Charting Spiritual Care: Ethical Perspectives

Guy Jobin

1 Introduction

The way in which healthcare institutions operate clearly has an influence on the provision of spiritual care. Clinical culture, i.e. all the knowledge, techniques, attitudes and values mobilized to provide care to patients in a healthcare institution or system, has an impact on several aspects of spiritual care, as do the administrative rules that govern each institution. In short, the provision of spiritual care in an institution or healthcare system is shaped by the normative and administrative framework of the prevailing institutional environment. This trend, inherent to the growing integration of spiritual care within the clinical system, illustrates spiritual care's ability to adapt but also its "precariousness." Its fragility requires chaplains to participate in processes that may change and transform their own approach to spiritual support.

Computerization is one of the changes that have forced chaplains to adopt new ways of communicating the information needed by the care team. This is always done with the goal of providing the best possible care, i.e. care that is appropriate and adjusted to the needs and expectations of patients and their families. As we will see, the new ways of sharing information have effects that go beyond a mere functional improvement to the communication of spiritual and religious information within the interdisciplinary care team. The computerization of patient files and charting processes may have unexpected consequences and raises a number of questions about the conditions for providing care and the quality of the spiritual care received by patients and their families.

The specialized literature presents a unanimous view: documenting the particularities of a specific clinical case helps improve care (Tartaglia et al. 2016). This observation holds true especially in the case of electronic health records (EHRs),

G. Jobin, (✉)
Laval University, Quebec City, QC, Canada
e-mail: Guy.Jobin@fts.ulaval.ca

which optimize the consultation of medical records for the purpose of verifying quality of care and conducting research to improve practices (King et al. 2014).

Chaplains often add notes to a patient's medical record, a process known as "charting." The practice established itself quickly in some jurisdictions, and more slowly in others (such as Québec, in particular), but is now part of the clinical landscape. Its importance is recognized by both chaplains' organizations, which see it as a skill to be acquired, developed and perfected (Board of Chaplaincy Certification 2017),¹ and by organizations that accredit and certify care institutions (JCAHO 2019).² As charting by chaplains has become an integral part of clinical life, it has also become subject to the general trend among care institutions to dematerialize medical, institutional and personal records.

The few studies that exist on the drafting of EHR notes by chaplains show that they are committed to the practice (Goldstein et al. 2011; Lee et al. 2017; Tartaglia et al. 2016), which is not surprising, given that it contributes to the goal of professionalization for spiritual care providers in the Western world (VandeCreek and Burton 2001; Handzo et al. 2014). The right to add notes to patient records was a demand that chaplains had been making for several decades in pursuit of greater recognition as professionals, in other words as peers within the interdisciplinary care team (Ruff 1996). EHR access consolidated their professional status. The fact that chaplains support the current practice, as noted by researchers, shows that there is little or no resistance to the trend if electronic tools are in place in the care environment.

EHR implementation raises ethical issues that must be addressed. An ethics-based review of information communication technologies must highlight the fact that they involve the same ethical challenges as the practices they replace and must also identify the challenges specifically raised by the use of technological innovations in the clinical environment. This is the goal of this chapter. The discussion is divided into four parts: (1) the ethical issues surrounding the communication of information, (2) the security of system access, (3) the impact of technology on clinical judgment and (4) the issue of recognition for the people involved in the care relationship.

Before examining these ethical issues directly, it is important to discuss some of the elements in the normative and professional context for EHR use by chaplains.

¹ professionalchaplains.org/files/2017%20Common%20Qualifications%20and%20Competencies%20for%20Professional%20Chaplains.pdf, retrieved March 1, 2019. The list of qualifications and skills has been adopted by five Canadian and American chaplaincy associations. Among the skills listed: PPS11 Document one's spiritual care effectively in the appropriate records.

² Joint Commission for the Accreditation of Healthcare Organisation (JCAHO), www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqId=1492&ProgramId=46m, retrieved March 1, 2019.

