CLINICAL BUDDHIST CHAPLAINCY SPIRITUAL CARE SUPPLY AND DEMAND IN THE US HEALTHCARE SYSTEM

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ABSTRACT

This study presents the findings of a statistical analysis exploring the correlation between supply and demand of clinical Buddhist chaplaincy in the US healthcare system. Quantitative data collected from the field (n=993; total visits(tv.)=1,188) analyze different aspects clinical Buddhist chaplaincy work with regard to patients' spiritual care needs and the distribution of patient ethnicity, religious/spiritual preference and geographical origin. Insights obtained from the data support a positive and strong correlation between patient spiritual care needs and the work of a clinical Buddhist chaplain as a spiritual care provider.

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Introduction

The work of a professional clinical Buddhist chaplain[1] in the US healthcare system first developed in 1993 when Rev. Madeline Koi Bastis (1940-2007) passed her board certification from the Association of Professional Chaplains and served cancer and AIDS patients in New York city.[2] Since then, practitioners and researchers in the field have contributed substantial efforts to the development of chaplaincy in both theory and practice. Only a handful of qualitative studies related to chaplaincy have so far been undertaken.[3] These studies mainly focus on spiritual caregiving perspectives related to the traditional Buddhist teachings of the Four Noble Truths, the Eightfold Path, bodhisattva-hood, non-self, and the teachings of interconnection between patients and clinical Buddhist chaplains from both Theravada, Mahayana, and Vajrayana traditions. These studies also emphasize the importance of patient advocacy, community outreach, crisis intervention and practical direction on how clinical Buddhist chaplains in the US may conduct themselves in a predominantly Christian culture.[4]

Upon reviewing currently available studies, there appears to be a lack of clarity on what clinical Buddhist chaplains do and what sort of spiritual care services are provided to patients in the US healthcare system. Further studies for examining the work of a clinical Buddhist chaplain and analyzing patients' spiritual care needs are therefore needed. Based on the author's one-year experience of working as a clinical Buddhist chaplain resident at F university hospital in D city in Northern California, this present study aims to provide statistical analysis for evaluating spiritual care the correlation between supply and demand between patients and a clinical Buddhist chaplain. Data (n=993; tv.=1,188) collected examining the work content of a clinical Buddhist chaplain, and analyzing patients' spiritual care needs based on the distribution of patient ethnicity, religious/spiritual preference and geographical origin. Due to the diversity of patients served, the spiritual and emotional needs of patients also varied greatly. The daily work of a clinical Buddhist chaplain employs the patient-centered model to provide appropriate care as requested based on practical and professional considerations. The purpose is to support patients in developing inner strength for healing and holistic improvement. However, the meaning of interfaith service as it relates to clinical Buddhist chaplain needs further exploration and definition.

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[1] The term "Clinical Buddhist chaplain" refers to Buddhist chaplain who is trained and work s in clinical healthcare settings such as within hospitals and hospices. The author uses this term to specify and distinguish these chaplains from the Buddhist chaplains serving in other contexts such as in the armed forces, higher education institutions, prisons , etc .

[2] Danny Fisher, *Benefit Beings! The Buddhist Guide to Professional Chaplaincy,* (CA: Off Cushion Books, 2013), 41-43.

[3] Guan Zhen, "Buddhist Chaplaincy in the United States: Theory Praxis Relationship in Formation and Profession," *Journal of International Buddhist Studies* 13 (2022): 51.

[4] Cheryl A. Giles and Willa B. Miller, *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral Work,* (Boston: Wisdom Publications, 2012), 54-110.

Method

Professor Earl R. Babbie's "actual participant" qualitative field research paradigm provided a helpful conceptual framework and theory for laying out plans and goals for data collection. It also provided a detailed format for interpreting the data. The paradigm produced "a richer understanding of many social phenomena than can be achieved through other observational methods, [and] provided…a deliberate, well-planned, and active way." [5] Within the 12-month period, 993 patients were randomly visited, resulting in a total of 1,188 patient visits. Spiritual Assessment and Intervention Model (Spiritual AIM) was utilized as a strategy to assess and measure patients' spiritual care needs and interventions. Spiritual AIM is based on "more than 20 years of chaplaincy experience and teaching, is currently taught to chaplain trainees, and has been disseminated to multiple clinical disciplines."[6] This current study followed the ethics as set forth by the Human Research Protection (OHRP) on human research based on the principles of the Belmont Report and the requirements of the revised Common Rule (or 2018 Requirements). OHRP ethical guidelines were further utilized for data protection, privacy and date management during and after the study.

Procedure

The yearlong data collection at the hospital was carried out in four phases: phase 1, from September 17, 2020 to November 26, 2020; phase 2, from November 30, 2020 to February 24, 2021; phase 3, from March 1, 2021 to May 30, 2021; phase 4, from June 1, 2021 to August 26, 2021. The four phases correspond to the four seasons in a year, a framework which this author found appliable and practical. The following categories were used in the data collection: date, unit, initial, gender, age, race, language, religious/spiritual preference, length of stay, care received, family support, and total visit. See **Appendix** for examples of formats used for data collection in the process of study. Results were processed to enable descriptive analysis on the spiritual care supply and demand correlation, to aid in examining the work content of a clinical Buddhist chaplain in the US healthcare system.

Measurement

Direct patient contact was utilized for data collection, employing Spiritual AIM for assessing and measuring patients' spiritual care needs and the interventions employed. Contacts were mainly

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[5] Earl R. Babbie, *The Practice of Social Research,* 14th edition, (CA: Wadsworth Publishing, 2014), 287.

