

Chaplains, Confidentiality and the Chart

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A 2007 article objects strenuously to hospital chaplains' practice of accessing and documenting in patients' medical records. This essay examines the ethical issues underlying this challenge, including confidentiality and privacy, the role of chaplains on health care teams, patients' expectations of chaplains, and the distinctiveness of spirituality. It also considers chaplains' actual documentation practices and the rationales offered to support them. The article concludes that there is a reasonable basis for chaplains' access to and documentation in patients' records, and proposes principles and priorities to guide confidentiality-related practices. Chaplains have a responsibility to inform patients that they chart and to engage reservations which patients may have.

IN 2007, A PROVOCATIVE ARTICLE with the innocuous title "Healthcare and the Hospital Chaplain" appeared in *Medscape General Medicine*. Among other things, the authors, bioethicists Roberta Springer Loewy and Erich Loewy, contended that chaplains had no business reading or "making notations" in the patient's medical record.¹

Arguably, Loewy and Loewy were late to the dance. By 2007, chaplain access to and documentation in medical records had become widespread, and charting was a frequent institutional expectation. In 2009 APC elevated documentation in the record to a formal standard of hospital chaplain practice, although outlier institutions that did not support this practice remained.² By 2012, leaders of an APC conference workshop on electronic documentation could write, "We are not here to discuss *if* chaplains should chart. That question has been resolved."³

Indeed, the practice of charting by chaplains has continued to grow, blessed and even mandated by more and more institutions.⁴ Nonetheless, the ethical issues raised by Loewy and Loewy remain germane although their questions are relevant in a way that the authors may not have anticipated—or accepted. It is worth remembering that what we in the HIPAA (Health Insurance Portability and Accountability Act) era casually call "PHI" (protected health information) may, from the patient's perspective, be far more than "information." Its disclosure—even to the health care team—may matter more to the patient than anyone knows. Therefore it is vital to reflect on how chaplains share—and protect—potentially sensitive information.

Further, I believe it is possible to suggest norms that, though not definitive, may provide helpful ethical guidance with respect to documenting or verbally sharing material about patients with colleagues. Such norms should aid reflection and decision making on critical ethical questions:

- How do chaplains responsibly access and document in patients' records?
- How should they respect and protect confidentiality in their work with patients, multidisciplinary colleagues, and institutions?

Unlike Loewy and Loewy, I maintain that chaplains should have access to patients' records on a need-to-know basis and the opportunity to write in the chart. I also think chaplains' approach to confidentiality requires a richer, more nuanced understanding of confidentiality *in their complex*

role than has emerged to date.⁵ That being said, Loewy and Loewy's arguments may help chaplains to think more clearly about the nature of confidentiality, the purposes of documentation, and their role in sharing and protecting sensitive material about patients within the health care team.

To contextualize and illustrate the ethical concerns, this article reviews one chaplain's account of the nature, purpose, and benefits of documentation in the medical record by chaplains and offers a constructive proposal outlining normative principles and value priorities that may help chaplains assess confidentiality- and documentation-related issues.⁶

The question of access

Although a thorough discussion of Loewy and Loewy's arguments about chaplains and confidentiality is not possible here, they make several important claims that suggest deeper questions about the identity of chaplains, the nature of health care, and confidentiality in the health care setting.⁷

1. Chaplains lack a sufficient basis for access to patients' medical records because they are neither "health care professionals" nor "full-fledged members of the health care team."
2. As clergy, chaplains are subject to a standard of strict confidentiality that would preclude documenting substantive patient information in the chart.
3. Patients view chaplains as clergy and expect them neither to read the patient's *medical* record nor to inform other staff members about conversations with the chaplain.
4. Spirituality itself is "the most deeply personal and private aspect of each patient's identity," and material in this vulnerable area requires special protection.

Gatekeeping issues

The issue of chaplains' status as health care professionals and full-fledged members of the health care team obscures a more fundamental issue: identifying an appropriate basis for chaplains' access to medical records.