2 Normative and Professional Context

In the complex world of healthcare institutions, where practically everything is regulated by technoscience and bureaucracy, spiritual care is part of an environment structured by many different legal, administrative, professional, ethical and conduct-related standards. The normative framework may vary from place to place, but some degree of regulation is found everywhere. In fact, the normative environment stems from, and is supported by, two sets of standards. The first comes from “outside” the world of spiritual care and consists of the standards enacted by health certification authorities³ and the legislation in force in the jurisdiction concerned,⁴ along with any other rules created by the legitimate powers and authorities.⁵

The second set of standards originates “inside” the world of spiritual care and includes the standards of practice defined by the professional chaplaincy associations.⁶ In addition to these standards, professional associations set standards for training and the skills needed to provide spiritual care. For example, under the *Common Qualifications and Competencies for Professional Chaplains*, a chaplain must possess the professional competency to “Formulate and utilize spiritual assessments, interventions, outcomes, and care plans in order to contribute effectively to the well-being of the person receiving care.”⁷

Both sets of standards contribute towards the professionalization of spiritual care. They reflect, in their own way, changes to the task of chaplaincy, which has gone from a vocational calling to a professional commitment. Chaplaincy has adapted to the changes in healthcare that have occurred in recent decades and, more generally, to the social transformation brought about by ethical and religious pluralization in Western countries and the accompanying disaffection with the monotheistic religious traditions and the groups that embody them.

³As noted above, the JCAHO in the United States, Accreditation Canada, etc.

⁴For example, the Civil Code of Québec; the Health Insurance Portability and Accountability Act (HIPAA) in the United States; the Regulation of the European Parliament and the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (<https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32016R0679&from=FR>); the Loi Informatique et libertés (France); etc.

⁵For example, the religious regulation framework adopted by a jurisdiction, charters of rights and freedoms, and any agreements between a hospital administration and a specific religious group.

⁶Such as the Canadian Association of Spiritual Care, Association des Intervenants et Intervenantes en soins spirituels du Québec, Association of Professional Chaplains (USA), etc.

⁷Common Qualifications and Competencies for Professional Chaplains, PPS10. To which must be added the competency of communicating results, noted above, cf. note 2.

3 Ethical Perspectives

As indicated in the introduction, four ethical issues will be examined here: (1) the ethical issues surrounding the communication of information, (2) the security of system access, (3) the impact of technology on clinical judgment and (4) the issue of recognition for the people involved in the care relationship. Readers will note that the ethical issues involved are not just issues of deontology and have a far broader scope than the standards that govern the professional task of providing patients with spiritual support. It is because they directly or indirectly affect the quality of clinical judgments and the decision-making process that these themes are examined here in detail.

3.1 *Ethical Issues Surrounding the Communication of Information*

The ethical issues surrounding the communication of information in a clinical setting did not emerge suddenly at the same time as EHR. Confidentiality, professional secrecy, and all aspects of the disclosure or non-disclosure by caregivers of information gathered from patients as part of the professional relationship, are all mentioned in the Hippocratic Corpus (Beauchamp and Childress 2009, 303). However, the emergence of a clinical culture based on the ideal of interprofessional collaboration significantly changed the rules governing confidentiality. Since the 1980s, the strict interpretation of medical privilege has not been matched in actual practice, and the pressure placed by recent changes in clinical culture on the normative framework for confidentiality that applies to care professionals has a parallel in the field of chaplaincy.

The fundamental question for professional secrecy arises at the point of intersection between two key normative realities: the patient's right to privacy and the needs of society, which include the need of the system and practitioners to ensure effective care delivery (Verdier 2007). This point is, in fact, a place of tension between professional secrecy and the "imperative" need of care professionals to share information (Gilbert and Mettler 2010; Pautier 2017; Gekière and Soudan 2015). At a time when interprofession collaboration within care teams is being consolidated, the sharing of private information is key to the efficient and effective coordination of care, provided the delicate balance between the rights and duties of all players in the care relationship is respected. Although the tension between privacy and public interest is well known and discussed in the fields of medical ethics and bioethics, it becomes even more acute when new technologies multiply the possibilities for accessing medical information and promote sharing between ever greater numbers of stakeholders.

The ethical issues surrounding communication can be encapsulated in a few key questions: What information should a chaplain enter in an EHR? What criterion or

criteria should be used to sort all the information gathered? What justification should be required if a chaplain communicates a piece of information? What should be done with information that could compromise the patient's insurability or influence the quality of the care relationship? To these questions we can add those concerning EHR access, which are addressed in Sect. 3.2.

