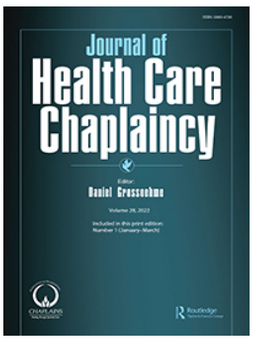

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The changing face of spiritual care: current developments in telechaplaincy.

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ABSTRACT

In recent years, and particularly since the Covid-19 pandemic, telehealth has been rapidly introduced into U.S. healthcare institutions. While preliminary data and best practices are beginning to emerge, it remains unclear how chaplains are responding to this development in practice. Consequently, professional organizations have tended to lag behind the changing demands of increasingly digital professional environments. This article addresses this gap by presenting three case studies of U.S. healthcare settings where chaplains have become an integral component of telehealth infrastructure: the Mercy system, Ascension Health, and the Veteran's Health Administration of the U.S. Department of Veteran Affairs. Based on interviews with chaplains and directors of chaplaincy departments, it shows how the 'telechaplains' at these institutions have adapted to the introduction of telehealth across the continuum of care, and discusses the legal, economic, practical and theological challenges and hopes reported in each case.

KEYWORDS

Case study; interviews; telechaplaincy; telehealth; virtual hospital

Few trends are transforming healthcare delivery like the introduction of information and communication technology (ICT) into healthcare. Among existing applications in diagnostic and therapeutic equipment, case management or patient education, 'telehealth', is displacing medical care from its traditional confinement within the walls of the hospital. Understood as the "delivery of health care services, where patients and providers are separated by distance", telehealth uses "ICT for the exchange of information for the diagnosis and treatment of diseases and injuries, research and evaluation, and for the continuing education of health professionals" (World Health Organization, 2016, p. 56).

Telehealth made its first inroads in 'low touch' applications such as laboratory information services, radiology, pathology, or patient monitoring and psychiatry (World Health Organization, 2016). In recent years, it has been introduced to most areas of general and specialist care, in particular to the care for time-critical conditions such as trauma and stroke, and to improve access for rural and other underserved populations (Barbosa, Zhou, Waddell, Myers, & Dorsey, 2021). Advocates of telehealth cite smoother

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post-discharge care transitions; improved monitoring of the elderly and chronically ill and patients with high-acuity care needs; prevention of infectious disease transmission; reduction of patient travel time; reduced no-show rates; the freeing up hospital beds for acute care; early detection through remote monitoring, and improved quality of life associated with at-home care (Brandes, 2021; Doarn, Henderson, Rasmussen, & Schoenberg, 2019).

According to the largest U.S. database of private health insurance claims, between 2016 and 2017, billing for telehealth services grew by 53%, outpacing all other modes of service provision (FAIR Health, 2019). In 2019 alone, over 100 U.S. hospitals and health systems launched telehealth services (Drees, 2019). With the Covid-19 pandemic, adoption has increased by several orders of magnitude. If trends since the peak of the pandemic are indicative, telehealth use has continued well above pre-pandemic levels, particularly in the field of behavioral health, where adoption after January 2020 stabilized at a 70% increase compared with pre-pandemic levels (Anderson, Bertram, Freedman, Ross, & Krivopal, 2021, p. 8). The Ohio-based Cleveland Clinic, for instance, which routinely tops U.S. hospital rankings, aims to conduct half of all outpatient visits virtually by 2023 (Doarn et al., 2019).

Where do chaplains stand in this development? The implications of the transition to outpatient care has long been of concern to chaplaincy researchers (Anderson, Holst, & Sunderland, 1990). This trend has accelerated with the Covid-19 pandemic and hastens the adoption of telehealth (Handzo et al., 2020). Although in some institutions chaplains have used telehealth for almost a decade, other than studies on telephone-based interventions (Betz et al., 2019; Sprik, Walsh, Boselli, & Meadors, 2019, Sprik et al., 2021; Zwart et al., 2020), little research is available on this development. The available literature has so far focused on possible practical and theological implications for spiritual care providers (Atkinson, 2017; Cobb & Chang, 2018; Fleenor, 2021; Haußmann, Teschmer, Wiesinger, & Wissner, 2021), with several articles published in response to the use of videocall technology during the Covid-19 pandemic (Byrne & Nuzum, 2020; Kwak, Rajagopal, Handzo, Hughes, & Lee, 2022; Papadopoulos, Lazzarino, Wright, Ellis Logan, & Koulouglioti, 2021; Swift, 2020). Currently there are no studies investigating how chaplains have integrated into increasingly complex telehealth infrastructure, and it remains unclear how telehealth affects the provision of spiritual care.

