Routledge
Taylor & Francis Group

Journal of Health Care Chaplaincy

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/whcc20

Navigating challenges in telechaplaincy: A thematic analysis of an international conference

Fabian Winiger & Petra Sprik

To cite this article: Fabian Winiger & Petra Sprik (19 Dec 2023): Navigating challenges in telechaplaincy: A thematic analysis of an international conference, Journal of Health Care Chaplaincy, DOI: 10.1080/08854726.2023.2294680

To link to this article: https://doi.org/10.1080/08854726.2023.2294680

Published online: 19 Dec 2023.

JOURNAL OF HEALTH CARE CHAPLAINCY
https://doi.org/10.1080/08854726.2023.2294680

Routledge
Taylor & Francis Group

Navigating challenges in telechaplaincy: A thematic analysis of an international conference

Fabian Winiger[a] and Petra Sprik[b]

[a]Professorship for Spiritual Care, University of Zurich, Zurich, Switzerland; [b]Department of Health Services Administration, University of Alabama, Tuscaloosa, AL, USA

ABSTRACT

Telehealth-based care models are being widely adopted by primary care providers and large healthcare institutions. Drawing on data collected at an international conference on the theory and practice of telechaplaincy, this article identifies and discusses how chaplains navigate various telechaplaincy-related challenges. A thematic analysis identified 49 codes and 11 themes at the individual-, organizational- and population levels. Presenters reported facing novel and qualitatively distinct challenges spanning an array of telechaplains' professional activities, including the structure of work routines, the types of interventions used, the ways provider-patient connections are established and experienced, the strategic positioning of chaplains, their role in the model of care, and ultimately, the populations served. It is argued that, though telechaplaincy has gained prominence since the Covid-19 pandemic, the maintenance of professional standards in digital care settings is a systemic challenge related to long-term trends towards outpatient care.

KEYWORDS

Digitalization; ehealth; outpatient care; technology; telechaplaincy; telehealth

Introduction

In North America and Europe, medicine is increasingly being provided via telehealth. In 2016, a survey of 1,300 physicians conducted by the American Medical Association suggested that 14% of physicians used virtual visits to care for their patients (AMA, 2016). In the most recent survey, 80% claimed to do so (AMA, 2022). Drawing on the diffusion of innovation theory (Rogers, 1995), the study suggested that tele-visits have entered a late stage of adoption. The cohort of physicians currently adopting telehealth are labelled "early" or "late majorities," and physicians engaging with this technology in coming years are identified as "laggards" (AMA, 2022). If this sample is representative, this suggests, digital health tools have become mainstream in healthcare.

This article builds on recent evidence suggesting that these developments have begun to affect the professional reality of healthcare chaplaincy. A 2019 study, conducted before Covid-19 catalyzed telehealth adoption, reported that approximately half of chaplains had provided spiritual care via telehealth (Sprik et al., 2023). This suggests that in

CONTACT Fabian Winiger fabian.winiger@uzh.ch Professorship for Spiritual Care, University of Zurich, Zurich, Switzerland

quantitative terms, telechaplaincy adoption is moving from an "early" to a "late" stage of adoption. In some cases, telehealth adoption by chaplains is relatively advanced: a recent case series has shown that at some major healthcare institutions, chaplains and chaplain directors have fully transitioned to digital or hybrid care models (Winiger, 2023). Professional chaplaincy organizations have also begun to formulate recommendations for the provision of remote care, often referred to as "telechaplaincy" (Palesy et al., 2023; cf. CASC/ACSS, 2021; SCA, 2021; SHA, 2020). "Telechaplaincy" is:

> 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. (Winiger, 2023, p. 2)

Yet, in other respects, telechaplaincy is in early stages of development. Until recently, the spiritual care literature has remained largely silent on telechaplaincy. Following a burst of speculative discussion in the early 1980s and 1990s, the topic received little attention (Albrecht, 1978; Allen, 1984; Berg, 1994; Valentino, 1997). In the mid-2000s, a review found "no systematic reports on how Information and Communication Technologies are being used to integrate spiritual and religious care more fully into healthcare in institutions" (van Nooten et al., 2006, p. 391). Over a decade later, research remains sparse, even though survey data indicates healthcare providers prefer technological means to trigger chaplain referrals (Rhee et al., 2019). Several studies emerged during the pandemic, reporting on the provision of spiritual care and other chaplain functions (i.e., clinical pastoral education) via telehealth. They noted the quick adoption of telechaplaincy to navigate Covid-19 barriers, and reported both challenges and successes in telechaplaincy practice (Papadopoulos et al., 2021; Snowden, 2021; Szilagyi et al., 2022; Vandenhoeck et al., 2021). Clear evidence-based practices for telechaplaincy are still needed.

While some chaplains may consider telechaplaincy a necessity of the pandemic, shifts in healthcare delivery suggest that it is likely here to stay. Major healthcare institutions such as the National Health System of the United Kingdom pursue a long-term, structural transition towards a digitally-enabled primary and outpatient care model (NHS, 2019). In recognition of this shift, and given the lack of evidence-based practices for telechaplaincy, in early 2022 a working group of telechaplaincy practitioners and -researchers launch a joint effort to expand dialogue on telechaplaincy. The Telechaplaincy Working Group, hosted by the University of Zurich and Transforming Chaplaincy, convened monthly to explore shared challenges and directions for telechaplaincy research, training, and practice. To expand the conversation and take steps toward the establishment of best practices, the group conceptualized an international telechaplaincy conference on the theory and practice of telechaplaincy. We report on the findings from this conference and present an overview of how chaplains navigate different types of telechaplaincy challenges.