In part it is a question of rationale: *why* do chaplains need access? If there is a sound *need-to-know* reason for chaplains to access confidential records, it provides a basis in principle for their participation in the health care "community of confidentiality" (my term) that accesses records and shares patient information. In a strictly biomedical model of patient care, there is no clear basis—and no obvious need—for the chaplain as a nonscientific, nonbiomedical specialist to read the patient's record.⁸ However, patient care also has a biopsychosocial dimension in which chaplains regularly engage patients.⁹ It has long been recognized that they are uniquely positioned to glean psychosocial information that is relevant to the course of the patient's medical care.¹⁰

Even more, provider organizations increasingly embrace an approach to care that stresses the whole person. The biopsychosocial-spiritual approach, whether deeply rooted in an organization's philosophical or theological vision or a product of prudent institutional choice, is supported in the medical literature.¹¹

Further, if institutional policy deems chaplains integral to the model of care, their activities, including accessing medical records, are encompassed in the patient's general consent to hospital treatment.¹² This is not merely a matter of bureaucratic authorization. Optimal wholistic care is possible only if relevant professional specialists may participate fully in the care.

While establishing this rationale provides a basis for access, the question of how chaplains are *qualified* to be fully involved in the care and therefore to access and write in the confidential record remains. The answer is multifaceted. Even without formal biomedical training, health care

chaplains' professional training and experience allows them to comprehend the key elements in medical records, recognize what they do not know, and obtain information as needed from other disciplines.¹³

More substantially, chaplains are qualified to contribute something of value to the confidential record and the health care team's wholistic understanding of patients. It is widely recognized that chaplains' training and preparation, coupled with a rigorous credentialing process, equip them both to contribute and to safeguard confidential material for the benefit and protection of patients.

An overlooked aspect of their competence, however, stems from the sometimes-denigrated status of chaplains as "clergy."¹⁴ Who more than chaplains is likely to be attentive to, and practiced at, managing confidential material?

Loewy and Loewy assert that chaplains should be subject to a standard of "strict confidentiality" approaching the secrecy of the confessional. This confidentiality standard would effectively preclude disclosure of any substantive material from patient-chaplain interactions to colleagues on the health care team. Clearly, chaplains' customary practice does not observe such restrictions. Chaplains are sure to find Loewy and Loewy's version of confidentiality too confining to fit the purposes or meet the expectations that institutions have for them in patient care.

Even when institutional expectations override other factors, however, it remains important for chaplains to integrate their information-sharing practices with an understanding of confidentiality in their role. It should be noted that this issue—what is and is not shared with the health care team—is rather narrow, and distinct from more frequently asked questions about when, and how much, information must be disclosed to external parties, e.g., law enforcement or endangered others.¹⁵

Documentation and confidentiality in context

Rob Ruff's 1996 article, "'Leaving Footprints': The Practice and Benefits of Hospital Chaplains Documenting Pastoral Care Activities in Patients' Medical Records," provides a useful context for understanding chaplains' documentation practices in relation to confidentiality.

The advent of chaplains' charting served multiple purposes.

- Participation in the community of documenting professionals was evidence that chaplaincy had come of age. Chaplains had joined the multi-professional mainstream, clearly belonged to the health care team, and had a new opportunity to contribute to patient care.
- Charting allowed chaplains to demonstrate their reliability in responding to referrals and to educate their interdisciplinary colleagues regarding their role. It also contributed to job preservation by increasing their visibility.¹⁶
- Institutionally, chaplains' participation in documentation helped hospitals to meet certain JCAHO (now Joint Commission) standards and to demonstrate that they were fulfilling their patient care mission wholistically.¹⁷

Ruff offers a primer on the content of appropriate documentation, maintaining that documentation should be concise, so that busy clinicians can glean information efficiently, and complete, so that nothing pertinent is omitted. Documentation should convey to team members what chaplains perceive of the patient *as a person*. It should also offer an assessment, largely a recording of impressions and observations, and should include a modest initial spiritual assessment.¹⁸

Ruff contends that patients normally have the right to expect that information shared with a clergyperson, including the chaplain, "will be ... held in private and not shared with others." He stresses that confessional information is privileged.¹⁹ Then he makes a critical distinction between what he terms the normal course of conversation and the confessional seal, stating that material

surfaced in the former may, "with appropriate pastoral sensitivity," be entered in the record.²⁰ This is the very prospect that would later alarm Loewy and Loewy. Why should a patient trust this third party to know what the patient would want disclosed, even to the health care team? Do patients understand their interactions with chaplains to be "normal" conversation?

