

Bioethics

Healthcare and the Hospital Chaplain

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Abstract

Many chaplains and most chaplaincy programs in the United States -- with encouragement from their accrediting organization, the Association for Clinical Pastoral Education (ACPE) -- have begun to assume a more proactive stance toward patients, healthcare professionals, and healthcare facilities. Some chaplains and chaplaincy programs have begun to engage in activities that have ranged from initiating conversations with and perusing the medical records of patients who have not requested their services to proposing that they be permitted to do "spiritual assessments" on patients -- in some instances whether these patients have been explicitly informed and have agreed to this beforehand. Moreover, many chaplains and chaplaincy programs have begun to assume that chaplains are full-fledged members of the healthcare team, complete with access to patients' medical records both to gather information and to make notations of their own.

It would appear that such novel activities are being justified by a questionable set of claims and assumptions that includes: (1) the claim that chaplains have a spiritual -- as opposed to purely religious -- expertise that entitles them to interact with patients and/or significant others (even those who have not requested a chaplain) -- presumably without in the least compromising patient autonomy or the confidentiality of the patient/healthcare professional relationship; (2) the assumption that the terms "spirituality" and "religiosity" mutually entail one another; (3) the claim that the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) mandates "spiritual assessments" (which it does not); (4) the assumption that chaplains are full-fledged members of the healthcare team; and (5) the claim that chaplains must, therefore, be permitted access to patients and patients' medical records both to gather information and to make notations of their own. We consider such claims and assumptions disquieting, and suggest that it is high time we revisit the terms "chaplaincy," "healthcare professional," and "member of the healthcare team" in reassessing what our professional commitments to respect and protect the bio-psycho-social integrity of patients require.

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Introduction

We have spent our entire careers emphasizing the importance of recognizing the unique bio-psycho-social integrity of each individual patient and the need for a robust interdisciplinary approach to good patient care in general.^[1-3] In addition, we have served as ethics consultants and taught introductory ethics sessions for clergy and chaplaincy programs for nearly 20 years. And, while we remain firmly convinced of the extremely important role that religion plays in the spiritual lives of some patients, we were astonished to discover the claims and assumptions that, increasingly, US chaplains have begun to make.

Upon investigation, we have learned that, since at least 1995, the Association for Clinical Pastoral Education (ACPE) -- the main accrediting organization for chaplaincy programs here in the United States -- has begun to require greater access to patients and their medical records as part of its accreditation requirements for chaplaincy programs.^[4] One of the authors (RSL) has spoken with both bioethics and chaplaincy colleagues across the country and, while such increased access is not universally the case, it is on the increase. Some chaplains and chaplaincy programs have begun to engage in activities that have ranged from initiating conversations with and perusing the medical records of patients who have not requested their services to suggesting that, because they are chaplains, they be permitted to do "spiritual assessments" on patients whether or not the patients are explicitly informed and agree to this beforehand -- justifying the latter with the claim that JCAHO mandates such assessments, which it does not. (JCAHO's primary concern is that such assessments not be denied to patients who wish them.) Some of the chaplains and program directors in question have attempted to justify such novel demands by claiming that chaplains are healthcare professionals who must be treated as full-fledged members of the healthcare team and given complete access to patients' medical records to gather patient information and to make notations of their own.^[5-8]

One of the reasons why we consider these findings so disquieting is that we suspect that most patients assume that chaplains in the healthcare setting operate on much the same principles as do clergy -- if I confide in my clergyperson, I can expect strict confidentiality (unless, of course, what I have confided places another at risk). I assume that a chaplain is also bound by that strict confidentiality unless I am explicitly told otherwise. This is why we suggest that it is high time we revisit the terms "chaplaincy," "healthcare professional," and "member of the healthcare team" in reassessing what our professional commitments to respect and protect the bio-psycho-social integrity of patients require.