Materials and methods

Setting

From October 19 to 20, 2022, the University of Zurich and Transforming Chaplaincy hosted a conference entitled "Spiritual Care for the 21st Century—An International Conference on the Theory and Practice of Telechaplaincy."

Participants

A call for papers was circulated by the major North American and European professional organizations and chaplain certifying bodies, as well as denominational and religious networks of spiritual care providers. Submissions were open from March 7 to May 10, 2022 for case studies or didactic presentations related to telechaplaincy. Submissions were first reviewed by the authors of this paper, and consensus on the selection of speakers reached among the Telechaplaincy Working Group. Of 19 submissions, 18 were accepted, constituting a purposive sample of self-identified telechaplains currently employed in an institutional setting with sufficient professional experience to lead a presentation on telechaplaincy. The sample was gender-balanced, ethnically and religiously diverse, with 13 female and 7 male presenters with various religious backgrounds: Roman Catholic, Unitarian Universalist, Zen Buddhist, Jewish, humanist, "religiously none," Mennonite, Evangelical and Mainline Protestant. A keynote speaker team was invited to present, based on consensus among the Telechaplaincy Working Group. Overall, 20 presentations were scheduled.

The conference was conducted via Zoom over two consecutive days. The total duration of the conference was eight hours. The first day focused on the theory and practice of telechaplaincy and contained a panel on "rituals from a distance." The second day focused on programs, best practices, and implementation, with a panel on "grief support from a distance." Presenters were provided instructions about time limitations and necessitated to use PowerPoint. Three-hundred-and-sixty-one people registered; between 80 and 130 participants attended at any given time. To our knowledge, this event was the first international conference on telechaplaincy.

Procedure

Approval was obtained from the ethics committee of the Faculty of Theology, University of Zurich. Presenters provided verbal consent for the conference to be recorded. Separately, presenters provided informed consent for inclusion of their presentation recording for study analysis and publication. To mitigate bias, the two organizers of the event and one person who did not wish to be recorded were removed. Seventeen speakers were included in the analysis, which is sufficient to reach theoretical saturation in qualitative studies (Guest et al., 2006; Hennink & Kaiser, 2022). The transcripts were transcribed using the AI-assisted transcription service "Otter.ai," resulting in a dataset of 63,964 words. Additionally, we included a post-conference survey which assessed attendees' experience and suggestions, and the chat window from the conference. This provided a supplementary dataset of 11,306 words.

The data were coded by the first author using MAXQDA Analytics Pro 2022 (VERBI GmbH, version 22.4). The coder is a European male with a doctorate in medical anthropology, training in qualitative data analysis, and no religious affiliation. Aside from having previous relationships with four presenters from the original working group, he had not interacted with any of the presenters previously.

Due to the relatively large and heterogeneous sample, and the aim to identify challenges shared across the presentations, the data was coded and analyzed using thematic analysis. A descriptive (semantic) phenomenological approach was taken, staying "close

to the participants' overt meanings' rather than the researchers' interpretation" (Braun & Clarke, 2021, p. 41; Sundler et al., 2019).

All presenters were approached to confirm that their presentation was accurately transcribed and reflected their intended meaning. Two presenters requested corrections to quotations. Additionally, member checking was used to validate the code structure (Candela, 2019; Motulsky, 2021). In the first round, all members of the original working group were invited to review and amend the codes and themes. Secondly, separate meetings were held consecutively with three presenters for detailed discussion of the themes and codes. Members unanimously validated the theme and code structure.

Finally, expert review was used to enhance validity of coding and interpretation. The expert reviewer was the second author, a female, North American doctoral-level student in Health Services Administration with training in qualitative analysis. She is ordained in the Presbyterian Church (USA) and a board-certified chaplain who has previously practiced and researched telechaplaincy.

Analysis

The aim of the analysis was to present emerging challenges in telechaplaincy and how chaplains navigate these challenges to inform the development of evidence-based practice. Themes were generated using a constant comparative, iterative method (Glaser & Strauss, 1967), using line-by-line coding. Codes were later aggregated into themes. Forty-nine codes and 11 themes were proposed. Lastly, relationships between themes were identified and thematically grouped into individual, organizational and population-level factors.

For the codes at the individual level, saturation was reached at 7 transcripts, at which point no additional codes were identified. Meaning saturation was reached when 13 transcripts were coded, at which point no further dimensions, nuances, or insights were found. Due to the institutional and geographic diversity in evidence at this conference, and the relatively brief contribution of each presenter, saturation was not reached for codes at the organizational- and population levels (cf. Hennink et al., 2017).

Results

Chaplains reportedly encountered individual, organizational and population-level challenges when providing telechaplaincy. See Table 1 for the themes, codes and representative quotations identified.

Individual challenges

Telechaplains reported the following individual challenges related to telechaplaincy related to patients and their families, or individual members of the interdisciplinary team.

Initiating change

By far the most frequently noted challenge was the need for creativity. The conference resounded with urgency to creatively reimagine spiritual care in the digital setting. This

Table 1. Code system aggregated into levels, themes and codes, with exemplary quotations.