[6] Michele Shields, Ellison Kestenbaum, and Laura B. Dunn, "Spiritual AIM and the Work of the Chaplain: A Model for Assessing Spiritual Needs and Outcomes in Relationship," *Palliative and Supportive Care* 13 (2015): 76.

gathered through two sources: (1) random recruitment and (2) referrals from nurses, doctors, other-chaplains, on-call duty chaplains, social workers, security workers, patients and patients' family loved ones:

Table 1. Type of referral.

Referral From	Number	Percentage
Random Recruitment	632	63.65%
Nurse and Doctor	136	13.70%
Other Chaplain	86	8.66%
On-Call Duty	53	5.34%
Social Worker	19	1.91%
Security	18	1.81%
Family Loved One	46	4.63%
Patient	3	0.30%
	993	**100.00%**

Spiritual AIM was also utilized as a consistent measurement for the results of patients' spiritual care assessments, interventions and the quality and consistency of care provided.

Results

Summary

Data collected in the four phases were loaded as excel spreadsheets. Data files were imported into Stata, summarized and tabulated for descriptive information and statistics. The results show that the populations of patients visited were male 53% (n=521), female 47% (n=468) and nonbinary 0.4% (n=4). Patients visited were mainly first- and second-generation immigrants from North America, Europe, Africa, the Middle East, South America and Asia. Religious/spiritual preferences represented were mainly: Catholicism, Protestantism, Eastern Orthodox, Mormons, Jehovah's Witnesses, Buddhism, Islam, Judaism, Hinduism, Sikhism, multi-religion, and others.

Within these, Catholic (n=305; 30.72%) and Protestant (n=254; 25.58%) patients accounted for the majority of patients visited. There were 14 languages used by patients, among which three were most frequently used: English (n=791; 79.66%), Spanish (n=92; 9.26%), and Chinese (both Mandarin and Cantonese, n=67; 6.75%).[7] The services that a clinical Buddhist chaplain provides

[7] Professional language interpreters at F university hospital provide more than 80 world language interpretation services for patients who do not speak English through either telephone call or in person service.

daily include prayers, pastoral counseling, feeling and emotional support, referral to other chaplains, facilitating advanced directives, comfort care, decedent care, facilitating the release of human remains, providing family and staff supports, etc.

Among the spiritual care services provided, prayers for Christian patients (n=237; 19.95%) and pastoral counseling (Bible passage reading and discussions, n=306; 25.76%) dominate the daily work of a clinical Buddhist chaplain. The data resulting from patient visits also showed that Buddhist patients (n=53; 5.33%) accounted for a small minority of the overall patients visited by the author in the hospital, and obviously did not constitute the main part of the daily work of a Buddhist chaplain.

F University Hospital and Characteristics of Patients Visited

F university hospital in D city is a secular medical institution founded on the value of healing humanity through science and compassion. The hospital has 600 beds and is located in the Silicon Valley. Located in diverse region of the country, the hospital services patients from many cultures, religions, spiritualities and social strata. It not only provides world-class medical services for patients from around the country and overseas, but also provides opportunities for medical students, medical residents, and physicians for disease research and new drug testing purposes.

The hospital has 34 medical units (from B1 to M7). During his one-year residency, the author was assigned to K7 (general medicine), L5 (general medicine), F3 (oncology) and M4 (critical care) units. Patient visit data was mainly collected from K7 (n=200; tv.=227), L5 (n=200; tv.=238), F3 (n=176; tv.=216) and M4 (n=133; tv.=151). Additionally, there were 5-6 on-call shifts per month which covered day and night-shifts, weekends, and holidays for all units at the hospital.

The total number of patients visited in the 12-month period was n=993; and the total number of visits was 1,188. The minimum number of visits was 1 visit and the highest was 6 visits. Patients who received only 1 visit accounted for 89.12% (n=885); patients with 2 visits accounted for 8.16 % (n=81); patients with 3 visits accounted for 1.1% (n=11); patients with 4 visits accounted for 0.7% (n=7); patients with 5 visits accounted for 0.2% (n=2); patients with 6 visits accounted for 0.1% (n=1); patients with unknown number of visits (statistical missing value) accounted for 0.6% (n=6). Of the total number of patient visits (n=993, tv.=1,188), 68% (n=675; tv.=808) were accomplished during the normal work week and 32% (n=318; tv.=380) were accomplished during on-call shifts.

Table 2. Patient visited and total visits in accordance with units.

Unit	Number	Percentage	Unit	Number	Percentage
B1	4	0.4%	J4	8	0.8%
B2	9	0.9%	J5	9	0.9%
B3	28	2.81%	J6	8	0.8%
C1	2	0.2%	J7	2	0.2%
C2	6	0.6%	K4	14	1.4%
C3	5	0.5%	K5	5	0.5%
E1	3	0.3%	K6	3	0.3%
E2	24	2.4%	K7	200	20.14%
E3	16	1.6%	L4	41	4.11%
ED	11	1.1%	L5	200	20.14%
EGR	8	0.8%	L6	9	0.9%
F3	176	17.64%	L7	2	0.2%
FGR	6	0.6%	M4	133	13.33%
G1	3	0.3%	M5	9	0.9%
G2P	5	0.5%	M6	6	0.6%
H1	3	0.3%	M7	2	0.2%
H2	7	0.7%	LPCHS	13	1.3%
J2	9	0.9%	Unknown	4	0.4%
				993	**100%**