Chaplaincy

The *Encyclopaedia Britannica* dates the concept of chaplaincy to the early centuries of the Christian church, and describes a chaplain as "originally a priest or minister who had charge of a chapel, now an ordained member of the clergy who is assigned to a special ministry."^[9] It adds that the term in its modern usage is not confined to any particular church or denomination, and that clergy may be "appointed to serve in a variety of institutions and corporate bodies, such as prisons, hospitals, schools, and universities."^[9]

Throughout the entry the operative words are "clergy" and "ministry." "Clergy" is generally understood to mean "a body of ordained ministers."^[10] "Ministry" is generally understood to mean "the office held by persons who are set apart by ecclesiastical authority to be ministers in the church or whose call to special vocational service in a church is afforded some measure of general recognition."^[11]

Thus, chaplains -- whatever else they may be -- are considered to be clergy, ministers affiliated with some particular religious organization. This is clearly confirmed by chaplaincy associations, which explicitly state that a foundational requirement for chaplains is their being, and "maintain[ing,] good standing in their faith group."^[12,13] So, irrespective of any other "specialty" training that chaplains may undergo, their entrée, as it were, and their continued standing as chaplains hinges upon their being members in good standing of a religious clergy and dedicated to a ministry that remains, in its essence, faith-based -- however broadly or narrowly construed.

Healthcare Professionals

The following is a rather lengthy list of occupations that are recognized as healthcare or allied healthcare professions in the United States:

- Audiologist
- Cardiovascular technician
- Certified nursing assistant
- Chiropractor
- Cytotechnologist
- Dentist
- Dental assistant
- Dietetic technician
- Diagnostic medical sonographer
- Dietician
- EKG technician
- Electroneurodiagnostic technician
- Emergency medical technician
- Laboratory technician
- Licensed vocational nurse
- Medical assistant
- Nuclear medicine technologist
- Nurse practitioner
- Occupational therapist
- Occupational therapy aide
- Orthopaedic technologist
- Paramedic
- Pharmacy technician
- Phlebotomist
- Physical therapist
- Physical therapist assistant
- Physician assistant
- Physician (MD or DO)
- Psychologist
- Radiology technician
- Registered nurse
- Respiratory therapist
- Speech pathologist
- Surgical technologist
- Ultrasound technician.

As diverse as they appear to be, what these occupations share is their biomedical foundation -- ie, each healthcare occupation is grounded in some particular field or fields of science. In addition, each offers a unique and complementary biomedical service that is recognized by all of the other healthcare occupations. Moreover, patients who require their services assume that these individuals have demonstrated their competence in their appropriate biomedical sphere.

While membership in the class "healthcare professional" has expanded almost exponentially in recent times -- a far cry from the original dyadic relationship between patient and physician -- it still presumes this fundamental biomedical foundation. Even psychiatrists (physicians) and psychologists who deal predominantly with patients' psyches are expected to do so from a scientific, as opposed to a spiritual,

foundation. Moreover, while each of the occupations listed previously provides a unique service, it is one that is -- whether explicitly or by default -- directly supervised by the patient's attending physician who ultimately bears the responsibility for that patient's care.

Thus, we would argue that chaplains are not healthcare professionals -- and, arguably, not even allied healthcare professionals -- for 3 rather important reasons: (1) chaplaincy has no biomedical foundation; (2) chaplains (*qua* chaplains) have no unique biomedical specialty training; and (3) chaplains would presumably reject the idea of being closely supervised by the patient's physician!

Members of the Healthcare Team

The fact that patient care today is based on a team approach is obvious; in most complicated illnesses various biomedical consultants may be asked to examine the medical records, evaluate the patient, and write a consult note. In some institutions they may also write orders; in others, such "orders" are funneled either through the attending physician or the resident, who is closely supervised by the attending. However, the fact that one may be a member of the healthcare team does not confer coequal status -- eg, nurses have their own section of the medical records and cannot ordinarily write orders (even nurse practitioners' "orders" are limited in scope and closely supervised by a physician), pronounce patients dead, or do other things that are understood to be solely within the physician's province.