For chaplains, the principle of charting is already accepted, since it is important to "leave footprints" (Ruff 1996), given that if it isn't charted, it didn't happen, according to the clinical adage. The "professional" imperative to document the spiritual support process arises as soon as the chaplain is required to "report" his or her actions to colleagues in the interdisciplinary care team. Although not needed to fulfil a reporting or accountability requirement, a note added to the file lets other clinical workers know what work the chaplain has done and what recommendations the chaplain has for the team.

An example will complete this examination of the ethical issues surrounding the communication of information using EHR: Ruff's proposal, although dated, nevertheless presents the question of confidentiality effectively from the chaplain's point of view (Ruff 1996, 389–390). Ruff uses principles such as the right to confidentiality and the right to privacy to establish a distinction between information collected under the confessional seal and information gathered during a "normal conversation" that is not *sub secreto*. The strict rules governing confession suffer no exceptions, while information from a conversation can be entered in the record unless the patient objects: "Chaplains must distinguish between information shared by a patient in the normal course of conversation and information shared under the confessional seal. The former, with appropriate pastoral sensitivity, can be charted. The latter should never be charted" (Ruff 1996, 389). If the chaplain has doubts, or if the patient has expressed reservations, the situation must be discussed and the chaplain must always respect the patient's wishes. Ruff's position is clearly in favour of sharing information with team members, but he specifies that "information can always be shared with other staff verbally if the chaplain feels it is appropriate or too sensitive to be included in the chart" (Ruff 1996, 390). The principles and rules presented by Ruff are still present in the latest versions of the codes of conduct for chaplains produced by professional associations such as the Association of Professional Chaplains (USA) and the Canadian Association for Spiritual Care and by associations that supervise training programs, such as the Association for Clinical Pastoral Education. All of these regulatory bodies expect that the "assessment and summary of a chaplain's care is documented" (Common Standards for Professional Chaplaincy 2004). There is therefore a professional duty to add notes to the file, whatever its format – a duty created by the professionalization of the actions that provide spiritual support during illness. The Canadian Association for Spiritual Care (CASC) states, in its 2016 revised *Code of Ethics*, that the spiritual care practitioner "provide[s] other professionals with chart notes where they are used that further the treatment of the clients or patients, obtaining consent when required" and that s/he

“communicate[s] sufficient information to other care team members while respecting the privacy of clients.”⁸

We can end this section by mentioning that the normative framework for the disclosure of information gathered by chaplains leaves room for professional judgment when determining what must be communicated, to whom, at what time, by what means and with what degree of consent from the patient. The relevant standards give chaplains a responsibility that, as it were, precedes the act of adding a note to the file. This is the responsibility to discern what can be disclosed and to obtain the patient’s consent to do so. In short, the responsibility is the same for any information entered in a file, whether paper-based or computerized.

3.2 *Security of Computer System Access*

This issue extends beyond the question of confidentiality between peers, to encompass institutional protection for the data gathered using the digital platforms made available to care teams. In addition to protection against piracy from outside the institution – obviously an issue that is not limited to healthcare institutions – institutions must guarantee that only authorized members of staff can access electronic files. Patients, of course, must have given consent to access (Manaouil 2009). But once these ethical and legal considerations are brought into play, a decision must be made concerning the extent of access. Who can consult the information in the EHR?

Three categories of “readers” other than care personnel come to mind, each with its own access context. The first category is clinical researchers, who may require access to the electronic files, just as they do to paper-based records. It has already been noted that EHRs are a significant source of research data, especially since consultation is facilitated by the digital format of the information stored. An anonymization process is needed before access to data and records is allowed. However, some jurisdictions prohibit the use of EHRs for epidemiological studies⁹ and limit access to purposes connected with the clinical coordination of care.

The second category is clinical training and covers interns in chaplaincy training programs. For these interns, training for their future profession necessarily relies on access to the information in the records, provided they, like other clinicians, undertake to comply with the usual rules on data confidentiality.