Responding to the call to investigate the on-the-ground experiences of healthcare chaplains (Fitchett & Nolan, 2015; Nolan, 2021), this article addresses this gap by presenting three brief case studies of institutions where the adoption of telehealth by chaplains is relatively advanced. While the WHO has thus far not engaged with professional spiritual care, in light of its active interest in 'digital health' (World Health Organization, 2021) and its ongoing rapprochement with religious communities (Winiger & Peng-Keller, 2021; Peng-Keller et al., in press), it seems appropriate to understand 'telechaplaincy' in terms of the WHO definition of telehealth: as "the delivery of spiritual care where patients and providers are separated by distance. Telechaplaincy uses ICT for the exchange of information for spiritual assessment, care for spiritual distress and injuries, research and evaluation, and for the continuing education of spiritual care professionals."

Between February and May 2021, the author conducted preliminary informal interviews ($n = 13$) with chaplaincy researchers and representatives of professional associations in Europe and the U.S. to gain a sense of present understandings, concerns and interest regarding telechaplaincy in the wider community of spiritual care professionals, and to identify healthcare institutions suitable for further investigation. A review of secondary literature and publicly available information on each institution was conducted. Three were selected according to the following inclusion criteria: (1) the institution is one of the largest healthcare providers in its catchment area; (2) the institution maintains a professional chaplaincy department where chaplains make "distinct contributions to medical teams", are "automatically called or regularly integrated" into patient care, are "seen as essential by the hospital and are always present in some situations", and (3), the institution actively integrates chaplains into its telehealth infrastructure (Cadge, 2013, p. 115). The three cases selected were the Mercy system, Ascension Health, and the Veteran's Health Administration of the U.S. Department of Veteran Affairs.

In a second step, targeted semi-structured interviews were conducted with chaplains and directors of the chaplaincy departments ($n = 7$) with a view to investigate how telechaplaincy was introduced and is currently used in each case. The interviews were conducted, transcribed and summarized by the author. An informal monthly discussion group with telechaplains ($n = 5$–10) presently employed at leading U.S. healthcare settings was initiated to explore how the issues raised in interviews compare with developments in other contexts. The group met via videocall 5 times between August 2021 and January 2022. The author had no prior knowledge of the persons or healthcare systems involved in this study and the cases are presented in no particular order.

A changing face: three cases

The U.S. Department of Veteran Affairs (VA)

With over 9 million enrolled veterans and nearly 1,300 health facilities, the VA's health administration is the second largest integrated healthcare system in the U.S. (House Committee on Appropriations, 2019; Robertson, 2021). As a federal agency, it is mandated to provide its services to communities living in underserved rural areas, a population estimated to constitute one-quarter of all veterans (Lee, Capra, & Klobucar, 2016). Due to the wide geographic spread of the veteran population, the VA has long figured as an early adopter of emerging technologies to improve access to its healthcare services (Elliot, 2019).

The VA's telehealth services are administered by its "Office of Connected Care". It provides telehealth services for remote monitoring; the asynchronous sharing of data for diagnostic purposes, and the use of videocall software to facilitate patient-provider consultations at a distance – termed 'Clinical Video Telehealth' ('CVT'. House Committee on Veterans' Affairs, 2016; Office of Connected Care, 2021c). CVT uses a tablet to link a patient at a 'Community Based Outpatient Clinic' (CBOC) with a provider, typically a specialist, at another clinic. In recent years, VA Video Connect (VVC) has been introduced to connect patient and provider through personal mobile devices, enabling what the VA refers to as 'anywhere-to-anywhere' consultations (House Committee on Veterans' Affairs, 2016). The VA has also developed a suite of several dozen

smartphone applications which can be downloaded by patients and providers to connect to its telehealth infrastructure. In 2018, the VA began to scale up the use of telehealth, particularly to improve mental health care referred to by then-VA secretary Robert Wilkie as the "last, great uncharted frontier of medicine" (Ogrysko, 2018). Citing gains in efficiency and patient satisfaction, the VA's leadership began to further institutionalize the move to digital infrastructure during the Covid-19 pandemic (Heyworth, Chapman, Zulman, Ferguson, & Kizer, 2020; Shane, 2021).

Chaplains are available 24 hours a day at every medical center operated by the VHA, with well over 800 chaplains employed nationwide (FOIA request, VA Office of Human Capital Management). As telehealth has accompanied a broader trend in the VA towards outpatient and community-based care, particularly among its large rural population, chaplains are transitioning to a healthcare environment increasingly dispersed across a network of outpatient clinics served through digital interactions. With the introduction of VVC and similar applications accessed directly from the patient's mobile device, this trend has further decentered healthcare from walk-in, 'brick and mortar' clinics where chaplains have typically met patients and their families.