Unit	Total Visits	Percentage	Unit	Total Visits	Percentage
B1	4	0.34%	J4	8	0.68%
B2	9	0.76%	J5	9	0.76%
B3	31	2.6%	J6	8	0.68%
C1	2	0.17%	J7	2	0.17%
C2	8	0.68%	K4	16	1.35%
C3	7	0.59%	K5	5	0.42%
E1	3	0.25%	K6	4	0.34%
E2	28	2.36%	K7	227	19.11%
E3	22	1.85%	L4	52	4.38%
ED	14	1.18%	L5	238	20.03%
EGR	9	0.76%	L6	10	0.84%
F3	216	18.18%	L7	2	0.17%
FGR	8	0.68%	M4	151	12.71%
G1	3	0.25%	M5	9	0.76%
G2P	6	0.51%	M6	7	0.59%
H1	3	0.25%	M7	3	0.25%
H2	7	0.59%	LPCHS	14	1.18%
J2	9	0.76%	Unknown	34	2.86%
				1,188	**100%**

Patients' age distribution ranged from <1 year old to >100 years old. The main age distribution of patient populations visited was between 21 to 90 (n=902; 90.83%). Three age groups accounted for the main distribution of patient visits: 51-60 years old, 61-70 years old and 71-80 years old. Patients' length of stay at the hospital was mainly short-term 1-10 days which accounted for 68.7% (n=682). Medium- and long-term stay of 11-30 days accounted for 25.78% (n=256). Long-term stay of more than 30 days accounted for 5.23% (n=52).

Table 3. Age and length of stay.

Age	Number	Percentage	Length of Stay	Number	Percentage
<1	6	0.6%	1~3	315	31.72%
2~5	2	0.2%	4~6	203	20.44%
6~10	1	0.1%	7-10	164	16.52%
11~20	12	1.21%	11-20	188	18.93%
21~30	57	5.74%	21-30	68	6.85%
31~40	82	8.26%	31-50	33	3.32%
41~50	103	10.37%	51-100	15	1.51%
51~60	185	18.63%	>100	4	0.4%
61~70	213	21.45%	Unknown	3	0.3%
71~80	174	17.52%			
81~90	88	8.86%			
91~100	24	2.42%			
>100	1	0.1%			
Unknown	45	4.53%			
	993	**100%**		**993**	**100%**

Patients in the 31-90 age group accounted for 85% (n=845), forming the majority of patients visited in a year. Within this 31-90 age group, patients aged 51 to 80 accounted for 57.6% (n=572), constituting the main portion of patients visited. Regarding the length of stay, 1-10 days comprised the majority patients, of which 1-3 days and 4-6 days accounted for 52.16% (n=518). The total duration of patient visits was 36,394 minutes, with the shortest being 6 minutes and the longest being >100 minutes. The main duration of patient visits was between 10 and 100 minutes, with an average value of 30 minutes. There was spiritual and emotional support provided to 571 family members in the hospital. Among the family loved ones served in a year, people with only 1 visit accounted for 23.32% (n=227).

Table 4. Visit duration and family support.

Single Visit Duration (minutes)	Total Visits	Percentage	Total Visits	Family Member Supported	Percentage
6~10	23	1.94%	1	277	23.32%
10~15	250	21.11%	2	62	5.22%
16~20	183	15.40%	3	26	2.19%
21~25	179	15.07%	4	6	0.51%
26~30	177	14.90%	5	2	0.17%
31~40	131	11.03%	6	7	0.59%
41~50	126	10.61%	7	1	0.08%
51~100	96	8.08%	9	1	0.08%
>100	13	1.09%	Unknown	806	67.85%
Unknown	10	10.84%			
Total Visits	**1,188**	**100%**	**Total Visits**	**1,188**	**100%**
Total Duration	**36,394 Minutes**		**Total Family Member Supported**	**571**	

Table 4, "Single Visit Duration" statistical missing value "unknown" (tv.=10; 10.84%) indicates that the visit duration less than six minutes. "Family Member Supported" statistical missing value "unknown" (n=806; 67.85%) is due to the following reasons: (1) patients visited had no family; (2) negative family dynamics caused the absence of family visits; (3) the hospital issued protocols forbidding family visits after the outbreak of COVID-19 pandemic. Among these reasons, the elimination of family visits after the outbreak of the pandemic constituted the main statistical missing value. From December 9, 2020 to March 22, 2021, due to the rapid increase in the mortality rate of patients caused by the pandemic,[8] no family visits were allowed, even when patients were in the process of dying.

The patients visited were mainly middle-aged and elderly. The overall length of stay was short term (1-10 days). Patients who stayed only 1 day constituted the majority (see **Table 3**), indicating that the nature of spiritual care services had to be concise in assessment and intervention as to meet patients' spiritual care needs.

[8] Between February 1, 2021 to March 1, 2021, the highest mortality rate of patients in a single month at the hospital exceeded 31% (n=187 vs. 600 beds).

Ethnicities, Religious/Spiritual Preferences and Geographical Origins

Patients visited in the 12-month period at the hospital were mainly first- and second-generation immigrants from North America, Europe, Africa, the Middle East, South America and Asia. Here, "second-generation immigrants" refers to the children of the first-generation immigrants born in the US. Among them, the first-generation immigrants were 2.5 times (n=252) more represented in the data than second-generation immigrants (n=105), accounting for 25.38% of the total number of patients visited. Of the patients visited, first-generation immigrants were mainly from Asia (n=139; 55.16%), South America (n=98; 38.89%), the Middle East (n=8; 3.17%), and Europe (n=7; 2.78%). Among the Asian first-generation immigrants, most were from China, Thailand, Myanmar, Laos, Singapore, Japan, Korea, India, Philippines and Vietnam. The second-generation immigrants were mainly Latinos (n=39; 37.14%) and Chinese-Americans (n=14; 13.33%).

Table 5. Ethnicity and Geographical Origin.