Nevertheless, Ruff says chaplains may chart what is shared nonconfessionally because the medical record "is assumed to be a confidential document."²¹ The standard of confidentiality implied by this statement is what I term the health care standard, in which all information (perhaps other than confessions) is essentially equal and the health care team functions rather like a collective confidant. There are no real secrets; yet the team is ostensibly a community of nondisclosure.

This model, however, begs the question of whether patients would accept these assumptions. Would they be comfortable with documentation in the medical record of material they may consider highly personal and private and that may be read by non-chaplain clinicians?²²

Ruff is aware of such questions and includes a caveat about "sensitive" information that may surface even in normal conversation. He writes that it is "prudent" to inform the patient if the chaplain plans to document such material and, if the patient shows concern, to discuss management of information the chaplain believes should be shared. In his view, verbal sharing with other staff is always an alternative to written documentation.²³

Confidentiality as "informational privacy"

In their standard bioethics text, Tom Beauchamp and James Childress place confidentiality under the umbrella of privacy.²⁴ Privacy refers to a person's control over when, where, and how much to share himself or herself with others.²⁵ While people sometimes treat confidentiality and privacy as synonyms, the universe of privacy encompasses anything about a person that might become public, including, but not limited to, information about the person. Confidentiality, in contrast, is a feature of certain relationships and communications in which a person's privacy, especially informational privacy, is a concern.²⁶

Confidentiality is therefore a characteristic both of the relationship itself and of information and communication within that relationship.²⁷ HIPAA regulations reflect this understanding. Health care providers are to safeguard not only communication between patients and providers, but also a host of PHI, including the fact that a person is in the provider's care as a patient.²⁸

A confidential relationship already reflects a relinquishment of privacy. Patients voluntarily provide information about themselves in exchange for a guarantee that this self-disclosure will be carefully contained as well as the prospect of hoped-for benefit. The issue in confidentiality, therefore, is not an initial disclosure of self or information, but "*rediscovery*." (emphasis added)²⁹ The distinctive issue facing chaplains is rediscovery within the health care team.

A dual role: religious professional and chaplain

Chaplains arguably belong to two professions.³⁰ As a result, their approach to confidentiality is likely to be influenced by two models of confidentiality, drawn from each of their professional identities. As clergy or otherwise identified religious professionals, their initial understanding of confidentiality is typically formed within a religious or spiritual community to which they are accountable.

In the Protestant Christian community and tradition, which I know best, confidentiality has theological roots in the concept of stewardship. To confide is to "place in trust" information about oneself, and by extension the self as well. The recipient of the confidence is a steward or trustee, even of the very being of the confider.³¹ Further, in the congregational context, confidentiality is commonly viewed as a promise of secrecy that envelops *all* communication with clergy.³² This understanding could support Loewy and Loewy's claim that confiding in a chaplain may mean

sharing what is most deeply personal and private, which must then be treated with strict confidentiality by the chaplain as “clergy.”

Ethical commitments of counseling and psychotherapy, which have affinities with the ethic of clergy confidentiality, also inform the ethic of confidentiality for chaplains.³³ Other influences come from the ethics of medicine and health care; from law and regulation, especially the HIPAA Privacy Rule; and from professional organizations’ standards and codes.

In bioethics, the principle of patient autonomy stresses the need to consult the patient when questions about confidential information arise. One grounding for confidentiality itself is a blend of utility—everyone, including providers, is better off when confidentiality is respected—and beneficence—patients benefit when confidences are handled trustworthily. This rationale reminds chaplains that they are not only stewards of patients’ information, but also stewards of patients’ access to the care process.³⁴ If patients trust the confidentiality of that process, they are more likely to seek the care they need when they need it.

Standards and ethics codes of professional organizations add some value, though their guidance is uneven.³⁵ The APC Standards of Practice for Professional Chaplains in Acute Care Settings expect adequate documentation of spiritual assessments, including spiritual/religious struggle issues.³⁶ Presumably these issues are highlighted because the potential impact of spiritual struggle on health is supported by credible research.³⁷ Assessment reports should be adequate to inform team colleagues—the central consideration—yet should observe appropriate privacy/confidentiality.³⁸ This passing appeal to confidentiality may reflect a continuing sense that there is something distinctive about confidentiality in the patient-chaplain relationship. It may suggest that the stricter confidentiality standard for clergy/religious professionals remains a relevant, if underdeveloped, consideration for chaplaincy.