In the early-2010s, Juliana M. Lesher, then the Chief Chaplain at the South Texas Veterans Health Care System and now national director of the VA Chaplain Service, created the VA's first telechaplaincy programme, intended to integrate chaplains into emerging telehealth applications and help bring them "into the 21st century" (VAntage Point, 2019, para. 13). In 2011, the VA's telechaplaincy service was launched (Office of Connected Care, 2020). Due to the highly regionalized organizational structure, the introduction of telechaplaincy occurred unevenly over the following years – as a VA-internal aphorism goes: "if you've seen one VA medical center, you've seen *one* VA medical center" (Interview, VA telechaplain 1). A VA medical center in Rollesberg, Oregon, became one of the first to integrate its chaplains into telehealth infrastructure after interviews with patients had shown that about half were interested in talking to a chaplain remotely. A year later, a veteran who had just come off active duty was hired as its first telechaplain. In 2015, chaplains at the Maine center began using a portable CVT tablet given to veterans in rural areas to reduce travel time to the nearest CBOC (Parker, 2015). Another major center in Houston introduced telechaplaincy, and eventually began to use it to educate clinicians remotely, join care planning meetings, or to facilitate self-help groups meeting at CBOCs (Interview, VA telechaplain 1). In 2016, the Office of Connected Care produced a detailed guide which adapted the VA's telehealth policies to chaplaincy, formally introducing the term 'telechaplain' into U.S. public healthcare (Office of Connected Care, 2021a).

For many VA chaplains, the integration into telehealth infrastructure has begun to change how they work. One chaplain in the Sioux Falls region involved in developing the VA's telechaplaincy policy was initially inspired by a veteran of the Second World War. Raised in the "horse and buggy days", he was "incredibly excited" when a chaplain allowed him to meet his nephew, who lived a considerable distance away, via VVC (Interview, regional chief chaplain). Another key moment occurred when a very ill patient, shortly before his death, was able to see his nephew one final time, on a Friday night at her birthday party via VVC. Since then, a volunteer donated several computer tablets to the clinic, and currently, an estimated 20–30% of interactions with veterans

are conducted through mobile devices. In the Sioux Falls healthcare system, veterans can contact a chaplain anytime through VVC, and chaplains are trained for what the VA refers to as "TeleChaplain Family Reunions" – often for "last goodbyes" with relatives (Interview, VA regional chief chaplain). Similar provisions have been rolled out at other clinics.

A reported advantage of telechaplaincy specific to the needs of veterans relates to the care for war trauma. Due to the high incidence of post-traumatic stress disorder among veterans, driving to the nearest clinic is often a stressful experience, especially for victims of road-side bombs, which in Iraq were estimated to be responsible for up to half of military deaths and were significantly related to suicide incidence rates among U.S. army soldiers (Bird & Fairweather, 2007; Ursano et al., 2017). "One of our biggest concerns in the beginning, recalls this chaplain, "was 'how do we help our veterans not feel so isolated?' Because they like to get out. They want to get out, but now they're afraid to get out". For these veterans, as for other former soldiers who suffer from recurring traumatic memories, meeting chaplains in the "safe space" of their own home and at a moment's notice helps to reduce anxiety related to travel and public spaces. It also allows the chaplain or a chaplain-led peer group to offer support during or immediately after such incidents. As she points out, "Vets connect to each other with stories, and if their stories are broken, we need to heal them" (Interview, VA regional chief chaplain). By allowing the chaplain to be present during moments of crisis, rather than weeks later during a health-related visit to a clinic, this chaplain can support the veteran as he or she is developing new, healing narratives of their wartime memories.

Another use case reported to be particularly relevant to veterans is in the struggle with substance abuse, endemic among service members returning from duty (VA National Center for PTSD, n.d.). In Sioux Falls, VVC has been introduced to a spiritual self-help group for alcohol addiction, which meets online twice a week. As the catchment area of the Sioux Falls system covers a vast rural area across three states, this has allowed the group to meet regularly despite being separated by vast distances.

