CHA
Catholic Health Association of the United States

Can We Strengthen Spiritual Care in Catholic Healthcare?

A White Paper on Present Challenges and Opportunities

FALL 2026

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Can We Strengthen Spiritual Care in Catholic Healthcare is a reaffirmation of Catholic health's commitment to spiritual care across our ministries. Catholic healthcare understands the human person as an integrated whole being, with physical, psychological, social, and spiritual dimensions. As a community of healing and compassion, Catholic health ministries are guided by *The Ethical and Religious Directives* to recognize that providing spiritual care is an essential component of Catholic identity, and one that must be assured into the future. This paper aims to guide Catholic health mission leaders, sponsors, executive leadership, spiritual care leaders, and chaplains on the essentiality of spiritual care in Catholic healthcare.

The authors of the white paper spent many hours in conversation about spiritual care across Catholic healthcare and the barriers to its sustainability within our shared ministry. With great gratitude, we recognize the paper's authors: Fr. Charles Bouchard, OP, STD; Rev. Christa Chappelle, M.Div., BCC; Allison DeLaney, MA, MPH, BCC. We also recognize the paper's steering team, a subcommittee of CHA's Spiritual Care Advisory Council, whose names and the institution they were associated with at the time are: Theresa Vithayathil Edmonson, BCC, Providence St. Joseph Health; Jill Fisk, MATM, CHA; Ruth Jandeska, Ed.D., MA, BCC, Bon Secours Mercy Health; Antonina Olszewski, MSQ, Ascension.

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ABOUT CHA

The mission of CHA is to advance the Catholic health ministry of the United States in caring for people and communities. Catholic healthcare is a ministry of the Catholic Church continuing Jesus' mission of love and healing in the world today. Comprised of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit healthcare providers in the nation. At the national level, these organizations join together in the Catholic Health Association of the United States. In CHA's vision, the ministry commits to empowering bold change to elevate human flourishing.

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Introduction

A 65-year-old patient we'll call Sophia has just received her annual mammogram results. Sophia is shocked to hear that she has stage II breast cancer. Sitting in her oncologist's office alone, feeling angry and confused, she struggles to process the larger meaning of her new diagnosis. She asks herself, "Why is this happening to me?" Sophia stopped attending Mass many years ago, is estranged from her children, and has only a few friends. While the clinic staff does their best to support Sophia, they are not trained to provide the "meaning-making" assistance of professional chaplains. Additionally, limited clinic visit times and the demands of a busy office prevent staff from spending much time with her individually.

This case illustrates a central paradox in contemporary spiritual care and chaplaincy. While growing evidence asserts the benefits of honoring spirituality in healthcare,[1] spiritual care departments face financial and societal challenges that threaten their sustainability. Catholic healthcare takes pride in providing care not only for the body and mind, but also for the spirit. But do patients like Sophia experience the priority of spiritual attention that we promise? Trained professional healthcare chaplains could provide spiritual support for Sophia. However, several internal and external factors have diminished the perceived value of both spirituality and spiritual care within healthcare settings. Key trends include a shift in leadership from religious to lay people, changes in healthcare delivery and reimbursement, inadequate support for spiritual care providers, persistently low compensation, and a reluctance to see chaplains as essential members of the care team.

Catholic identity hinges on recognizing one's spirituality as an inherent part of what it means to be human. From this perspective, spiritual care is necessary for whole-person care.[2] This belief is not at odds with medical or scientific excellence; it enhances both. For this reason, the diminishment of spiritual care should deeply concern Catholic healthcare leaders. This White Paper examines spiritual care: its centrality to the Catholic healthcare mission, the evidence demonstrating its effectiveness, the challenges (both internal and external) that threaten its future, and how stakeholders can collaborate to address them. Overall, the paper asks how mission leaders, sponsors, executive leadership, spiritual care leaders, and chaplains can amplify the alignment between spiritual care and healthcare to protect the quality of patient care.

