HBHPs who participated in the study, 85% were White (n=6), and 15% were Black (n=1). Length of employment ranged from 1 to 20 years (x = 3). Of the HBHPs, 43% were administrators (n=3); 85% were registered nurses (n=6), and15% were occupational therapists (n=1). Majority of the HBHPs were female (86%; n=6). Participants' ages ranged from 30-68 (x=47). Four of the HBHPs had been employed at the hospital over 20 years (57%); 1, 15-20 years (15%); 1, 5-10 years (15%); and 1, 2-5 years (15%). All of the participants identified themselves as spiritual but declined to offer a faith-based designation for confidentiality purposes.

Procedures

HCs were approached via email and asked to participate. HCs, regardless of decision to consent to participate in the study, agreed to identify and contact HBHPs to whom they had extended spiritual care and inform them about the study. HBHPs who were willing to consent to the study contacted the researcher via email or phone. All interviews were digitally audio-taped and transcribed verbatim. Interviews occurred at locations and times mutually convenient for

participants and the interviewing researcher. Only one researcher conducted the interviews to help reduce potential variance from the interview protocol.

After informed consent was obtained from each participant, a brief demographic survey was completed prior to the beginning of each interview. HCs were asked to respond to the following queries verbally: What has been your experience providing spiritual support from the hospital chaplaincy service? Please describe the current culture and climate in the hospital around spirituality and employees accessing chaplaincy services for spiritual support. On a typical day, what types of personal scenarios might lead employees of this hospital to interact with you about a spiritual care or concern? What do you think has been the impact of this work with healthcare providers and other hospital-based employees? What have been some of the more impressionable moments without revealing the identity of the person you supported? How were you made aware of the person(s)' need? Is there anything that I did not ask you about related to your care of the hospital employee that you think is relevant to this study? HBHPs were asked to respond to the following: What has been your experience receiving spiritual support from the hospital chaplaincy service? Please describe the current culture and climate in the hospital around attending to the spiritual well-being of its employees. On a typical day, what types of scenarios might lead you to interact with hospital chaplains? If you have ever sought spiritual care from a hospital chaplain for your own personal need, please describe your experience. What do you think was the impact of the hospital chaplain's work on your well-being? How was the chaplain made aware of your need? Is there anything that I did not ask you about related to your experience with one or more of the hospital chaplains that you think is relevant to this study? The same interviewer conducted all of the interviews. HC interviews

lasted between 23 and 55 minutes; the interviews of HBHPs were between 15 and 35 minutes in length.

Data Analysis

Colaizzi's (1978) phenomenological method of analysis was utilized to conceptualize the participants' experiences of providing or receiving hospital chaplaincy services. Each transcription was read multiple times by this researcher and her triangulated investigator. Initial reactions about possible codes were recorded separately. This allowed biases to be tracked and double checked throughout the study to assure that the final results are actually grounded in the data and not just in our initial impressions of it. The triangulated investigator and researcher reviewed their work together throughout the entire data analysis process. Significant statements and meaning key words and phrases relative to hospital chaplaincy were extracted from participants' transcripts, and used to develop meaning statements, which helped consolidate the findings into a more manageable form that is easier to interpret. Thematic clusters were developed by combining similar meaning statements. The triangulated investigator and researcher determined when thematic saturation occurred. An exhaustive description of the participant's lived experiences of the phenomenon was drafted after thematic categorization of the data was completed. The accuracy of the researcher's work and adherence to Colaizzi's data analysis method was verified by the triangulated investigator and peer debriefer to assure results from each stage of the analyses were grounded in the actual interview data.

Verification strategies were utilized to help increase the trustworthiness of research findings. Trustworthiness relates to the level of confidence a qualitative researcher has in his or her data; it is measured using four criteria: credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Among the multiple verification methods employed

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were use of a triangulated investigator, peer debriefer, audit trail (which included a research log, handwritten dated field notes, analysis and interpretation memos, code book, drafts of research findings, complete list of in vivo codes) and a reflexive journal (in which the researcher documented her self-reflection relative to the research and analysis processes).

Results

Seventy-seven meaning statements and one hundred sixteen significant statements were formulated from the 12 verbatim transcripts. Six themes emerged when the statements were collapsed into clusters: (1) Awareness of chaplain availability, (2) Chaplains focus on building relationships with providers and staff, (3) Chaplains are integrated in varying degrees on certain hospital units, (4) Chaplains meet providers' personal and professional needs, (5) Providers appreciate chaplains, and (6) Barriers to expanding hospital chaplains' services. Table 1 contains a list of the themes along with the associated formulated meaning statements. The themes were divided into two groups: hospital chaplains (HCs) and hospital-based healthcare providers (HBHPs). Each theme is described in detail below.

Theme 1: Awareness of Chaplain Availability

The awareness and availability of hospital chaplains was an area that both participant groups discussed with great interest. Whereas other thematic clusters revealed more activity by the HBHPs, HCs appeared to have more content to add to this category. HCs offered eight meaning statements about awareness and availability; whereas, HBHP interviews resulted in four. Very "intentional" in their approach, chaplains noted that care can "happen at a moment, at any time [staff] are open." Often contacted by pager, two of the HCs acknowledged they "go in when others are fleeing" particularly when patients are dying or a death has occurred. While the care they provide is influenced by their job description, unit assignments, and hospital policies,

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the chaplains reported they assist providers with care all over the hospital, even though they "are assigned to specific units and floors." Chaplains noted that they work to educate providers about services which are available "on a continual basis as staff is constantly changing."

HCs noted that while they are engaged in "educational process[es] on the units," they work to "make them [HBHPs] aware that the chaplains are not here just for the patients and families, but for them as well." Providers confirmed that HCs "are available to meet emotional and spiritual needs of the staff members." Although care is available, one HBHP shared she "does not recognize a program for [the] formal delivery of spiritual care [to providers], even though "the pastoral care services provides electronic notification to staff of spiritual care opportunities." While it was noted that care can happen at any time, one HBHP related that providers may need to initiate care with chaplains, even seek them out. It was also shared by three providers that HBHPs may seek care from HCs because of their negative perceptions of other "support" resources which exist within the system (e.g. psychological services, EAPs).

Theme 2: Chaplains Focus on Building Relationships with Providers and Staff

HCs and HBHPs noted that the interpersonal relationship was a critical component to whether or not HC services were accessed. HCs offered 10 meaning statements and HBHPs revealed seven related to the importance of building relationships as a point of entry into seeking, receiving, and maintaining HC support. Both groups appeared to value the relationship dimension greatly as evidenced by the greater number of meaning statements extracted under this theme than previously found under the "awareness of HC availability" thematic cluster.

HCs reported feeling accepted by staff. Relationships, however, "are nourished" and usually begin with HCs initiating them. While name cards are used by one chaplain as a means of introduction and for future contact, others meet staff when making their daily rounds, and may

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"hang out with staff" when work demands permit. Multiple HCs expressed that being assigned to a unit or area did not necessarily translate into staff feeling any type of "connection" or relationship with the HBHPs. Being invited to share food with HBHPs was seen to be a sign of acceptance and inclusion, as one chaplain expressed, "they have been accepted when [staff] say[s], 'We are having food tonight; come and join us.'" Multiple chaplains explained inclusion to be an acknowledgement of "being part of the family," and indicated staff often express a sense of possession or ownership. One noted how he tried "to integrate with [staff] so much that they really think of us as 'you're my chaplain,'" which is significant as "it's a matter of forming relationships and connections."

All of the chaplains stressed the important role played by their connection with HBHPs; one HC offered: "Because I hang out with them, they [are] open to me. So, it's like they have to get to know me." Several chaplains reported providers may call on them once a relationship has been established and that relationships serve to facilitate them having opportunities to provide spiritual care to other providers, patients, and families via a "circle of interaction:" "it's kinda a circle that closes…it constantly goes around opening and closing…I know them, they know me, they come to me, they open the door."

All but one of the providers noted chaplains had introduced themselves personally, but all reported knowing that chaplains are willing to assist with the spiritual needs of their patients. One provider indicated they "are very engaged with the staff, nourishing and actually meeting the spiritual needs of the staff, definitely identifying what the individual spiritual needs of the person are." While nourishing these relationships, often on a daily basis, all of the HBHPs said HCs "were attentive," "spent time with them," and "responded to [providers'] needs." One HBHP's description appeared to summarize the opinion of those HBHPs interviewed, "The

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chaplains have been vital and intentional. The intentionality of the chaplain helped establish a spiritual connection which allowed me to feel comfortable enough to seek help." Over half of the providers indicated they see at least one chaplain as being a friend, and acknowledged they "get attached to some more than others."   Providers reported being more open to the HCs over time, after relationships were established and trust was developed.

Theme 3: Chaplains Are Integrated in Varying Degrees on Certain Hospital Units

Members of both participant groups recognize the significance of integrated treatment teams in patient-centered care. According to the HCs, not all HCs are integrated into all of the different hospital units equally. In some units they are not accessed at all. The HCs and HBHPs each appeared to find this to be of interest with each participant group contributing two meaning statements to this thematic cluster. Participation under this theme was less than in the other themes, but this appeared to be a reflection of lack of opportunity rather than interest for individuals in both participant groups.