Level	Theme	Code	Exemplary quotation
Individual	Initiating change	Creativity, curiosity, reevaluating old beliefs, being proactive	"So, the pandemic in essence was a Genesis one moment, it gave us an opportunity to create and become a solution." (CG) "So, we've had to become creative. And it is that creativity that we'll speak to today, as well as just delivery." (AO)
	Workflow	Technological literacy, appointments, screening & referral, follow-up, documentation & EHR	"I now work primarily remotely again with a few exceptional in-person appointments if the patient desires the in-person. Doctors, APRs, nurses and social workers send over emails and text referrals as they used to, but they now also put in orders for spiritual care." (JJ) "We created basically the clinical spec and then we worked with their EPIC tech people to create a chaplain work queue embedded fully within EPIC." (JF)
	Interventions	Bedside visit, crisis management, support groups, primer for later encounter, telling stories	"We saw the importance of providing a continuation of care for our patients and as they left our facility, recognizing that this was a novel disease […] Our team decided to figure out a way to use technology to reach our audience to help provide hope and healing." (TV) "Other aspects might be considering crisis management when meeting with someone at a distance. Do you have a plan in place and the training required? Should someone express suicidal ideation? Or Should someone begin to present physical distress?" (HV)
	Presence and connection	Self-care, body, touch & non-verbal, (lack of) visual cues, setting & situational awareness, disturbing & distracting, self-presentation, vulnerability,	"[…] custody of the eyes, we called it in seminary, be very aware where your eyes are. So, if you're working with multiple screens, you need your person, front and center on the screen that has your camera, your documents can be over here, the things that you're not working on can be over here." (THB) "So you may have wondered, at some point or another in your work as a chaplain, if I call this patient or caregiver at home, won't I really be interrupting them in their day?" (JJ)
	Ethics & safety	Consent, security, pastoral secrecy, privacy, risk management	"Become familiar with that platform so that when something goes wrong with it, or something happens, that you don't raise certain ethically sensitive matters of privacy and confidentiality, because of some glitch in the technology." (MS) "A big issue certainly is that pastoral secrecy is not given on those channels, which is a great deal for really existential topics and private communication." (AH)
	Credibility	Accreditation, religious prohibitions, efficacy of ritual, pastoral authority	"I officiated a wedding over zoom. What's the first reaction you might have to that statement? If you're like many people that I've shared that story with including chaplains and spiritual care providers, one of the first responses I tend to get as well, but it wasn't a real wedding. Right?" (KH) "The anointing of the sick as it is classically understood […] cannot be administered over a video or audio connection. The formula of the sacramental ritual, the presence of a priest applying the blessed oil, offering prayers in the presence of a patient cannot be replicated in another way. Okay, with that said,

(*continued*)

Table 1. Continued.

Level	Theme	Code	Exemplary quotation
			there are some ways forward in the telehealth context I'd like to suggest." (SO)
Organizational	Strategic alignment	Advocacy, vision & marketing, strategic partners	"With the help from marketing, we were able to craft this registration letter that met all the guidelines that the enterprise established, we were able to scale it by creating a QR code and a hyperlink. We recognize that technology could be a barrier for some people. So, we provided our email addresses and contact information as well." (TV)
			"And I had incredible partners in palliative care. So that did make it much, much easier. But I did work with the director of outpatient palliative care, implement all along the way. And I did also check in with the director of spiritual care, all along the way. Those key stakeholders definitely need to be a part of any changes that you make." (JJ)
	Adapting to new models of care	New delivery models, continuum of care, lack of training, utilization of resources, best practices, patient-centered care	"So, healthcare has at its fingertips, just this infinite amount of information about the people that we serve. And yet, spiritual care had never really tapped into all of that information. So, we began to become far more familiar with parts of our care delivery system, where spiritual care hadn't been closely aligned, for instance, with our data analysts, with our IT departments, with our billing infrastructure … and started to ask questions […]" (AO)
			"And so I think that one of the things that will have to change for us in the spiritual care community is that our best practice interventions may actually require a full sort of look at or revision of our delivery models." (CC)
	Evidence-base	Data, funding, research & assessment	"And so, of course, we did a formal study […] And we found out that it increased their compassion a lot for the patients, and it also helped in transitions of care. […] these files ended up being extremely important in facilitating the conversation between clinicians and the loved ones." (ET)
			"We showed that we could use the existing platforms within the enterprise to capitalize on our efforts without any funding." (TV)
Population	Drivers of Telechaplaincy Adoption	Shift toward outpatient, long-term and chronic care, multifactorial morbidities, heterogeneous patient populations	"As a chaplain myself in an outpatient cos context, pre-COVID, my practice was almost exclusively conducted in person. Whereas at present, I'd say about 90% of my clinical interactions are by virtual means either by phone, or video conferencing." (HV)
			"How do we actually identify patients that are at high risk, are high need for spiritual care, who are likely to have spiritual distress? […] You can do this by medical condition, you can look at them in many different ways of grouping those populations, and start using some data-driven processes to identify them" (AO)
	Barriers	Physical distance, socio-economic, patient acceptance	"And so early on, I realized the limitations of not being able to be at two places at the same time, I could be making a hospital or a hospice visit in one part of the county and receive an urgent call about a critically ill or dying patient, located a 45 to 60 minutes' drive away." (RD)
			"The meetings are free, and the virtual platform removes most logistical barriers, our participants have a safe space to interact with fellow COVID-19 survivors. (TV)

ranged from navigating challenges related a sense of paralysis wrought by the Covid-19 pandemic (Curtisha Grant, Baylor Scott & White Health), to adapting Jewish rituals to telehealth use (Susan Moss, Yale New Haven Hospital), providing non-confessional wedding ceremonies (University of Louisville Hospital and Health Brown Cancer Center), and connecting with terminally ill children at a distance (Hugo Gonzalez, Lucile Packard Children's Hospital Stanford). Telechaplains also reported extending finite resource to meet demands presented at one of the nation's largest health systems (Antonina Olszewski & Cathy Chang, Ascension). Presenters further converged on the importance of critically reevaluating 'old beliefs' related to how chaplaincy must be provided, and being curious and proactive about how chaplaincy could be provided. In the words of chaplain Grant, "there is no cookie cutter way to offer telechaplaincy […] every opportunity is a new opportunity to create."

