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When and why patients and families reject chaplains: challenges, strategies and solutions

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ABSTRACT

Hospital chaplains perform important activities, but critical questions arise about the challenges they may face in working with patients, and how these professionals respond. Thirty-three telephone interviews of approximately 1 hour and were conducted with 21 board-certified chaplains. When asked about their biggest challenges and most rewarding interactions, several chaplains described rejections by patients or families. Patients and families at times rejected chaplains, and did so for six broad types of reasons – not wanting to discuss the disease due to conflicted feelings, including anger or frustration at the patient, the cosmos or God; or wanting to minimize it; wanting a chaplain of their own faith; or of a particular gender or other characteristic; being atheist or wary of religion; or misunderstanding what chaplains do. Patients at times also disagreed with family members about whether to reject a chaplain. Chaplains responded variously: feeling transitory hurt (which generally decreases with experience); respecting patients' autonomy and leaving; exploring reasons for rejection; and revisiting later and often then making helpful connections. These data have important implications for future practice, education and research regarding chaplains and other providers – suggesting, for example, how patients' families and the public might benefit from increased understanding about the field.

KEYWORDS

Chaplains; coping; provider-patient communication; religion; spirituality

Background

Hospital chaplains perform a range of important activities, but often feel marginalized and experience challenges. Several recent studies have examined the activities chaplains perform, noting the importance and impact of religion and spiritual issues for patients and families, especially in palliative and end-of-life care, and chaplain care for staff (Fitchett, 2017; Handzo et al., 2008). Chaplains serve several vital roles and functions in interacting with patients. In palliative care ICUs, for instance, the main chaplaincy activities and interventions include active listening, demonstrating care and concern, providing pastoral presence, preserving dignity and respect, providing emotional support, establishing relationships, demonstrating acceptance, collaborating with the team, and building rapport and connectedness (Massey et al., 2015).

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Yet research has shown that physicians and other types of healthcare providers, in communicating and interacting with patients, face a wide range of challenges and uncertainties (Kenny et al., 2010; Matusitz & Spear, 2014). Challenges in doctor-patient communication, for instance, have received much attention in training and afterwards (Fox, 1980; Helitzer et al., 2011).

The published literature has mentioned a few challenges faced by chaplains, particularly barriers from institutions, doctors, nurses, patients and chaplaincy itself (Best et al., 2020). But chaplains may also face certain types of challenges that physicians might not. In part, the religious and spiritual landscape in the U.S. is rapidly changing, with shifting attitudes, views and practices. Several religious institutions have faced scandals in recent years, with revelations about abuse to various people, especially children (Otterman & Rivera, 2021; Stack, 2021). Growing proportions of Americans are unaffiliated with any religious tradition and, when asked about their religious affiliation, indicate “None of the above,” and have hence been dubbed “Nones” (Hayward et al., 2016; Pew Research Center for Religion and Public Life, 2014). Religious and spiritual issues have recently also become highly politicized and often controversial (World Health Organization, 2022; Zagano, 2022), with the rise of evangelicals on the one hand and atheists on the other, with best-selling books with titles such as *The God Delusion* (Dawkins, 2006) and *Why God is Not Great* (Hitchens, 2007). Patients and families may be thus wary of religion, and hence of chaplains.

Partly in response to these changes, chaplaincy has shifted, becoming more interdenominational, and focusing on broader issues of spirituality, not just religion alone *per se*. But many critical questions remain regarding whether chaplains nonetheless confront challenges in their day-to-day work regarding these or other issues, and if so, what and when, and how these professionals respond – e.g., what chaplains actually say to patient when challenges arise, and how they decide, and react to these challenges, and may change in doing so over time.

A recent semi-structured qualitative interview study of chaplains hence asked chaplains what the biggest challenges as well as the most rewarding interactions they have faced have been. Several interviewees replied by describing their experiences of being rejected by patients and/or families, and having to decide how then to respond and proceed. The semi-structured nature of this study allowed for further exploration of issues regarding these phenomena, several notable aspects of which are presented below. Key themes surfaced regarding what these professionals do when a patient or family does not want to see them, how chaplains and patients address and navigate possible tensions that may be involved, how these interactions play out, and what factors might be entailed.