The treatment of substance abuse is often supported by moving away from environments known to trigger relapses. In one reported case, a veteran chose to move to a 40-acre farm to raise horses, where he became active in a local equestrian therapy association, greatly helping him work through his addiction (Interview, VA national programme manager). Through the VA's telechaplaincy provisions, this veteran continued to receive spiritual care. Accordingly, the normalization of chaplains in the daily life of military staff, and the fact that over half of VA chaplains themselves are veterans, has eased the delivery of telechaplaincy in the patient's own home, particularly for health problems which are perceived as shameful. Cases such as these are felt to illustrate that integration into the VA's telehealth infrastructure ought not be framed as a matter cost savings, but as a tool allowing chaplains to meet veterans where they are, and help them to live the kind of life they want (Interview, VA national program manager). The avoidance of stigma associated with mental health problems in particular is recognized by Lesher as a key contribution made by chaplains, and seen to be enhanced by the privacy afforded by telechaplaincy (Office of Connected Care, 2020)

Ascension Health

With 151 hospitals and operations across 20 states, Ascension Health is one of the largest U.S. healthcare systems, ranking just behind the VA (Dyrda, 2020). The adoption of telehealth has rapidly expanded since 2010, when Ascension Health began to partner with Amwell, a leading provider of telehealth technology. In 2018, as part of major restructuring to reduce costs, the institution began to step up the transition from hospital-based care to home-based, outpatient care facilitated through telehealth (Kacik, 2018).

As a Catholic faith-based institution – Ascension describes its work as "health ministry" – chaplains play an important role in its operations. In addition to providing spiritual care across the continuum of care, they have a broader institutional function which includes mentoring clinical staff, conducting new staff orientation, and sitting on institutional review boards (Heintzkill, Lou O'Gorman, & Richter, 2012). Chaplains at Ascension began to experiment with telehealth in the mid-2010s, and began to build what is now referred to as "On Demand Spiritual Care". As recalled by one chaplain closely involved in this development, chaplains working at the institution's population health division began to notice the widening gap in the manner in which chaplains worked compared with physicians, who routinely used various telehealth applications: "we looked out the window and saw an ocean on the other side … the clinical care team already had all of it [telehealth infrastructure], and spiritual care didn't even know it existed" (Interview, director of spiritual care). In the following years, senior management tasked chaplains to integrate more closely with Ascension's telehealth infrastructure, and in the past two years, telechaplains have become recognized as an insurance benefit and integral component of telehealth workflows. Unlike many institutions, where during the Covid-19 pandemic chaplains were barred from seeing patients, chaplains at Ascension were well prepared. Most inpatient chaplains stayed on-site, where they could connect relatives and quarantined patients using a tablet brought into the room, in some cases to facilitate last goodbyes. Telechaplains could seamlessly transition to work from home if needed, and many continued to work from home following the peak of the pandemic (Interview, director of spiritual care).

Ascension's "On Demand" service aims particularly to meet the needs of outpatients who require long-term care, but is deployed across a continuum of care spanning from prevention to palliation. Like the VA, Ascension serves a vast geographic catchment area, which brings the challenge of travel time both for patients required to visit a treatment site, and for chaplains visiting outpatient clinics. "On Demand" chaplaincy is thus also intended to help serve a large population of patients who could not be reached with conventional on-site interactions during hospital visits, in particular the chronically ill. Telechaplaincy is also valued for making it easier to establish contact with particularly busy patients at a time suitable to them, and supports patients who would like to reduce on-site visits in order to maintain a sense of normalcy in their life (Muehlhausen & Chappelle, 2021). As the patient determines when and where contact is made, chaplains often find themselves "in their space" and must adapt to the environment of the patient. Sometimes, spiritual care is provided while the patient is doing other things, such as driving to a doctor's appointment. Interestingly, despite the

availability of video calling apps, many patients prefer to speak on the phone (Interview, director of spiritual care).

Integration into the institution's rapidly expanding telehealth infrastructure and the concurrent shift to "On Demand" spiritual care has also brought the challenge of maintaining such demand. Unlike conventional inpatient care, where chaplains can knock on the doors of patients and encounters with relatives unfold spontaneously at the bedside, in corridors and in waiting rooms, chaplains must find new ways to make themselves available. One way of generating 'leads' is through cooperation with Ascension's preventive care strategy, for which the institution analyses large data sets to identify at risk populations to be screened by a care management team. The program is aimed, *inter alia*, at populations living with chronic disease, high-risk maternity cases, patients with elevated health risk factors, pediatric Medicaid members, and dual eligible Medicaid and Medicare patients with significant illness. As part of this strategy, Ascension employs a 'research chaplain' specifically responsible for interfacing with epidemiologists and data scientists working in this area.

Over the past years, this effort has resulted in the inclusion of questions testing for spiritual distress included in the preventive screening administered to patients through their mobile device. If spiritual distress is indicated, the nurse in charge notifies a chaplain, who then contacts the patient via phone or videocall. The app can also send messages to the patient, such as reminders to take medication, and can be expanded to include invitations for spiritual exercise such as meditation.

