November 2011 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Goldstein, H. R., Marin, D. and Umpierre, M. "**Chaplains and Access to Medical Records**." *Journal of Health Care Chaplaincy* 17, nos. 3-4 (2011): 162–168.

SUMMARY and COMMENT: This month's article is an excellent illustration of a chaplain's use of research to address a matter of professional practice. When access to patients' medical records was questioned at his institution, Rabbi H. Rafael Goldstein undertook a systematic survey of pastoral care access/documentation at major hospitals in the US, partnering with co-authors Deborah Marin, MD, and Mari Umpierre, PhD. The findings not only helped bring about change for the chaplains at Mount Sinai Hospital but suggest a *de facto* standard of practice for pastoral care among top hospitals, potentially useful to all chaplains.

The lead author personally contacted the pastoral care departments at 44 hospitals that were ranked highest by *US News and World Reports*: their Honor Roll and top hospitals for oncology, cardiology, and geriatrics, along with additional high-ranking hospitals for neurology, diabetes, kidney disease, gastroenterology, pulmonology, and ear, nose and throat treatment. Four key questions were posed, with the following results:

1) Does the hospital chaplain(s) have access to the medical chart?
RESULT: 100% of all of the hospitals surveyed "grant chaplains access to the medical record." [p. 165]

2) Does the chaplain(s) enter notes in the chart?
RESULT: 100% of the Honor Roll hospitals and all but one of the other hospitals surveyed had chaplains enter notes in the chart. "One hospital did not allow chaplains to make notes in the medical record, but chaplains kept their notes in the Department of Pastoral Care." [p. 165]

3) Does the chaplain (s) have access to the electronic medical record, if any?
RESULT: Chaplains had access to electronic charting in all of the hospitals that currently had electronic documentation systems. Among hospitals that did not yet have electronic documentation, "there was anticipation that if and when the electronic medical chart would be implemented in these hospitals, chaplains' notes would be included" [pp. 165-166], with the exception of the one institution (noted in #2, above) where chaplains documented only in a departmental record.

4) Is there any special credentialing required by the hospital to allow for this access, beyond the qualifications to be hired as chaplain?
RESULT: "None of the hospitals required additional hospital credentialing for chaplains." [p. 166]

The authors sum up the practical affect of this study:

> Based on this research, the decision was made at our institution to allow chaplains access to the medical chart, to make notes in the chart, and to be fully integrated into the electronic medical record. No additional credentialing was required for this access. The Medical Board also agreed that there was no need for additional credentialing for chaplains. ...The Director of the Department of Pastoral Care was asked to be involved in the development, design, implementation, and testing of the electronic medical record.

The authors note the limits of the study: namely that the research questions "did not address the contents of what is actually written in the medical records by Chaplains" [p. 166] and that the results should not be generalized, since the top institutions surveyed here "may have more resources than other hospitals" [p. 166]. However, the *US News and World Reports* rankings are often touted within health care and, in this reader's experience as a chaplain, the practices of the so-called "top hospitals" are frequently looked upon as *best practices*. The fact that this survey showed 100% of the Honor Roll hospitals, and all but one of the others in the sample, had chaplains document in the medical record should make a powerful argument for the practice in any institution.

The article lists the hospitals surveyed [pp. 166-167] according to their categories and offers a sound bibliography. The target audience is one for which the role of professional chaplains requires some explanation, hence an introductory section on chaplaincy in general [--see pp. 162-164]. The usefulness of this article should extend beyond the question of documentation, to discussion of what it means for chaplains to be fully integrated into multidisciplinary health care teams.

Suggestions for the Use of the Article for Discussion in CPE:

Students' discussion of this article may well follow different lines, depending on whether they have access to and document in the medical record. For those who do have access and who document, the study may engender a new sense of the *value* of that activity (with which students are sometimes uncomfortable); and for those who do not have access, it may pose an image of multidisciplinary integration worth considering. The authors are careful to note that chaplains' documentation in the medical record remains debatable (--see Related Items of Interest, §3, below). Are students able to articulate their own position with a sense of both pros and cons? Another area for discussion could revolve around the use of research to promote the role and function of chaplains. There is a strength to an argument based upon empirical data, since it is usually less dismissible in the modern world than an argument based mainly upon logic or ideals. Research isn't only a means for discovery; it is can be a means for being *heard* on an issue. Students might want to think about what aspects of chaplaincy they wish were better understood by non-chaplains, and how research might provide a voice for their concerns.