Methods

Thirty-three telephone interviews of approximately 1 hour each were conducted with 21 board-certified chaplains. As seen on Table 1, 12 were men and 9 were women; 81.0% were Caucasian, 14.3% were African American and 4.8% were Latino; the mean age was 63 (range 42–72); They were from throughout the United States, and represented

Table 1. Characteristics of sample.

Variable:	Number:	Percentile:
Gender:		
Male	12	57.1%
Female	9	42.9%
Race & Ethnicity:		
Caucasian	17	81.0%
African American	3	14.3%
Latino	1	4.8%
Age:		
Range	42–75	years
Mean	63	years
Geographic Region:		
Northeast	10	47.6%
Midwest	4	19.0%
Southeast	3	14.3%
Southwest	3	14.3%
West	1	4.8%
Religion:		
Protestant	6	28.6%
Catholic	4	19.0%
Christian, not otherwise specified	6	28.6%
Jewish	2	9.5%
Muslim	2	9.5%
Buddhist	1	4.8%
Highest Degree Held:		
Master's	8	38.1%
Doctorate	5	23.8%
Bachelor	1	4.8%
Associate	1	4.8%
Unknown	6	28.6%
Years Practiced as Chaplain:		
Range	3–30	years
Mean	18.8	years
Percentage Board Certified:	20	95.2%

diverse religions; 38.1% had Masters degrees and 23.8% had doctorates; 95.2% were Board Certified; and they had practiced for a mean of 18.8 years (range 3–30).

Additional informational conversations were held, as background, with 15 chaplains and 12 physicians regarding these issues, to help inform the 33 formal interviews with chaplains. Qualitative methods were chosen because these can best elicit the full range and typologies of attitudes, interactions and practices involved, and can inform subsequent quantitative studies. From a theoretical standpoint, Geertz (1973) has advocated studying aspects of individuals' lives, decisions, and social situations not by imposing theoretical structures, but by trying to understand these individuals' own experiences and perspectives drawing on their own words to obtain a "thick description."

Participants

The chaplains were recruited through the listservs of the Association of Professional Chaplains and through word of mouth. Chaplains who were interested in participating contacted the Principal Investigator (PI) by email. Participants were from across the U.S. Interviews were conducted until "saturation" was reached (i.e., "the point at which no new information of themes are observed in the data" (Guest et al., 2006). The

Table 2. Semi-structured interview questionnaire: sample questions.

-
- What kind of work do you now do as a chaplain?
 - What have been your most rewarding experiences/cases you have had as a chaplain?
 - What were the most difficult experiences/cases you have had as a chaplain? How did you address them?
 - What are the biggest challenges you have faced as a chaplain? How have you viewed and addressed these issues?
 - What additional thoughts do you have about these issues?
-

Columbia University Department of Psychiatry Institutional Review Board approved the study.

Instruments

The semi-structured interview questionnaire was drafted, drawing on the prior literature on chaplains. Questions explored chaplains' views, experiences, and decisions. The PI conducted all the interviews. Sample questions, asked of all participants, appear in Table 2.

Data analysis

The methods for the present study adapted key elements from “grounded theory” (Corbin & Strauss, 2008), and were thus informed by techniques of “constant comparison,” with data from different contexts compared for similarities and differences, to see if they suggest hypotheses. This technique generates new analytic categories and questions, and checks them for reasonableness.

Interviews were audio-recorded. Transcriptions and initial analyses of interviews occurred during the period in which the interviews were being conducted, helping to shape subsequent interviews. Once the full set of interviews was completed, subsequent analyses were conducted in two phases, primarily by trained research assistants (RAs) and the PI. In phase I, each independently examined a subset of interviews to assess factors that shaped participants' experiences, identifying categories of recurrent themes and issues that were subsequently given codes. The PI and RAs read each interview, systematically coding blocks of text to assign “core” codes or categories (e.g., instances of rejection or other types of interactions chaplains have).

