Introduction

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1 Documentation: A Key Issue for Spiritual Care in a Digital Age

At first glance, this book deals with a dry, technical question. The issue of digital records sounds like an unremarkable aspect of our increasingly bureaucratic health-care systems rather than a topic for intriguing discussion. However, our experience of digital records tells a different story. In the academic and pastoral forums in which the issue has been discussed, it has led to intense, foundational, and often emotionally charged debates. Why should such a seemingly mundane subject trigger such lively discussions? At least three reasons can be given: First, documenting spiritual care in electronic medical records (EMR), and the associated training, tools, and collaborative work, may divert chaplains' time and energy away from their primary purposes of personal engagement and spiritual care. One may wonder whether the investment of scant resources in an activity of unclear benefit to patients can be justified. Second, documenting spiritual care touches on the professional identity of healthcare chaplains. For many decades, this has been characterized by a clear demarcation from health professionals, which has manifested itself in nonparticipation in typical health professional practices. Documentation was one of them. While it has long been the professional standard of clinical psychologists and social workers to document their work in medical records, it was until recently an unwritten rule that chaplains should not participate in this task. Pastoral confidentiality was and remains the standard argument for this abstention. In the light of this, one might ask: Doesn't chaplaincy jeopardize its professional identity by now conforming to health professional standards? This point leads to a third issue: the emergence of interprofessional spiritual care. Chaplains are confronted with the fact that nurses,

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psycho-oncologists, physicians, and other healthcare providers have started to record information about patients' spiritual needs. The traditional abstention of chaplains from interprofessional documentation is difficult to sustain when health professionals are already recording spiritual matters in their notes. What does it mean for healthcare chaplaincy and its documentation that spiritual care is becoming an interprofessional task?

If discussions about documenting spiritual care in EMR are passionate, this is not only because they raise concerns about chaplains' professional identity and the increasing demands placed on them. There are also positive reasons for this. Many sense in this new practice the opportunity for professionalization and a better integration of the spiritual dimension into healthcare. Among them are the majority of the authors represented in this volume. What unites all of the contributors to this collection, however, is a shared concern for the development of healthcare chaplaincy. The models presented in the following chapters showcase their very different visions for the future of spiritual care. The reader of this volume is invited not only to embark on a journey through different health systems but also to enter a laboratory where future models and tools are discussed and tested. Much is still in development, even though impressive prototypes are already in use.

The urgency of a discussion about the various models and forms of chaplaincy documentation can also be questioned. Are we not giving too much attention to something that is ultimately nothing more than a working aid? However, there is now little doubt that future healthcare chaplaincy will be required to demonstrate the extent to which it benefits patients and that documentation will play a necessary part in this. Given the primacy of patient well-being and the centrality of the personal encounter to the chaplain's vocation, it is essential that the impact of any system of documentation on these be carefully considered. Documentation practices require scientific support and a theoretical foundation. This book is intended as a contribution to this work. The next section sums up the research to date. The main desiderata and some perspectives for future research will be outlined in the last chapter of this book.

2 Research on Documenting Spiritual Care

The research on charting spiritual care in EMRs has been growing in recent years. In the following brief overview, we assign the studies relevant to our topic to five overlapping areas: (a) conceptual questions, (b) spiritual assessment, (c) models of documentation, (d) practices of documentation, and (e) patients' perspectives.

- (a) *Conceptual questions*: Robert A. Ruff's 1996 contribution, which has been much quoted since, can be seen as the starting point of the conceptual discussion. The title was programmatic: "Leaving Footprints: The Practice and Benefits of Hospital Chaplains Documenting Pastoral Care Activity in Patients' Medical Records." With their notes, chaplains leave traces of their work. Ruff