Ethnic Group Distribution	**Number**	**Percentage**	**First- Generation Immigrant Origin**	**Number**	**Percentage**
Caucasian	631	63.54%	Europe	7	2.78%
Indians	2	0.2%	Middle East	8	3.17%
Fist-Generation Immigrant	252	25.38%	South America	98	38.89%
Second-Generation Immigrant	105	10.58%	Asia	139	55.16%
Unknown	3	0.3%			
	993	**100%**		**252**	**100%**

Asian Immigrant Origin	**Number**	**Percentage**	**Second-Generation Immigrant Distribution**	**Number**	**Percentage**
Thailand	1	0.72%	Vietnamese-American	2	1.9%
Myanmar	1	0.72%	Korean-American	2	1.9%
Loas	1	0.72%	Indian-American	3	2.86%
Singapore	2	1.44%	Middle-Eastern-American	6	5.71%
China	69	49.64%	Jewish-American	6	5.71%
Japan	3	2.16%	Filipino-American	6	5.71%
South Korea	7	5.04%	Japanese-American	7	6.7%
Philippines	8	5.76%	Chinese-American	14	13.33%
India	18	12.95%	African-American	20	19.04%
Vietnam	29	20.86%	Latino-American	39	37.14%
	139	**100%**		**105**	**100%**

Table 5, Middle-Eastern and Jewish categories were separated in order to differentiate that these Jewish patients were from Germany and the former Soviet Union, not from Israel. Among patients visited, the religious/spiritual preferences mainly were: Catholicism, Protestantism, Orthodox Christianity, Buddhism, Islam, Judaism, Hinduism, Sikhism, multi-religion and others. The language used by the patients involved 14 languages, with English as the most widespread as the patients' primary language (n=791; 79.66%); Spanish was used by immigrants from South America accounting for the second (n=92; 9.26%); Chinese (both Mandarin and Cantonese) accounted for the third group (n=92; 9.26%).

Table 6. Religious/spiritual preference and language.

Religious Preference	**Number**	**Percentage**	**Language**	**Number**	**Percentage**
Catholic	305	30.72%	Ukrainian	1	0.1%
Protestant	254	25.58%	Russian	1	0.1%
Orthodox	2	0.2%	Hindi	2	0.2%
Mormons	1	0.1%	Lao	1	0.1%
Jehovah's Witnesses	1	0.1%	Italian	1	0.1%
Greek Orthodox	1	0.1%	Punjabi	6	0.6%
Armenian	2	0.2%	Japanese	2	0.2%
Non-religious Preference	222	22.36%	Mandarin/ Cantonese	67	6.75%
Buddhist	53	5.33%	French	2	0.2%
Hindus	14	1.41%	Burmese	1	0.1%
Judaist	13	1.31%	English	791	79.66%
Sikh	5	0.5%	Spanish	92	9.26%
Muslim	7	0.71%	Vietnamese	18	1.81%
Multi-religious	4	0.4%	Chinese and English	1	0.1%
Other	32	3.22%	Unknown	7	0.61%
Atheist	48	4.84%			
Unknown	29	2.92%			
	993	**100%**		**993**	**100%**

Table 6 lists the various religious/spiritual traditions patients endorsed, of which the majority of patients belonged to Christian denominations (n=566; 57%). Non-religious preference accounted for an important proportion of the total number of patients visited (n=222; 22.36%). Protestant patients (n=254; 25.58%) were mainly from the following denominations: Evangelical, Presbyterian, Baptists, Lutheran, Latter-day Saints, Quaker, Seventh-day Adventist, Anglican, Methodist, and United Church of Christ.

By employing Spiritual AIM for patients' spiritual care assessments and interventions, the self-reports of patients with non-religious preference indicated the following four characteristics: (1) have faith in God but no longer participate in church activities; (2) maintain friendship with a priest or pastor of the previous church attended although no longer in active attendance, but read the Bible and pray with family loved ones or friends; (3) have devotion in God and believe that God is everywhere, not limited to church; (4) believe that each individual was created and blessed by God in daily life, and that one can communicate directly with God without going through a church or clergy as an intermediary. This group of patients appears to be individuals who self-identity as unaffiliated Christians.

Patients with multi-religious beliefs (n=4; 0.4%) share characteristics of the unaffiliated Christians described above, especially with regard to the fourth point. These "non-religious preference" patients, with a Christian background, accept and integrate other religious traditions (such as Buddhism, Islam, and Judaism) into their religious practice. Through Spiritual AIM assessment and intervention, this group of patients expressed that different religious beliefs are just different manifestations of God. The statistical missing value "unknown" (n=29; 2.92%) in **Table 6** is mainly comprised of minority religious traditions including Native American religions, Chinese folk religious belief of Guan Di *民間關帝信仰*, Japanese Shintoism, etc.

Accordingly, the total number of Buddhist patients visited was n=53. Among them, Vietnamese Buddhists and Chinese Buddhists accounted for the majority of Buddhist patients visited (n=39; 73.58%), followed by Japanese Buddhists (n=6; 11.32) %) and Theravada Buddhists (n=2; 3.77%).

Table 7. Buddhist traditions.