Workflow

Presenters discussed how their workflows were expanded and structured around capabilities of telehealth platforms used at their place of work. Namely, telechaplaincy expanded the ability to schedule appointments, provided increased structure for screening and referral, allowed for more systematic follow-up visits, and expanded or altered documentation within the electronic health record (EHR).

Jane Jeuland (Yale New Haven Hospital) reported that improvements in the integration of spiritual care into her institutions' EHR allowed her to exchange a cramped clinical setting for a hybrid in-person-telechaplaincy service which included on-site appointments, physician referrals, and appropriate follow-ups. Judy Fleischmann (Healthcare Chaplaincy Network) presented how collaboration with EPIC specialists enabled implementation of a chaplain workflow queue and improved spiritual need screening. Elizabeth Tracey and Jason Wilson (The Johns Hopkins Hospital) reported on the This is My Story (TIMS)-intervention, short autobiographical interviews playable within the EHR and consulted during interdisciplinary team meetings. Heather Vanderstelt (St. Joseph's Health Care London), Tracey Hand-Breckenridge (psychotherapist in private practice) and Marvin Shank (formerly Joseph's Health Care London) reported on the telechaplaincy guidelines produced by the Canadian Association for Spiritual Care, and Judy Fleischmann on those of the Spiritual Care Association (CASC/ACSS, 2021; SCA, 2021).

Interventions

Presenters reported on adaptations of existing interventions, and the development of new interventions tailored to digital care settings. An example is using handheld tablets to allow parents to see their newborn in neonatal intensive care units during daily medical reports when they were unable to be physically present. The chaplain noted that this service was greatly appreciated, particularly in cases where he, as a bilingual chaplain, could help the families navigate communication barriers with the medical team (Gonzales). Another example is virtual support groups for patients affected by post-Covid conditions or experiencing vaccination-denial grief (Vilagos). Telechaplaincy allowed this intervention to be delivered to a widely dispersed population, and enabled

further continuity of care. A recurrent intervention was story-telling. Presenters shared how the writing and publication of illness narratives with patients had a powerful generative effect (Jeuland), helped physicians humanize patients (Tracey & Wilson), and could be used to elicit similar stories from others (Haussman, University of Heidelberg). In many cases, interventions delivered via telechaplaincy moved beyond presence-focused chaplaincy towards an outcome-oriented model, where specific actions were delivered to accomplish expected outcomes (Damen et al., 2020). However, this was not all cases. Telehealth interventions were often routine spiritual care. Presenters discussed telechaplaincy as a 'primer' for in-person encounters, used to introduce the chaplain or establish rapport (Gonzales). Chaplain Moss (Yale New Haven Hospital) used telechaplaincy encounters to address anticipatory grief and establish trust for potentially challenging in-person encounters (Susan Moss, Yale New Haven Hospital).

Presence and connection

Presenters voiced concerns about establishing a sense of presence and connection via telehealth modalities. Chaplain Jeuland's presentation focused on this issue, with her primary concern being interrupting patients' lives, and thus, being unable to establish a connection. She found the opposite to be true. Telechaplaincy encounters enabled her to see people within their own settings, and for them to see her in a personal setting. In contrast to in-person work environments, in telechaplaincy the background is within the chaplain's control, and can either serve as a source of visual distraction (Vanderstelt, Hand-Breckenridge & Shank), or be adapted to create a sense of warmth and sacred space to enhance personal connection (Grant). Ultimately, presence and connection were often more intensely experienced when patients are encountered virtually – the telechaplain may not be "physically in [the patient's] *presence*," but can "most certainly be *present* for him." (Ralph Dalin, Jewish Federation of San Diego County). Contrary to the perception that technology compromises the intensity of the patient-provider encounter, presenters highlighted how providers navigate a sense of mutuality and vulnerability as the boundaries of clinical space become less visible (Jeuland). Yet, there were many hurdles that had to be overcome to establish connection. Lack of visual cues presented a challenge. Presenters reported having to read patients' subtle facial cues rather than gross motor movements, and attend to subtleties in voice and speech rather than normal visual cues. This was necessary for establishing rapport (Tracey & Wilson), and assessing signs of domestic violence or other concerns which may trigger referrals (Vanderstelt, Hand-Breckenridge & Shank).

The lack of an embodied presence, touch and non-verbal ways of connecting was frequently discussed. Presenters explored how to "take the conversation out of this very cerebral place" by using verbal cues (Moss), mindfulness-based breathing exercises (Fleischmann), and ritual objects which can provide a sense of "mediated social touch" (Kirt Hodges, UofL Hospital and UofL Health Brown Cancer Center).

Finally, the additional strain of establishing connection via telehealth required further work by the chaplain. Presenters highlighted how remote care requires both professional reflection and "a healthy dose of self-care" (Vanderstelt, Hand-Breckenridge & Shank). One presenter reported using the time otherwise used for his commute to reflect and meditate (Gonzales).

Safety & ethics

Safety and ethics presented multiple challenges including difficulty obtaining (signed) consent when not meeting in-person, lacking secure technology, maintaining privacy regarding the purpose of a call when initiating contact (Vanderstelt, Hand-Breckenridge & Shank), and preserving pastoral secrecy when using media not designed or generally used for discussing sensitive information (Haussmann). Presenters also considered the potential risk associated with end-of-life-care that crosses state jurisdictions (Gonzales), and the problem, encountered when conducting interviews for the TIMS-intervention, that a patients' legally authorized representative may not actually know the patient and may have been absent in the person's life for many years (Tracey & Wilson). In each case, telechaplains reported the challenge of making safe and ethically sound choices, though most often these were not directed by the institution or a certifying body.