Part One:
Defining Spiritual Care

Catholic health understands spiritual care as an integral and essential part of whole-person care. The Catholic tradition believes this applies to everyone, regardless of religious practice or background. Puchalski et al. describe two core dimensions of spirituality. The first is the search for and expression of meaning and purpose. The second is connectedness — to "the moment, to self, to others, to nature, and to the significant or sacred."[3]

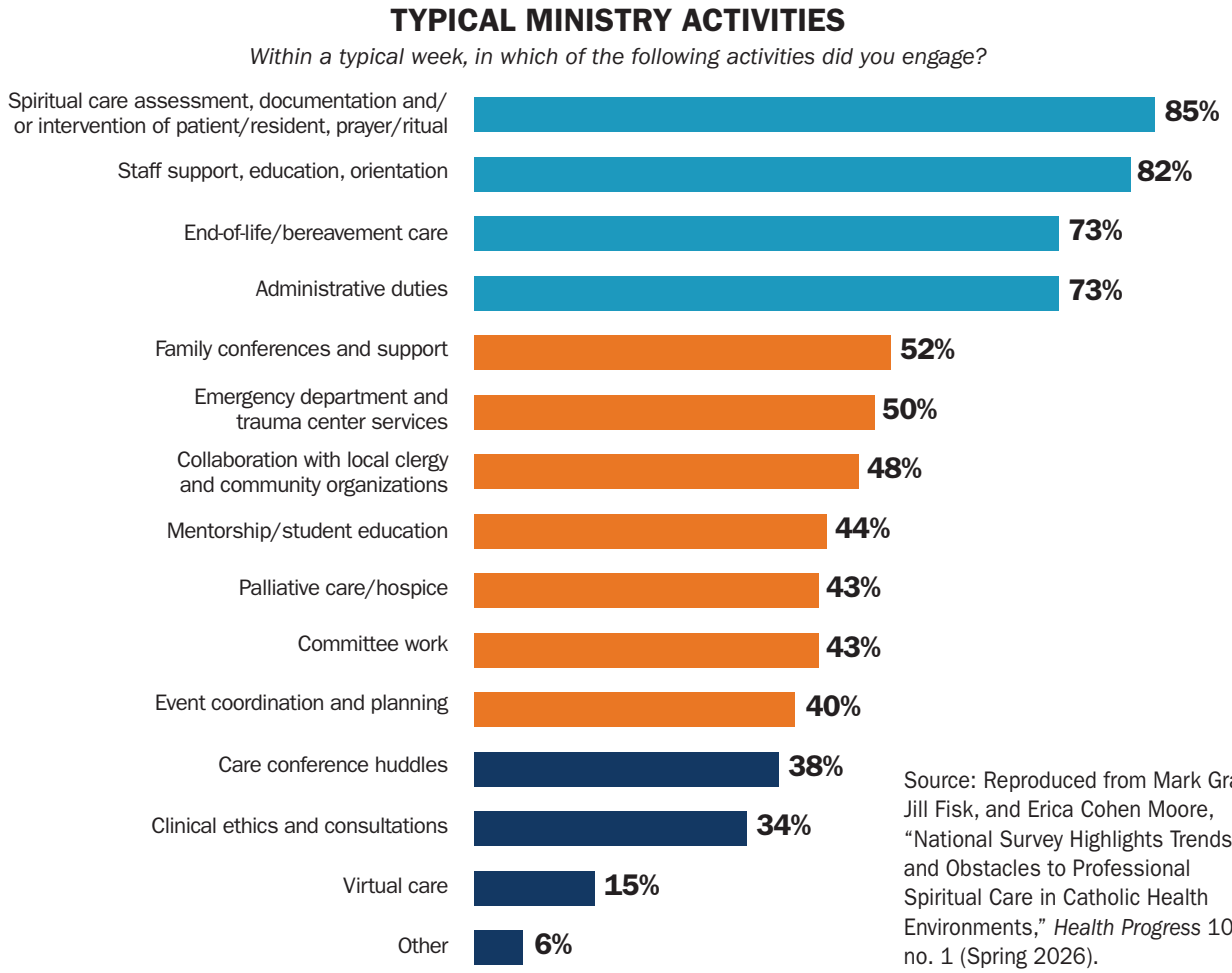
Research underscores the value of spiritual care for patients as they process new diagnoses, weigh treatment options, and confront the realities of illness and mortality.[4] It also helps providers (e.g., caregivers, healthcare staff, executives, and leaders) preserve the human dimensions of care while managing clinical and operational realities.

Who Is Responsible for Providing Spiritual Care?

Healthcare chaplains are the primary providers of spiritual care across care settings. Like other medical professionals, they receive specialized training through education and clinic-based learning to support individuals experiencing spiritual distress.[5] They can become Board Certified Chaplains (BCC) through their professional organization.[6]

Table 1 illustrates the wide range of responsibilities chaplains perform in a typical week. Their main role, however, is to assess spiritual distress, identify appropriate evidence-based interventions, and create a plan of care that incorporates the spiritual beliefs and values of the person receiving support.[7] To best serve the faith needs of their community, Catholic healthcare systems hire, collaborate, and partner with chaplains and clergy from various faith traditions and denominations.