Urgent care provisions are also in place for spiritual care, and a chaplain can be requested 24 hours a day and at 10 minutes notice through an online interface. The interface allows the patient to choose which chaplain to speak to and provides basic information about who is available at the time – as it does for urgent care physicians and some other clinical staff. An in-house software moreover allows patients to book a chaplain in advance and initiate a videocall directly within the web browser, removing the need to navigate additional apps, which remains a challenge for some patients (Interview, director of spiritual care).

By working closely with the institution's preventive health strategy, including an initial spiritual assessment in routine screenings administered via mobile device, demand for spiritual care has been maintained in a healthcare setting where, in many scenarios, virtual encounters are becoming the norm.

Mercy

Mercy is a medium-sized health system (Robertson, 2021) active in the U.S. South and Midwest, where it employs over 40,000 staff. Over the past decade, Mercy has introduced telehealth to manage real-time patient records, to schedule and conduct routine clinical consultations, and monitor and intervene in intensive care units. Mercy also uses telehealth to relieve staff at other hospitals during nighttime, and when clinicians are occupied during emergencies. In 2015, the institution opened a "virtual care facility" in St. Louis dedicated entirely to telehealth, which it describes as a "hospital without beds" (Mercy, 2022). Health care providers at this facility spend most of their days sitting in workstations equipped with six computer screens, through which care teams

communicate with the patient and coordinate interventions. A central focus at the St. Louis facility is the remote monitoring of outpatients suffering from chronic illness through a program termed "vEngagement". Patients enrolled in the program receive a computer tablet with attachments which collect and transmit biometric data to the care team, allowing the detection of problems before the patient experiences any symptoms. It also allows the patient to conduct videocalls with the care team, see upcoming medical appointments and complete daily surveys about their health.

As a Catholic faith-based health system, chaplains are felt to play a well-respected role in the interdisciplinary team, and they are consulted formally using the electronic medical record and informally through secure chat. Spiritual care is understood as a responsibility of all staff, and chaplains are seen as specialists responsible for a program termed 'vSpiritualCare'. On admission, every patient is approached by the telechaplain on duty, who contacts the patient via videocall to conduct a spiritual distress screening and create a follow-up plan if needed. Visits with telechaplains are typically planned in weekly, biweekly or monthly intervals, with the possibility to speak to a chaplain on the same day in cases of acute distress (Austin, 2021). Like at Ascension, telechaplaincy is part of a population health program, in this case aimed at patients over the age of 65 years old living with chronic life-limiting illness. A large proportion of patient volume comes through this program. About 5000 patients and/or families are seen a year through telechaplaincy, with a year-over-year increase in volume, particularly since the Covid-19 pandemic.

At the time of writing, Mercy employs two dedicated telechaplains who serve a widely dispersed population from their workstations at the Virtual Care Center. In their experience, integration into Mercy's telehealth infrastructure has transformed how they serve their patients (Interview, Mercy telechaplains 1 and 2; Mercy director of spiritual care). The routine use of videocall opens what one chaplain describes as a "window into the patient's world" through which they may revise their assumptions about a patient. In one recent case, a patient had been viewed as medically non-compliant as she ignored phone calls and did not take her insulin. It was not until a chaplain spoke to her via videocall that it was noticed that the patient had been living out of her car, had nowhere to charge her phone and store her medication. This information was relayed back to her care team who then worked with social workers to support this patient. Chaplains have also learned to use the 'window'-effect to gather contextual clues about the patient, alerting them to potential safety issues, or gaining an impression of the general lifeworld of the person.

Often, children's drawings or photos of relatives stuck to the fridge or hung on living room walls emplace the patient in his wider social environment in a way not possible during conventional in-person visit in a hospital or physician office: "I can point to those literally and say, who's that behind you? And it is, 'oh, that's my grandchild. And that's my, you know, daughter over there. […] Oh, that's a picture of me hiking the Appalachian Trail" (Interview, Mercy telechaplain 2). While encounters with patients' family members in inpatient settings are typically coincidental, patients consulted via videocall sometimes drag their spouse into the video camera or introduce the chaplains to "everyone for the last 13 generations" shown on a legacy wall behind them. Meeting patients in their own home in this way, not bedridden or wearing a hospital gown, is

perceived by Mercy's chaplains as reframing the patient as not defined by their disease, and thus as profoundly humanizing (ibid.).