Credibility

Chaplains discussed how telechaplaincy practice raised concerns about the legitimacy of their profession, or their practices. Specifically, lack of accreditation when providing spiritual care on social media was an issue (Haussmann). Relatedly, claiming pastoral authority for providing telechaplaincy was more difficult without theological grounds for practice, and required courage of practitioners (Hodges, Moss). In Judaism, there are religious prohibitions on the use of technology which inhibited professional practice (Moss). Presenters also considered the efficacy of ritual when conducted remotely (Hodges; Stephen Ott, KU Leuven). The two included quotes of a chaplain-delivered wedding and Jewish rituals show how chaplains navigated the credibility of rituals within their ecclesial traditions, and the complications of the delivery-mode.

Organizational challenges

The organizational level aggregates challenges related to multiple stakeholders and long-term institutional developments generally outside the immediate locus of control of individual care providers.

Strategic alignment

Several presenters perceived the urgency of identifying strategic partners ("allies") to support technical implementation of telechaplaincy, and to help advocate for the integration of spiritual care into telehealth care delivery pathways. Allies included a director of outpatient palliative care (Jeuland), corporate leadership (Vilagos), and medical students and physicians (Tracey and Wilson).

At Ascension, telechaplains began to familiarize themselves with parts of the organization with which spiritual care had not been closely aligned, such as data analysts, IT departments and billing infrastructure. While these departments supported other clinical team members, they had not been "tapped into" by chaplains. Spiritual care managers also engaged with the organization's advocacy team in Washington, DC. They advocated at the Center for Medicaid and Medicare to elevate spiritual care from a supplemental benefit attached to a condition within the scope of Medicaid, to one considered a

primary benefit within Medicare Advantage plans. This allowed the organization to screen for spiritual distress and deliver spiritual care as a primary care benefit. Strategic alignment also entailed rethinking how existing chaplaincy services fit into the organizational vision, and positioning telechaplaincy as an initiative to align spiritual care with the broader corporate strategy (Olszewski & Chang).

Adapting to new models of care

Several presenters understood telechaplaincy as a new model of care responsive to broad, population-level demographic and epidemiological developments. As healthcare increasingly transitions to an outpatient care model, patients are monitored remotely, and provided care at home. At Ascension, the launch of "On Demand Spiritual Care" aimed to incorporate chaplains into these new delivery models (Olszewski & Chang), while Jeuland and Gonzales emphasized telechaplaincy as a way to ensure continuum of care for outpatients and families of pediatric patients. As pointed out by Vilagos, in the absence of earmarked funds, revising how care is delivered within these settings requires a strategic plan which builds on existing resources available within the enterprise. Particularly during the Covid-19 pandemic, new models of care were introduced without institutional supports, and "many practitioners were forced to engage telechaplaincy with little or no training" until individual providers developed didactic modules on virtual care models (Vanderstelt, Hand-Breckenridge & Shank). Best practices have thus emerged organically and generally with little or no guidance by professional organizations, leaving some telechaplains to feel like they are "building a plane as they are flying it" (Grant).

Evidence-base

Closely related to the lack of best practices is the challenge posed by a perceived lack of evidence at every level of telechaplaincy implementation, ranging from remote screening tools to specific interventions to outcome assessment. In large institutions, data is available and may be used by telechaplains to identify patients willing to participate in the development of new interventions (Tracey & Wilson). At Ascension, the "On Demand Spiritual Care" team worked closely with the organization's population management department to preventively identify and contact populations at risk of spiritual distress (Olszewski & Chang). At Johns Hopkins, Covid-19 support funds and significant grants from external foundations were obtained to develop the TIMS-intervention, and further funding was pursued by presenting telechaplaincy as an effort to advance "humanism in medicine" and promote patient-centered care (Tracey & Wilson).

Population challenges

This section aggregates demographic and epidemiological trends which drive telehealth adoption at the individual and organizational levels.

Drivers of telechaplaincy adoption

Different societal trends necessitated the use of telechaplaincy at institutions. Several telechaplains reported working in an organization transitioning towards, or already serving, a

significant outpatient population. At Ascension, at least 50% of patients never enter an acute care facility (Olszewski & Chang). Where chaplains are traditionally employed for inpatients, a significant proportion of the population is not served, or on an ad-hoc basis when patients visit for treatment. With the shift towards outpatient care, telechaplains also encounter fewer patients with spiritual distress related to acute emergencies and more patients with spiritual distress related to long-term, chronic illness, comorbidity, or psychosocial complications. This challenge is further aggravated when telechaplains serve highly heterogeneous populations where patients may not have a clearly defined "spiritual home," such as at the Lucile Packard Children's Hospital Stanford, where 42% of patients have no religious affiliation (Gonzales).

Barriers

Telechaplaincy was discussed as a way to navigate barriers certain patient demographics face when accessing in-person care. The most frequently discussed barrier to care was physical distance due to the wide geographic dispersal of patient populations. Specific cases where geographic distance provided reason for telechaplaincy included dispersed long-term care homes (Kang), and pre-surgery visits which outnumbered chaplain availability (Olszewski & Chang). Socio-economic barriers were also discussed as preventing patients from receiving on-site care, with one organization offering a free telechaplaincy service to abate this issue (Fleischmann). The incorporation of a translator or language ability into interventions (Gonzales; Tracey & Wilson), and the use of the telephone in populations which do not have access to reliable internet or a computer (Tracey & Wilson) were also examined.