In reality all people -- lay or professional -- concerned with patient care are potential members of the healthcare team. Various therapists are often extremely important members of the "team." The nursing assistant who bathes the patient and does many other things to help comfort the patient is most certainly a member of the healthcare team, as are staff who make sure that patients are given the correct diets -- even housekeeping, who provide the patient with a clean and safe physical environment. Those people (physicians, nurses, allied healthcare professionals, chaplains, a patient's personal clergyperson, social services, housekeeping, occupational therapists, hospital ombudsmen, risk management, bioethicists, ethics committees, etc.) are all potential members of the healthcare team of each and every patient, depending on the specific biomedical needs and personal preferences (wherever and whenever possible) of the patient or patient's surrogate decision maker.

Moreover, these members are not "full-fledged" in the sense of being completely equal. Patients do not (as yet!) expect their care to be run by democratic committee (however interdisciplinary it may be). The adoption of the word "team" in healthcare team is not accidental; it is an apt description precisely because -- as in all teamwork -- while everyone on each particular patient's healthcare team is working toward the same goal or set of goals, the team comprises various sorts of players, including a captain. Thus, healthcare teams, if they are to function optimally, do not come equal or ready-made; they are organized and evolve to fit the needs of each individual patient.

On the vast majority of healthcare teams today, the patient (or the patient's surrogate) and the attending physician are, in essence, the cocaptains. When admission to a healthcare facility becomes necessary, the cocaptains will decide jointly -- sometimes tacitly, sometimes explicitly -- who else ought to be active players on the patient's team. Just as an attending would request an oncology consult if biomedically indicated, so he or she would request the presence of a chaplain or, even more ideally, the patient's spiritual advisor if the patient or patient's surrogate thought that it was spiritually indicated. As we have written elsewhere,^[14] the relationship between patient (or surrogate) and physician is much like a *pas de deux*,^[15] a rich, yet delicate exploration -- sometimes intuitive, sometimes explicitly arranged -- between 2 individual dancers.

Most US healthcare facilities divide the "healthcare team" into the following hierarchical structure:

- Attending physician
- Physician interns and residents (in all educationally dedicated healthcare institutions)

- Physician consultants
- Nurses
- Other allied healthcare professionals
- Other hospital staff.

Like most US medical facilities, our healthcare institution lists separately, under the last rung of the hierarchy, "other hospital staff," the following services: patient escorts, hospital volunteers and hospital chaplains, food-service hosts, and hospital interpreters.^[16] Individuals in this classification do not have access to patients' medical records, nor is there any reason why they should. Hospital chaplains are not considered healthcare professionals -- either in fact or in principle -- and, arguably, not even allied healthcare professionals. Rather, they are considered an ancillary part of the healthcare team that is generally classified under the further, functional descriptor, "patient support services."

In general, and especially in this post-Health Insurance and Portability Act (HIPAA) regulatory environment, the further down this hierarchical listing any given member of the healthcare team is located, the more restricted is -- and, we argue, should be -- access to, or use or disclosure of, a patient's records and/or confidential information, and the more pressing is -- and should be -- the obligation to seek the patient's explicit permission when such access, use, or disclosure is thought, by healthcare professionals, to be in a patient's best interests. The current default presumption is that, until proven otherwise, patients are the best arbiters of their best interests. This presumption is so strong that, even when it can clearly be demonstrated that a patient has lost (or never attained) decisional capacity (ie, the ability to reason and to deliberate about one's choices in light of one's values, interests, life plans, and goals),^[17] we turn to that patient's next best arbiter, the patient's legitimately designated or recognized surrogate, to speak for the patient. Moreover, since we restrict even the highest level of the hierarchy (ie, physicians) access to medical records -- unless, of course, a physician is directly asked to do a consult by the healthcare team caring for the patient -- why would anyone else along the hierarchy legitimately expect, much less demand, that they be able to initiate unrestricted access to patients or their medical records?