Like chaplains at other institutions interviewed for this study, meeting patients digitally on their own terms is felt to alter the balance of power between patient and provider: "oftentimes when a patient is in our hospitals […] there's this constant barrage of people cycling through" (ibid.). During digital visits, chaplain and patient receive each other's undivided attention, and the patient has a much lower barrier to refuse or end an encounter, "allowing them to have the power to say when that relationship begins, and when that relationship ends" (Interview, Mercy telechaplains 1 and 2). As the patient decides the time, duration and place of engagement, chaplains also are conscious to ensure that they are sufficiently integrated across the continuum of care, so that demand does not drop off when patients cannot be actively visited in-person. Like at Ascension, this is achieved by analyzing large socio-demographic and epidemiological datasets in order to identify at-risk populations, who are then screened remotely for spiritual distress. Anecdotal evidence seems to suggest that populations with high mortality risk scores generally have relatively high levels of spiritual distress, allowing chaplains to use epidemiological risk as a proxy to infer populations where more targeted interventions may be appropriate (ibid.).

The changing balance of power has also affected how chaplains are present with patients. Conscious that a conversation can be ended at any time, every moment requires active "buy in" from the patient: When the patient is "completely empowered to end this conversation at the push of a button", chaplains are in every moment "buying time" to provide spiritual support. "When you're actually in the same room as someone you can be quiet for three minutes, and it feels comfortable. But in a virtual setting, you really have to bring your own energy to the encounter […] when you are providing virtual spiritual care, you can't just be there. You have to *be* there." (Interview, Mercy telechaplain 1).

Being more actively present promotes more intervention-based encounters – which, incidentally, lend themselves to demands for outcome assessment – and pushes chaplains to find new ways of bringing significance to each encounter. Focusing on events such as anniversaries is one technique, as is the maintenance of eye contact. The signification and ritualization of events in a patient's life are well-honed skills for hospital chaplains, but still, keeping eye contact through a digital encounter – achieved by looking directly into the camera while watching the patient through one's peripheral vision – has taken the chaplains interviewed for this case several years to learn. Whereas conventionally, healthcare chaplains tend to minister to the patient through their presence at the bedside, telechaplaincy has made encounters more fluid: "Sometimes you lead, sometimes the patient leads, but it's a dance, and when the song ends, the encounter is over." (Interview, Mercy telechaplain 1).

Lastly, the 21st Century Cures Act passed in 2016 requires patients to be given unfettered access to their chart notes, which includes those written by chaplains. The ability of patients to view their chart notes on their mobile device immediately after an encounter greatly increased the pressure on chaplains to appropriately record the encounter, including correct names and relevant biographical details. Even more so, the patient's ability to view the revision history and comment directly on the notes has

further complicated conventional ways of charting (Peng-Keller & Neuhold, 2020). Mercy's chaplains report being able to adapt to this change through telechaplaincy, as chart notes can be written as the chaplain is speaking with the patient, and details do not have to be remember until he or she has returned to the office. Mercy chaplains also report using Google to look up information relevant to the patient's condition or spiritual needs while in a meeting with a patient – which would be very disruptive if done during inpatient visits (Interview, Mercy telechaplains 1 and 2).

Discussion

The possibilities of computer-assisted healthcare chaplaincy have long been on the horizon (Buehler, 1986/1988). Today, spiritual care professionals are rapidly adapting to the introduction of digital media into nearly every aspect of society. The internet has been taken up as a new means for educating chaplains, ranging from newsletters to webinar-series and online certification programs (Handzo & Wintz, 2020) and lively debates on social media. Online museums (Densford, 2020) and -communities (Coutts, 2013) have furnished novel venues for the production and exploration of professional self-identity and virtual and augmented reality are creating new forms of 'telepresence' with potential applications in healthcare (Walking Cinema, 2021; Young, 2022). Enterprising organizations have begun to provide "spiritual first-aid" on websites tailored to specific audiences (Strano, 2014, para. 7; The Company Chaplain, 2021), and telehealth has been rapidly introduced in many clinical contexts where chaplains work.

With the Covid-19 pandemic, many chaplains have gained extensive experience with digital interventions. Recent survey data (Best, Rajaee, & Vandenhoeck, 2021; Flynn, Tan, & Vandenhoeck, 2021; Snowden, 2021; Sprik, forthcoming), pilot projects such as the "Video Goodbye Tool" (Frydman, Choi, & Lindenberger, 2020) and interviews conducted by colleagues (Swift, 2020) suggest a growing acceptance of telechaplaincy among the larger European and North American community of spiritual care professionals. Some telechaplains have begun to articulate best practices (Austin, 2021; Chaplaincy Innovation Lab, 2020; Fleischman, 2016, 2017; Massey, 2021; Muehlhausen & Chappelle, 2021; Sprik et al., forthcoming). However, in view of the rapid adoption of telehealth in U.S. healthcare institutions, particularly since the Covid-19 pandemic, this work has not kept pace with the changing professional realities of many providers. Institutional norms (Association of Professional Chaplains, 2020; Spiritual Care Association, 2021; Spiritual Health Association, 2020) tend to lag behind this development, and professional associations have been slow to formulate educational curricula to equip coming generations of chaplains working in the emerging "digital hospital" (World Health Organization, 2021, p. 40).