Buddhist Tradition	Number	Percentage
Vietnamese Buddhism	20	37.73%
Chinese Buddhism	19	35.85%
Theravada Buddhism	2	3.77%
Japanese Buddhism	6	11.32%
Korean Buddhism	1	1.9%
Other	5	9.43%
	53	**100%**

The Buddhist patients belonged to diverse Buddhist traditions. Theravada Buddhist patients were from Thailand and Laos respectively. Japanese Buddhist patients were mainly from the Soka Gakkai, Shingon and Nichiren traditions. "Other" represents a mixture of Buddhist practice with Catholicism, Protestantism, Islam and Armenian Apostolicism. The total number of Buddhist services to Buddhist patients accounted for 4.29% (n=51, see **Table 8**). Buddhist services provided

to Buddhist patients included the following contents: breathing and mindfulness meditation, counseling on Buddhist teachings such as the Four Noble Truths, the Noble Eightfold Path, Madhyamika and the meaning of Karma.

Buddhist services provided to Buddhist patients also included the following rituals: chanting of the Great Compassion Mantra and reciting the *Heart Sutra* for protection and purification; chanting the Medicine Buddha Mantra for healing; chanting the Rebirth in Pure-land Mantra for comfort care; hearing repentances (similar to taking confession); other rituals for eliminating negative karma and resentments; and conducting Pali chanting for taking Three Refuge and receiving the Five Precepts, etc.

Work Content of a Clinical Buddhist Chaplain

The work of a clinical Buddhist chaplain in the US healthcare system can be summarized into three aspects: (1) to provide spiritual care and emotional support to patients and their families; (2) to work with interdisciplinary teams for the well-being of patients; (3) to provide staff support as needed. In the author's one year of patient visits, spiritual care services provided to patients included the following: prayer, pastoral counseling, emotional support, referral to other chaplains, facilitating advanced directives, providing Buddhist services, comfort/decedent cares, as well as release of human remains.

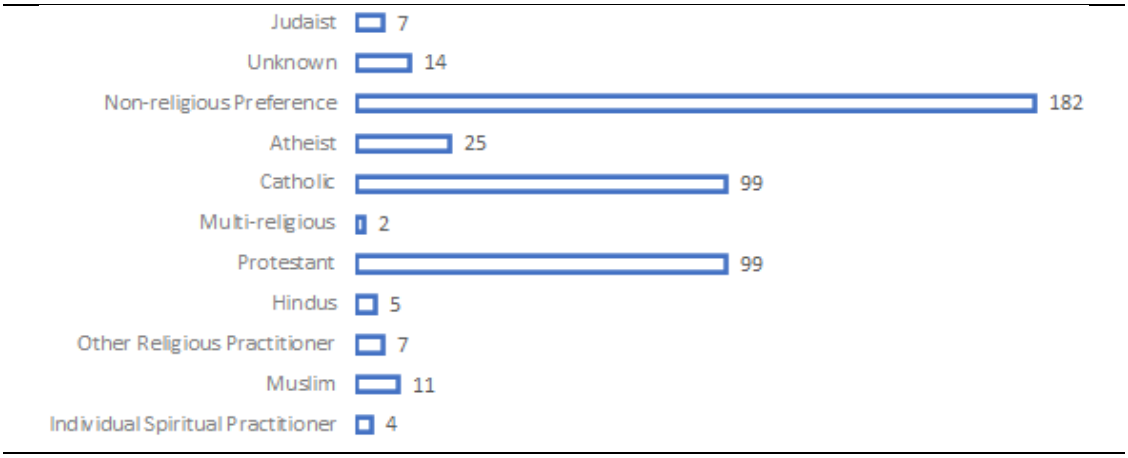
Table 8. Spiritual care services provided.

Content of Service	number	Percentage
Prayer	237	19.95%
Pastoral Counseling	306	25.76%
Emotional Support	469	39.48%
Referral to Other Chaplains	38	3.2%
Advanced Directive	11	0.93%
Declined Visit	4	0.34%
Buddhist Service	51	4.29%
Comfort/Decedent Care	52	4.38%
Release of Human Remain	14	1.17%
Unknown	6	0.5%
	1,188	**100%**

Prayer, pastoral counseling, and emotional support constitute the main proportion of spiritual care services provided (n=1,012; 85.19%). Among these, prayer and pastoral counseling were provided mainly to followers of Catholicism, Protestantism, Mormonism, Islam, Hinduism and non-religious preference. The contents of the prayers offered were mainly for increasing hope,

blessing, healing, comfort, strength, peace and redemption. The contents of pastoral counseling—in an environment dominated by Catholic and Protestant patients—mainly involved reading and discussing Bible passages from Psalms, Ruth, Philippians, Matthew, Isaiah, Jeremiah, Ecclesiastes, and James. Emotional support involved a wide range of subjects, covering major religion traditions, multi-religion, non-religious preference, atheist, etc.

Figure 1. Emotional Support.



In the above figure, Catholic and Protestant patients and patients with non-religious preference constitute the main patient groups offered emotional support (n=380; 83.15%). Patients in these groups recognized that the author was a Buddhist monk, representing a different religious tradition, requesting only emotional support. Even after meaningful spiritual conversations, the author offered "would you like a prayer before I leave?" These groups of patients would politely thank the author the visit, but decline the offer. Such groups of patients devoted in Christianity, had clear religious boundaries, but were still respectful to the chaplain whose religion was different from their own. This group of patients comprised the main source of referrals to other chaplains (Catholic Father and Protestant chaplains in the hospital).

As a profession, the work of a clinical Buddhist chaplain is tied to his or her medical institution's policies, and must follow the ethics of professional chaplains set forth by the *Code of Ethics for Professional Chaplains* and the *Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students*.[9] In this regard, the yearlong work of this author at F university hospital also included attending regular interdisciplinary team meetings at assigned F3, K7, L5 and M4 units, and providing staff support to all staff at the hospital as needed.

[9] Association of Professional Chaplains, Code of Ethics for Professional Chaplains (IL: APC, September 2000); The Constituent Boards of the Council on Collaboration, Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students (OR: CBCC, November 7, 2004).