So, given the above considerations, what is a chaplain's role on the "healthcare" team? It is by no means the case that all patients think that chaplains are necessary for having their spiritual needs met nor do spiritual needs in the patient's and the public's minds necessarily involve religion or the clergy. For many individuals, religion (which The Oxford English Dictionary defines as "[r]ecognition on the part of man [sic] of some higher unseen power as being in control of his [sic] destiny, and as being entitled to obedience, reverence and worship")^[18] is but one expression of spirituality (an "attachment to or regard for things of the spiritual as opposed to material or worldly interests").^[19] Indeed, for some of us, spiritual needs may be met by religion; but for some of us they are met by Mozart, for others by the sun glistening on fall leaves. Still others have those needs met by the presence of spouses, friends, or children. If a patient believes that a chaplain might meet such needs -- or perhaps a chaplain in addition to Mozart and sparkling leaves -- this can be of immense help in his or her care.

Some chaplains may, in fact, agree that religiosity is merely one expression of spirituality yet claim that, because all patients are spiritual beings, they should routinely be visited by a chaplaincy service because chaplains have "special expertise" in all matters spiritual. Even if such a claim to special expertise were proven (which it is not), having all patients routinely visited by a chaplain would be equivalent to having all patients seen by a cardiologist; after all, the argument is the same: We all have spiritual needs and we all have hearts. A chaplain, like a cardiologist, may -- or may not -- be an important member of a particular healthcare team for a particular patient. To claim otherwise requires compelling evidence that, thus far, has not been provided.

There is no doubt that meeting the spiritual needs of the patient is extremely important and that chaplains -- for the right patients and at the right time -- may fill an important role in making some (but by no means all) patients well. The reason patients enter healthcare facilities, however, is not primarily to have their

spiritual needs met. Patients generally come to healthcare facilities to have urgent physical needs met. That meeting their spiritual needs can in some (but by no means all) patients be most helpful is undoubtedly true and not something that ought to be overlooked. However, the bottom line is that patients do not expect their physicians to order tests or do procedures that are not indicated; such things are not only biomedically unnecessary, but also are costly and potentially not without danger. For similar reasons, patients do not expect their physicians to expand the members of the healthcare team unnecessarily -- an expectation that is also currently reflected in the spirit and tone of both JCAHO^[20] and HIPAA^[21] regulations.

Respecting and Protecting Patients

One of the greatest legacies of the American philosopher John Dewey is his analysis of the reciprocal interaction between living organisms and their equally complex and dynamic environment. In discussing how organisms become individuated, he explains why the integrity of any organism/environment relationship is a critical material condition for the integrity of the organism itself^[22] -- and, of course, the more complex the organism, the more crucial it is to understand this immensely complex and dynamic relationship.

One implication of this view is that, to the degree we wish to be autonomous agents -- individuals who are not simply passively alive, but who can exert some degree of meaningful control over their own lives -- we must understand our relationships with our environment. Another implication of this view is that if we are truly committed to helping patients, we must understand how each patient has been formed by and interacts with his or her environment. This includes not only ferreting out what sort of assistance patients might need to cope with their illnesses, but how best to provide that assistance; eg, if a patient is vegetarian and needs more protein in his diet, the healthcare team would never insist that the only solution is for him to eat meat! There are other, equally nutritious nonmeat sources of protein readily available. It also includes making a good faith effort to understand what the patient considers assistance! What one patient might presume to be assistance -- and, perhaps even expect as a matter of course -- another might consider an unnecessary, unwarranted, or even egregious intrusion. This is especially the case when it comes to the spirituality of patients, the most deeply personal and private aspect of each patient's identity.

Thus, while it is quite true that the healthcare team must always be sensitive to the fact that patients are bio-psycho-social entities, and it is true that patients have the right to have their bio-psycho-social needs met, it does not logically or ethically follow that patients have the obligation to submit to any potential member of the healthcare team's arbitrary interpretation of what those needs are and how best they should be met. Nor does it follow that anyone may arbitrarily join a patient's healthcare team. Nor does it follow that even physicians be allowed a completely free hand to tailor the composition of the remainder of a patient's healthcare team without first soliciting, as it were, the advice and consent of that patient! This is especially so when it comes to decisions that may profoundly affect the freedom of patients to determine whether or not -- and if so, with whom -- they wish to discuss spiritual issues.