The third category poses a more delicate question. It is composed of natural caregivers, volunteers and other non-care personnel who may be closely associated with the care of a sick person, but have no professional qualifications or care mandate from the institution. In general, volunteers do not have access to data, as confirmed by the studies mentioned previously. Besides volunteers, the most difficult

⁸CASC, Code of ethics, respectively Section D. #9 and 10; www.spiritualcare.ca/ethics_home/casc-code-ethics, retrieved March 6, 2019.

⁹This is the case in France, cf. Bourdaire-Mignot 2012.

case in this category is that of family members acting as natural caregivers, in other words family members or friends who take responsibility for some of the care provided in the home. The EHR could be a source of relevant information for the care given. There is little documentation on this topic.¹⁰ Chaplains must then be careful about the information they enter in the record when natural caregivers are involved in providing care, especially over a long time period.

3.3 *Influence on Clinical Judgments*

The use of standardized tools is already widespread in the technoscientific clinical culture and office environment of contemporary healthcare institutions and, as a result, there are calls from the world of chaplaincy itself to allow chaplains to participate in electronic platforms. These calls for closer involvement by chaplains in the clinical process, although they tend to show that healthcare institutions can promote and confirm the objective of professionalization,¹¹ nevertheless introduce a constraint that can be seen as the price to pay: the growing standardization of charting practices.

Discussion of this ethical issue – because it affects the quality of the communication of the clinical judgment – must begin with the observation that many different researchers, after looking at the question of charting by chaplains, agree with the push for standardization, in other words the adoption of a “charting model” (Peery 2012).¹² This objective of clinical research in the field of spiritual care, known as outcome-oriented chaplaincy, clearly has links to the movement in support of a form of evidence-based chaplaincy, in other words a focus “on outcomes of spiritual care, the development and testing of effectiveness of interventions, the development and evaluation of assessment and screening tools and research about key subgroups of patients” (Damen et al. 2018, 62).

Standardized charting does not automatically lead to a reductive format or, in other words, a reduction in the quality of the information communicated. It may, on the contrary, encourage chaplains to add information to the file that is significant for the decision-making process. This conclusion emerges from the small number of studies already cited: the use of a template acts as a filter for sorting information that is useful from information that is not. Training in charting ensures that chaplains do not add a mass of descriptive detail that may already be recorded elsewhere in the file but, instead, include elements of interpretation and assessment from each spiritual support situation (Lee et al. 2017, 194–195). Adding notes to an electronic file

¹⁰ The article by Smeets and de Vries, in this book, indicates that in the Netherlands, patients retain ownership of the data recorded in the file, meaning that the patient and the patient’s family have full access to the record. Elsewhere, as in Québec, the record is owned by the healthcare institution.

¹¹ Recognition is even more significant in jurisdictions where spiritual care is not legally recognized as a profession, such as the Netherlands and Quebec.

¹² Cf. also the contribution by Brent Peery in this book.

offers an opportunity to improve the charting procedure. After all, chaplains' notes may offer a significant contribution to clinical discussion and decision-making (Johnson et al. 2016, 145).

Johnson et al. nevertheless raise a question that is relevant to our discussion. The standardization of charting procedures must not lead to the omission of details that are idiosyncratic by nature (Johnson et al. 2016). They emphasize that charting must allow the inclusion of information that enriches the understanding of the patient's overall situation. Similarly, standardized charting must not be limited simply to an observation of the current state or a generic and even superficial judgment of the case. Each episode recorded must be part of a biographical progression and personal history that is already under way, for which the record is one element of tangible proof. The interpretation of a patient's situation can gain from being re-centred over time on the "long term." This added perspective will certainly improve the accuracy of the decisions made by the clinical team.

In addition, just as the virtues of a narrative approach have been recognized in medical practice (Charon 2006; Charon and Montello 2002), it is clear that a narrative recording of information about the patient for clinical judgment purposes can improve EHR use, provided chaplains are given the opportunity to provide the relevant data. The study by Johnson et al. of free-text documentation by chaplains highlights its impact in improving the decision-making process by recording elements that would be hard to report would otherwise be because they are so deeply rooted in the specifics of the case.