Table 9. Staff meeting and support.

Type of Work	Number	Percentage
Interdisciplinary Team Meeting	86	44.33%
Tea for the Soul	8	4.12%
Other	99	51.03%
Unknown	1	0.5%
	194	**100%**

Length of Work (Minutes)	Frequency	Percentage
6~10	5	2.58%
10~15	14	7.22%
16~20	23	11.86%
21~25	16	8.25%
26~30	83	42.78%
31~40	20	10.31%
41~50	5	2.58%
50~100	14	7.22%
>100	14	7.22%
Total	**7,720 Minutes**	**100%**

Members who attended interdisciplinary team meetings were physicians, nurses, clinical social workers, case managers, chaplains, pharmacists and physiotherapists. This type of meeting usually lasted for 30 minutes per unit. Interdisciplinary team meetings summarized the physical, social, emotional and spiritual needs of patients from various professional perspectives as to provide appropriate and effective services as needed, striving for whole-person care of patients. "Tea for the Soul" meetings had a general duration of 180 minutes (120 minutes per service plus 60 minutes for preliminary preparation). It provided staff a place for developing inner peace as well as spiritual and emotional reflection for reducing potential anxiety and fear caused by the stressful workload during the pandemic.

"Other" in **Table 9** accounts for 51.03% (n=99) which was a substantial proportion of the author's day devoted to staff support. This category mainly contains the following six contents: (1) to provide staff support to assigned units (F3 and M4) during the processes of relocation; (2) to provide Buddhist meditation counseling to nurses and doctors as requested; (3) to support nurses and social workers in communicating with patients' family and loved ones during family meetings with the medical teams; (4) to provide spiritual and emotional support to staff as needed through telephone calls; (5) to support social workers in communicating with funeral home staff for safely transporting COVID-19 infected deceased patients to funeral homes; (6) to coordinate with

hospital departments and/or community organizations to organize important religious, spiritual and cultural event celebrations.

During his one-year residency, the author and his Christian chaplain colleague PA were assigned to coordinate and support the religious, spiritual and cultural event celebrations in the hospital. Events that were coordinated, supported and celebrated were: Hindu Diwali, Kwanzza, Spiritual Week, Good Friday, Jewish Hanukkah (Chanukah), Christmas and the Chinese Lunar New Year, etc. In these events, respect for diversity in culture, religion, spirituality and the value of interfaith, were emphasized.

Discussion

The results show the diverse distribution in religious/spiritual preferences, ethnicities and geographical origins of patients served. Data analysis demonstrated that the spiritual care supply and demand correlation between patients and clinical Buddhist chaplaincy is positive and strong. The author provided unique contributions to the fulfillment of the religious/spiritual care needs and emotional support of patients, family loved ones and staff in the hospital. Most of the spiritual care services provided were to meet Christian patients' spiritual care need for prayers (n=237 for hope, blessing, healing, strength, comfort, peace and redemption) and pastoral counseling related to Bible readings (n=306). The traditional role of chaplains in addressing the religious and spiritual needs of patients was clearly predominant,[10] even though a less traditional chaplaincy approaches were also practiced (such as facilitating advanced directives, decedent care, release of human remains and community outreach).[11]

Quantitative data analysis showed that hospital patients were primarily Christians of various denominations looking for Christian spiritual services (Christian prayers and pastoral counseling n=543). In providing spiritual care to these groups of patients, most of them treated the author as a "Christian" chaplain, addressing him "Father" (Catholic patients) or "pastor" (Protestant patients) and assuming that he was endorsed by a local church and sent by his church to serve patients in the hospital. The question that he was often asked by these groups of patients was: "chaplain (or Father or pastor), which church are you from?" Some Catholic and Protestant patients even attempted to offer donations to the author's "church" which the author had to turn down. Emotional support for non-religious preference (unaffiliated Christian) patients (n=182; 18.32%) also comprised a significant proportion of the chaplain's work. In practice, a study conducted in 2006

[10] Allan W. Reed, "Images of the Hospice Chaplain," *Hospice Journal* 1 (1985): 111-118.; Ambrose K. Phillips, "The Chaplain's Role in a Nursing Home," *Hospice Progress* 56 (1973): 75-78.

[11] Edna C. Mason, "The Changing Role of Hospital Chaplaincy," *Reformed Liturgy and Music* 24 (1990): 127-130.; Paul A. Mandziuk, "Is There a Chaplain in Your Clinic?" *Journal of Religion and Health* 35 (1996): 5-9; Marilyn D. Harris and Lamont R. Satterly, "The Chaplain as a Member of the Hospice Team," *Home Healthcare Nurse* 6 (1998): 591-593.

surveyed 1,431 hospital administrators, asking them to rate chaplains' activities across the United States. The results showed that emotional support for patients and families was rated as "very important and extremely important" work of chaplains.[12]

Table 1, random recruitment, n=632 (63.65%) comprised a substantial proportion of patients visited. Referrals from nurses and doctors n=136 (13.70%) constituted a significantly smaller proportion. Taking initiative to randomly knock patients' doors for random recruitment visits led to vast majority of services provided and visits recorded in this present study. Random recruitment visits and referrals from other chaplains comprised 77.65% (n=771) and were in marked contrast to referrals from nurses and doctors, social workers, security workers, and family loved ones (n=219; 22.05%). This contrast may reflect staff attitudes at the hospital where spiritual care services are considered less important than other services provided. Of course, this finding requires further investigation.