This article has begun to address this gap by briefly presenting three cases which illustrate how specialized spiritual care providers in leading U.S. healthcare institutions are responding to this development. As there are still relatively few chaplains with extensive experience using telehealth, this sample is biased towards early adopters who have made some initial positive experiences with this development, work in institutions which for religious or other reasons place high value on spiritual care, and were willing to share their views on the record. The cases presented here thus seem to concur with a

comment made by a director of spiritual care at a major health system serving the Chicago area: "telechaplaincy is not the future of healthcare – it is a reality, and we are merely staying in step" (cf. Bingaman, 2018). This may be an overstatement in many institutions, yet an open conversation is clearly needed on the role individual chaplains, chaplaincy departments, professional organizations and accrediting bodies may wish to play in the transition to increasingly decentralized healthcare settings. In the following, several challenges and opportunities identified during interviews are briefly discussed with regard to their potential implications for the cost, access and quality of telechaplaincy. The points raised may be understood not as a conclusive analysis, but as themes likely relevant to such a conversation.

Barriers to access

The cases presented here suggest the transition to telechaplaincy promotes two contradictory tendences: on one hand it improves access for rural, unhoused and disabled populations who struggle to visit a chaplain on-site and may do so only when visiting a clinic for medical care. Patients may be able to meet with a chaplain of a faith tradition not represented at their current location (UK-based chaplains 1 and 2). On the other hand, telechaplaincy may exacerbate existing barriers relating to the 'digital divide', i.e., the lack of broadband access and technological literacy particularly among the elderly and socio-economically disadvantaged. Further study is needed to determine whether the provisions put in place to address this issue – such as the VA's 'Digital Divide Consult' (Office of Connected Care, 2021b) – can ensure access to spiritual care is maintained. An additional and potentially intersecting challenge may be posed by the 'bedside divide' – the gulf between state-of-the-art medical technology and its applicability and relevance in 'real life'. Software and hardware will need to be designed bearing in mind the needs of patients living with conditions such as cognitive decline, visual impairment, motor dysfunction, or injury or paralysis of the arms or hands. Studies on barriers to mobile health (mHealth) adoption (Zakerabasali, Ayyoubzadeh, Baniasadi, Yazdani, & Abhari, 2021) may inform the design of future telechaplaincy interventions and help avoid creating new systemic vulnerabilities.

Regulatory and economic risks

Regulatory issues also remain unclear; though the U.S. Centers for Disease Control and Prevention have endorsed telehealth and during the pandemic waived regulatory hurdles to reimbursement (Centers for Disease Control & Prevention, 2021, 2020), it is uncertain whether regulations will revert back in the mid-term, which may also affect telechaplains. Legal hurdles aside, the (partial) substitution of personal encounters with AI-assisted methods of population screening and triage, built on 'big data' and self-administered remote screening, may be valued by some as a tool to predict populations in need of care. Or, it may be questioned as a challenge to theological first principles.

Economic arguments can be made both *pro* and *contra* telechaplaincy. In at least one of the institutions discussed here, telechaplaincy was initially introduced as a cost-saving measure – and certainly, the boom of telehealth owes much to federal rules introduced

with the Affordable Care Act, which incentivize keeping patients out of the hospital. Interviewees mentioned worries among colleagues that integration into telehealth may negatively affect the job market, as fewer chaplains are needed to serve the same population of patients. Related to this concern is the necessity to maintain demand: unlike the conventional, 'supply-side' model of inpatient care, where chaplains knock on doors and introduce themselves to the patient, telechaplains may rely more strongly on patient-initiated encounters and close integration with the interdisciplinary team to create and maintain 'leads'. At one VA clinic, chaplains used phone calls to remind patients of their appointments and leaflets placed in waiting rooms to advertise their services; at Ascension Health and Mercy, questions on spiritual distress were included in routine screenings. But in one case, the introduction of telechaplaincy was perceived to have increased demand for spiritual care due to the higher rate of outpatient referrals by physicians (UK-based chaplain 1). The maintenance of demand for spiritual care may be a particular challenge in highly secular hospitals, as the removal of chaplains from on-site location reduces informal exchange with other members of staff, making chaplains even more invisible. This may adversely affect their integration into the hospital and thus funding for chaplaincy departments (cf. Cadge, 2013).