Bringing all the above remarks together, we can suggest that, ideally, any note added to an EHR should provide descriptive elements that are not already included in the record, elements that contribute to the interpretation and assessment of the situation, and elements to situate the clinical case in the patient's specific life history. This is why the choice of the interface model used in the clinical world is crucial, since it will partly determine the quality of the decision-making process and, ultimately, the appropriateness of the decisions made with respect to the actual case. This is confirmed in the study by Rathert et al. about caregiver/patient communications in the era of electronic health records (Rathert et al. 2017, 50–64). In a review article, the authors show that the use of EHR tools produces ambivalent results: "EHR use improves capture and sharing of certain biomedical information. However, it may interfere with collection of psychosocial and emotional information, and therefore may interfere with development of supportive, healing relationships" (Rathert et al. 2017, 62). This means that the standardization of charting practices may have an influence, via the decision-making process, on care practices and outcomes.

3.4 *Ethical Issues Surrounding Recognition*

The next issue examined here touches on a fundamental question in the field of ethics: recognition of subjectivity, in other words the fact (and normative ideal) of seeing the other as a subject in his or her own right, and not simply as a means or even an object upon which work is performed. A long philosophical tradition, beginning in the late eighteenth century, has addressed the specific question of recognition.¹³

To summarize succinctly, the “problem” of recognition can be defined as “identifying the conditions, processes and situations that lead to a situation in which *Ego* and *Alter* consider each other as equals [in dignity and law] and where the link between them is based on mutual respect and esteem. [...] [The notion of recognition] attempts to encapsulate the origin and consolidation of moral subjectivity in inter-subject relations – within the family, within society – and in the genesis of moral, social and legal relations within society” (Jobin 2013).

Recognition of the other as a subject has an undeniably moral scope since it confirms the other as an autonomous subject. In addition, recognition is expressed in several ways, such as respect for the other’s integrity in interpersonal relations and the equality of all in dignity and in law. But beyond the legal aspect, the process of recognition involves everything that defines the particularity and unicity of individuals or groups in a given society and all that “deserves” esteem. Attention paid to the other as an other, as different from one’s self, a unique being with a singular life path, is a mark of recognition, and the recognition offered in this way is a mark of mutual respect and esteem between individuals who recognize each other with their own specific differences. The link between the ethical question of recognition and the main focus of this text is based, specifically, on the latter aspect of the theory of recognition, and we can group some of the issues raised in the EHR literature under the theme of the ethics of recognition. The following discussion, without referring directly to chaplains, can shed some light on the topic.

Some criticism has been directed at various potentially problematic aspects of EHR implementation. The issue of anchoring a clinical situation in a life story, which can easily be masked by the standardized information required by the interface, resurfaces in an analysis of the political interests that underlie the implementation of templates. “No doubt, EHR interfaces are designed to make their use as efficient as possible, allowing clinicians to choose between checkboxes and radio buttons for predefined options. As EHRs evolve, these embedded layers add up and increasingly require that clinicians, at the time of care, enter a vast amount of highly structured information, much of which may not be clearly relevant to the individual patient” (Hunt et al. 2017, 406). This criticism by Hunt et al. points to the danger of obscuring the patient’s singularity behind the generic information “required” for the EHR. In the end, the authors make the hypothesis that “the EHR enforces the

¹³ German philosophers including Fichte (1762–1814) and Hegel (1770–1831) addressed recognition specifically. More recently, Jürgen Habermas and, above all, Axel Honneth have returned to the topic.

centrality of market principles in clinical medicine, redefining the clinician's role to be less of a medical expert and more of an administrative bureaucrat, and transforming the patient into a digital entity with standardized conditions, treatments, and goals, without a personal narrative." (Hunt et al. 2017, 418). One unwanted side-effect is the "patient disappearing," just when the goal is to share as much information about the patient as effectively as possible. The irony of the situation is clearly apparent. The patient, as a whole person, is hidden behind the general data generated by the methods used to investigate, gather and share data in an attempt to take responsibility for the patient.¹⁴