The chaplains reported varying levels of integration, "depending upon what clinical area [one is] assigned to." While assignments "kinda determine how well [one might be] integrated into that process," it was noted higher levels of care and involvement typically "develop over time." The chaplains also explained they are available for collaboration, as "there is culture within culture." One chaplain explained, "When I first got here, I was assigned to the Medical Intensive Care Unit and recall going to the ICU and looking at charts and visiting patients and the staff member saying, 'We will call you when we need you.' But I said, 'No, I'm going to go when I see a need to because I am a part of the treatment team.'" Another chaplain emphatically responded, "Yes, definitely [with] that team," when asked if she felt as though she were integrated into treatment teams on her respective unit. Yet a different chaplain explained he

believes the level at which he is involved with the treatment team "depends on the physician." Another HC expanded the concept of "team" and offered this scenario:

> I went to everybody who pushed a broom, everybody who was there, and [said], 'I've got 80 beds I am responsible for and I'm not going to see everybody. I'm counting on you to notice anybody's who in need. I can't see them all. I'm looking forward to hearing from you.' And I was told more than once, 'You're the first person who ever asked me to do that.' Especially the housekeeping staff. I said, 'Well, we're a team. We have to work together.' 'No one's ever said that to me before. No chaplain's ever said that to me before.'

The providers all recounted experiences where they collaborated with chaplains about patients and families, appreciating times when they "would do morning rounds with the social worker, chaplain, OT, PT, and the nurse; [afterwards we would] sit in the social worker's office and talk about each patient." One provider noted the important role she believes chaplains fill when team members join in the exchange to "see what is your perspective, what is yours, this is mine, let's collaborate, what can we do different[ly]?" While most of the HBHPs explained chaplains are integrated into their treatment teams, one provider expressed her desire for them to be more fully integrated. This particular provider did not suggest what an integrated team would look like; she did, however, report "that is something that we have tried to do...they are usually aware of the sick patients and they round on their own, but they are not directly involved in our medical team plan of care."

Theme 4: Chaplains Meet Providers' Professional and Personal Needs

The way HCs met the professional and personal needs of HBHPs failed to foster the same level of discussion in both participant groups. Interestingly, HBHPs were the main contributors

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to this thematic cluster contributing 14 meaning statements as compared to the 5 meaning statements extracted from the HC interviews.

The chaplains noted they utilized multiple interventions with the HBHPs. All of the chaplains shared examples when they were available to talk with HBHPs about personal matters. They described the importance of being present, listening to the HBHPs' feelings, and praying for them. Four of the HCs recounted discussing marital and family matters with HBHPs. One shared about a HBHP talking about his children. One had also been present when the relative of a HBHP died; she also accompanied the HBHP to the relative's funeral. All of the chaplains shared accounts of praying with HBHPs about personal matters. One chaplain discussed times when he offered Scripture, therapeutic touch, and songs with HBHPs. The HCs all cited providing support and services to HBHPs during times of trauma and deaths. One participant noted the following example:

> Eight days ago, I got a call from Carolina Donor Services…There was a 16-year-old boy who had an argument with his mom and shot himself and was getting ready to be harvested, I did what I needed to do, asked the family if they wanted me to go down with their son all the way to the OR…and before they went in to do the surgery, the prayer that I did was for the soul of the patient, for the family, and for the staff, and everybody makes their contribution…And on the way to the OR, the nurses were just crying, just inconsolent. In the room with the family, they were professional. As soon as we walked off the ward, and on to the elevator, they just started crying.

Chaplain respondents reported providers may talk with them about everything from hospital decisions relative to scrub colors to ethical matters.

While HBHPs may talk to HCs about a plethora of topics, it appears HCs often responded with a non-judgmental presence. They reported that HCs listen, are present and attentive, and "allow the [providers] to vent, share feelings, and feel validated." Some needs are expressed while the HCs are "hanging out with the staff" or after patients have been seen. One chaplain quipped, "[L]ots of good things happen ministerally on the smoking porch," explaining one HBHP used this venue "to open up about his marriage." While the HCs interact with HBHPs during "emergencies, traumas, and deaths," they also inquire about provider well-being. Chaplains may be "the first to know a provider is seeking employment" elsewhere, or the one who assists an administrator "with [the] organizational structure, problems with stuff on the unit, personal problems, [and those] with other staff." They may be the one who offers prayer for staff when a shift has been particularly trying, or the one who accompanies a traveling healthcare provider to a chapel for spiritual contemplation.

All of the providers reported that the chaplains provide care according to their individual and collective needs. One HBHP summed up the care provided by the HCs this way: "The chaplain provided one-on-one attention, time, clear answers, and encouragement." While "chaplains are automatically called when a death occurs," providers reported that chaplains follow-up with them to make sure their individual personal needs have been met. They participate in quarterly memorial services held in the palliative care unit and help providers "look at [things] from a more healthy perspective." The chaplains serve as the liaison between HBHPs and the hospital Ethics Committee. This responsibility has been heralded by HBHPs, as they explained the chaplains "listen to [their] input and concerns, and validate[d their] feelings, kinda [give them] some direction, [explaining] where [they] need[ed] to go with this emotionally and tangibly." Over half of the providers explained the HCs helped them "reconcile their personal

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confusion relative to [their] spiritual beliefs." They have also assisted "with job stress and depression." One provider offered,

> Even as a healthcare provider, when you feel as though you have done all you can and your best just wasn't good enough is the nature of what we do, but [the chaplains] help us keep renewed and spiritually healthy to move forward.

Theme 5: Providers Appreciate Chaplains

The HBHPs were appreciative of the care and support they were provided by the HCs. While 2 meaning statements emerged from the HC transcripts about feeling appreciated, 12 meaning statements emerged from the HBHPs' interviews.

Overall, the HCs who commented under this theme believed they are accepted by providers and staff and appreciated for their time, efforts, and work even if it is not always expressed verbally. One chaplain profoundly explained, "I…believe that the staff, mostly the nursing staff, have the sense that the chaplain can be valuable…[even though they may not always] know why that's true." Another chaplain noted, "they have come back to me, affirming that they are really truly appreciative of the time and care I offer," another chaplain noted she believed the HBHPs appreciate their willingness to "run in when everyone else is running out."

The providers expressed gratitude to the chaplains for the care they offered. One provider indicated a chaplain helped her end her "two-year spiritual struggle." As a result of the spiritual care she received, the provider reported feeling renewed and spiritually healthy enough to move forward with her workday, and expressed the chaplain helped her "save her spiritual life." The continual physical presence chaplains provided during a difficult shift in an intensive care unit helped one provider "make it through the shift." She also remembered the significant importance of the chaplain's prayers for the unit staff and for her individually. Her ability to talk

with a HC without fear of judgment, provided one HBHP a forum wherein she could challenge

her theology while coming to terms with individual and relationship decisions. Listening and

encouragement helped one HBHP cope when she felt she had been unable to provide care to a

dying 17-year-old with whom she could not communicate because of a language barrier.

Another chaplain helped a provider understand the rites of passage adopted by cultures about

which the HBHP had little knowledge. The providers also appreciated rituals led by the

chaplains, such as the "Blessing of the Hands," which they perform twice annually.

Theme 6: Barriers to Expanding Hospital Chaplains' Services

While the HCs are available and provide care, both participant groups noted there are

obstacles that may prevent HBHPs from seeking spiritual support from HCs. The HC interviews

yielded two meaning statements in this thematic area. Nine statements surfaced from the

interviews of the HBHPs.

Even though the chaplains reported feeling accepted by staff and usually appreciated,

they did report the care they offered was sometimes rejected. This tended to happen when faith

traditions held by a provider differed from that of a particular chaplain. One chaplain explained,

> I have only twice been rejected [by patients] on the basis of religious affiliation. There
>
> have been a number of cases during a number of times when people will ask, 'Why are
>
> you here?' And I explain the difference between chaplaincy and ministry. I ask if there
>
> are any problems and they say, 'No, you'll be okay' [as if to suggest I am not what or
>
> who they want, but that I will suffice]…one was in my residency and it was a blatant case
>
> of anti-Semitism.

While most of their comments were positive, the providers reported the spiritual care

received has "not always been helpful." There have been times when providers felt chaplains

were merely "going through a mental checklist," rather than attending to what might be needed.

One provider explained different faith traditions and practices have presented an issue when

patients and/or families may desire a religious practice/ritual the chaplain on duty did not

perform/practice. Providers recognized they are closer to some chaplains than others and may

seek out those with whom they are comfortable, limiting the ability of other chaplains to provide

care. One provider, however, explained her position limits how much she can share with the

chaplain she describes as "a friend." The multiple responsibilities chaplains are assigned is seen

to "stretch the chaplains thin," and may limit their availability. There are times when chaplains

do not appear to know what to do or how to respond spiritually. One provider had a personal

experience years ago when her son was receiving care in the Emergency Department. She

explained,

> I was referred to pastoral services and the particular [chaplain] came up and I was not at
>
> all comfortable with [his] demeanor, with the silence of him not knowing what to say or
>
> how to say it, the awkwardness of being in the present moment, the lack of comfort. My
>
> son was like, 'I don't want any part of [him.]'