Discussion

This study illustrates the challenges encountered by chaplains as they navigate telehealth-based models of care, which are increasingly widely adopted in North American and European healthcare. The research literature has thus far tended to discuss telechaplaincy as a primarily Covid-19-related phenomenon (Papadopoulos et al., 2021; Snowden, 2021; Szilagyi et al., 2022; Vandenhoeck et al., 2021). Against this background, it is noticeable that the challenges reported at this conference were generally presented as long-term transformations of their workplace, rather than a temporary adaptation to Covid-19. Though several presenters reported their first contact with telechaplaincy occurring during the pandemic, presenters highlighted how they adapted to ongoing structural changes at their workplace. Indeed, as suggested by private U.S. health insurance claims, the rapid increase in telehealth adoption rates predates the pandemic and may continue due to long-term shifts towards outpatient care, protracted staff shortages, and increases in quality of care, accessibility, and cost efficiency (Bestsennyy et al., 2021; FAIR Health, 2019; Perlman & Foote, 2021). Similarly, the "long-term plan" of the National Health System of the United Kingdom, published before the pandemic in 2019, declared the intention to "mainstream" a model of "digital-first primary care" (NHS, 2019, p. 26, 27). While the extent to which telechaplaincy will remain, recede, or grow in professional practice remains unclear, this

suggests a long-term shift in healthcare systems. As such, it appears an urgent matter for chaplains to learn from practicing telechaplains, and develop evidence-based practices.

The challenges in providing telechaplaincy identified here are qualitatively distinct from those of chaplaincy in conventional models of care. Chaplains have developed strategies to navigate these individual, organizational, and population-level challenges, and their experiences can inform evidence-based practice. The considerable number of codes identified (n = 49) is indicative of the breadth and complexity of challenges faced by telechaplains. They did not merely concern the difficulty of translating conventional, "brick-and-mortar" models of bedside care into digital media. Instead, presenters reported protracted, systemic, and multifaceted challenges which spanned the gamut of telechaplains' professional activities, ranging from integration into models of care based on population-management to questions over the validity of remotely conducted rituals. Other significant areas of exploration included confusion over clinical ethics in digital care settings. The event also suggested that in some institutions, EHR systems appear to be evolving from their conventional role as sites of documentation and communication, into platforms on which telechaplains strategically position themselves to receive referrals, maintain visibility in clinical workflows, and coordinate care in decentralized and "demand-focused" work environments (CIL, 2020; Peng-Keller & Neuhold, 2020). Whereas traditionally chaplain allies have often been found in the nursing profession, telechaplains reported the need to find new strategic social ties. IT staff, particularly those responsible for EHR applications, were identified as allies uniquely placed to facilitate integration into an institution's workflow (Weaver et al., 2008). The presenters thus significantly expanded the common but misleading framing of telechaplaincy in terms of questions such as how to conduct effective phone- or video calls when in-person encounters were not possible. They highlighted the complexity of what has been referred to as "telechaplaincy 2.0" – a qualitatively distinct field of specialized spiritual care emerging as spiritual care professionals are integrated into increasingly, and in some cases entirely, virtual care settings (Winiger, 2023).

Comparing these findings with a recent investigation of perceptions of barriers to telechaplaincy in a pre-pandemic sample of chaplains, it appears that chaplain's experience of telechaplaincy are shifting (Sprik et al., 2023). Presenters identified most of the same themes identified in the pre-pandemic sample but did not mention four additional barriers: limitations of interdisciplinary work, chaplain resistance, limited interventions or technology quickly becoming irrelevant. Instead, chaplains in the post-pandemic sample highlighted new interdisciplinary partners, creativity, successful interventions, and engaging with long-term technological changes. This suggests that how telechaplaincy is embedded into healthcare institutions continues to evolve after the Covid-19 pandemic.

Finally, it is important to note the role of creativity in telechaplaincy adoption as a central issue presented by this study. Although in quantitative terms, approximately half of chaplains in the U.S. report using telehealth (Sprik et al., 2023), a qualitative gap remains in the degree to which they are effectively integrated into telehealth workflows. As demonstrated by this event, this requires telechaplains to adapt, advocate and acquire additional proficiencies. Returning to the language employed in the recent AMA survey of telehealth adoption, several presenters perceived themselves to be

"innovators" and "early adopters" by the standards of their own profession. Conversely, viewed in context of the larger life cycle of telehealth technology, they may appear as "laggards," as presenters reported keeping pace or gaining ground on rapid changes occurring at organizational and population levels. This is evident in the most frequently coded issue of "creativity," and other codes related to "initiating change" ("curiosity," "reevaluating old beliefs," "being proactive"). As one presenter exclaimed, "I'm building the plane as I'm flying it!" (Grant) – a statement also endorsed by Sprik and colleagues' national study which reported that most chaplains had no or little formal training, and had created their own practices (Sprik et al., 2023).

Creativity has recently emerged in the literature as a professional virtue in quality improvement, intercultural healthcare, and crisis resilience, and gains additional importance in this context (Beachy, 2015; Lyndes et al., 2008; Vandenhoeck et al., 2021). As suggested by this event, the clichéd construction of chaplains as perpetually out of touch with social change is contested by a contingent of spiritual care professionals which adopts a technology-forward attitude. Presenters generally discussed challenges wrought by their integration into telehealth infrastructure as a liberating and empowering, if not unproblematic, process, and narrated their encounter with technology in terms of creativity, agency, and opportunities to improve when, where and how they serve their communities.