Table 1. Chaplain Functions from the CARA CHA/NACC Spiritual Care 2025 Survey



Source: Reproduced from Mark Gray, Jill Fisk, and Erica Cohen Moore, "National Survey Highlights Trends and Obstacles to Professional Spiritual Care in Catholic Health Environments," *Health Progress* 107, no. 1 (Spring 2026).

While chaplains are the primary providers of spiritual care in a faith-based setting like Catholic healthcare, spiritual care is not solely their responsibility. An interprofessional spiritual care model positions other team members (e.g., nurses, physicians, social workers) as "spiritual care generalists." These "generalists" help recognize spiritual distress in patients or caregivers and can refer them to "spiritual care specialists" (i.e., trained chaplains) for tailored spiritual assessments and care.[8]

This collaborative model of care also extends beyond the patient-clinician encounter. Spiritual care departments form and maintain relationships with community clergy and trained volunteers to support patients' pastoral and sacramental needs. These individuals do not replace professional healthcare chaplains, but partner with them to help patients stay connected to their faith communities during illness and hospitalization.

Assuring patients' spiritual needs requires collaboration across facilities and health systems. Effective spiritual care cannot depend solely on the efforts of individual chaplains or departments. Building and sustaining a culture of whole-health requires commitment at every level of leadership—from executive teams and governing boards to healthcare leaders responsible for strategy, operations, and performance.

This broad network of support reflects the relational nature of quality spiritual care in healthcare settings. It helps patients and caregivers explore meaning, purpose, and connection during illness and is grounded in presence, listening, and relationship rather than procedure or efficiency. As a result, spiritual care plays a vital role in nurturing the spiritual dimension of the human person within increasingly technical healthcare systems.

Spiritual Care in Scripture and Tradition

Throughout Christian history, spiritual care has been understood not as separate from healthcare, but as an essential dimension of healing itself. Christian spiritual care has its roots in the healing ministry of Jesus and in a longstanding tradition of caring for both body and soul. The first Christians knew Jesus personally. They walked and ate with him, and they witnessed his power to heal. These healings took many forms. At times, Jesus used physical acts, applying mud to a blind man's eyes in John 9:1–7, or placing his fingers into a deaf man's ears in Mark 7:32–35. In other cases, he healed from a distance, as when he tells a royal official that his dying son "will live" without ever seeing the child in person (John 4:46–54). Elsewhere, he delivers individuals from spiritual affliction rather than physical illness, as in the story of the Gerasene demoniac (Mark 5:1–20). Some healings even unfold

gradually: at Bethsaida, a blind man first sees people "like trees walking around" before Jesus touches him a second time and restores his sight fully (Mark 8:22–26). Together, these stories portray healing as relational attention to the whole person. This model would shape Christian understandings of care for centuries.

Early Christians understood care for the sick as an extension of Jesus' healing ministry. What began as informal, individual acts of care gradually developed into monasteries and other institutions devoted to the care of both spiritual and physical suffering. These institutions were the beginning of today's healthcare ministry.[9]

In the Middle Ages, orders such as the Hospitalers of St. John of God and the Order of St. Camillus integrated spiritual care with healthcare. A genre of self-help books for dying, called the *Ars Moriendi* (the "art of dying"), emerged in the 15th century, at a time when medical care was limited or nonexistent, and most priests had died in the plague. (See Figure 1).

Figure 1.
***Ars moriendi* (The Art of Dying), German woodcut from a block-book edition, ca. 1500-1510.**

These "handbooks for dying" offered spiritual care in the absence of a priest.[10] Viewing death as a profound spiritual event, they emphasized prayer and the presence of the community to protect the sick person and their family from despair. Over time, many other apostolic religious communities continued this tradition of caring for both body and soul as an expression of spiritual commitment. By the 17th century, numerous religious orders dedicated themselves to caring for the poor and sick.

This integrated understanding of healing began to change in the 18th century with the rise of modern scientific medicine. Daniel Sulmasy describes this transition as the "birth of the clinic," not the clinic as we know it today, but a form of healthcare increasingly grounded in science and reason, freed "from the trappings of religion." While this model transformed the treatment of disease, it viewed the patient as an object of scientific investigation rather than as a human being created in the image of God. Sulmasy argues that medicine "[eschewed] the mystical and became blind to the mystery within the patient."[11] Thus, healthcare was gradually "reconceptualized to be like any other industry," where efficiency displaced virtues of "compassion, empathy, [and] fidelity." Yet, he observes, "illness is a spiritual event. It grasps persons by the soul as well as by the body and disturbs both."[12] If illness affects both body and soul, then healthcare that aims to treat the human

person must attend to both. In this sense, the clinic requires a "rebirth," one that recovers a vision of spiritual care as an indispensable element in treating patients according to their humanity.