The setting of this study has a training program for chaplains; those involved in the year-long

program are called residents and help provide spiritual care within the hospital. The level of the

residents' training was cited as an issue by one provider who questioned their ability to attend to

highly acute areas, such as the Emergency Department (ED). This provider explained,

> I understand why the chaplain residency program is located in a large hospital setting like
>
> [ours.] I disagree that chaplain residents should be placed initially in the high stress, high
>
> acute areas like the SICU, MICU, and the ED, until they have some concrete experiences
>
> dealing with people dealing with extremely critical circumstances. The chaplain

residents themselves may have never been in these high acuity areas and to expect them

to be helpful to the families and staff when they are so inexperienced is unrealistic. Their

learning experience is more a trial by fire and less than effective for the families in the

ICUs and ED.

Significant, too, is one provider's concern that hospital administrators, staff, and providers "may

not understand spiritual services are available to them, and how to access those services if and

when they are desired." This lack of awareness not only limits the services HCs can provide, it

hinders HBHPs from accessing care that could improve their well-being. This is particularly

noteworthy because the care HCs provide is spiritual in nature and provided at no cost to staff.

Exhaustive Descriptions

The results were then integrated into two distinct and in-depth exhaustive descriptions

reflecting the phenomenon experienced by HCs and HBHPs. The descriptions are intended to

help readers understand the overall essence of each phenomenon from the participants'

perspectives (Colaizzi, 1978. What was found during the analysis process was that the perceived

experiences of the HCs and HBHPs differed in depth and breadth across all thematic categories.

Distinct perspectives would have been de-emphasized, and possibly lost, if the two participant

groups were combined into one exhaustive description. Therefore, the exhaustive description

representing the HCs experience is found in Table 2, while the HBHP's description is found in

Table 3.

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Discussion

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Much of the available research on hospital chaplaincy has been written to understand and

describe the role of HCs and the impact of their work on patient well-being (e.g., Handzo,

Flannelly, Kudler et al., 2008; Flannelly, Weaver, & Handzo, 2003; Montonye & Calderone,

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2010; Piderman et al., 2008; Sharp, 1991; VandeCreek & Lyon, 1994). Even though there have been studies conducted with patients and families, this is the first known research to detail the experience of hospital-based healthcare providers who have received professional and personal care from HCs. A phenomenological design was employed to explore hospital-based healthcare providers' experience of receiving spiritual care and support from HCs and to expand the existing knowledge base of literature on hospital chaplaincy and BPS-S care in hospital settings.

Participants described the spiritual care provided by HCs in ways often cited in the literature, noting they assist with religious and non-religious interventions (Cadge, Calles, & Dillinger, 2011; Handzo, Flannelly, Murphy et al., 2008; VandeCreek & Smith, 1992). More specifically, the interventions employed were similar to those described by Hummel et al. (2008): religious and spiritual intervention delivery, counseling, emotional support, advocacy, presence, and adjunct therapy. They also reported performing blessings and religious rites/rituals (also found in Handzo, Flannelly, Murphy et al., 2008; Hummel et al., 2008). In addition, the HCs offered insight into how they see themselves. While the chaplains acknowledged the spiritual care and support they provided was influenced by their job descriptions, unit assignments, and hospital policies, they embraced their work as a calling and ministry. As a result, the HBHPs, patients, and families are their congregants. They recognized they "go in when others are fleeing" and sometimes took on the role of being "spiritual first responders." Even though often intense, their accounts elucidated their commitment to their work.

While the HBHPs interviewed were appreciative of the care and support HCs had provided, citing the significance of their emotional sensitivity (also found in Chapman & Grossoehme, 2002), those interviewed noted that administrators may not recognize the significance of the care HCs provide (also found in Manns, 1990). It is believed this failure

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appeared to contribute to HCs feeling marginalized (also found in Norwood, 2006), not included

in treatment teams, or permitted access to certain hospital units, which prevented the seamless

delivery of integrated care, a finding not previously highlighted in the literature.

Unique to this study are the personal accounts of HBHPs who have received spiritual care

from HCs. The HBHPs were particularly vocal when discussing how the HCs met their personal

and professional needs, the appreciation they have for the care provided, as well as when noting

barriers to receiving spiritual care. They noted being able to regain focus and continue in their

work after accessing the support of a HC. Chaplains described how personal and spiritual

conflicts were resolved. Their accounts yield insight into how they were then able to provide

better care to the patients and families as a result of the care they acquired from the HCs.

Training Implications

Participants in the study indicated that when HCs are not comfortable in certain units that

they become more manualized and less personal. This serves to reduce referrals and HBHPs'

confidence in the HC service. However, according to the participants, it is HCs' personalities and

relationship building skills that gain them better access to patients and providers. HCs may need

more training in providing care across a broader range of units, as well as how to establish

relationships when time is limited (e.g., emergency department) and/or providers are less

familiar with their service. Additional rotations in hospital units where HC residents or

experienced clergy demonstrate minimal experience may help them to be more open, receptive,

and competent with referrals. Additionally, chaplain residents and new hires may need more

supervision and support when working in critical care units and emergency departments where

providers require that HC are able to think on their feet and act quickly.

Participants noted that HCs are integrated more fully into some settings than others. Units such as Palliative Care, Pediatric, Surgical and Medical Intensive Care describe HCs as being more fully integrated than the Neonatal Intensive Care Unit. Higher degrees of integration allow HCs to be more fully involved in both the treatment of patients and engagement with HBHPs. Higher levels of involvement may make HCs more present and aware of HBHPs' needs. The level of integration in highly acute areas such as the Emergency Department vary by the time of day, staff on duty, and/or the chaplain(s) involved. Bringing in outside trainers skilled in integrated care may help units incorporate HCs, as well as other disciplines, more fully in a co-located or integrated way (Hawkey, Kellar, Reilly, Whalen, & Inkpen, 2005); thereby, improving the quality and attention given to patients' biopsychosocial and spiritual dimensions.

Clinical Implications

Religion and spirituality have been recognized as critical to one's healthcare and well-being (Chapman & Grossoehme, 2002). Based on the findings of this study, however, it seems staff may not know how to access care. This appears to be true because providers do not recognize a program for the formal delivery of spiritual care. One idea for addressing this matter would be to include information about care availability during staff orientations to the hospital. Signage in staff areas and special notations relative to care in electronic communications to staff could prove beneficial. Focus groups conducted with hospital employees could also offer insight about additional needs they have, which could be addressed by HCs. This information could be used by the Pastoral Care Department to expand existing services. Regardless of these methods to increase clinical access, HCs will need to target administrators who may not understand the benefits of HC services for their patients, families, and employees. Administrators will want quantitative evidence of HCs clinical success to complement qualitative stories. Therefore, HCs

will want to partner with researchers to help design program evaluation studies to improve the data that supports the biopsychosocial impact of HC services.

Research Implications

This study has opened up opportunities to understand further the value of chaplaincy services beyond those which impact patient care directly (Flannelly, Oettinger, Galek, Braun-Storck, & Kreger, 2009; Parkum, 1985; VandeCreek, 2004) or which are financial in nature (Cadge, Calles, & Dillinger, 2011; Clark, Drain, & Malone, 2003; Yankelovich Partners, 1997). This study expanded findings of how chaplaincy intervention could improve the provision of healthcare (also found in Balboni et al., 2009; Florell, 1973; Hover, Travis, Koenig, & Bearon, 1992; Sheehan & Wathen, 1982) by highlighting how their work enabled staff to provide effective patient care when staff had experienced multiple losses, were encountering personal struggles, and were having a difficult time focusing on their work. While HBHPs reported the HCs' work, time, and efforts to be helpful, the full impact of the spiritual and emotional care provided by the HCs is not known, nor is the degree to which the care made a long-term effect on the HBHPs. A provider/staff retention study could yield insight into the efficacy of care. A longitudinal study which examines how well HBHPs are able to perform their respective job responsibilities, be retained in their positions, as well as patient and provider satisfaction with their work could provide information about the longstanding impact of HC services to HBHPs. A comparative effectiveness study could also offer insight into which chaplaincy interventions are seen to be most effective with HBHPs on different units and in which situation each is appropriate.

Additional research into the effectiveness of care when the HCs are integrated could help strengthen the quality of clinical care while recognizing the contributions of all team members

(IOM, 2003). While each team member is trained in a different discipline, the various individuals may not recognize or acknowledge each others' strengths and/or weaknesses until a time of crisis. A mixed method study examining the team makeup, team processes, team tasks, and environmental tasks (Fried, Topping, & Rundall, 2000; IOM, 2003) in which HCs are integrated at various degrees is recommended as a means to gather information about how the various team members respond in different scenarios. Such an investigation could provide information about how the various team members communicate, establish leadership roles, handle conflict, and are able to secure needed resources. Insight about how each individual is prepared for the responsibilities of his respective job assignment could also be gleaned, as well as new policies introducing employees to chaplaincy services, including their availability for staff spiritual care, during orientation. An outcome of this study might include policies which require training for all HCs in varying types of care settings, as well as protocols for referrals to HCs, and integrated care treatment teams. A randomized control trial could also provide insight into HC effectiveness. Hospital-based healthcare providers could be randomly assigned at orientation to receive an initial consult from a HC and a monthly check in versus other HBHPs who are informed by the normal orientation process about HC services. Investigators could track provider wellbeing, work satisfaction, patient satisfaction scores, and other biopsychosocial indicators to determine if there is a difference between the groups. At the end of the study, data gathered through mixed-methodology would be reviewed to see the impact of HC spiritual support.