Related Items of Interest:

I. Documentation in the medical record is part of the Standards of Practice developed through the Association for Professional Chaplains. In 2009, the organization published Standards of Practice for Professional Chaplains in Acute Care Settings. See Standard #3: "Documentation of Care," which includes a list of basic elements of a chaplain's documentation. This was followed in 2011 by the publication of Standards of Practice for Professional Chaplains in Long-term Care Settings. The content of Standard #3 differs somewhat here.

Chaplains' documentation is also addressed in the military context by Army regulations: "Medical Record Administration and Healthcare Documentation" (version of January 4, 2010). See pp. 2-3: "Hospital chaplains are allowed access to medical records subject to standards contained in the American Hospital Association Guidelines for Recording Chaplains' Notes in Medical Records. Visiting clergy will not have access to ITRs

[inpatient treatment record]. Chaplains enrolled as students in clinical pastoral education courses will be afforded the same privileges as hospital chaplains. Chaplains assigned to a residential treatment facility (RTF) will be allowed, but not required, to document information in medical records. The RTF chaplain will document the factual and observational information called for in the American Hospital Association Guidelines. As a team member in an RTF, the chaplain is encouraged to include additional information that would be helpful for the total care and treatment of the patient. Such information is considered observational." [See also the note about the American Hospital Association Guidelines on p. 144.]

II. The Association for Professional Chaplains traces their project for Standards of Practice back to the development of standards by the American Protestant Hospital Association in 1940. These early standards were inspired in part by a presentation at the APHA's 1939 meeting by Russell L. Dicks, who was the chaplain of the Presbyterian Hospital in Chicago. Dicks' address, "**Standards for the Work of the Chaplain in the General Hospital**," was published in 1940 in the journal *Hospitals* (and later reprinted in *The Caregiver Journal* [vol. 12 (1996): 2-5]. It is available online through the APC. See Section 4: Records of the Chaplain. This article is an interesting glimpse into the development of professional chaplaincy and provides an important background to the issue of documentation. While Dicks says that documentation might not be considered indispensable, "the fact that [the chaplain] does not [document] is the chief reason why a chaplain has not up to the present time been considered a necessary person in a well equipped hospital" [--see the fourth of unnumbered pages].

III. Our featured article notes a 2007 piece by Roberta Springer Loewy, PhD, and Erich H. Loewy, MD: "**Healthcare and the hospital chaplain**," in the online publication *Medscape General Medicine* [9(1):53]. Loewy & Loewy make an argument *against* documentation by chaplains. They write quite polemically and with an emphasis on issues of confidentiality. It is available freely online through the National Center for Biotechnology Information (NCBI) database, as well as through Medscape (which offers access after free registration).

IV. The bibliography of our featured article provides a number of good leads for further reading, but one article that may be of special interest is by Chaplain Rob A. Ruff: "**'Leaving footprints': the practice and benefits of hospital chaplains documenting pastoral care activity in patients' medical records**," *Journal of Pastoral Care* 50, no. 4 (1996): 383-391. The author, a staff chaplain at Hennepin County Medical Center in Minneapolis, MN, uses the SOAP method for documentation: S = Subjective Information, O = Objective Information, A = Assessment, and P = Plan (of care). Though that particular method may not be of interest to all chaplains, readers should appreciate Ruff's list of "Outcomes of Chaplain Charting" [p. 390] --what he sees as the practical benefits of documentation.

V. [Added 6/8/17:] For research into how documentation plays into CPE residency programs, specifically with regard to electronic medical records, see:

> Tartaglia, A., Dodd-McCue, D., Ford, T., Demm, C. and Hassell, A. "**Chaplain documentation and the electronic medical record: a survey of ACPE residency programs**." *Journal of Health Care Chaplaincy* 22, no. 2 (2016): 41-53. [(Abstract:) This study explores the extent to which chaplaincy departments at ACPE-accredited residency programs make use of the electronic medical record (EMR) for documentation and training. Survey data solicited from 219 programs with a 45% response rate and interview findings from 11 centers demonstrate a high level of usage of the EMR as well as an expectation that CPE residents document each patient/family encounter. Centers provided considerable initial training, but less ongoing monitoring of chaplain documentation. Centers used multiple sources to develop documentation tools for the EMR. One

center was verified as having created the spiritual assessment component of the documentation tool from a peer reviewed published model. Interviews found intermittent use of the student chart notes for educational purposes. One center verified a structured manner of monitoring chart notes as a performance improvement activity. Findings suggested potential for the development of a standard documentation tool for chaplain charting and training.]

VI. [Added 6/11/17:] See also the June 2017 Article-of-the-Month, which explores several questions relating to chaplains' roles, including: "What are the implications of allowing chaplains full access to patient medical records?" In addition, see the October 2016 Article-of-the-Month for a study of chaplains' notes in an ICU.