Privacy and Patient Confidentiality

One of the presumptions foundational to a democracy is that persons have a "right" to privacy, which, in one of the first philosophical treatments of privacy, Fried defined as "the control we have over information about ourselves."^[23] In discussing the moral importance of privacy, Schoeman emphasizes: "Privacy is important as a means of constructing moral personality...because of the way control over one's thoughts and body enables one to develop trust for, or love and friendship with one another..."^[24]

That our particular Western Culture values the right to privacy so highly has been confirmed and elucidated over the years by the US Supreme Court from as early as 1891, when the court eloquently opined: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person..."^[25] However, long before the existence

of the US Supreme Court, the development of trust and the sacredness of privacy have been seminal features of the "classic" professions -- medicine, law and the clergy -- and historically, legal institutions have traditionally considered conversations with physicians, clergypersons, and attorneys to be privileged. Unfortunately, confidentiality is a species of privacy that has been greatly eroded of late by a variety of institutions. However, in our opinion, confidentiality is neither a decrepit concept, as some would have it,^[26] nor absolute as Kottow has held.^[27] Rawls considers it to be an agreement bound by the principle of fairness,^[28] which would make it an important but not absolute obligation.

This question of confidentiality, of course, is central to our concerns. In regard to chaplaincy, the potential for breeches of confidentiality that most concern us here are: (1) Unless informed otherwise, in advance, patients do not expect chaplains, other members of the clergy (or, frankly, anyone else!) to be told things they have confided to the healthcare professionals caring for them. (2) Patients do not expect physicians or other healthcare professionals to be told things they have confided to their clergyperson or a chaplain (and the fact that hospital chaplains say that they will be selective in what they put into progress notes is hardly comforting since it is they, and not the patient, who are doing the selecting).

As for the first, we claim that it is a breach of confidentiality to allow a chaplain access to a patient's medical records unless the patient is fully informed, understands the implications of such access, and either wholeheartedly acquiesces or initiates such a request. We base this claim on the fact that the default understanding of most patients is that their physicians and nurses will have such access and that, on a very strict "need to know" basis, other biomedical therapists may have as well. What is decidedly not the default understanding of many patients is that members of the clergy, chaplains, or pastoral care programs have such access -- whether or not they have been invited to be members of the healthcare team. We maintain that, of all the conversations patients may have while hospitalized, patients are least likely to expect that those held with chaplains would be recorded or discussed without their knowledge or assent. Furthermore, we find it rather ironic that an institution's arbitrary decision to grant such rights to chaplains can place some patients in the peculiar position of having their own clergyperson, who has taken care of their spiritual needs, who knows them, and with whom they have developed ongoing relationships of trust, barred from access to such information while a hospital chaplain -- who is, comparatively speaking, a stranger to the patient -- isn't!

As for the second -- and, we think, more dangerous -- breach of confidentiality: What we fear is that a chaplain will not simply write "patient seen and spiritual needs discussed" but will record some portion of the content of such a discussion, a discussion held without the patient's awareness that what he or she says may be entered in the record to be seen by physician, nurse, or anyone else entitled to see the record. Patients may tell chaplains information that they would not tell their doctors (eg, an episode of childhood incest that the patient believes led to damnation and illness). Whether or not such information may be useful for a doctor to know, it is really a patient's choice whether, and to whom, to reveal it. In short, healthcare professionals have neither right nor privilege to access what a patient presumes to be a privileged conversation between himself or herself and a chaplain -- or, for that matter, anyone else.