The call for creativity may offer an important corrective to the narrative of chaplains as passive subjects of technological change, but sound a clarion call to educators and norm-setting associations concerned with the maintenance of professional standards of spiritual care providers, which do not account for the growing need for technological literacy in healthcare settings (e.g., ACPE et al., 2017). As indicated by the post-conference evaluation and ongoing interest in the Telechaplaincy Working Group (now "Telechaplaincy Community of Practice," see telechaplaincy.io/network), there is a considerable demand for individual and group learning to acquire the competencies required for effective ministry in digital care settings.

Limitations

This study has several limitations. Firstly, presenters were exclusively from North American and European healthcare settings. This study cannot comment on telechaplaincy-related challenges in other geographic locations, or other settings such as community, military or correctional care. Subsequent meetings of the Telechaplaincy Community of Practice highlighted the specific challenges encountered by Asian, South American, and African participants; these are not described. Secondly, opinions were presented by chaplains and not by the populations they serve. Some challenges may have been overlooked. For instance, while telechaplaincy may bridge spatial and temporal gaps, telechaplaincy may also work to create new socio-economic chasms between technologically advantaged and -disadvantaged populations (Cullen, 2001; Office of Connected Care, 2021). Specific illnesses may also pose unique challenges to telechaplains, particularly in the care for patient populations affected by cognitive impairment. The sampling strategy employed here did not capture the differences specific to each context. In addition to the lack of data on these care contexts and patient populations,

potential bias may be present as this study design relied on a single coder, validated by member checking and expert review.

Future research may address these gaps by analyzing data with a diverse group of co-coders and identifying challenges specific to organizational and population-level contexts, with particular attention to varying care settings, socio-economic factors, and patient populations. While this study focused on provider-side challenges, comparative analysis of patient-reported outcome measures is urgently needed to assess the efficacy of telechaplaincy care in each context (Snowden & Telfer, 2017).

Conclusion

With the adoption of hybrid- and remote care models, spiritual care providers are challenged by increasingly complex telehealth infrastructure. The event analyzed here attests to a rapidly changing professional reality for chaplains, which significantly differs from traditional, in-person spiritual care. As suggested by the large number of codes identified (n = 49), challenges encountered by spiritual care providers are multifaceted, and range across the individual to organizational and population-levels. While telechaplaincy includes practical matters such as how to conduct effective video calls, this framing fails to capture the complexity and diversity of challenges encountered by telechaplains. Presenters reported little access to existing resources and emphasized the need for creativity and personal initiative to adapt to this development.

As with the rise of social justice and intercultural literacy, the emergence of technology in the professional reality of spiritual care providers, significant gaps in research and training exist (Cadge & Rambo, 2022). They are unlikely to be addressed by individual, ad-hoc efforts and call for a multipronged and strategic response by professional organization, educational institutes, and standard setting bodies.

Acknowledgments

We thank the conference presenters for their participation. The following participants of the Telechaplaincy Working Group contributed to the organization of the event: Catherine Chang, Christa Chappelle, Seung Hee Kang, Jane Jeuland, Susan Moss, Geoff Tyrrell. The event and study were supported by Transforming Chaplaincy, the University Research Priority Project "Digital Religion(s)" and the Professorship of Spiritual Care, University of Zurich.

Disclosure statement

No conflicts of interest declared.

Funding

This work was supported by the URPP Digital Religion(s), University of Zurich.

ORCID

Fabian Winiger http://orcid.org/0000-0003-3799-4523

References

ACPE, CASC/ACSS, NAJC, NACC, & BCCI. (2017). *Common qualifications and competencies for professional chaplains*.

Albrecht, V. (1978). Using video-tape devotions in a general hospital. *Bulletin—American Protestant Hospital Association*, *42*(2), 103–105.

Allen, M. D. (1984). Computers and chaplains: Using the technology revolution. *Journal of Pastoral Care*, *38*(3), 187–194. doi:10.1177/002234098403800303

AMA. (2016). *Digital health study physicians' motivations and requirements for adopting digital clinical tools*. American Medical Association. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/specialty%20group/washington/ama-digital-health-report923.pdf

AMA. (2022). *American Medical Association Digital Health Research—Physicians' motivations and key requirements for adopting digital health adoption and attitudinal shifts from 2016 to 2022*. American Medical Association.

Beachy, J. (2015). *Spiritual care as creative interruption: Exploring a generative metaphor for intercultural healthcare chaplaincy* [Doctoral dissertation, University of Denver.

Berg, G. (1994). The use of the computer as a tool for assessment and research in pastoral care. *Journal of Health Care Chaplaincy*, *6*(1), 11–25. doi:10.1300/j080v06n01_03

Bestsennyy, O., Gilbert, G., Harris, A., & Rost, J. (2021, July 9). *Telehealth: A quarter-trillion-dollar post-COVID-19 reality?* [McKinsey & Company]. https://www.mckinsey.com/industries/healthcare/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. doi:10.1002/capr.12360

Cadge, W., & Rambo, S. (2022). *Chaplaincy and spiritual care in the twenty-first century: An introduction*. University of North Carolina Press.

Candela, A. G. (2019). Exploring the function of member checking. *The Qualitative Report*, *24*(3), 619–628. doi:10.46743/2160-3715/2019.3726

CASC/ACSS. (2021). *Guidelines for virtual practice—A resource to support CASC/ACSS members*. Professional Practice Commission, Canadian Association for Spiritual Care.