Limitations. While this study breaks new ground into the dynamic role of the HC, the HBHPs appeared to share more details about their HC experiences, while the HCs were more succinct in their accounts. It is surmised the HBHPs offered more detail because they

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remembered the intensity of their needs and the resulting relief gained as a result. It is possible, too, that the HBHPs who agreed to participate had more positive interactions with the HCs than those who did not choose to participate. The HCs were not as expressive when discussing a few thematic clusters (personal and professional needs, appreciation, and barriers). Their lack of detail may exist because of the confidential nature of their work, sense that their work is a result of a calling versus a job, and possibly an inability to recognize how the demands of their respective assignments limit their wider availability to staff at times (VandeCreek & Burton, 2001).

Also, of the seven who consented to participate, six were registered nurses. Their participation and connections with HCs highlights the finding that nurses often embrace spirituality, access, and make more referrals to HCs than other healthcare professionals (e.g., Flannelly & Galek, 2006; Fogg, Flannelly, Weaver, & Handzo, 2004; Galek, Flannelly, Koenig, & Fogg, 2007; Hover, Travis, Koenig, & Bearon, 1992), and do so more often than those in other disciplines found in the hospital setting (Flannelly & Galek, 2006; Galek et al., 2009; Scott, Gryzbowski, & Webb, 1994; Taylor & Amenta, 1994). The fact that nurses were easiest and most willing to participate in the study may either be a limitation in how participants were recruited or telling about the frequency with which nurses solicit HC services, thereby making it easy for HCs to identify them as having used their services.

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Table 1

Thematic Clusters and Meaning Statements

Thematic Clusters and Meaning Statements	
Theme 1: Awareness of Chaplain Availability	
Meaning Statements of HCs	Meaning Statements of HBHPs
Availability is influenced by job descriptions, unit assignment, and hospital policies	Providers may seek care from chaplains because of perceptions within system of other resources
Administrators may not be aware of what chaplains contribute to healthcare system	Pastoral care services provide electronic notification to staff of spiritual care opportunities
Care can happen anytime or anywhere with patients, families, and providers/staff/administrators	Care can happen at anytime
Chaplains are intentional about the care they provide	Providers may need to initiate care with chaplains, to seek them out
Chaplains are called upon to assist providers with personal and professional needs	
Chaplains often "go in when others are fleeing"	
Chaplains are available by page and usually come when called	
Theme 2: Chaplains Focus on Building Relationships with Providers and Staff	
Meaning Statements of HCs	Meaning Statements of HBHPs
Chaplains feel accepted by staff	Chaplains are engaged with providers in multiple ways
Relationships are nourished as they are seen to be important for care to occur	Chaplains go out of their way to meet providers and nourish a relationship with them
Chaplains are often made to feel as though they are members of the healthcare family	Chaplains are attentive and respond to provider needs
Relationships with staff often lead to staff introducing them to patients and staff who may need spiritual care	Chaplains spend time with providers when rounding, during breaks, during emergent situations, and whenever providers desire time with them
Staff may call on chaplains for spiritual and professional care when they have a relationship with them	Chaplains seem to be intentional in care provision and connection with providers
Providers may access chaplains more after relationships are established and a level of trust has developed	Providers consider chaplains to be friends
When providers trust a chaplain, they will confide more in him/her	Providers feel closer to some chaplains than others
Chaplain personalities/personal traits aid in relationship establishment	
Chaplains work to educate/remind providers of services which are available	
Chaplains often check on staff before or after they visit with patients and families	
Daily contact with providers helps build relationship between chaplains and providers	
Theme 3: Chaplains Are Integrated in Varying Degrees on Certain Hospital Units	
Meaning Statements of HCs	Meaning Statements of HBHPs
Chaplains experience a higher level of integration with healthcare teams over time	Chaplains are better integrated into certain units
Chaplains are called upon by providers to collaborate on patient care	
Theme 4: Chaplains Meet Providers' Professional and Personal Needs	
Meaning Statements of HCs	Meaning Statements of HBHPs
Chaplains listen, are present and attentive, make providers feel important and heard	Chaplains follow up with providers to make sure their needs have been addressed

Chaplains allow providers to vent, share feelings, feel validated	Chaplains are automatically called whenever a death occurs within the hospital
Chaplains interact with providers during emergencies, traumas, and deaths	Chaplains perform religious rituals
Chaplains pray for providers when requested to do so	Providers call chaplains when they have really sick patients
Chaplains model self-care for providers	Chaplains help with the impact of death and dying
	Chaplains help providers discuss and reconcile personal confusion relative to spiritual beliefs
	Chaplains offer spiritual resources to providers (e.g., chapel access, books)
	Chaplains provide professional assistance with families have emotional difficulties
	Chaplains help providers with ethical issues/concerns
	Chaplains initiate Ethics Committee consults
	Chaplains assist with job stress and depression
	Chaplains round and assess well-being of staff
	Chaplains are open to discussion with staff
	Chaplains participate in quarterly memorial services
	Chaplain has talked with administrator about meeting spiritual care needs of staff
	Chaplains provide care according to staff need and contact

Theme 5: Providers Appreciate Chaplains	
Meaning Statements of HCs	Meaning Statements of HBHPs
Staff members believe chaplain services to be valuable	Staff believe chaplains are compassionate
Providers are vocal about their appreciation of chaplain time, efforts, and work	Chaplains help providers feel renewed and spiritually healthy enough to move forward
	Chaplains helped provider "save [her] spiritual life"
	Chaplain helped provider regain focus and enabled her ability to concentrate fully
	Chaplains helped provider end 2-year struggle
	Providers are grateful for chaplain care
	Chaplains helped provider view her job in a healthier manner
	Provider described chaplain contact of comforting
	Provider believes chaplain support is available if/when needed
	Providers feel they can talk with chaplains without fear of judgment
	Chaplain work, time, and efforts are seen to be helpful
	Chaplains have provided refreshment breaks to providers (ice cream, fish fry)

Theme 6: Barriers to Expanding Hospital Chaplains' Services	
Meaning Statements of HCs	Meaning Statements of HBHPS
Chaplain care is sometimes rejected by patients, families, and staff	Providers reported care may not always be helpful
Chaplains may have faith traditions which are different than those who seek help/care	Providers do not recognize a program for formal delivery of spiritual care
	Chaplains are stretched by multiple responsibilities
	Staff may not have a good understanding of how to access services from hospital chaplaincy
	Patients and staff may have different faith traditions than chaplains and can find it difficult to seek care as a result

	Lack of preparedness by chaplain residents for level of care on certain units
	Some chaplains appear to be going through "mental checklist" versus building relationships with patients and staff
	Administrators find chaplains can offer them a different perspective
	Providers may not understand services are available to them and how to access services if/when desired

Table 2

Exhaustive Description of Spiritual Care Provision to Hospital-based Healthcare Providers: HC Perspectives

Hospital chaplains (HCs) believe the spiritual and emotional care they provide hospital-based healthcare providers (HBHPs) to be part of their ministry. Because of the rate of turnover in HBHPs, the HCs engage in educational sessions to assure HBHPs are aware of the services available to them.   Intentional in their work, HCs describe connections with staff to be significant, as staff members are more willing to talk with them about personal and professional concerns when a level of comfort and familiarity exists. HCs explain they build relationships by introducing themselves to HBHPs and check in with them daily when rounding their respective assigned units, making every effort possible to assure the personal and professional needs of HBHPs are addressed. They discuss patient care with HBHPs, coordinate services, and participate in varying degrees on treatment teams. The HCs describe the personal scenarios that cause them to interact with staff to range from being in the trenches addressing trauma and emergent patient needs with HBHPs to hanging out with them when work demands permit. Because the HCs recognize HBHPs work in stressful situations under duress and can easily be impacted by their job responsibilities, the HCs explain they offer their presence, prayers, and even therapeutic touch to HBHPs during these times in particular. HCs note, however, spiritual care may be challenged by lack of unit access/acceptance of spiritual care and a religious fit between faith of chaplain and those they are helping.

Table 3

Exhaustive Description of Spiritual Care Provision to Hospital-based Healthcare Providers: HBHP Perspectives

Hospital-based healthcare providers (HBHPs) believe hospital chaplains (HCs) are attentive and responsive to their spiritual and emotional needs. Willing to assist, the HCs are described as being friendly, vital, and intentional in the care they provide. The HCs introduce themselves to HBHPs and are engaged with staff on a daily basis because of their job responsibilities. The HCs assess the well-being of staff when rounding and try to spend time with every staff member individually. The visibility, exposure to, and culture of interaction of HCs often helps HBHPs develop friendships with HCs and they become closer to some HCs than others, which is particularly significant when HBHPs seek a compassionate and objective listening ear, and/or a place to ventilate. HBHPs appreciate the one-on-one attention, time, clear answers, and encouragement the HCs provide them. The HBHPs find the HCs are a source of educational insight when they encounter dilemmas and situations about which they need direction, whether profession (such as end-of-life rituals of various ethnic groups), career-related, ethical, or matters of spiritual confusion. They are available to spend time with HBHPs, have shared books and resources, and helped lessen the impact of death, dying, and multiple losses experienced by HBHPs, helping them feel renewed and healthy enough to move forward and work the balance of their shifts. The spiritual care HCs have provided has helped HBHPs reconcile their religious beliefs, helping providers feel as though their spiritual lives have been saved; helped providers regain focus and enabled them to concentrate once more; they have lessened feelings of inadequacy, taken the pressure off the system, and helped HBHPs approach their work in a healthier manner. They provide a gamut of care that ranges from attending quarterly memorial services in the Palliative Care Unit and offering prayer to HBHPs to doing patient consults and providing ice cream breaks and a fish fry for all the HBHPs on a unit. While a formal program for spiritual care delivery does not appear to be operative, HCs are available when HBHPs reach out to them. It is recognized, however, that HCs are stretched thin by their job-assigned responsibilities. Different faith traditions can be a barrier to approaching some HCs, as well as the fact HBHPs feel closer to some HCs than others. HBHPs may also be selective about spiritual care when experiences with HCs has made them feel as though a HC did not know how to address a certain situation or if their respective training has not prepared them to work in highly acute settings, as may be the case with chaplain residents. HBHPs who have administrative jobs may limit the care they access from HCs and HCs are not integrated into treatment teams and care in all hospital units, even though HBHPs wish they were. Even though HBHPs do not believe the availability of HC services is advertised enough, they do appreciate the care HCs provide.