Accordingly, the low probability of referral from nurses and doctors could have been related to the following factors: (1) the lengths of stay of the majority of patients were short-term 1-6 days (n=518; 52.16%, see **Table 3**); (2) after the outbreak of the pandemic, the requirement of social distance had a substantial impact on concern for both patient and staff health and safety; (3) nurses and doctors who embrace science as a primary life paradigm may have trouble recognizing the value of spirituality in healing processes; and (4) medical staff such as nurses may also be providing spiritual care services to patients. The short length of stay in the hospital necessitates the prioritization of medical procedures. Since the outbreak of the pandemic, the hospital also faced higher pressure to discharge patients as soon as feasible.

As for the social distancing related to the outbreak of the pandemic on March 11, 2020, recent studies of healthcare chaplaincy have demonstrated "exacerbated enduring problems pertaining to professional identity, leadership and status."[13] According to studies, nurses and doctors who embrace science as a primary life paradigm most likely would not consider patients' religious/spiritual care needs as significant for healing, and they might not feel comfortable with stepping outside their comfort zone by referring patients to spiritual care services as an alternative treatment for illness.[14] They may become confused or conflicted when patients prefer spiritual care as "alternative or complementary treatment in their approach to illness." [15] As for medical staff involved in providing spiritual care services to patients, according to a 2020 study of spiritual care

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[12] Kevin J. Flannelly et al., "A National Survey of Hospital Directors' Views about the Importance of Various' Chaplain Roles: Differences among Disciplines and Types of Hospitals," *Journal of Pastoral Care and Counseling* 60 (2006): 213 –225.

[13] Austyn Snowden, "What Did Chaplains Do During the Covid Pandemic? An International Survey," *Journal of Pastoral Care & Counseling* 75 (2021): 12.

[14] Bonnie W. Battey, "Perspectives of Spiritual Care for Nurse Managers," *Journal of Nursing Management* 20 (2021): 1012-1020.

[15] Richard H. Savel et al., "The Importance of Spirituality in Patient-Centered Care," *American Journal of Critical Care* 23 (2014): 277.

experienced by n=281 patients, results show 30% (n=84) of patients indicated that they received spiritual care from their medical staff.[16]

Analyzing the number of patient visits at the hospital, Buddhist patients evidently constitute a minority of the patients visited in the 12-month period (n=53 vs. n=993). If viewed from the lens of the supply and demand relationship, the need for clinical Buddhist chaplains in the US healthcare system may not be as high as has been portrayed in recent media.[17] The specific data on the distribution of patients' religious/spiritual preferences demonstrate that the main populations of patients who received spiritual care services were Catholic and Protestant patients (total n=559; 56.3%). This indicates that the "spiritual care" services provided by the author were primarily to Christian patients in a Christian context.

It is reasonable to observe that the daily work of a clinical Buddhist chaplain in the US healthcare system is mainly shadowing the work of a Christian chaplain. In practice, this could also cause confusion between Buddhist and Christian chaplaincies at least with respect to their roles and practices.[18] From the author's perspective, the confusion is often explained through the concept of "interfaith". From April 2021 to July 2021, the author interviewed four Buddhist chaplains in the field, asking them the following question: "when patients ask you which church you are from, how do you usually respond?" Every Buddhist chaplain interviewed was not surprised with the question and expressed that they had been asked the question by their patients in the past. Three Buddhist chaplains responded with the following, "the hospital is my 'church', and I am an interfaith chaplain." One Buddhist chaplain responded, "my church is far from here in another state. I am a Buddhist chaplain, and I also practice interfaith." "Interfaith" here appears to be a "sacred veil" for protecting a Buddhist chaplain's self-identity and maintaining connection and relationship with patients in Christian dominated context. The sacred veil also provides a psychological means of imbuing and justifying a clinical Buddhist chaplain's position and actions with perceived meaning and value through the "patient-centered" model. However, this idea of interfaith leaves little room for the integrity and uniqueness of Buddhist clinical chaplaincy as a discipline related to, but distinct from Christian clinical chaplaincy.

As a profession, clinical Buddhist chaplains follow the spiritual care service standards and principles laid out by their certification bodies (such as Association of Professional Chaplains and Spiritual Care Association). They utilize the patient-centered model to serve patients in need.

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[16] Heather Tan et al., "Understanding the Outcomes of Spiritual Care as Experienced by Patients," *Journal of Health Care Chaplaincy* 28 (2020): 155.

[17] Emily Demaionewton and Karen Jensen, *Buddha Buzz Weekly: Interest in Buddhist Chaplaincy Increases During the Pandemic*, Accessed October 10, 2022, https:/ /tricycle.org/article/buddhist-chaplaincy-pandemic.; Caitlin Y. Kandil, *Pandemic's Suffering Opens Way for Buddhist Chaplains*, Accessed October 10, 2022, https://religionnews.com/2020/12/02/pandemics-suffering-opens-way-for-buddhist-chaplains.

[18] Guan Zhen, "Buddhist Chaplaincy in the United States: Theory Praxis Relationship in Formation and Profession," 202.

When patients do not ask about a Buddhist chaplain's identity, he or she usually does not have to correct patients even though they might address him or her as "Father" or "pastor", assuming he or she is a Christian chaplain. In which case, the author found that it was meaningful to simply identify as "interfaith" obscuring the Buddhist identifier. Nevertheless, even while utilizing the "patient-centered" model, the author experienced some cases of Christian patients feeling awaked, confused, and somehow ashamed after receiving the services of a Buddhist chaplain.