Changing core competencies

Effective telechaplaincy demands new skills, ranging from strategic camera placement to 'eye-to-camera' -contact, the use of charting software through peripheral vision, and the appropriate involvement of the patient's environment (family members, pets, living space). Several of the providers interviewed also welcomed telechaplaincy as an opportunity to rethink more deeply how they work with patients. Owing perhaps to a sense of anonymity attached to online encounters, and the fact that a patient can place the camera to reveal as little of themselves as they choose, some chaplains report what may be described as a 'disinhibition'-effect (Suler, 2004). This effect, familiar from the confessional booth and the psychoanalyst's couch, describes a greater inclination to disclose private matters due to a perception of privacy (cf. Norbert Holland, in Bobert, 1964/2000). As the patient can easily control the terms of his presence on a mobile device, telechaplains reported having to rethink their own ministry of presence. Preliminary findings from interviews suggest that telechaplaincy encounters are often shorter and, when initiated by the patient, tend to be geared towards specific needs or crises. As meetings are often set up with a specific purpose, small talk may be skipped. The tendency towards briefer and more focused encounters seems to be encouraged by the relatively short notice at which meetings can be arranged, and the awkwardness of silence while on a smartphone or tablet (compared to sitting at the bedside). In this sense, in the institutions surveyed here, the introduction of telechaplaincy dovetails with a trend in North American spiritual care away from Rogerian therapeutic dialogue and towards intervention- and outcome-based chaplaincy (Handzo, Cobb, Holmes, Kelly, & Sinclair, 2014).

Here too, a seemingly countervailing trend can be observed: concurrent to facilitating a tendency towards relatively brief, issue-focused and outcome-oriented encounters – which, as some have argued, promotes "McDonaldization" and distorts core values of the profession (Nolan, 2015, p. 12) – the cases discussed here suggest that telechaplaincy

enables longer-term and more personal relationships. Patients can be seen not only by the chaplain on duty on admission to a clinic, but by the same chaplain and over periods of several weeks or months. Whereas for on-site chaplains the encounter is typically limited to the period of hospitalization, for telechaplains the patient's admission may merely mark the beginning of the therapeutic relationship. In institutions where patients are preventively screened for spiritual distress, admission to a clinic is thus but one station on a continuum of spiritual care.

Finally, critical scholars since Foucault (1963/1994) have debated the 'medical gaze', argued to strip patients of identity and agency (see e.g., Bishop, 2011; Haker, 2016). Draped in hospital gowns and exposed to bright fluorescent light, personal effects stowed away in a paper bag, the patient is rendered a body and claimed as a "terrain of medical practice" (Lyon & Barbalet, 1994 in Norwood, 2006, 15). To the extent that digital technology is construed as a depersonalizing force, telechaplaincy may be suspected to exacerbate the clinical alienation of personhood. Surprisingly, the individuals interviewed for this study rather reported feeling a deeper sense of connection with their patients. As suggested by one chaplain, being able to meet patients in their own homes can be profoundly humanizing, as the patient is seen in his or her dignity, as a person with a history, and power over his or her own body. In some cases, this has affected how the patient is cared for by the clinical team; particularly advanced care planning unfolds differently when the patient is not in a hospital bed and his or her overriding priority is to be discharged as soon as possible (Interview, Mercy telechaplain 1; California-based telechaplain 1). Outcome studies on telechaplaincy may consider using a mixed-methods approach (Damen, Schuhmann, Leget, & Fitchett, 2020) to account for the complexity of patient-provider relationships which are built on shorter encounters conducted over a longer term, and more outcome-oriented yet more 'holistic' in the sense of unfolding in the patient's own lifeworld.

To conclude, the integration of healthcare chaplains into telehealth infrastructure differs from earlier forms of remote chaplaincy, such as telephone-based spiritual care, which boomed during the 1970s and 1980s. As suggested by the cases presented here, the rapid development of technology has added new and unique complexities which have the potential to radically alter why, how, when, where and for how long patients and chaplains interact. For this reason, this article suggests distinguishing between conventional, on-site inpatient care conducted in conjunction with the occasional and typically ad-hoc use of telephone or videocalls, and what may be tentatively referred to as telechaplaincy '2.0' – where chaplains routinely use highly integrated telehealth technologies across the continuum of care, and in some cases, conduct most or all of their activities online.

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