CHAPTER 5: DISCUSSION

The articles presented in this dissertation contribute to the growing body of literature on the biopsychosocial-spiritual (BPS-S) approach to healthcare, in particular as it relates to the importance of spiritual care in the hospital setting. Foundational insight into how to integrate hospital chaplains into hospital-based healthcare delivery systems aligns well with the Institute of Medicine's 2003 mandate to address the spiritual needs of patients and families. These findings are particularly significant to this researcher, too, as she is a Medical Family Therapist and systemic thinking who looks at medical and mental health care from a BPS-S lens. A limited body of literature addresses the merits of spiritual support for the hospital-based healthcare provider. The purpose of this dissertation was to expand and enhance the literature in this area and discuss clinical, training, and research implications and recommendations.

Chapter One provides a general introduction to the topic and anchors the need for this research in the Institute of Medicine's (IOM, 2003) call for a patient- and family-centered model of care. The IOM stresses the importance of attending to patients' respective "preferences, needs, and values" (IOM, 2003, p. 6), including those which are spiritual, as well as promoting the move toward integrated care models and approaches that help reduce recidivism rates. While some studies exist on the merits of having hospital chaplains work directly with patients and families (e.g., Fitchett, Meyer, & Burton, 2000; Piderman et al., 2008; VandeCreek & Smith, 1992), no one has attempted to systematically review the literature on hospital chaplains' impact with regard to patient and provider care, satisfaction, and BPS-S health outcomes.

In Chapter Two, the results of this systematic literature review were presented. The purpose of the review was to analyze research-based literature on the role and activities of hospital chaplains in spiritual care provision, examine the affect of spiritual care provided by

hospital chaplains on health outcomes, organize the literature, and analyze themes and gaps in

knowledge. Outcomes and implications from this review are described later in the discussion.

The third chapter (i.e., article one) was written to present the methodology used for this

dissertation. The study applied a phenomenological method (Husserl, 1901) to address the

following query, "Can hospital-based healthcare providers provide better care when their

spiritual and emotional needs are met?" Rigorous verification strategies and an analysis

procedure that resulted in thematic saturation helped to raise confidence in the trustworthiness of

the findings (Lincoln & Guba, 1985). Chapter four (i.e., article two) includes the article intended

for publication that was written to report the study's findings. It yields foundational insight into

the need to integrate hospital chaplaincy support and spiritual care into hospital-based healthcare

delivery systems, as well as the merits of caring for the hospital-based healthcare provider

(HBHP). What follows is a discussion about the possible implications of both the systematic

literature review and research study chapters, offering insight into the role and impact of hospital

chaplains (HCs) and recommendations that hospital systems provide more integrated care

services and include HCs on these teams.

Article One

The various components of the BPS-S approach (Engel, 1977, 1980; Wright, Watson, &

Bell, 1996) allow for providers to address patient needs in a more holistic manner. The approach

is used to encourage providers to assess patient's biomedical, psychological, social, and spiritual

dimensions and prepare treatment plans which reflect a more comprehensive review of a

patient's whole health. While spirituality is the least explored of these domains, within hospital

settings, chaplains are assigned the responsibility of attending to the spiritual needs of patients,

families, and staff. Five themes emerged when the 68 research-based literature articles written

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on the role and activities of HCs were reviewed: (a) spiritual care provision, (b) chaplain activities and interventions, (c) satisfaction with chaplaincy intervention, (d) interdisciplinary team work and collaboration, and (e) referral patterns. Researchers found that spiritual care provision not only has a positive effect on health outcomes and patient satisfaction with medical care, it decreased patient demands placed on nurses (e.g., Florell, 1973; Iler, Obenshain, & Camac, 2001), as well as patient length of stay (e.g., Iler, Obenshain, & Camac). Nurses were consistently cited as providing more referrals to chaplains than other healthcare providers (e.g., Chapman & Grossoehme, 2002), even though few referral protocols exist for making referrals to HCs (Taylor & Amenta, 1994). Chaplains also shared their desired to be more engaged as active members of interdisciplinary treatment teams (e.g., Norwood, 2006; Wittenberg-Lyles, Oliver, Demiris, Baldwin, & Regehr, 2008). While offering an understanding of the care provided by hospital chaplains, the review highlighted clinical, research, and training opportunities.

Among the areas where additional research is suggested is that which relates to BPS-S outcomes of including HCs in healthcare treatment teams. At the present time, no published qualitative studies have been found on ways to integrate HCs into interdisciplinary treatment teams. While there are multiple research questions which could be explored quantitatively (e.g., randomized control trials, biopsychosocial and spiritual data chart audits, patient recidivism or provider/staff retention studies, patient/provider well-being and satisfaction studies, as well as focus groups), it is possible hospital systems could benefit more if an initial qualitative focus group study were conducted so the model could be tailored to their specific organizational structure, geographic location, and population demographics (e.g., race, age, socioeconomic well-being, faith, and levels of spirituality). Results can be used to assist with integrating trainings related to inclusion of HCs and spirituality as a part of medical care treatment, and help

researchers hone in on key variables that would be important in tracking and studying HC effectiveness. Not only could this training boost the confidence providers have in assessing patients' spiritual needs, it could also be used to develop metrics to be used in outcome based assessments on the merits of attending to patients, family members, and providers' spiritual well-being.

While trained to meet the emotional and spiritual concerns of patients, family members, and staff members, HCs are overtly or covertly given the responsibility of attending to the system at the patient, family, staff, and system levels. The empirical focus heretofore has been on the care HCs have provided patients and families, with no known research published on the lived experience of HBHPs who have received support or spiritual care from on-staff chaplains. A qualitative study followed by a mixed method investigation which explores the experience of HBHPs who have received emotional and spiritual support from HCs would not only serve to expand existing knowledge, it could inform the reach of the BPS-S approach. Driven by the query, "Can hospital-based healthcare providers provide better care when spiritual and emotional needs are met?", findings will help to highlight outcomes of having HCs on staff not previously realized through research (e.g., cost reductions/off set, staff retention, and HBHPs quality of life).

Research is also needed to better understand how referrals are made to HCs and the unique barriers in different hospital settings (e.g., rural vs. urban; large vs. small). While it has been found that patient and family members desired to have their spiritual needs attended to (e.g., Koenig, McCullough, & Larson, 2001; VandeCreek & Gibson, 1997) and HCs often relied on other treatment team members to make referrals (e.g., Chapman & Grossoehme, 2002; Daaleman & Frey, 1998; Fogg, Flannelly, Koenig, & Fogg, 2004), it seems many HBHPs failed

to see the link between biomedical, emotional, and spiritual issues (e.g., Daaleman & Frey, 1998; Flannelly, Galek, Bucchino, Handzo, & Tannenbaum, 2005; Hover, Travis, Koenig, & Bearon, 1992). Little understanding exists about why some HBHPs (e.g., hospital-based physicians) make fewer referrals than other hospital-based healthcare providers (e.g., nurses). Likewise, it is not known why HCs are not included more on hospital-based integrated and non-integrated care teams. An ethnographic study could help elucidate the characteristics of cultures wherein referral protocols to HCs result in successful connections between patients, families, and HBHPs. Insight obtained from such an investigation could also help transform systems toward effective transdisciplinary integrated care that is biopsychosocially *and spiritually based*. However, before studies on the inclusion of HCs on integrated care teams take place, a greater understanding and appreciation for the depth and breadth of their work with HBHPs is needed. Article two was written to address this gap in the literature. It is based on a phenomenological study designed to expand and enhance researchers understanding of the role HCs play in direct support of HBHPs.

