Twice weekly I grabbed my well-worn, hand-held, tiny-print black Bible, hopped into the little white “Le Car,” and trucked on over to the community hospital less than five miles from the parish. Entering the hospital lobby, I moved to a desk in an alcove, opened a small, unlocked metal file box, and thumbed through the 3" x 5" cards looking for any Catholics or “unaffiliated” from the community where I was one of two priests in a 1500-family parish. I would make my list from those cards and would always have between eight and 12 Catholics from the town, as well as several names I would recognize from the “unaffiliated.”

The cards listed the age of the person, the admitting diagnosis, the marital status, and the person’s attending physician. I would jot this information down on a slip of paper that I took from another box filled with scrap paper, conveniently set on this desk for the local clergy. And then I would methodically begin my visitation. I generally had the Eucharist with me, my holy oil, and that black Bible with the broken binding that now opened on its own to the creased Psalm 27, a scripture well traveled.

I found that metal box and the information within to be of invaluable worth in helping me to offer the best spiritual care to my parishioners, known and unknown.

“John Doe, 47, male, ca. of the lung, divorced, a patient of Dr. Kaplan,” prepared me in a way that was much different than knocking on a door cold. I met people who will never forget the presence of the Church in a time of such vulnerability. I cried with them in their losses, sat with them in the heat of their rage and anger, touched them in the quiet of tender and deep prayer, shook my head with them in the existential, sometimes torturing, questions of life, meaning, and purpose. I, too, will never forget the presence of the Church in a time of such vulnerability.

But I had no right to the information in that metal box. As much as it provided me with knowledge of inestimable worth, I had no right to that knowledge.

I was a parish priest, who walked through a door, up to a desk with no attendant, opened an unlocked box, and had access to some of the most personal information about the 280 people in that community hospital. I was an ordained Catholic priest, but I was not
that brings us to the first definition of professional, that is, one who is of the profession. The profession is health care. One of the most confusing aspects of spiritual care is the blur in the distinction between clergy, local parish pastoral staff and the professional chaplain. The chaplain’s profession is health care and by virtue of that profession she or he, along with the physician, nurse, pharmacist, respiratory therapist, social worker, dietitian, etc., is a member of the health care team.

The local priest, the pastoral associate, the Stephen ministry person, and the parish visitor are not health care professionals—; they are not of the profession. Religious leadership in the community is one profession; spiritual care in health care is another profession. A subtle, yet immensely important distinction is in the identification of that which is religious and that which is spiritual with its correlation in that which is community and that which is institution.

This distinction in no way undervalues the tremendous impact of the local clergy and parish staff upon the lives of their parishioners. Patients, by and large, want and need that connection to the familiar, to the healthy community from which they have been separated and to which they long to return. The local religious leader can often be the lifeline for this person, for her or his family, for the community that misses and worries about the ill person.

The rise in concern about patients’ rights, especially the right to privacy, is an important redress to a much more lax system that did not adequately safeguard confidentiality. Violation of confidentiality was so widespread that nearly all health care institutions in the 1980s developed the practice of posting reminders in the elevators. Sometimes deliberate, but more often just careless, people acted less than professional in the way in which they conducted themselves in the profession.

And that brings us to a second definition of professional, that is, a way of conducting oneself in the profession, whether as a pastor of a religious community or as a chaplain on the team in the health care setting or in the correctional setting. We are all called to be professional in our respective professions.

With the rise in concern about patients’ rights, and its resultant safeguards, there has also been a move to restrict access to patient information, and of late, this has been directed toward clergy and chaplains. And there’s the problem. Clergy and chaplains are distinctly different and should not be treated the same. The chaplain is
not a religious leader (ordinarily) in the community, and the religious leader is not a member of the staff in the institution.

In Connecticut and Virginia, two states from which I have heard recent stories, some hospitals have initiated new policies that restrict the release of patient information to clergy and chaplains. In Virginia, parish priests were very upset when all of a sudden they were told that the institution would not produce any more lists of Catholics who lived in their parishes. While I understand the dismay, the inconvenience, and the loss of a very important opportunity for ministry, I can appreciate the institution’s responsibility to at least put some protective barriers in the flow of confidential information.

We also know, however, there are ways to obtain that information at the time of admissions which can protect the rights of the patients without denying them the right they have to have their spiritual needs addressed. The questions, however, must be worded carefully—and I would say directly—so as not to convey the wrong meaning.

For example, “Do you want to see a chaplain during your stay?” is not a good question. A person could respond, “No,” meaning “I don’t want to bother anyone—there are people much sicker than I am,” or out of anxiety or fear, the “no” could mean, “I am not that sick!” Perhaps a more appropriate statement/question could be: “At our institution we are committed to holistic care of our patients, part of which is spiritual care. Do you have a religious congregation or Church that you would like us to contact?”

Note that this question addressed the provision of care by local clergy/parish pastoral care staff. I don’t believe any question should restrict the professional staff chaplain any more than one would exclude the respiratory therapist in the care plan for the COPD patient, for example.

The situation in Connecticut crossed over this line when a hospital would not even allow its paid staff chaplains to visit patients unless there was a specific request from a patient. A furor arose from both the local clergy and the professional staff that forced the institution to re-think these new restrictions.

These and other situations, however, raise a challenge to our profession. First, we need to educate, at every opportunity, the public, the institutions, and the local religious communities to the fact that we are health care professionals. We study theology. We are steeped in developing and deepening our life of prayer. We are called by our religious bodies to come forth and minister God’s love and care. In this way, like our leaders in the churches and congregations,
we are religious.

But then we move into a different and distinct profession. We are trained extensively in the clinical setting within a clinical model of learning. We separate out, and when appropriate, integrate in, the religious and the spiritual. We learn the necessity and the skills training for collaboration on a professional interdisciplinary health care team. We sensitize and familiarize ourselves in diversity, especially in the interfaith setting. We are trained in crisis intervention, intensive and extensive listening skills, the complexities of ethics and medicine, and the ability to work in systems and networks.

Second, we need to act professionally at all times and in all places. Practically speaking, we need to work the system when, for example, a new admissions policy is approved without our input. We have to be proactive. Look at the nurses. If they were not up and out and in your face—institutionally—they never would be the professionals that they are today.

Chaplains need to be certified. Any time that a person is paid and on staff at an institution and is not credentialed—by the profession—then he or she undermines the profession. What other professional on the health care team would be hired without proper credentials?

Chaplains should sign off on charts with the authorized initials of the profession (NACC Cert. is ours). It sends a message. The colleague may not know what NACC means, but from the context knows that this note is signed by a professional.

Everywhere we go and everything we do reflect on our profession. And the more professional we are, the stronger the profession.