CIL. (2020, September 7). What is demand-focused spiritual care? *Chaplaincy Innovation Lab*. https://chaplaincyinnovation.org/2020/09/what-is-demand-focused-spiritual-care

Cullen, R. (2001). Addressing the digital divide. *Online Information Review*, *25*(5), 311–320. doi:10.1108/14684520110410517

Damen, A., Schuhmann, C., Leget, C., & Fitchett, G. (2020). Can outcome research respect the integrity of chaplaincy? A review of outcome studies. *Journal of Health Care Chaplaincy*, *26*(4), 131–158. doi:10.1080/08854726.2019.1599258

FAIR Health. (2019). *FH® healthcare indicators and FH® Medical Price Index 2019—An annual view of place of service trends and medical pricing*. FAIR Health, Inc.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldine Publishing Company.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82. doi:10.1177/1525822X05279903

Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, *292*, 114523. doi:10.1016/j.socscimed.2021.114523

Hennink, M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research*, *27*(4), 591–608. doi:10.1177/1049732316665344

Lyndes, K. A., Fitchett, G., Thomason, C. L., Berlinger, N., & Jacobs, M. R. (2008). Chaplains and quality improvement: Can we make our case by improving our care? *Journal of Health Care Chaplaincy*, *15*(2), 65–79. doi:10.1080/08854720903113416

Motulsky, S. L. (2021). Is member checking the gold standard of quality in qualitative research? *Qualitative Psychology*, *8*(3), 389–406. doi:10.1037/qup0000215

NHS. (2019). *The NHS long term plan*. National Health Service.
Office of Connected Care. (2021). *Connecting veterans to telehealth care*. https://connectedcare.va.gov/sites/default/files/telehealth-digital-divide-fact-sheet.pdf
Palesy, D., Forrest, G., & Crowley, M. E. (2023). Education guidelines, frameworks and resources for building virtual care capacity: An integrative review. *Journal of Telemedicine and Telecare*, *29*(3), 222–243. doi:10.1177/1357633X221149230
Papadopoulos, I., Lazzarino, R., Wright, S., Ellis Logan, P., & Koulouglioti, C. (2021). Spiritual support during COVID-19 in England: A scoping study of online sources. *Journal of Religion and Health*, *60*(4), 2209–2230. doi:10.1007/s10943-021-01254-1
Peng-Keller, S., & Neuhold, D. (Eds.). (2020). *Charting spiritual care: The emerging role of chaplaincy records in global health care*. Springer International Publishing. doi:10.1007/978-3-030-47070-8
Perlman, M., & Foote, E. (2021). *Digital transformation and health care delivery model convergence*. Deloitte Global Life Sciences & Health Care Industry Group.
Rhee, J. Y., Nguyen, V.-T., Goldstein, R., Sharma, V., & Marin, D. (2019). Integrating chaplaincy into healthcare: A survey shows providers are interested in technology-based options. *BMJ Supportive & Palliative Care*, *9*(2), 232–234. doi:10.1136/bmjspcare-2017-001352
Rogers, E. M. (1995). *Diffusion of innovations* (4th ed.). Free Press.
SCA. (2021). *Telechaplaincy—Why is it important and how is it best done?* Spiritual Care Association.
SHA. (2020). *Telehealth guidelines for spiritual care*. Spiritual Health Association.
Snowden, A. (2021). What did chaplains do during the covid pandemic? An international survey. *The Journal of Pastoral Care & Counseling*, *75*(1_suppl), 6–16. doi:10.1177/1542305021992039
Snowden, A., & Telfer, I. (2017). Patient reported outcome measure of spiritual care as delivered by chaplains. *Journal of Health Care Chaplaincy*, *23*(4), 131–155. doi:10.1080/08854726.2017.1279935
Sprik, P. J., Janssen Keenan, A., Boselli, D., & Grossoehme, D. H. (2023). Chaplains and telechaplaincy: Best practices, strengths, weaknesses—A national study. *Journal of Health Care Chaplaincy*, *29*(1), 41–63. doi:10.1080/08854726.2022.2026103
Sundler, A. J., Lindberg, E., Nilsson, C., & Palmér, L. (2019). Qualitative thematic analysis based on descriptive phenomenology. *Nursing Open*, *6*(3), 733–739. doi:10.1002/nop2.275
Szilagyi, C., Tartaglia, A., Palmer, P. K., Fleenor, D. W., Jackson-Jordan, E., Knoll Sweeney, S., & Slaven, J. E. (2022). COVID-19 and clinical pastoral education: How ACPE educators pivoted amid the pandemic. *The Journal of Pastoral Care & Counseling*, *76*(1), 37–47. doi:10.1177/15423050211073572
Valentino, J. (1997). My hospital has a robot!. *Journal of Pastoral Care*, *51*(1), 117–118. doi:10.1177/002234099705100117
van Nooten, J., Oh, H., Pierce, B., Koning, F. J., & Jadad, A. R. (2006). Spiritual care as eHealth: A systematic review. *The Journal of Pastoral Care & Counseling*, *60*(4), 387–394. doi:10.1177/154230500606000408
Vandenhoeck, A., Holmes, C., Desjardins, C. M., & Verhoef, J. (2021). 'The most effective experience was a flexible and creative attitude'—Reflections on those aspects of spiritual care that were lost, gained, or deemed ineffective during the pandemic. *The Journal of Pastoral Care & Counseling*, *75*(1_suppl), 17–23. doi:10.1177/1542305020987991
Weaver, A. J., Koenig, H. G., & Flannelly, L. T. (2008). Nurses and healthcare chaplains: Natural allies. *Journal of Health Care Chaplaincy*, *14*(2), 91–98. doi:10.1080/08854720802129042
Winiger, F. (2023). The changing face of spiritual care: Current developments in telechaplaincy. *Journal of Health Care Chaplaincy*, *29*(1), 114–131. doi:10.1080/08854726.2022.2040895