Article Two

The purpose of this study was to explore the lived experience of HBHPs who received emotional and spiritual support from a HC. A phenomenological design (Husserl, 1901) was utilized to explore possible benefits HBHPs might receive when their personal and spiritual needs are addressed by HCs. The research was conducted in a southeastern academic medical center and included qualitative data from 12 interviewees, 5 of whom were HCs, and the remaining 7 were HBHPs who had received care from HCs at a prior time. Colaizzi's (1978) phenomenological method of analysis was used to conceptualize the participants' experiences. Distinct themes emerged when the data were collapsed into the following six thematic clusters:

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(a) Awareness of chaplain availability, (b) chaplains focus on building relationships with providers and staff, (c) chaplains are integrated in varying degrees on certain hospital units, (d) chaplains meet providers' personal and professional needs, (e) providers appreciate chaplains, and (f) barriers to expanding hospital chaplains' services. Distinctive to this study are comments made by HBHPs who reported the care they were provided helped them feel renewed, able to focus more on medical tasks and patient care, and become spiritually healthy enough to forwarder-engage in patient care. Even though the HBHPs appreciated the care received, and were able to provide better patient care as a result, they noted that the true value of the care provided may not be recognized by administrators or be widely known by all HBHPs. The lack of HC inclusion on treatment teams in some hospital units caused questions to be raised about the existence of seamless care delivery. Implications from this study were applied to clinical, research, and educational opportunities in the area of hospital chaplaincy.

　　　　Clinical implications. While many HBHPs acknowledged the value HCs provide within their respective medical settings, it was noted that HBHPs may not know how to access care for themselves if and when desired. While some providers explained they watched HCs as they attended to their patient-centered job-related responsibilities, and even talked with them daily as the chaplains rounded, the lack of a formal program for the delivery of spiritual care to staff members caused providers to have uncertainty about both how to access care and if doing so were appropriate. This apparent gap in awareness could prevent staff from acquiring care that would assist in their day-to-day functioning.

　　　　The responsibility of meeting patients' BPS-S needs can be challenging for HBHPs, especially if they are encountering professional and personal concerns which could hamper care delivery. Matters related to their respective individual and family issues can be exacerbated

when patients share similar dynamics. For example, when a HBHP is providing care for a dying

16-year-old male youth, thoughts may surface of his or her own adolescent child, making it

harder to separate psychologically from the care. A HBHP who has an aging parent with a

terminal illness may find it harder to work with geriatric populations providing end of life care.

If HBHPs were aware that HCs were available to talk with, this may be a more welcome

resource for some HBHPs who are spiritually aware and/or who may not find discussing it with a

supervisor or mental health provider appropriate or needed. While it would seem that

highlighting available services during orientation trainings, electronic notifications from the

Pastoral Care Department, as well as signage throughout the medical facility could alleviate the

lack of awareness, it is possible chaplains and hospital administrators may need additional

training on how to market the respective skills of HCs and how to integrate them onto healthcare

units where they are not found as often. Focus groups conducted with hospital employees could

also be used to identify resources for employees' spiritual needs. A compilation of participant

concerns would not only help elucidate existing HBHP spiritual needs, it could guide hospital

leaders as they plan ways to assist employees and design healthier workplace environments. In

particular, research findings could be utilized by the Pastoral Care Department to expand the

services they provide, strengthen their clinical skills, and foster better models of collaboration

with other disciplines to enhance existing services.

   Training implications. HCs and HBHPs noted that the HCs do not always appear and

feel comfortable in settings that are less personal in nature. While personalities and training

strengthen HCs' ability to build and foster relationships, challenges exist in settings and

circumstances which do not lend themselves for chaplains to enjoy extended periods of time to

build relationships.   HCs receive experience providing spiritual care in ambulatory medicine as

part of their training for certification. However, additional training within ambulatory and critical care units, and in integrated care, could help chaplain residents as they gain more experience working on teams with difficult and traumatic cases and scenarios. Supervision during these experiences can help HCs learn additional skills, gain mastery of situations with which they will have to deal in their professional lives, as well as address their own reactions to what they have encountered. Additional hours of training and supervision could serve to not only strengthen chaplain skills, but also give other healthcare team members greater confidence in the chaplain's ability to work in difficult situations.

While annual in-service trainings within the hospital could help HCs expand and strengthen existing skills, in-service educational opportunities designed to strengthen the interprofessional skills of treatment team members assigned to units could improve health outcomes. Educational opportunities conducted by individuals who understand systemic dynamics and integrated care, such as Medical Family Therapists, might help all participants gain greater understanding into collaborative care models wherein the individual resources of each provider is integrated for optimal health outcomes (CIHC, 2010). The elements of collaboration (respect, trust, shared decision-making, and partnerships) would be stressed and team members would learn that to work effectively, roles and communication must be clear. Training which focuses on interprofessional skills would also help establish interdependent relationships between team members. These relationships would foster confidence in and knowledge of one's own discipline as well as that of other team members (BC Competency Framework for IPC, 2008; CIHC, 2010).

Research implications. The HBHPs heralded the work, time, and efforts of the hospital chaplains and cited how the HCs attended their respective needs. Providers noted how they were

able to focus more clearly and attend to patient needs as a result of the care they received from HCs; but, it is not known how much this care could reduce medical costs and improve care over time. At a time when economists are struggling to make healthcare more affordable, it is believed that additional research could solidify understanding of the systemic value of HCs within medical settings. How healthcare is impacted when HCs are integrated into healthcare teams could be significant. A longitudinal study which examines providers' coping before and post chaplaincy intervention could offer insight into how HBHPs' ability to focus, as well as provide patient care, is altered by means of the intervention; it would also be enlightening to see which interventions are most effective. A qualitative inquiry into the effectiveness of healthcare teams when HCs are integrated might add clarity not only to the impact of chaplain inclusion but also into how patients respond when their spiritual care needs are addressed as a part of a team-based care model versus a direct referral to a HC off the unit. Interviews of team members could add insight into how each provider feels the team works well together, the contribution each team member makes to team functioning, as well as what interventions might foster process and systemic changes.

The Connection

At present, the healthcare climate is changing. Amidst the alterations are movements toward more integration and less fragmentation of health care provision (BC Competency Framework for IPC, 2008; CIHC, 2010; IOM, 2003). The resulting environmental shifts have systems and providers looking for modalities of care which incorporate biomedical and psychosocial care. The BPS-S approach (Engel, 1977, 1980; Wright, Watson, & Bell, 1996) offers a means whereby biomedical, psychological, social, and spiritual components can be addressed, whether one is looking at the patient, provider, or system level.

While article two was written to review the existing literature and note areas for growth and enhancement, this study responded to one area of need and offers insight into the lived experience of HBHPs who have received emotional and spiritual support from HCs. Both articles highlight the continued struggle that chaplains have being integrated into hospital systems. The IOM (2001) recommended healthcare providers cooperate as treatment teams, as doing so can help optimize "patient-centered care that is safe, timely, more effective, efficient, and equitable" (p. 15), as well as address spiritual concerns However, patient-centered and family-focused care involves partners in group decision-making, operating according to interdependent relationships characterized by professional conduct, flexibility, and adaptability. The need for additional interprofessional training and BPS-S education could help strengthen the elements of collaboration for HCs, as well as other HBHPs, as respect and trust can be fostered and partnerships forged. Interprofessional training could help prepare chaplains and providers to offer collaborative care more effectively.

The research presented in this dissertation offers insight into the lived experience of HBHPs who have received emotional and spiritual support from HCs. While multiple needs and implications beg to be addressed, findings can inform future researchers, educators, and clinicians in their attempts to provide biopsychosocial-spiritual care in an affordable and integrated way. The logical deductions one might make when surmising that spiritual care could improve staff's ability to offer care, as well as the belief that care offered by means of integrated treatment teams should include chaplains in their constituency, must be founded on empirical data, especially at a time when outcomes are so heralded and healthcare costs need to be contained.

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> *illness.* Basic Books: New York.

APPENDIX A

Researcher's Qualifications, Biases, and Assumptions

Researcher's Background and Training

For many years of my life, I have served in various roles within the church. As a child, I played the piano and organ for my local congregation. When I became a young adult, I started directing choirs and working with various youth ministries, both in my local congregation and denomination, where I have been engaged in music, teaching, and missions work. In order to gain a better understanding of ministry, I completed an undergraduate degree in religion and philosophy. After working for two years as a children's writer for a Baptist denomination, I became editor for the agency. During this time, I continued to work within various musical ministries in my local church, directed a summer encampment for adolescents, taught within my church's educational program, and studied sacred writings, as well as the teachings of the church and historical church leaders. I also married a minister and worked with him in multiple capacities.

Throughout my life, I have known many individuals who were hospitalized. Likewise, I have visited many who were gravely ill, experiencing trauma, as well as some who were dying. It has not been uncommon for me to be present in medical settings when chaplains would visit with and/or offer spiritual care to individuals and families I was visiting. I have friends who are hospital chaplains, and have presented several didactic sessions for chaplains in training. These experiences have helped provide me with insight into the demands of offering spiritual care and the personal struggles those providing care can have.

As time has passed, I have continued my formal training. At present, I have two Master's degrees, one in biblical counseling and the other in Marriage and Family Therapy. Both of these

degrees have given me additional skills in listening to individuals and hearing their stories. I am able to glean the narratives being presented, while simultaneously doing a meta-analysis of how the individual, couple, and/or family system processes the story being presented. I have also continued my education and am a doctoral candidate in East Carolina University's Medical Family Therapy degree program. This training has expanded my knowledge base, especially in the area of working with individuals and families experiencing medical issues, as well as with collaborating with healthcare providers within medical contexts. Requirements for this degree have included supervised clinical work within the behavioral health unit of UHS/Pitt County Memorial Hospital. My internship was done in the Greenville, NC, satellite facility of the pastoral care department of North Carolina Baptist Hospital in Winston-Salem, NC (CareNet Counseling East). At present, I am a full-time therapist in the Greenville CareNet office.