spoke also of the professional need for the “visibility of chaplains” (Ruff 1996, 390). They carry out their work in an evidence-based environment with an emphasis on accountability. Through their participation in interprofessional record keeping, they demonstrate a more comprehensive view of their work than that of their predecessors, conventionally restricted to religious care in a narrower sense (Cadge et al. 2011). It was in 2007, during the first wave of web-based EMRs, that this “visibility of chaplains” led to a burning debate revolving around the professional identity of healthcare chaplains. It was initiated by the physician Roberta Springer Loewy and her husband, the bioethicist Erich H. Loewy (Springer Loewy and Loewy 2007). In their view, chaplaincy certainly has a place in the clinical environment. Nevertheless, chaplains should be denied the right to access or contribute to patient-centered EMRs. The Loewys criticized the increasing professionalization of healthcare chaplaincy and its ever more systemic integration as problematic. Their argument follows the motto: cobbler, stick to your last, i.e., chaplain, stay in your religious field, and don’t invade the medical space! The critical position of the Loewys was addressed by McCurdy (2012) and others. Wintz and Handzo (2013/2015), for their part, draw attention to the main difference between parish clergy and healthcare chaplains. They define “clergy confidentiality” as a referring “to the information that someone seeking forgiveness shares with a clergyperson within the context of ritual confession.” As ritual confession only plays a marginal role in the work of healthcare chaplains, the reference to “clergy confidentiality” is misleading. According to Wintz and Handzo, the confidentiality of chaplains should be shaped by their specific duties. They point to the standards of the APC [Association of Professional Chaplains] which state that the passing on of information is allowed if it is “relevant to the patient’s medical, psycho-social, and spiritual/religious goals of care.” In the same vein, Alex Liégeois speaks of the “application of the relevance filter” (Liégeois 2010, 93). Only information relevant for interprofessional care can be written down.

- (b) *Documenting spiritual assessments*: The issues of spiritual assessment and documentation are closely connected. The results of any particular spiritual assessment have to be recorded in appropriate form. This is true as much for chaplains as for healthcare professionals (nurses, McSherry 2008; physicians, Puchalski et al. 2009; social workers, Hodge 2014). Although the literature on spiritual assessment is vast (cf. Balboni 2013; Rumbold 2013), the need for adequate forms and tools for documentation has so far rarely been discussed in this context. An exception is the doctoral thesis of Adams (2015) which investigates the relationship between spiritual assessment and the concrete interventions subsequently carried out. In his qualitative study of the patterns of documentation, Adams concluded that there was a need for a more consistent relationship between the two parameters of assessment and intervention. Hilsman offered an approach based primarily on (his own) experience. He brought into play twenty-two “spiritual needs” to be assessed and pleaded for a narrative, interprofessional record consisting of a few sentences (Hilsman 2017, 157). While Hilsman constructs a coherent tool for assessment and documenta-

tion in his own terms, the staff chaplains at The Ottawa Hospital followed the requirements of the College of Registered Psychotherapists of Ontario, which they had recently joined. Here, the development of new templates for electronic charting was embedded in a quality improvement project, which also included a qualitative examination of 104 spiritual care assessments that had been posted on the EMR (Stang 2017). This study is seminal in that it proves that electronic records can be both the object of a study and the instrument for research on healthcare chaplaincy. Because of their model-building approach, both Hilsman and Stang could also be included in the next area.

- (c) *Models of documentation:* In developing new models and tools for record keeping, chaplains essentially have two options, narratives or click-boxes. The question touches on the essence of spiritual care. In his paper “Pastoral Products or Pastoral Care? How Marketplace Language Affects Ministry in Veterans Hospitals,” Tarris D. Rosell (2006) referred specifically to the terminology used in charting and the power of language to both describe and create realities. But even if a mix of both documentation methods seems advisable and narrative practice is widely seen as the more comprehensive approach, there are voices that point to the merits of using checkboxes (Mösli et al. 2020).¹ Burkhart (2011) discussed the advantages and disadvantages of a Likert-scaled flow sheet with fixed categories compared to progress notes. While the click-box approach saves time and is more discreet, the question arises whether such standardization adequately reflects the self-conception of spiritual caregivers. Do narrative entries not reflect more faithfully the individualized approach of chaplaincy? Rebecca Johnson et al. (2016) advocate the development of new language skills and the cultivation of clarity so that the work of spiritual caregivers can be properly understood and accessible for later reference. The available literature (and the present volume) indicates not only that disparate models for charting spiritual care are in use but also that different models may be most beneficial in different contexts. A strict standardization is still far from being achieved, and may not even be desirable (Tartaglia et al. 2016).
- (d) *Practices of documentation:* A fourth group of studies examines current practices of record keeping. The research questions here extend in different directions, reflecting the spectrum from more descriptive to more evaluative approaches. An example of the former is the study of Johnson et al. (2016). The data – more than 400 free-text EMR notes – was taken from a particular and highly specialized place: a 23-bed neuroscience-spine intensive care unit. Through content analysis, recurrent topics are identified. The most common topics were reports of “patient and family practices, beliefs, coping mechanisms, concerns, emotional resources and needs, family and faith support, medical decision making and medical communications” (ibid. 137–139). Chaplains’