Thus, it is our position that, unless the patient has been explicitly informed and freely gives permission, we risk violating patient confidentiality in either of 2 directions: from biomedical professionals to chaplains and -- perhaps more important -- from chaplains to biomedical professionals. In short, we claim that the default presumption of patients is that chaplains are not privy to the biomedical particulars of their case and that biomedical professionals are not privy to what patients confide to a chaplain.

Conclusion

We reiterate that hospital chaplains may, in appropriate cases, serve a critically important function in a patient's care. However, we are deeply concerned about the demands on the part of some chaplains and chaplaincy associations to be treated as full-fledged members of every patient's healthcare team and/or to have complete access to patients' medical records whether to gather patient information or to make notations of their own.

In what we consider a highly contentious article (written from the perspective of a hospital chaplain who is part of a chaplaincy training program) it is claimed that today's chaplaincy program constitutes "the emergence of a secularized professional practice from a more religious-based theological practice of chaplaincy."^[29] Aside from the fact that we really do not understand what this is supposed to mean (how can a secularized practice be based on a religious one?), we have serious concerns about the validity of subsuming secular issues or ideas under the mantle of either religion or theology (ie, whose religion? whose theology? who would decide, and how?).

Moreover, from a purely practical standpoint, there are many patients who either eschew religion as part of their spirituality in general or who prefer, for whatever reasons, not to have any clergy, including chaplaincy, participate as members of their healthcare team, and we fear that, for them, the unsolicited appearance of a chaplain may range from innocuous -- simply embarrassing or uncomfortable -- to intrusive or even threatening (we are reminded here of a case in which the patient did not wish for a chaplain, but the family's desire for chaplain involvement prevailed). As to the claim of any particular chaplain that he or she would never dream of making a patient feel embarrassed, uncomfortable, intruded upon, or threatened, we are sure that the chaplain may, indeed, honestly feel that way; we may even feel that way...but, as healthcare professionals, our focus is supposed to be patient-centered. When it comes to issues of spirituality, it is the patient's feelings that count here, not our interpretation of the patient's feelings, and certainly not a chaplain's interpretation of the patient's feelings.

So, what are we suggesting? We are suggesting that chaplains visit only those patients who, upon admission to a healthcare facility or at any time thereafter, have indicated -- either in a designated space on the admission sheet or by verbal request -- that they wish to be visited by a chaplain. It is our position that, if a patient indicates that he or she would not like such a visit, it should be recorded in the medical record and the chaplaincy office should be notified not to visit the patient. If a patient does wish to be visited by a chaplain, it should be recorded in the medical record and a request forwarded to the chaplaincy office. In cases in which it is unclear what the patient's wishes may be, then a member of the patient's healthcare team should ask the patient or designated surrogate for clarification.

We have argued that, aside from the legalities of the issue, it is not necessary -- indeed, it may even be counterproductive -- for a chaplain to have access to patients' medical records. While it is true that a patient's spiritual needs may differ depending on the diagnosis, it is up to patients to determine what they wish to disclose or to be disclosed to chaplains or other spiritual counselors. We agree that chaplains might find it helpful to take notes about the patients who have requested visits, especially when there is a group of chaplains rotating duty. However, such notes should be kept under separate lock and key by the chaplains, only for the purposes of continuity of spiritual care, and not placed in the patient's medical records. In many facilities, these notes are then destroyed upon the patient's discharge.

Chaplains have raised the concern that the fact they have visited a patient upon request may inadvertently fail to get recorded in the patient's medical records. One simple remedy would be to create a sticker that reads, "Chaplain visited," with the date and time penciled in. Upon leaving the patient's room, the chaplain can hand it to one of the staff to place on the front of the patient's medical record. Because the risk of confidentiality getting breached rises exponentially with every additional person who is given access, we claim that the potential burdens of chaplain access to patient records far outweigh the potential benefits. Whose burdens? Whose benefits? Without clear and compelling evidence to the contrary it surely must be the person most relevantly affected: the patient. If we are truly committed to

patient-centered care, then we must err on the side of respecting and protecting the patient's privacy by restricting the healthcare team and access to patients and their medical records to a bare minimum.

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