One source from the counseling/therapy sector holds that making patients aware of how their information may be used is critical to establishing and maintaining trust.³⁹ Absent such clarification, and perhaps specific authorization by the patient to document or verbally share certain information within the team, some potential for confidentiality-related violation of the do-no-harm principle will exist.⁴⁰ The nature of the possible harm will depend, in part, on what the patient expects regarding confidentiality.

Spirituality and patient expectations

Loewy and Loewy believe that patients expect chaplains not to share with other staff any material shared with the chaplain. They link this stringent confidentiality standard to a view of spirituality as the most deeply personal and private aspect of a patient’s life. The implication seems to be that spirituality is unique in its content and its peril, a *tertium quid* unlike biomedical or even biopsychosocial material in its need for confidential protection.

Not unlike some religious communities, Loewy and Loewy seem to treat spiritual material as that which is holy and therefore not to be repeated in written or even spoken form outside a limited context. Further, they treat spirituality as a source of special vulnerability, especially once its content is disclosed to others. As a result, they would extend virtually absolute protection to all that passes between patient and chaplain.

Perhaps spirituality is such a tender area because it has been fraught with risk. In a historically Christian culture, non-“orthodox” expressions of religion and spirituality have long been subject to judgment and condemnation. Even in an age of “religion-less” spirituality, the vestiges of this history cast a long shadow. Feelings of exposure, embarrassment, guilt and shame may readily attend the disclosure of one’s spirituality and spiritual life.

Is spirituality then so special that it requires a unique standard of confidential protection? I believe that, from a chaplain’s perspective, this question is too narrowly posed. Both the vulnerability and

the specialness associated with spirituality also may emerge when patients talk to chaplains about ostensibly *non*spiritual but emotionally charged events and experiences in their lives. Paradoxically, this “holy ground” may include some of the most “unholy” memories and feelings. Finding an opportunity to traverse that ground with an empathic other may prove deeply meaningful and nourish the soul. In the process, it may have implications for the biopsychosocial-spiritual care and potential outcomes for the patient and merit notice in the chart on that account.

Nevertheless, regard for the vulnerability that may accompany the emergence of powerful material requires a thoughtful approach to documentation. More than “patient seen and spiritual needs discussed” may be called for, but what is noted and how it is framed require discernment.⁴¹ Moreover, one will seldom know what a given patient expects about confidentiality without asking. Patients are not monolithic, and their expectations may be diverse—especially in the terrain of their holy ground.

Toward a normative framework: Principles and priorities

This article’s extended examination of confidentiality lays the foundation for a normative framework that chaplains and institutions may use to address documentation and confidentiality issues. The principles and value priorities that follow may inform chaplains’ and institutions’ approaches.

Though the principles are not arranged hierarchically, there is an overarching intent: to put patients and their interests—as *they* understand them—first. Principle 1 largely addresses issues at the organizational level; the others address concerns that chaplains may encounter in their work with patients, although these too may have organizational ramifications. While these six principles do not promise a neat and tidy resolution of confidentiality-related issues, they may promote and aid reflection. As they are subject to ongoing refinement, this articulation may be viewed as “Version 1.0.”

Principle 1: Identify and prioritize the values and interests at stake, putting the patient’s interests first.

In organizational (or departmental) deliberation about chaplains’ participation in documentation and their confidentiality-related practices, two questions may always be asked:

- What purposes and values, and whose interests, will be served by the use and protection of confidential information?
- Whose interests and what values *should* be prioritized, promoted and protected?

Ruff suggests a list of interested parties whose good is to be considered: patients; staff in clinical disciplines, the institution, the chaplaincy profession and the chaplaincy enterprise within the institution.⁴² Individual chaplains’ interests are a part of that enterprise, and I propose two others: the interests of future patients (who may benefit from policy decisions) and the good of spiritual care as a multidisciplinary endeavor in which chaplains are recognized specialists.⁴³

Patients’ best interests are central, but they are not a simple matter and should be thoughtfully construed. It is a truism that patients come to hospitals primarily to have biomedical needs addressed; however, their interests typically include other important values, such as preserving privacy, which they may prioritize over what others consider their best, i.e., medical, interests.⁴⁴

In addition, optimal biopsychosocial-spiritual documentation by chaplains not only benefits patients one at a time but, over time, indirectly benefits future patients and spiritual care itself. Team members’ understanding of and contribution to spiritual care can grow; chaplain documentation may facilitate this growth and help to orient new staff members to this aspect of care—again, to

the potential benefit of future patients. Not incidentally, professional chaplaincy may benefit as well.⁴⁵

As for institutional interests, optimizing biopsychosocial-spiritual care is not an institution's sole priority, whatever its philosophy of care. The term "institutional interests" covers a broad range of possibilities, e.g., regulatory compliance, avoiding potential litigation, meeting accreditation standards, minimizing reputational risk (or maximizing opportunity).