As highlighted by the last quote, the possibility of losing sight of the patient is not just a problem for the patient, but also for clinicians whose role now includes an extra administrative component that may distance them from their primary expertise. Other researchers have made similar observations. Petrakaki et al. claim that the introduction of EPRs (Electronic Personal Records) in England had a clear impact on clinical practice and the cooperative relationship between members of the care team. The research team showed that "EPR affords, as it interacts with health-care professional practice, some level of standardisation of healthcare professional conduct and practice, curtailment of professional autonomy concerning clinical decision-making and enlargement of nurses' roles and redistribution of clinical work within and across professional boundaries" (Petrakaki et al. 2016, 221). The point that attracts our attention here is the effect on clinical judgment, which can be perceived negatively by some players in the clinical world. Clinicians' autonomy with regard to their clinical judgment and active involvement in the decision-making process for a given patient may be affected by the limits imposed by a computer interface. Recognition for clinicians as subjects in their own right also requires respect for their professional autonomy.

4 Conclusion

The introduction of electronic health records (EHRs) into clinical practice appears to be irreversible. Where EHRs are used, chaplains have cooperated willingly with this way of reporting and sharing information with other members of the care team. They will have to, as a result, adapt their own note-taking practices to ensure effective, relevant and meaningful communication as part of the joint decision-making process.

¹⁴ The possibility of the patient disappearing reinforces the need for templates that offer space for entering free text and recording information that will provide a more substantial and contextual view of the patient and his or her situation. The issue of recognition clearly creates tension between effective inter-professional communication, based on formalization and standardization, and an exhaustive approach, which supports appropriate decision-making tailored to the patient's overall situation. I thank Simon Peng-Keller for his pertinent comments on this topic.

Although the specialized literature has addressed some of the “classic” ethical issues raised by EHRs, in particular those in connection with confidentiality and access, other questions, no less crucial, have received less attention and are addressed here. They include questions about the recognition of all players in the care relationship (both patients and caregivers) as subjects and the communication of “non-generic” information about emotions, values, life history, etc. The fact that chaplains contribute to EHRs is both a sign of and a vector for recognition of their work within healthcare institutions – yet a recognition that could involve a price to pay for chaplains and patients.

The classic issues do not acquire a new status because of the features of the computerized tools used – the regulation of professional and deontological conduct is the same as for paper-based tools. However, what requires more attention and discussion is the potential that computerized tools offer for noting the specific features of each situation, which in turn can provide maximally relevant and coherent input for clinical judgment. It is clear that, in everyday clinical practice, the ideal conditions for making a clinical judgment are not always present, but the shortcomings of the tools used to gather and share information should not be allowed to exacerbate to this situation.

Lastly, as with paper records, the fact that chaplains contribute to EHRs is both a sign of and a vehicle for recognition of their work within healthcare institutions. The overall picture that emerges from the literature so far as that the situation must be closely monitored, because recognition could involve an unacceptable price to pay for chaplains and patients. As in many other cases of technological innovation in a clinical setting, the effects on the quality of the clinical relationship – whether a care relationship or a support relationship – must be the main concern for players in the relationship and for the assessment of the practices involved.

References

- Association of Professional Chaplains, *Common standards for professional chaplaincy*. 2004. https://www.professionalchaplains.org/Files/professional_standards/common_standards/common_standards_professional_chaplaincy.pdf. Retrieved 3, 2020.
- Beauchamp, Tom L., and James F. Childress. 2009. *Principles of biomedical ethics*. 6th ed. Oxford: Oxford University Press.
- Board of Chaplaincy Certification Inc. 2017. *Common qualifications and competencies for professional chaplains*. www.professionalchaplains.org/files/2017%20Common%20Qualifications%20and%20Competencies%20for%20Professional%20Chaplains.pdf. Retrieved March 1, 2019.
- Bourdairé-Mignot, Camille. 2012. Le dossier médical personnel (DMP): un outil de stockage des données de santé en vue d'un partage. *Revue générale de droit médical*: 295–311.
- Charon, Rita. 2006. *Narrative medicine. Honoring the stories of illness*. Oxford: Oxford University Press.