While reading the interviews, a topic name (or code) was inserted beside each excerpt of the interview to indicate the themes being discussed. The PI and RAs then worked together to reconcile these independently developed coding schemes into a single scheme. Next, a coding manual was prepared, defining each code and examining areas of disagreement until reaching consensus. New themes that did not fit into the original coding framework were discussed, and modifications made in the manual, adding these themes, or sub-dividing existing codes, as deemed appropriate.

In phase II of the analysis, the PI and RAs independently content-analyzed the data to identify the principal subcategories, and ranges of variation within each of the core codes. They reconciled the sub-themes identified by each coder into a single set of “secondary” codes and an elaborated set of core codes. These codes assessed subcategories and other situational and social factors (e.g., specific types or causes of rejection,

such as different religious faiths or being too emotionally upset to talk to anyone at that moment and chaplains' subsequent responses).

Codes and sub-codes were then used in analysis of all of the interviews. To ensure coding reliability, two coders analyzed all interviews. Where necessary, multiple codes were used. Similarities and differences were assessed among participants, examining categories that emerged, ranges of variation within categories, and variables that may be involved. Areas of disagreement were examined through closer analysis until consensus was reached. Consistency and accuracy in ratings was checked regularly by comparing earlier and later coded excerpts. The themes that emerged in the data are illustrated below by excerpts from the interviews.

Results

In brief, as shown in Figure 1, and described below, patients and families at times reject chaplains, and do so for six broad types of reasons – because of not wanting to discuss the disease due to anger or frustration at the patient, the cosmos or God; or wanting to minimize the disease; wanting a chaplain of their own faith; or a particular gender or other characteristic; being atheist or wary of religion; or misunderstanding what chaplains do. Rejections may come from patients and/or families. Chaplains respond variously: feeling transitory hurt (which generally decreases with professional experience); respecting patients' autonomy and leaving gingerly; exploring reasons for the patient's or family's rejection; and trying to revisit another time and often then making helpful connections. Examples of each type of rejection are presented below, along with how chaplains responded.

Reasons for rejections

Not wanting to discuss the situation due to anger at the patient, god or the cosmos

Certain patients and families do not wish to speak to a chaplain about the medical situation they confront because they are angry at the ill family member, the

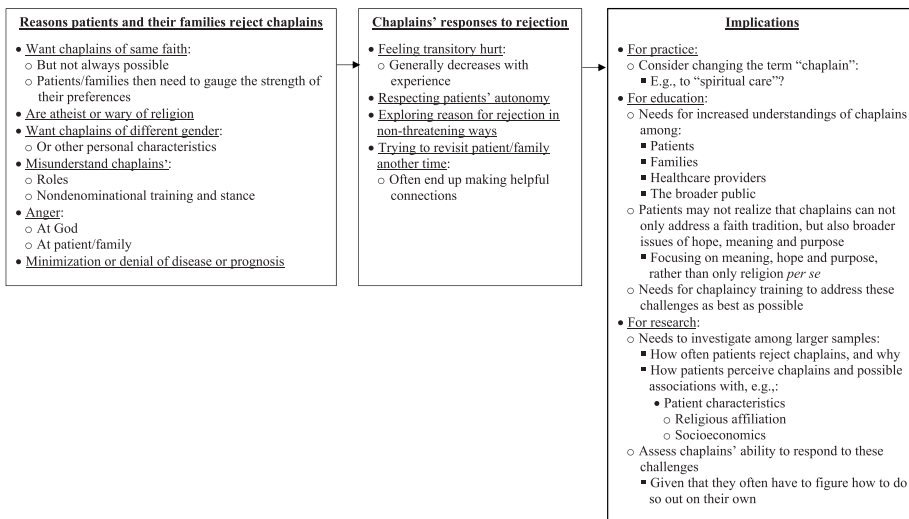


Figure 1. Themes concerning patients' rejections of chaplains.