With such considerations in mind, the array of interests might be prioritized as follows:

1. The patient's best interests, including privacy-related interests.
2. Interests of future patients.
3. The cause of spiritual care as a vital aspect of biopsychosocial-spiritual care.
4. Institutional interests.
5. Clinical staff members' interests, including their role in addressing numbers 1, 2 or 3.
6. Professional chaplaincy's interests.
7. Intra-institutional chaplaincy interests.

The items to be included in this list, or their ranking, may be debated. One constant should remain, however: put patients first.

Principle 2: Respect and appreciate the potential sacredness in what the patient communicates and document accordingly.

This principle draws on what chaplains tend to do by nature and/or formation and training. In respecting holy ground, the chaplain is truly a steward, a trustee, of what patients share.⁴⁶ Because patients place their communications in the chaplain's safekeeping, "handle with care" is always an appropriate maxim and should extend to disclosure within the health care team.

What chaplains write should not simply be "routine." It may be a disservice to the mystery of the person, and to the spiritual realm that chaplains seek to illumine, to reduce it to repetitive clinical terminology. Evoking the spiritual dimension in an economy of words is worth creative effort.⁴⁷

Principle 3: First, do no harm.

In the documentation-confidentiality context, harms to the individual patient resulting from disclosure are the main concern. Today's patients, for example, have the opportunity to read their medical record, especially after an episode of care. If the person's sense of psychological or spiritual safety might be jeopardized if he or she knew—or were later to read—what the chaplain plans to write, it should be reconsidered.⁴⁸

Such vulnerability is one reason that some theological understandings of confidentiality emphasize the priestly or pastoral relationship as a form of sanctuary in which the vulnerable confider can find refuge, a protected space of safety in which to disclose without fear.⁴⁹ The do-no-harm principle protects this sanctuary.

Principle 4: Inform patients that chaplains document and are open to discussing what this means.

Some observers caution against assuming that patients/clients/congregants understand confidentiality and the terms of a professional relationship in a certain way, then acting on that assumption without testing it.⁵⁰ Even more, "if you know that in good faith you are supposed to share information with, say, other members of your staff, it is improper to suggest otherwise to those who tell you things."⁵¹ No less than misleading words, a professional's silence on this point

may serve to “suggest otherwise.” The omission may reinforce a confider’s assumption of secrecy or a near equivalent, and the professional who later discloses information, even to staff colleagues, is guilty of being unfaithful to “implicit promises made.”⁵² Harm may not be inflicted—a patient may never know, for example—but arguably the person is wronged.⁵³

Patients may not understand that chaplains routinely document patient encounters. I believe that the default practice should be to inform patients that the chaplain will document and to provide an opportunity for the patient to respond with any questions or concerns.

The default practice would admit of some exceptions, but only in carefully circumscribed situations. If this practice is adopted, chaplains may fear that patients will be more hesitant to share, that trust will be undermined, and that needless anxiety will be introduced into the patient-chaplain relationship. I think that most patients will recognize the inevitability of documentation in the hospital setting and that worst-case, or even difficult, scenarios will be rare. Over time, best practices to address such scenarios may be developed.

If a patient does refuse assent to documentation of conversations with the chaplain, I think the chaplain normally will be obligated to honor the refusal, perhaps with a brief note to that effect in the record. A patient’s desire for the chaplain’s silence, even within the interdisciplinary team, appeals especially to the ethic of the chaplain’s first profession. It may call for a professional integrity that supersedes institutional protocol and even the team’s access to information that could optimize biopsychosocial-spiritual care.

Principle 5: Apply the “need-to-know” test thoughtfully.

The HIPAA Privacy Rule permits the use or disclosure of PHI on a need-to-know basis for treatment purposes.⁵⁴ This is also a longstanding ethical criterion of confidentiality. Several questions may facilitate thoughtful and creative use of the criterion.