- Charon, Rita, and Martha Montello. 2002. *Stories matter. The role of narrative in medical ethics*. New York: Routledge.
- Damen, Annelieke, Allison Delaney, and George Fitchett. 2018. Research priorities for healthcare chaplaincy: Views of U.S. chaplains. *Journal of Healthcare Chaplaincy* 24 (2): 62.
- Gekière, Claire, and Serge Soudan. 2015. Dossier patient informatisé et confidentialité: évolution des modèles et des pratiques. *L'information psychiatrique* 91 (4): 323–330.
- Gilbert, Muriel, and Désirée Mettler. 2010. Confidentialité et partage d'information en soins palliatifs. *Médecine et Hygiène* 25 (3): 105–112.
- Goldstein, H. Rafael, Deborah Marin, and Mari Umpierre. 2011. Chaplains and access to medical records. *Journal of Health Care Chaplaincy* 17: 162–168.
- Handzo, George, Mark Cobb, Cheryl Holmes, Ewan Kelly, and Shane Sinclair. 2014. Outcomes for professional health care chaplaincy: An international call to action. *Journal of Health Care Chaplaincy* 20 (2): 43–53.
- Hunt, Linda M., Hannah S. Bell, Allison M. Baker, and Heather A. Howard. 2017. Electronic health records and the disappearing patient. *Medical Anthropology Quarterly* 31 (3): 403–421.
- Jobin, Guy. 2013. Reconnaissance. In *Dictionnaire encyclopédique d'éthique chrétienne*, ed. L. Lemoine, E. Gaziaux, and D. Müller, 1713–1714. Paris: Cerf.
- Johnson, Rebecca, M. Jeanne Wirspa, Lara Boyken, Matthew Sakumoto, George Handzo, Abel Kho, and Linda Emanuel. 2016. Communication chaplains' care: Narrative documentation in a neuroscience-spine intensive care unit. *Journal of Health Care Chaplaincy* 22: 133–150.
- Joint Commission for the Agreement of Healthcare Organisation (JCAHO). www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqlId=1492&ProgramId=46m. Retrieved March 1, 2019.
- King, Jennifer, Vaishali Patel, Eric W. Jamoom, and Michael F. Furukawa. 2014. Clinical benefits of electronic health record use: National findings. *Health Services Research* 49 (1): 392–404.
- Lee, Brittany M., Farr A. Curlin, and Philipp J. Choi. 2017. Documenting presence: A descriptive study of chaplain notes in the intensive care unit. *Palliative and Supportive Care* 15: 190–196.
- Manaouil, Cécile. 2009. Le dossier médical personnel (DMP): “autopsie” d'un projet ambitieux? *Médecine et droit* 94: 24–41.
- Pautier, Silvére. 2017. Le secret professionnel soignant: un enjeu de démocratie sanitaire entre immanence et aliénation. *Recherche en Soins Infirmiers* 130: 53–67.
- Peery, Brent. 2012. Outcome oriented chaplaincy. Intentional caring. In *Professional spiritual and pastoral care: A practical clergy and chaplain's book*, ed. S.R. Roberts, 342–361. Woodstock: Skylight Paths Publishing.
- Petrakaki, Dimitra, Ela Klecun, and Tony Cornford. 2016. Changes in healthcare professional work afforded by technology: The introduction of a national electronic patient record in an English hospital. *Organization* 23 (2): 221.
- Rathert, Cheryl, Jessica N. Mittler, Sudeep Banerjee, and Jennifer McDaniel. 2017. Patient-centered communication in the era of electronic health records: What does the evidence say? *Patient Education and Counseling* 100: 50–64.
- Ruff, Robert A. 1996. “Leaving footprints”: The practice and benefits of hospital Chaplains documenting pastoral care activity in patients' medical records. *The Journal of Pastoral Care* 50 (4): 383–391.
- Tartaglia, Alexander, Diane Dodd-McCue, Timothy Ford, Charles Demm, and Alma Hassell. 2016. Chaplain documentation and the electronic medical record: A survey of ACPE residency programs. *Journal of Health Care Chaplaincy* 22: 41–53.
- VandeCreek, Larry, and Laurel Burton. 2001. Professional chaplaincy: Its role and importance in healthcare. *Journal of Pastoral Care* 55 (1): 81–97.
- Verdier, Pierre. 2007. Secret professionnel et partage des informations. *Journal du droit des jeunes* 269 (9): 8–21.

Open Access This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.