The data on spiritual care supply and demand correlation support interfaith practice in the field because affiliated and unaffiliated Christian patients comprise the majority of patients visited (n=788; 79.36%, see **Table 6**). To a Christian chaplain, "interfaith" appears to be mainly serving patients from different Christian denominations and those unaffiliated with any particular Christian denomination. For a Buddhist chaplain however, "interfaith" generally means having to work effectively as a Christian chaplain. Furthermore, as a profession and a branch of social service, the interfaith work of a clinical Buddhist chaplain, from the market perspective, principally follows the dictates of supply and demand to evaluate for efficiency, effectiveness, quality and consistency of care provided. In this regard, the prevalence of interfaith work undertaken by a Buddhist chaplain in the US healthcare system is arguably a product of market power, specifically issues of supply and demand.

Limitation

Since patients visited were mainly Christians (affiliated and unaffiliated), the low occurrence of Buddhist patients visited in the 12-month period prevented a fuller exploration of the role of Buddhist chaplains. A further limitation was that since F hospital was secular institution located in a large city, a similar study might be undertaken in rural, religious hospital for the sake of comparison.

Conclusion

The results of this current study indicate that the supply and demand correlation was positive and strong. Further, the results show that a clinical Buddhist chaplain's daily work was/is mainly meeting Christian patients' spiritual care needs. The results also showed that the majority of a clinical Buddhist chaplain's work is based on an "interfaith" approach due to the predominance of Christian patients in the US healthcare system. Such an interfaith approach is helpful for facilitating chaplaincy work, but is limiting to a clinical Buddhist chaplain.

The 21st century evolution of healthcare chaplaincy appears to have placed emphasis on the non-traditional roles of chaplains, and has presented chaplaincy as a profession of an accompany-

ship or cheerleader-ship that adopts modern social sciences such as psychology as its model of how to appropriately serve patients.[19] Nevertheless, this study suggests that the current spiritual care needs of patients in the US healthcare system are largely fulfilled by the traditional services offered by chaplains while a less traditional approach to chaplaincy is also practiced.

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Appendix

2020.9.17 - 2020.11.26											
Date	**Unit**	**Initial**	**Gender**	**age**	**Race**	**Language**	**Religious/ Spiritual Preference**	**Length of Stay**	**Care Received**	**Family Support**	**Total Visit**
2020.9.17	B3	LXX, D	Male	47	Vietnamese-American	English	Vietnamese Buddhism	4	Meditation and Buddhist Counseling.	/	1
2020.9.23 2020.10.7 2020.10.13 2020.10.27	K7	KXX, D	Female	33	Caucasian	English	Protestant	51	Read Palms 53: 1-6; read Ruth 4:1-22; Prayer.	/	4
2020.9.23	M4	SXX, T	Male	82	Caucasian	English	Catholic	12	Comfort/ decedent care.	/	1
2020.9.23	B3	PXX, L	Female	61	Latino	Spanish	Catholic	3	Prayer.	/	1

SAMPLE LOG W3 W4 W5 W6 W7 **W8** W9 W10 W11 W12 W13 W14

Date	On-Call (ONC)	Unit	Pt. Initials	Type of Encou	Contac from:	Referr made to:	# Family	# Staff	Emoti Suppo	Prayer or Medita	Sacrar or Ritual	Tea for the Soul	Decea Care	Devot Mater	Advan Direct	Servic Recov	Length of Stay-LLOS	Wayfi	Notes	Total Min
10/27		B3	PXX, W	IV	SR				X											30
10/27		B3	CXX, T	IV	SR			1	X	X										35
10/27		B3	GXX, N	IV	SR				X											20
10/27		B3	TXX, F	IV	SR			1	X											15
10/27		K7																	Interdisciplinary Rounds	35
12/27																			Met with M4 preceptor Anna	30
10/27		M4	RXX, M	IV	SR			1	X											20
12/27		K7	SXX, Z	IV	SR			1	X											15
10/27		K7	TXX, D	FV	SR				X								x			15
12/27		K7	TXX, M	IV	OTC			1	X											40
10/27		B3	WXX, L	IV	SR		1		X											40
10/28		M4	HXX, J	IV	OTC			1	X											20
10/28		M4	JXX, K	IV	OTC				X											20
10/28		L5	VX, P	IV	SR			1	x	x										40
10/28		L5																	Interdisciplinary Rounds	30
10/28		B3						6											Tea for Soul	120
10/28		L5	LXX, K	IV	SR		1		x											25
10/28		M4	SXX, S	IV	ONC		1		x	x										40
10/28		K7	SXX, G	IV	ONC				x											30
10/29		B3	CXX, J																Referral to Christian chaplain as requested	5

LEGEND

TYPE (TP)

IV Pt. Care I
FV Pt. Care I
FM Family
PO Pre-op
DF Death
CC Care Con
SV Staff/Volu
FM Family M
SG Spirituali

SOURCES OF CONT

SR Self-Rou
RM RN/MD
SW Social W

SAMPLE LOG				W1			W2			W3			W4			W5			W6	W7	W
Date	On-Call (ONC)	Unit	Pt. Initials	Type of Encou	Contac from:	Referr made to:	# Family	# Staff	Emoti Suppo	Prayer or Medita	Sacran or Ritual	Tea for the Soul	Deced Care	Devot Mater	Advan Direct	Servic Recov	Length of Stay-LLOS	Wayfi	Notes	Total Min	
1/11		K7																	Interdisciplinary Rounds	20	
1/11		L5																	Interdisciplinary Rounds	15	
1/12		K7																	Interdisciplinary Rounds	40	
1/13		M4																	Interdisciplinary Rounds	30	
1/13																			Lunar New Year Celebration meeting with L[redacted]	50	
1/15																			Mortuary staff D[redacted] called for a covid-19 positive pt remain releasing inquiery. Contacted S[redacted] and had S[redacted] called back to the staff.	20	