- What information needs to be shared—and not shared—to advance the patient’s best interests, as the patient would see them?
- What information would be likely to promote optimal biopsychosocial-spiritual care for this patient?
- What information would help the human dimension of this patient emerge, so that the whole person may be better cared for?

In this context, recall that while HIPAA’s need-to-know standard is also a minimum necessary standard and imposes a certain limiting discipline, it is not a nothing-at-all standard.

Principle 6: Ask, “What would I want—and not want—disclosed to the health care team if I were this patient?”

It may rightly be argued that this tack has its perils. The chaplain is not the patient. Even health care chaplains are shaped by the health care worldview, whose values could skew their decision making.⁵⁵ Nonetheless, it may be a useful thought experiment for the chaplain to imagine being in *this* patient’s place and seeing confidentiality through his or her eyes. Alternatively, and without reference to an individual patient, the chaplain might ask “what would I would want if I were a CPE student, a therapy client, or a candidate for professional certification and my confidential information was to be included in a supervisory evaluation, therapist’s notes, or presenter’s report?”⁵⁶

Admittedly, these six principles do not sound a fully clear and consistent note about what and how much chaplains should document. Perhaps Version 2.0 will succeed in that endeavor. If this article facilitates productive reflection on confidentiality and documentation questions, it will have accomplished an important task.

Postscript

Ruff's 1996 article, referred to earlier, situates confidentiality and documentation in the real-world pressures and opportunities that chaplains continue to face in 2012. Electronic documentation is poised to become the new normal and brings its own challenges and opportunities.⁵⁷ In the electronic medical record (EMR) era, documentation may help to establish spiritual care and chaplaincy care as consistent patient care expectations and also may drive quality improvement efforts.⁵⁸

There is anecdotal evidence to suggest that chaplains' current documentation practices lean more toward concise, even reticent, than complete as Ruff envisioned.⁵⁹ Some in the profession point to a bare-bones tendency in charting with a paucity of narrative and commentary resulting in notes that go unread by other disciplines.

If such reports are representative, patient confidentiality should be well protected, at least in the written record. However, sparse documentation may not display the larger biopsychosocial-spiritual picture that Ruff sought. Indirect benefits to patient care and to future patients, especially the teaching function that narrative notes may serve, can fall by the wayside. Institutional introduction of EMR formats that offer only a check box option for chaplain documentation may hardwire the problem. Chaplains would be wise to seek inclusion of a narrative option in hospital EMR systems.⁶⁰ In any case, achieving a reasonable balance between expression and parsimony in documentation may be an emerging challenge.

Study of the issues faced by chaplains in documentation and confidentiality suggests a possible research agenda. There appears to be little or no formal research on chaplains' documentation practices or their understanding of confidentiality. It would be helpful to know more about how chaplains document, as well as their views of and attitudes toward confidentiality. It would also serve professional chaplaincy to have a clearer idea of patients' assumptions about confidentiality and their expectations regarding chaplains' documentation or verbal communication about them.

Finally, a word of gratitude is in order for both Roberta Springer Loewy and her husband Erich Loewy, who died in 2011. They have done the field of chaplaincy a perhaps unintended service with their provocative challenge to chaplains' practices. The Loewys press chaplains to be more reflective about documentation and confidentiality, to be articulate about why they do what they do, and, not least, to avoid assuming that good intentions guarantee ethical practice. In my view this is all to the good.🔥

¹ Roberta Springer Loewy and Erich Loewy, "Healthcare and the hospital chaplain," *Medscape General Medicine* 9, no. 1 (2007): 53, www.ncbi.nlm.nih.gov/pmc/articles/PMC1924976/?report=printable.

² Association of Professional Chaplains (APC), "Standards of practice for professional chaplains in acute care settings," December 15, 2009, Standard 3, Association of Professional Chaplains http://professionalchaplains.org/index.aspx?id=1210#acute_care (accessed August 4, 2012); Loewy and Loewy, "Healthcare"; H. Rafael Goldstein, Deborah Marin and Mari Umpierre, "Chaplains and access to medical records," *Journal of Health Care Chaplaincy* 17, nos. 3-4 (July-December 2011): 163.