¹ Cf. the contributions of Peery (Chaplaincy Documentation in a Large U.S. Health System), Vandenhoeck (The Spiritual Caregiver as a Bearer of Stories: A Belgian Exploration of the Best Possible Spiritual Care from the Perspective of Charting), and Smeets and de Vries (Spiritual Care and Electronic Medical Recording in Dutch Hospitals) in this volume.

free-text EMR notes were also studied by Lee et al. (2017). Their goal, though, is not merely descriptive but also evaluative. They question the usefulness of chaplaincy EMR notes for interprofessional communication, for “documentation should provide clinically relevant communication.” The result of their study on free-text entries, however, indicates a great need for further development: “The value that chaplains contribute, however, through the depth of their interactions with patients, does not seem to be conveyed in the pattern of clinical documentation we observed” (ibid. 195). Most entries were insufficiently specific or contained only information already available in the EMR. Another 2017 study by Aslakson and others examined how the EMR entries of chaplains address spiritual matters, especially in the environment of intensive care. The study found that spirituality is extremely important to patients in intensive care units and their families but identified various environmental hindrances to the proper completion of spiritual care notes (Aslakson 2017, 653). Aslakson and her colleagues are critical of standardized schemes and checkboxes and prefer free-form notes that are characterized in particular by a certain narrative scope (ibid. 654). They draw on patient assessments and underline the importance of these, which are the topic of the next section.

- (e) *Patients’ perspectives:* The study of Lee and colleagues also highlights the problem of self-reporting bias. There may be a tendency to overreport perceived positive experiences or events that are more important for the chaplains themselves than for others. In their study of chaplain’s reports, Montonye and Calderone observed that they provided more information about the caregivers themselves than about the needs of patients (Montonye and Calderone 2010, 65). The notes reflected the perspective of the chaplains themselves rather than providing information from the patient perspective. In order to correct this self-reporting bias, studies are needed that systematically incorporate the patient’s perspective (cf. Snowden and Telfer 2017). A pioneering study along these lines was conducted in French-speaking Switzerland. Tschannen et al. (2014) surveyed 50 patients about their general attitudes toward the interprofessional documentation of chaplains. Significantly, the interviews were led by chaplains. The patients were asked whether they were in principle in favor of the passing on of personal information or whether they considered the idea to be problematic. About 70% of the respondents considered it to be desirable. Patients who were more pessimistic about their health status were more inclined to find the disclosure problematic. Remarkably, the study also found that the patients’ attitudes were dependent on the interviewer: the answers varied according to interviewing chaplain.

3 Overview of the Volume

The majority of the studies summarized in the previous section were conducted in the United States, reflecting the fact that the integration of chaplaincy in healthcare is most advanced there. Goldstein and colleagues have captured that deep integration in their survey of the US landscape in 2011. At that time, leading hospitals in the United States had fully integrated spiritual care departments, with chaplains retaining write access to the EMRs in the vast majority of cases (Goldstein et al. 2011). One of the aims of this book is to extend this research to other country contexts. In this book, this expansion of geographical scope begins with a historical exploration. The first chapter traces the history of spiritual documentation from an ancient discovery: the practice of notation as an instrument for spiritual self-care. It ends in an age in which digitalization has already penetrated large parts of the healthcare system and world in which the charting of spiritual care has spread to unexpected places, such as the slums of Nairobi.

This globalization of spiritual care and its documentation are described in more detail in the following chapters. They survey national developments in the United States, Canada, Australia, the United Kingdom, the Netherlands, Belgium, and Switzerland. Earlier versions of these papers were presented and discussed at an international conference in Switzerland. The comments after the contributions pick up the issues raised in these lively discussions.