cosmos, the universe and/or God. Such patients and families may be emotionally upset and have conflicting feelings and difficulty understanding how disease and misfortune can fit into their notion of a benevolent God. Patients or family may be frustrated, at both the disease and the larger cosmos, but are not ready to probe these feelings and underlying tensions, and may direct rage at others, such as the chaplain. As one chaplain said, “At times, patients are really angry about life and feel: ‘I don’t want to talk about it. Why are you bringing this crap into my life?’” [Chaplain #10]. As another chaplain reported,

Several families have told me, ‘Get out of my room! Get out of my sight! There is no God to me. A God who would let my child die is no God to me!’ Sometimes, there’s no language at all. Just un-engagement. We respect that and step out. We continue to remain available for the staff. [Chaplain #17]

Other patients and their families are angry or deeply ambivalent regarding an ill relative, and may not want to probe these feelings or the situation. As another chaplain said,

A lot of my best visits started with, ‘I don’t need no goddam fucking chaplain!’ One woman, the sister of a man who died, recently told me that, and I said, ‘That’s fine. I can leave if you want. I’ll be glad to, but I’d like to just be here with you, since you’ve been by yourself and your brother has just died.’ She said, ‘I hated that fucking idiot!’ I replied, ‘Wow. You’ve got a lot of strong feelings. Tell me about that.’ She said, ‘He abused me. I’m *glad* he’s dead.’ She was hinting: ‘and now you can leave.’ I said, ‘I’m so sorry that happened to you. It sounds like you’re relieved.’ She said, ‘Yes, I’m fucking relieved!’ I said, ‘I can see why.’ She was rough around the edges, tattooed, and used to offending people, kicking them out. But in the end, we made a beautiful connection. She wasn’t redeemed, but let me in and began to integrate who she was in front of me, saying, ‘I’m glad you’re here.’ [Chaplain #16]

Chaplains can thus find such an interaction initially challenging, but ultimately rewarding, since they can draw on their interpersonal training and skills, discerning and addressing the individual’s underlying feelings, which may be conflicted (e.g., “relieved”), and thus aid the person.

Not wanting to discuss the disease in order to minimize it

Relatedly, patients and families at times do not wish to see a chaplain because they want to minimize the extent of the disease, and resist efforts to see it otherwise. When asked, “What have been the hardest or most challenging cases you have had?” one hospital chaplain replied,

An Orthodox Jewish woman had a son turn completely yellow because of jaundice. I asked her, ‘How is everything?’ She said, ‘We’re *fine!*’ [with a definite snap to abruptly end the conversation]. ‘How is your son doing?’ ‘He’ll be *fine!*’ I asked my supervisor what to do. She said, ‘The mother’s not ready yet. When she’s ready, she’ll let us know, and we will be there for her.’ Patients might benefit from talking to us, but not yet want or feel ready to do so. [Chaplain #24]

Chaplains then need to know how to proceed.

Rejecting a chaplain because patients or families want one of their own faith

Other patients and families request or prefer a chaplain of their own faith. Patients and families clearly have important rights to such preferences that these professionals generally strive to respect. Chaplains who get rejected because of their particular faith may readily be able to arrange for a colleague to visit instead.

If a Jewish patient says, 'I only want a Jew,' or 'I only want a rabbi,' I tell them I'm Jewish, which usually lowers their guard. Some Christian families really only want a Christian chaplain. I found myself getting rejected. I then refer them to a Christian colleague. [Chaplain #9]

Yet, especially outside of usual hospital hours, such as in middle of the night, visits from a chaplain of another faith may not be possible. Chaplains on call must thus determine how best to respond to such requests, since colleagues of other faiths are ordinarily unavailable then. In addressing such situations, chaplains may adjust their practice over time, trying to present themselves in various ways that patients might accept, rather than dismiss. Chaplains may, for example, carefully explain up front that they are the only chaplains currently available, and give families the option of seeing another colleague on another day.