Each aspect of my education, ministerial experience, and therapeutic training and experience has contributed to my preparation to conduct the proposed study. Not only can I empathize and understand the life of one who ministers, I am also capable of being an objective observer and analyzing responses provided. Even though I am a licensed Marriage and Family Therapist, I am self-aware and understand that I have assumptions and biases. I know, too, that my role as a researcher calls for me to utilize different skills. I continuously engage in reflexivity and efforts to "bracket" my experiences, theories, beliefs, assumptions, and biases.

Researcher's Biases

I believe in a loving God who desires to be in relationship with men and women. As a higher power, God "calls" some people such as clergy or ministers into special areas of service for Him. These individuals serve in a capacity wherein they help bring others into a closer

relationship with Him. It is my assumption that these individuals serve as clergy because of their beliefs in God, which is called "faith," as well as their desire to help others.

There are many venues in which clergy members serve in the ministry. Although serving as the leader of a church, or pastor, is often perceived as a major calling for a clergy member, I recognize there are multiple places where the work of clergy can occur; among these places is a hospital, wherein an individual can serve as a chaplain. Hospital chaplains specialize in providing spiritual care to individuals within medical settings. Care can be provided to patients, the family members of patients, as well as hospital staff members. I assume that hospital chaplains experience stress as a result of their work, as they often are called upon to minister to those in trauma and crisis. I assume that hospital chaplains know their job descriptions. While I recognize that serving as a hospital chaplain can be stressful, I also assume that the role can be pleasant, satisfying, and fulfilling.

It is my assumption that hospital chaplains may believe that helping others is a high and noble calling, and one that makes all the demands and pressures encountered of little or no consequence. My belief that individuals are created with purpose helps to serve as the foundation for this assumption. It is thus assumed that persons who serve as chaplains are not only operating according to and within their divine calling, but they are serving as extensions of the Divine, operating on earth but transcending the realm of the natural to connect with that which is spiritual. Attending to the spiritual needs of another would be a normal expression of one's faith and calling. I realize my own beliefs about meeting the spiritual needs of another could cause me to apply my own beliefs, experiences, and assumptions to the responses of both chaplains and healthcare staff and personnel participating in the study. To the best of my ability, I will keep my beliefs about hospital chaplaincy and the role of spirituality from influencing my

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interpretations and findings. It is also hoped that this research will provide information about the current culture and climate that exists in the hospital environment around spirituality and hospital chaplaincy services.

I am aware that I expect hospital chaplains to have near-daily opportunities to provide spiritual care and support to hospital-based healthcare providers. I believe many of those who work within medical settings have chosen to do so because of their desire to improve the lives of others, primarily by helping to meet their physical or medical needs. Because of this desire, I assume these providers will be more open to having their own needs met, thereby enabling hospital chaplains to have opportunities for meeting their spiritual needs. I also believe individuals who have their spiritual needs met find life to be more enjoyable. Thus, I assume hospital-based providers will be positively impacted by having their spiritual needs met by hospital chaplains.

Interview Protocol

INTERVIEW GUIDE FOR CHAPLAINS

Over the next few minutes I will be asking you about your experience as a hospital chaplain when providing spiritual support to hospital providers for personal and professional reasons. The literature includes several studies detailing the support hospital chaplains extend to patients but nothing has been done detailing the work that you do to support spiritually the healthcare providers employed at this hospital. Please know I do not want you to feel pressured to answer any question. If at any time I ask something you prefer not to answer, just tell me you do not want to reply and I will move to the next question. Do you have any questions before we begin?

Overarching Question:

What has been your experience providing spiritual support to the providers of this healthcare system?

Sub Questions:

1. Please describe the current culture and climate in the hospital around spirituality and employees accessing chaplaincy services for spiritual support.

2. On a typical day, what types of personal scenarios might lead employees of this hospital to interact with you about a spiritual care or concern?

3. What do you think has been the impact of this work with healthcare providers and other hospital-based employees?

4. What have been some of the more impressionable moments without revealing the identity of the person you supported?

5. How were you made aware of the person(s)' need?

6. Is there anything that I did not ask you about related to your care of the hospital employee that you think is relevant to this study?

INTERVIEW GUIDE FOR INTERDISCIPLINARY CARE TEAM MEMBERS

AND SUPPORT STAFF

Over the next few minutes I will be asking you about any experience you may have had working with a hospital chaplain. I would ask that you be comfortable and share your thoughts with me. Please know I do not want you to feel pressure to answer any question. If at any time I ask something you prefer not to answer, just tell me you do not want to reply and I will move to the next question. Do you have any questions before we begin?

Overarching Question:

What has been your experience receiving spiritual support from the hospital chaplaincy service?

Sub questions:

1. Please describe the current culture and climate in the hospital around spirituality and employees accessing chaplaincy services for spiritual support.

2. On a typical day, what types of personal scenarios might lead employees of this hospital to interact with hospital chaplains about a spiritual care or concern?

3. What do you think has been the impact of this work with healthcare providers and other hospital-based employees?

4. If you have ever sought spiritual care from a hospital chaplain for your own personal need, please describe your experience.

5. What do you think was the impact of the hospital chaplain's work on your well-being?

6. How was the chaplain made aware of your need?

7. Is there anything that I did not ask you about related to your experience with one or more of the hospital chaplains that you think is relevant to this study?

APPENDIX C

Informational email for Hospital Chaplains

Dear Hospital Chaplain:

I am inviting all chaplains employed by University Health Systems in Greenville, NC, to participate in a research study which will examine spiritual care hospital chaplains provide to hospital-based healthcare providers. Your participation in this study will greatly add to my research and help me better understand how hospital chaplains not only care for patients but also hospital employees.

All responses will be strictly confidential and will be reported in a manner that protects identity. Participation in this study is voluntary and should take no longer than 60 minutes to complete. There is no payment or direct benefits provided to you for your participation in this study. However, your responses will contribute to existing knowledge and advance current literature. Information will be used by the researcher in her dissertation. There are no perceived risks for participating in this study; and, you can decide to end your participation at any time without any negative effect on yourself and/or your job. I will be contacting you by phone within the next week to discuss this opportunity with you.

If you have any questions about this study, please contact Janie Taylor, MS, LMFT, principal investigator, at Taylorj94@students.ecu.edu or (252) 714-0612; or Jennifer Hodgson, PhD, LMFT, research supervisor, Hodgsonj@ecu.edu or (252) 328-1349. If you have questions about your rights as a research subject, you are encouraged to contact Norma Epley, Administrative Director, OHRI, (252) 744-1971.

Thank you for your participation,

Janie Taylor, MS, LMFT
Primary Investigator

 Jennifer Hodgson, PhD, LMFT
Research Supervisor

Informational Sheet for Hospital-based Healthcare Providers

HAS A HOSPITAL CHAPLAIN EVER OFFERED YOU SUPPORT OR MET A SPIRITUAL NEED?

If so, are you willing to help advance research findings in the area of spirituality and healthcare? Contact Janie Jones Taylor, MS, principal investigator, for
The Shared Experience of Personalized Spiritual Care Services Between Hospital Chaplains and Hospital-Based Healthcare Providers Study.
Completion of a short demographic survey and a brief 60-minute interview is **all** that is requested of providers.

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PRINCIPAL INVESTIGATOR: Janie Taylor, MS, LMFT, Doctoral Candidate
East Carolina University
(252) 714-0612
Taylorj94@students.ecu.edu

RESEARCH SUPERVISOR: Jennifer Hodgson, PhD, LMFT
East Carolina University
(252) 328-1349
Hodgsonj@ecu.edu

Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research: The Shared Experience of Personalized Spiritual Care Services Between
Hospital Chaplains and Hospital-based Healthcare Providers
Principal Investigator: Janie Taylor, MS, LMFT, Doctoral Candidate, East Carolina University
Research Supervisor: Jennifer Hodgson, PhD, LMFT, East Carolina University
Institution/Department or Division: Department of Child Development & Family Relations
Address: 130 Rivers Building, Greenville, NC 27858
Telephone: (252) 714-0612

Why is this research being done?
The purpose of this research is to describe hospital-based healthcare providers' experiences of
being a recipient of spiritual care from a hospital chaplain and hospital chaplains' experiences
providing spiritual care to hospital-based healthcare providers. There is no known research on
the possible benefits of spiritual care provision to healthcare providers. No known research
exists either on how spiritual care provision might impact a provider's ability to work within his
or her respective job environment. It is believed that by interviewing both hospital chaplains and
hospital-based healthcare providers' insight can be gained into the providers' and chaplains'
experiences of the care received and the impact of that care.

Why am I being invited to take part in this research?
You are being invited to take part in this research because you are a Pitt County Memorial
Hospital (PCMH) hospital chaplain or staff member who has indicated that you have provided or
have received spiritual care in your role as a hospital chaplain or a hospital-based healthcare
provider. The decision to participate in this research is voluntary.

Are there reasons I should not take part in this research?
I understand I should not volunteer for this study if I am under 18 years of age, am no longer
employed by PCMH, or if I am unable to fluently communicate and read in English.