Let us briefly outline the individual contributions: Brent Peery expounds how healthcare chaplaincy has been charted in the United States in recent years. The focus is on the model which chaplains in the Memorial Hermann Health System in Houston, Texas, work with. The templates used have been constantly revised and have reached a high level of development.

A similar dynamic of development, while more recent, can also be seen in the Canadian model presented in the next chapter. Bruno Bélanger and colleagues trace the careful process of reflection, construction, and implementation over the last few years. More than the other models considered in this book, the Canadian charting tool has been constructed around a theological core.

In the following paper, the perspective changes to a more administrative view on the development. As in Canada, new structures for healthcare chaplaincy are also emerging in Australia. Typical for a period of transition, divergent models and practices are being employed side by side. Remarkably, the officials of the administrative body “Spiritual Health Victoria” have fostered and steered this change by issuing guidelines as well as by implementing the “pastoral care intervention codes” in the Australian version of the ICD-10.

Finally, we turn to Europe, starting with a contribution from the United Kingdom which introduces also another professional perspective. Wilfred McSherry and Linda Ross, both rooted in nursing studies, offer an assessment tool for spiritual care in the field of general care. The fraught standing of religion(s) in the United Kingdom complicates the integration of chaplains into an interprofessional spiritual care. Standardized procedures and tools are still lacking. McSherry and Ross point out the importance of appropriate language and terminology.

The Dutch context is represented by Wim Smeets and Anneke de Vries. While interprofessional spiritual care and the integration of chaplains are more advanced here than in the United Kingdom, it is still a contentious whether chaplains' records should be part of the EMRs. The authors see this development as a facet of the professionalization of spiritual care which ultimately serves the well-being of patients.

With Anne Vandenhoeck's paper on the situation in Flanders/Belgium, the circle starts to close. The background of the model introduced at the University Hospital of Leuven accords with that of the Memorial Hermann Hospital in Houston. It builds on the outcome-oriented chaplaincy developed in the 1990s by Arthur Lucas in St. Louis/Missouri. Highlighting the importance of language and terminology, Vandenhoeck advocates a "narrative approach."

Last but not the least, Pascal Möslé offers a view on a small but nonetheless highly diverse context: the microcosmos of healthcare chaplaincy in Switzerland. On the basis of a survey, the contribution summarizes the viewpoints of chaplains. The majority see the current developments as an opportunity for professionalization. Finally, Möslé gives us an insight into a "construction site" where much is in motion and still to be decided.

The contributions in the second half of the book take up key topics already alluded to in the first part. These include the relationship between pastoral and psychological-psychiatric documentation and the spiritual aspects of the latter. Psychiatrists are used to keeping medical records, but not on spiritual issues. With a new openness for religious-spiritual aspects in psychiatry and psychotherapy, the question of the documentation of spiritual aspects arises. Eckhard Frick pleads in his chapter for a hermeneutic approach and speaks of a "translation work" of the psychiatric and psychotherapeutic guild, which has to be done in the documentation.

Most of the documentation models presented in this volume are cross-sectoral. At the same time, it is undisputed that documentation practices should be well adapted to the specific needs of a particular care area or profession. Paul Galchutt and Judy Connolly's contribution is dedicated to the field of palliative care, which plays a key role in the development of interprofessional spiritual care. What expectations do team members have of chaplains' record keeping? The paper makes it clear that chaplains must navigate a broad set of demands.

Finally, Guy Jobin approaches the issue from an ethical perspective. He addresses, among other things, the challenge of standardized information and documentation and the fears that the patient might disappear within the clinical setting. In principle, the "improvement of a deepened clinical relationship" should be the benchmark of technologization, digitalization, and, last but not the least, documentation.

In his final synopsis, Simon Peng-Keller concentrates on the analysis of the main drivers of the development and on perspectives for the future. He concludes that there have been three main drivers which have led to the rapid development of charting spiritual care in EMRs: first, the rise of outcome-oriented chaplaincy; second, the digitalization of society and healthcare; and, third, the religious-spiritual pluralization of Western societies and the subsequent "new governance in religious affairs."

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