I've changed my practice for when a family says in the middle of the night that they want a Baptist or Pentecostal chaplain, and I'm the only one in the hospital. I now introduce myself and say, 'I know you're asking for a Baptist chaplain, and I'm Jewish. But I'm the only one here right now. I want to see if I could still help. If I can't, I'll see whomever I can track down someone else tonight, but I don't know if anybody will be available. I can try to get someone here in the morning.' I almost reject myself, and give them full license to do so. I am not pretending, intruding or asserting myself. I have found that they then welcome me in. Their guard really only goes up when there's vagueness and ambiguity. I'm clear about the difference from the very start, respecting the family's boundary, and presume that they won't want my care. Since I've made that change, I've never been turned away! In those situations, families really don't care that much about the boundaries in the ways they usually do. Not that they don't care about them at all, but they are open – more permeable than usual. [Chaplain #9]

As this chaplain suggests, patients may vary in the strength of their preferences – the degrees to which they would prefer to see a chaplain of a different faith, rather than no chaplain at all at that particular point.

Patients and families may, however, have preferences regarding not just a particular major religious tradition, but a specific approach within a faith tradition in ways that chaplains may not be able, or want to accommodate. A chaplain rejected by a patient on such grounds may then try to reframe the issue to seek common ground. One chaplain was told by a trainee, "I can't go see this patient. She wants a born-again Christian." This chaplain responded,

'Let's talk about *born again*. Are you going to let one group of people define that for you?' The trainee automatically assumed what the patient meant. I said, 'In some ways, we're *all* born again every day – sleep is a form of death. Instead of assuming you know what she means by *born again*, get more comfortable with language like that. She's trying to figure out if you're safe: Are you going to judge me? Are you in my tribe? Will you respect my values?' [Chaplain #13]

This chaplain thus encouraged the trainee to first explore and address the patient's underlying concerns.

Rejecting chaplains because of atheism or wariness of religion

Other patients and families may reject a chaplain because they are atheists and suspicious of religion in general. Chaplains might nonetheless then seek to engage such a patient by discussing these views, expressing their own past or present religious doubts.

If someone says, 'I don't believe in God,' I say, '*Tell me about the God you don't believe in.* Half the time, I wouldn't believe in that God anyway; so, what's the matter?' I love working with people who say they're 'atheist,' because they're the most reflective, interesting people. Somebody will say, 'I don't mean to upset you, but I'm an atheist.' I say, 'Atheists have often given a lot of thought to their faith, and what they don't believe in. Would you tell me about it? I'd be interested.' [Chaplain #16]

Atheists themselves vary in their degrees of wariness or hostility toward religion, and chaplains, when faced with such rejection, often seek to understand and engage the patient's underlying beliefs, to ascertain why – what negative interactions with religion may have occurred.

Religion is not always a good thing for people. A lot of people have been abused in religion, temples and churches. Not only physically or sexually, but psychologically and spiritually. So, people might be very scared or put off by a chaplain, or think, 'Thanks but no thanks.' [Chaplain #7]

Rejecting chaplains because of their gender or other characteristics

Chaplains may also face rejection because of their gender. One male patient was wary of a female chaplain, for example, because he didn't accept female clergy. As this female chaplain reported,

I remember one very good visit. I went in, and this guy said, 'What's a chaplain?' I said, 'It's kind of like a minister who works in a hospital with a lot of patients. He said, 'Well, I don't believe women can be ministers.' He was an African-American pastor in the African Methodist Episcopal Church, and said, 'You can't tell me what to believe.' I'm a white woman and he was African-American man. Perhaps white people have imposed their views on him and disrespected him, and he felt that I might do that. I said, 'It sounds like you have a lot of strong opinions.' He said, 'I do.' I said, 'I'm always interested in what people believe. Tell me about those strong beliefs.' He said he was 'very conservative.' I said, 'What was that like, growing up? How did you learn about that?' I just let him talk. His tradition did not believe in ordaining women. He didn't want me to try to convince him that women could be ministers. But he got so engaged with his story that it didn't matter anymore. He felt like I cared about him. And I *did* care about him. I was really curious about his story. [Chaplain #16]

Chaplains thus can work to counteract biases by engaging patients, even about such wariness, hesitancy, or opposition.