What other choices do I have if I do not take part in this research?
Participation in this research is voluntary, and you can decide not to participate at any time.
Your feedback on spiritual care extended or received by hospital chaplains while at work is of
value to this study. We also welcome suggestions and concerns regardless of your decision to
participate in this research.

Where is the research going to take place and how long will it last?
The research will take place in a confidential location convenient to you and accessible by the
researcher. The interview will take no more than 60 minutes.

What will I be asked to do?
You are being asked to participate in an interview which will last no more than 60 minutes. The researcher will contact you to schedule the interview at a time that is convenient to you. At any time, you may refuse to answer any question, or if you choose, withdraw from the study. Your responses will be audio-taped and notes will be recorded by the interviewer. Records will be destroyed (via shredding) after three years for paper documents and any audiotapes will be erased and destroyed after three years. No identifying information will be used in the research. Every effort will be made so there is no direct link between you and your recorded experience or between a recorded experience and those individuals described in it.

What possible harms or discomforts might I experience if I take place in the research?
There are minimal risks to you by taking part in this study. However, questions about a spiritual care interaction you had at work may upset you. This is considered an indirect risk, and should this or any other situation occur, you will be provided with a list of therapists available in your area.

What are the possible benefits I may experience I may experience from taking part in this research?
If you take part in this study, there may be no immediate, direct benefit to you. However, by your taking part in this study, the researcher hopes to learn more about your experience as a hospital chaplain or receiving care from a hospital chaplain. Results of this study may lead to further research and/or policies that may enhance your job satisfaction as a hospital-based healthcare team member and hospital chaplain employed within a hospital setting.

Will I be paid for taking part in this research?
We will not be able to pay you for the time you volunteer to be in this study.

What will it cost me to take part in this research?
There are no monetary costs to you associated with taking part in this study.

Who will know that I took part in this research and learn personal information about me?
Every attempt will be made to maintain your confidentiality during and after the study. As part of maintaining confidentiality, you will be identified by a non-related number and false name. All information will be held confidential. Your actual name and other identifying information will not be used in connection with any data reported from this study. Your actual name will also never be used in any presentation or publications of the study results.

How will you keep the information collected about me secure? How long will you keep it?
The information you provide will be kept for three years after the study is completed. The information will be kept in a secure area (i.e., locked filing cabinet) and maintained by the investigator or the investigator's faculty supervisor.

What if I decide I do not want to continue in this research?
If at any time you do not wish to continue in the study, for whatever reason, you may withdraw. You do not have to give a reason for no longer continuing in the study. If you withdraw from the study, it will not impact your employment.

Who should I contact if I have questions?

The people conducting this study will be available to answer any question concerning this research, now or in the future. You may contact the Principal Investigator, Janie Taylor, at (252)714-0612.

If at any time during the course of this study I feel I have been inadequately informed of the risks, benefits, or that I have been encouraged to continue in this study beyond my wish to do so, I can contact Dr. Jennifer Hodgson, Dissertation Committee Chair and Research Supervisor, at (252)328-1349.

If you have questions about your rights as someone taking part in research, you may call the OHRI at phone number (252)744-2914 (days, 8:00 a.m.-5:00 p.m.). If you would like to report a complaint or concern about this research study, you may call the OHRI Administrative Director, Norma Epley, at (252)744-1971.

Neither the Principal Investigator, any individual assisting in the research, nor their family members have conflicting interests associated with this research.

I have decided I want to take part in this research. What should I do now?

The person obtaining informed consent will ask you to read the following and if you agree, you should sign this form:

- I have read (or had read to me) all of the above information.

- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.

- I know I can stop taking part in this study at any time.

- By signing this informed consent form, I am not giving up any of my rights.

- I have been given a copy of this consent document, and it is mine to keep.

_____   _____
Participant's Name (PRINT)   **Signature**   **Date**

Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person's questions about the research.

_____
Person Obtaining Consent (**PRINT**)   **Signature**   **Date**

_____
Principal Investigator   (PRINT)   **Signature**   **Date**

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Demographic Questionnaire for Chaplains

Participant #: ___ ___ ___ ___ ___

 Date: ___ ___ / ___ ___ / ___ ___ ___ ___

What is your date of birth?

___ ___ / ___ ___ / ___ ___ ___ ___

What is your age? _____

What is your gender?

    Male

    Female

Which of the following languages can you speak and read fluently?

    English

    Spanish

    Chinese

    French

    Urdu

    Others (please explain)

    _____

What is your current marital status?

    Divorced
    Living with another
    Married
    Separated
    Single (nor married)
    Widowed
    Would rather not say

How many years have you worked in the medical field?

    < 1

    2-5

    5-10

    10-15

    15-20

    > 20

How many years have you worked at your current location?

    < 1

    2-5

    5-10

    10-15

    15-20

    > 20

What best describes your current employment status?

    Full-time (>32 hrs/week)

    Part-time (<32 hrs/week)

    Practicum/Intern Student

What best describes your position at the

medical center? Check all that apply.

Staff Chaplain

Chaplain Resident

Chaplain Intern

How would you classify yourself?

African-American/Black

Asian/Pacific Islander

Caucasian/White

Hispanic

Latino

Multi-racial

Would rather not say

Other (please explain) _____

Demographic Questionnaire for Hospital-based Healthcare Providers

Participant #: ___ ___ ___ ___ ___

 Date: ___ ___ / ___ ___ / ___ ___ ___ ___

What is your date of birth?

 ___ ___ / ___ ___ / ___ ___ ___ ___

What is your age? _____

What is your gender?

    Male

    Female

Which of the following languages can you speak and read fluently?

    English
    Spanish
    Chinese
    French
    Urdu
    Others (please explain)
    _____

What is your current marital status?

    Divorced
    Living with another
    Married
    Separated
    Single (not married)
    Widowed
    Would rather not say

How many years have you worked in the medical field?

    < 1
    2-5
    5-10
    10-15
    15-20
    > 20

How many years have you worked at your current location?

    < 1
    2-5
    5-10
    10-15
    15-20
    > 20

What best describes your current employment status?

    Full-time (>32 hrs/week)

    Part-time (<32 hrs/week)

    Practicum/Intern Student

What best describes your position at the medical center? Check all that apply.

Administration

Nursing Assistant/LPN

Registered Nurse

Nurse practitioner

Physician's Assistant

Physician

Resident Physician (year _____)

Behavioral Health Provider

Substance Abuse Specialist

Other

How would you classify yourself?

African-American/Black

Asian/Pacific Islander

Caucasian/White

Hispanic

Latino

Multi-racial

Would rather not say

Other (please explain)

_____

Which of the following languages can you speak and read fluently?

English

Spanish

Chinese

French

Urdu

Other _____

What is your current marital status?

Divorced

Living with another

Married

Separated

Single (not married)

Widowed

Would rather not say

How many years have you worked in the medical field?

< 1

2-5

5-10

10-15

15-20

> 20

How many years have you worked at your current location?

< 1

2-5

5-10

10-15

15-20

> 20

What best describes your current employment status?

Full-time (>32 hrs/week)

Part-time (<32 hrs/week)

Practicum/Intern Student

APPENDIX H

Institutional Review Board Approval Form

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
1L-09 Brody Medical Sciences Building• 600 Moye Boulevard • Greenville, NC 27834
Office **252-744-2914** • Fax **252-744-2284** • www.ecu.edu/irb

TO: Janie Jones Taylor, MS. LMFT, Doctoral Candidate, Dept. of CDFR, College of Human Ecology, ECU

FROM: UMCIRB

DATE: August 24, 2011

RE: Expedited Category Research Study

TITLE: "The Shared Experiences of Personalized Spiritual Care Services Between Hospital Chaplains and Hospital-Based Healthcare Providers Study"

UMCIRB #11-0517

This research study has undergone review and approval using expedited review on 8.18.11. This research study is eligible for review under an expedited category number 6 & 7 which include collection of data from voice, video, digital, or image recordings made for research purposes and it is also a research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)2) and (b)(3). This listing refers only to research that is not exempt.)
The Chairperson (or designee) deemed this **unfunded** study **no more than minimal risk** requiring a continuing review in **12 months**. Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a continuing review/closure application to the UMCIRB prior to the date of study expiration. The investigator must adhere to all reporting requirements for this study.

The above referenced research study has been given approval for the period of **8.18.11** to **8.17.12**. The approval includes the following items:
- Internal Processing Form (dated 8.15.11) (received 8.24.11)
- COI Disclosure Form (dated 8.15.11)
- Informed Consent (received 8.18.11)
- Interview Guide for Chaplains
- Interview Guide for Hospital-Based Healthcare Providers
- Informational email for Hospital Chaplains
- Demographic Information: Chaplains & Hospital Based healthcare Providers
- Letter of Support (dated 8.12.11)

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

The UMCIRB applies 45 CFR 46, Subparts A-D, to all research reviewed by the UMCIRB regardless of the funding source. 21 CFR 50 and 21 CFR 56 are applied to all research studies under the Food and Drug Administration regulation. The UMCIRB follows applicable International Conference on Harmonisation Good Clinical Practice guidelines.

IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418
IRB00003781 East Carolina U IRB #2 (Behavioral SS) IORC0000-18
IRB00004973 East Carolina U IRB #4 (Behavioral SS Summer) IORG0000418
Version 3-507

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