³ George Handzo, Susan Wintz and Cassie McCarty, "If it's not in the chart, it didn't happen: The challenges and opportunities of EMRs," workshop, 2012 APC Annual Conference, Schaumburg, IL, June 2012.

⁴ Goldstein et al., "Chaplains and access," 166.

⁵ Margaret E. Mohrmann, "Ethical grounding for a profession of hospital chaplaincy," *Hastings Center Report* 38, no. 6 (November-December 2008): 19; Martha R. Jacobs, "What are we doing here? Chaplains in contemporary health care," *Hastings Center Report* 38, no. 6 (November-December 2008): 15-18.

⁶ Rob A. Ruff, "'Leaving footprints': The practice and benefits of hospital chaplains documenting pastoral care activities in patients' medical records," *Journal of Pastoral Care* 50, no. 4 (Winter 1996): 390f.

⁷ Loewy and Loewy, "Healthcare."

⁸ Ibid.

⁹ Ibid.; George L. Engel, "The need for a new medical model: A challenge for biomedicine," *Science* 196, no. 4286 (8 April 1977): 129-136, cited in Bruce D. Feldstein, C. George Fitzgerald, D'vorah Rose, Mary Kraft and Angelika Zollfrank, "Healthcare and the hospital chaplain revisited," unpublished, May 2007.

¹⁰ Russell L. Dicks, "Standards for the work of the chaplain in the general hospital," *Hospitals* (November 1940): reprint without pagination; Ruff, "Leaving footprints," 390-91.

¹¹ Daniel P. Sulmasy, "A biopsychosocial-spiritual model for the care of patients at the end of life," *The Gerontologist* 42, Special Issue III (2002): 25-33, cited in Feldstein et al., "Healthcare and hospital chaplain."

¹² Joseph Tamborini Czolgosz, personal conversation, December 16, 2011.

¹³ Loewy and Loewy, "Healthcare."

¹⁴ Ibid.

¹⁵ Barbara Blodgett, *Lives Entrusted: An Ethic of Trust for Ministry* (Minneapolis: Fortress, 2008), 42; Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York, NY: Oxford University Press, 2009), 296-310.

¹⁶ Ruff, "Leaving footprints," 384, 390f.

¹⁷ Ibid., 384, 391.

¹⁸ Ibid., 387f.

¹⁹ Ibid., 389.

²⁰ Ibid.

²¹ Ibid.

²² Loewy and Loewy, "Healthcare."

²³ Ruff, "Leaving footprints," 389-90.

²⁴ Beauchamp and Childress, *Principles*, 296-310.

²⁵ Gerald Corey, Marianne Schneider Corey and Patrick Callanan, *Issues and Ethics in the Helping Professions*, 7th ed. (Belmont, CA: Thomson Brooks/Cole, 2006), 212.

²⁶ Beauchamp and Childress, *Principles*, 296, 302.

²⁷ David B. McCurdy and George Fitchett, "Ethical issues in case study publication: 'Making our cases' ethically," *Journal of Health Care Chaplaincy* 17, nos. 1-2 (January-July 2011): 59.

²⁸ Code of Federal Regulations, 45 CFR 164.508, 2010 <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=edebd741a6cb311d3973b4fe26b72d8e&rqn=div8&view=text&node=45:1.0.1.3.79.5.27.6&idno=45> (accessed September 18, 2012).

²⁹ Beauchamp and Childress, *Principles*, 302.

³⁰ Mohrmann, "Ethical grounding," 19; McCurdy and Fitchett, "Ethical issues," 60.

³¹ D. Gene Kraus, *Confidentiality in the United Church of Christ: Some Theological Reflections* (Cleveland, OH: Parish Life and Leadership Ministry Team, United Church of Christ, 2002), 2.

³² Blodgett, *Lives Entrusted*, 33, 36.

³³ Ibid., 36, 41.

³⁴ Kraus, *Confidentiality in the UCC*, 2.

³⁵ APC, "Standards of practice"; Spiritual Care Collaborative, "Common code of ethics for chaplains, pastoral counselors, pastoral educators, and students," 2004, Association of Professional Chaplains <http://professionalchaplains.org/uploadedFiles/pdf/common-code-ethics.pdf> (accessed August 4, 2012).

³⁶ APC, "Standards of practice," Standard 3.

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- ³⁸ APC, "Standards of practice," Standard 3.
- ³⁹ Corey et al., *Issues and Ethics*, 167.
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