Rejection because of misunderstandings of what chaplains do

A patient or family can also decline to see chaplains because of misunderstandings about these professionals' roles, functions or identity – the fact that contemporary

chaplains take non-denominational approaches and address broader issues of meaning, purpose and hope, rather than necessarily focusing on religion *per se*. Many patients at first reject a chaplain, seeing the role as strictly religious *per se*.

Sometimes it's difficult to get in the door because patients or families have some preconceived notion that a chaplain is only going to want to talk about religious God things... Once you get in, as long as you honor that person, and his or her wishes, it's fine, because we all wrestle with what suffering means, what our life has meant, and whether we have lived to its purpose. [Chaplain #13]

Other patients and families may fear that a chaplain will somehow judge them or their religious practices or beliefs. As another chaplain reported,

When I was a brand-new chaplain and went into the room and said, 'Hi, I'm your chaplain today,' people automatically felt judged. They'd say, 'Oh, we go to church!' as if I were going to preach to them about Jesus. My guess is that they thought they weren't being good Christians and I was there to just that. So, I'd say, 'Good.' I never ask people where they do to church. It doesn't matter. [Chaplain #17]

Rejection by whom: patients and/or families

A patient may also disagree with his or her family about whether to accept or refuse a chaplain's visit and may then argue or discuss the possibility. Patients may initially decline to see a chaplain, but then be persuaded otherwise by family members. As another chaplain reported,

Yesterday, I knocked on a patient's curtain, introduced myself and said: 'I'm from the chaplaincy department.' An older gentleman was lying in bed, staring at the ceiling and said, 'No, thank you. We don't need you.' But his wife said to him, 'Come on! Why not? What's the harm?' He reluctantly agreed. I moved to his bedside and said, 'I give you good wishes: 'Oh God, please give the anesthesiologist, surgeon and recovery room nurses the guidance, good skill and judgement today. Especially if they face difficult issues, give them all the skill and good judgment you can so that they help [this man] get better. We hope that he gets the best care, which he deserves. Let today be a new beginning for him, filled with hope and joy.' He grabbed my hand. 'YES, Sister! I was just thinking about that this morning. Thank you for coming today!' He looked me in the eye and said, 'THANK YOU,' emphasizing each syllable, giving it added weight. 'YES!! YES!! God Bless you.'

This chaplain was thus able to aid him, despite his initial misgivings.

Chaplains' responses to rejection

In their responses to rejection, chaplains clearly vary. Especially initially in their careers, they may find such rebuffs personally unsettling. "I don't often get refused," one chaplain explained, "but when I do, my tail's between my legs – it hurts my pride." [Chaplain #7].

Gradually, over time, however, these professionals tend to develop more confidence, skills and abilities to respond more effectively. Chaplains learn, for instance, how to avoid challenging or confronting the individual at the time, but rather to acquiesce at the moment and return another day.

Seven or ten years ago, I would have taken it personally. When patients said, 'I'm spiritual, but not religious,' I felt a little more insecure. But I don't now. One guy told me, 'Just go

away.’ But I always go back to that person. The next day, he said, ‘I told you: No!’ I said, ‘I know. I’m only going to take 30 seconds of your time to thank you so much for not wasting my time. That was perfect! You didn’t waste my time, and I didn’t waste your time. And I’ve got to tell you: I wish more people would be upfront and honest with me. Ok, I’ll see you later.’ Then all of a sudden, he said, ‘No, wait, deacon, hold on. Let me just ...’ If you don’t fight with them, and go with the flow, most times that’s what happens – they want to sit and chat. It might be a goodwill conversation, a meeting. Sometimes when I’m talking with patients, I’m not even sure what I’m talking about, but I like to speak in metaphors with them. They’ll talk about anything. When I’m training chaplains, they want to know what the cookbook structure is: Ok, you say this first, then this second, this third, and fourth. I don’t know. This guy talked about our baseball team with us, and how they messed up. [Chaplain #2]

Chaplains can thus alter a patient’s conception of what they do, implicitly correcting misunderstandings or misapprehensions. As suggested above, these professionals need to be flexible and nimble in responding to such ostensible obstacles.

In responding to rejection by patients or families, chaplains also frequently draw on their own religious perspectives or personal approaches. One chaplain reported that when patients reject him,

Because I’m Buddhist, I can play the non-threatening Buddhist card: ‘It’s not about proselytizing precepts. We’re not allowed to convert people.’ One staunch atheist put her hands up in front of her in a cross, saying, ‘Get out! I don’t want you. You are anathema to me! My religion is watching CNN. That is my religion – politics and knowledge.’ So, I said, ‘OK, that

s fine ...’ and left. [Chaplain #7]

In returning to such patients another day, patients are often surprised, but ultimately able to establish a vital connection. As this chaplain continued,

The next day, I came back, just to try it out. I said, ‘Hi, remember me?’ She said, ‘Yeah ...?’ I said, ‘I know your religion is CNN, but what do you think about what’s going on now?’ At that point, Fox was making fun of Obama’s beige suit. People were up in arms, saying it was the wrong color for a president to wear ... But that was the start of our conversation. I sat down, and she talked to me about her life, family and vacation house, and why she was an atheist, and what’s bad about religion. It became a wonderful visit. [Chaplain #7]

This chaplain concluded that when he hears ‘get out’: “there’s usually a story to it. It may just be a defense about something. So, I just try again and see. I’ve got nothing to lose, except my pride.”

In reacting, chaplains try to come to learn not to take rejection personally, but instead to see it as an important manifestation of patients’ own autonomy and freedom. As this chaplain explained,

I’m the only person *whom* they can really kick out of their room. They can’t say to the doctors: ‘Get out of my room!’ or ‘No, it’s not a good time.’ When we chaplains say, ‘I got rejected,’ ‘refused’ or ‘kicked out of a room today,’ I reply: ‘Wow, congratulations! Because in this small, limited, vulnerable time in their life, wearing a bathrobe, a number on their wrist, and having a roommate, you gave them autonomy. Deprivation is everywhere in the hospital. It’s not a healing environment at all. But you gave them the opportunity to say ‘no,’ and you left. Isn’t that a wonderful thing? [Chaplain #7]

He encourages fellow chaplains to reframe these experiences of rejection – to feel less personally hurt, and try to see these episodes positively, not negatively.

When chaplains do get rebuffed, they tend to strive to remain open-minded, take a relatively open-ended approach, and engage at an authentic person-to-person human level, following the patient's direction, rather than trying to impose an agenda. Yet not all chaplains may do so:

It helps to be sensitive and go wherever the patient wants, and make sure that it's not *your* agenda. But I've seen chaplains use *their* agenda – where *they* want to take the patient. That's a mistake. Our job is to just manage the energy. It's total *indirection*. We don't want to direct the patient, but just help lead them to see if there's a place where they can experience some healing. I try to avoid directing the person, especially when they have that kind of attitude. I'll say, 'Let's talk about what's going on.' Typically, if you come across as *kind and real*, they'll trust you and go there with you. [Chaplain #10]

Still, as this chaplain indicates, colleagues occasionally make a “mistake” in reacting otherwise.

Conclusions

These data elucidate how patients and/or families at times initially reject chaplains, but often nonetheless end up appreciating such visits. Patients or families may turn down a chaplain because of conflicted feelings that they do not wish to probe at that moment, or because of wanting a chaplain of a different religion or gender, or being wary of religion, or misunderstanding what these professionals do.

While Best et al. (2020), based on a study of 14 chaplains in Australia, briefly mentioned that patients may reject a chaplain because of concerns that the conversation may be too “intimate” or because they do not speak English, the present data suggest additional key reasons for rejection, as well as how these professionals respond.

The present findings also help make sense of data reported in other studies. For instance, in one investigation, most hospitalized patients (59%), when asked, indicated that they did *not* desire to discuss religious and spiritual topics with staff (Williams et al., 2011). Yet 20% of these individuals ended up having such a discussion anyway, and were later more satisfied with their overall care than were respondents who did not see a chaplain ($p < .05$). The present data suggest that a major reason many patients didn't want to see a chaplain, but were more satisfied with their care if they ended up doing so, is that they had *misconceptions* about these professionals, and about what such discussions would entail.

Hospital chaplains do not speak with all patients who might benefit from such discussions. In one study, for instance, only 6% of intensive care unit patients have seen a chaplain (Choi et al., 2015). While these gaps may result from chaplaincy departments being short-staffed, other factors may also be involved (e.g., families not wanting to see a chaplain, due to misunderstandings or other reasons) that are in need of further examination.

Misunderstandings of chaplains by physicians have been described (Wirpsa et al., 2019). Yet strikingly, we have found no other published research examining *patients'* misconceptions and additional reasons for rejections of chaplains, and these professionals' responses.

These data have important implications for future practice, education, and research. Chaplains often described difficulties early in their career, in reacting to patients' rejections and then only gradually overtime becoming more comfortable, and figuring out, frequently on their own, how to best respond to these rebuffs. Chaplaincy education could therefore potentially address these situations more fully and explicitly.

The term "chaplain" itself can, however, make certain patients wary because they do not know exactly what a chaplain is, and thus decline, when asked, if they want to see one. Indeed, the term initially referred only to Christians. Specifically, the word derives from the Old French, *chapelain*, from the medieval Latin *cappellanus*, from *cappella* or "little cloak," and in the mid-14th century came to mean "minister of a chapel" (since the priest who oversaw the relic, kept by the Frankish kings, of Saint Martin of Tours' cloak, half of which he had given to a needy beggar, was called a *chapelain*) (Simpson & Weiner, 2021). Yet this term's explicitly Christian derivation and connotations may deter patients with other beliefs.

As a field, chaplaincy should thus engage more fully in education of patients, families, and the public at large, to convey how the field has evolved and now focuses on not only Christianity but other faiths, and addresses not only religion *per se* but these broader issues of spirituality, meaning, purpose and hope, and addresses needs of not only religious individuals but also so-called Nones, including those who are atheist, agnostic or spiritual but not religious. Consideration should also thus be given to changing the term "chaplain" to, for instance, "spiritual care specialist" or "staff member from spiritual care," or from "spiritual services" or pastoral care (though patients from non-Western cultures and religions may not fully know what "pastoral care" means, since the term derives from Christianity).

These data also have implications for physicians, nurses, psychotherapists, social workers, medical trainees, and others whom patients might also reject, suggesting methods of nonetheless engaging with such patients and developing beneficial relationships and rapport.

These data reveal, too, needs to investigate quantitatively among larger samples how often patients reject chaplains and why, what conceptions and misconceptions patients have of chaplains, how frequently and fully patients realize that chaplains can address not only specific faith traditions but broader issues of hope, meaning and connection, and how these issues may vary, related to patients' characteristics such as affiliation with religious institutions, specific faith tradition or socioeconomic characteristics. While recent research has focused on several key aspects of chaplaincy (Fitchett, 2017; Handzo et al., 2008), the current data suggest the importance of also examining other challenges that these professionals may face as well, in order to understand how best to address and overcome these. These findings underscore, too, a benefit of qualitative research, uncovering key themes that arise but have received little, if any prior, systematic attention and can be investigated further quantitatively in future studies using larger samples.

These data have several potential limitations. These findings are based on a sample of 33 chaplains, which is sufficient for qualitative analysis. Yet, further studies using larger samples can help elucidate these issues and factors that may be involved (e.g., training

or number of years of practice as a chaplain and specific religious and spiritual background of patients).

In short, chaplains at times face rejection from patients and families for six broad kinds of reasons, including misunderstandings about the roles and functions of these professionals, who may then need to determine how best to navigate these challenges. Chaplains frequently learn over time how to do so effectively. These data have important implications for future practice, education and research regarding chaplains, as well as physicians, nurses, psychotherapists, social workers and other providers and trainees.

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