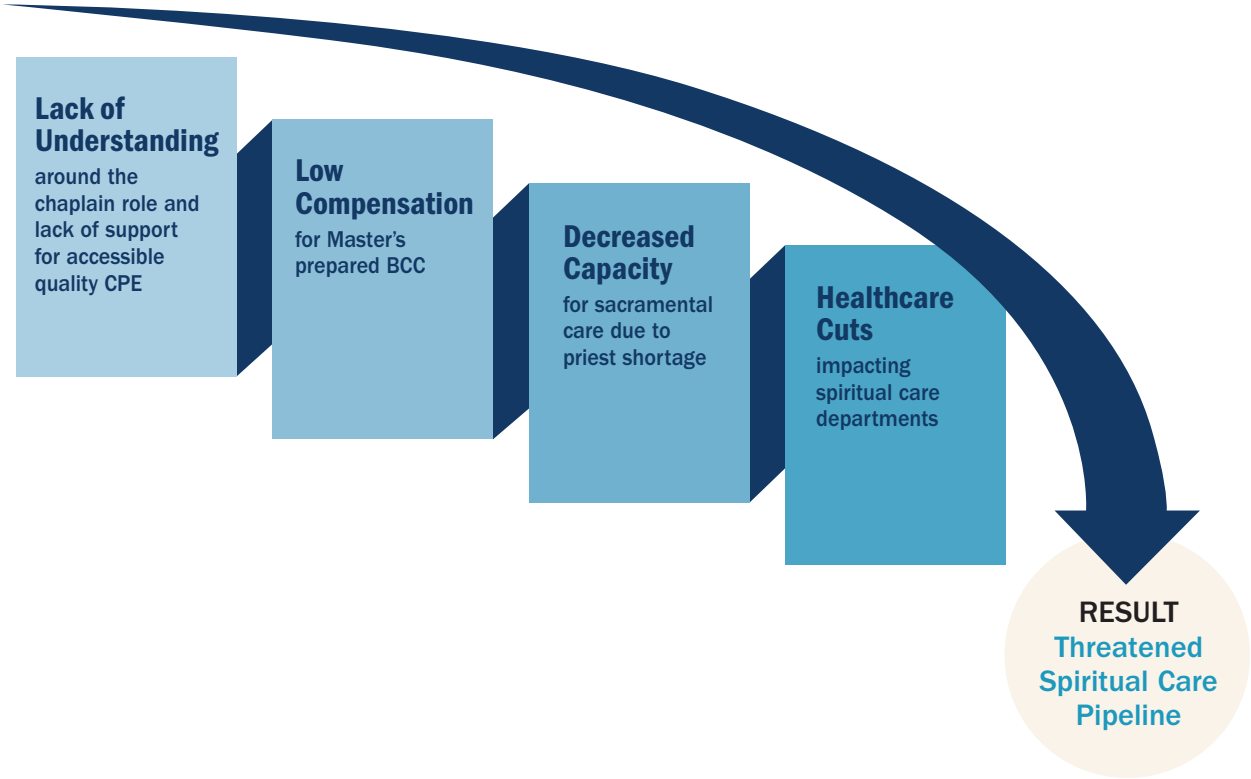
Contemporary Church Teaching

Contemporary Catholic teaching explicitly reaffirms the importance of spiritual care within healthcare ministry. *The Ethical and Religious Directives for Catholic Health Care Services (ERDs)* are a foundational guide for Catholic healthcare institutions. [13] The directives emphasize the unity of body and soul, affirming the responsibility of healthcare to attend to the "religious and spiritual needs of all those [the institution] serves."[14] Because this mission requires skilled spiritual care providers, the ERDs also emphasize appropriate professional, mission-based formation for chaplains and others who serve in Catholic healthcare.[15]

Part Two:
Spiritual Care Within Catholic Healthcare: Current Challenges

While spiritual care is foundational to Catholic healthcare, spiritual care departments face multiple challenges. These include a lack of understanding of chaplains' roles, a lack of accessible Clinical Pastoral Education (CPE) programs, a lack of staffing to support spiritual and sacramental care needs, and financial and organizational challenges.[16] (See Figure 2).

Figure 2. Challenges to the Spiritual Care Pipeline



The Challenge of Balancing Spiritual and Sacramental Care

An increasing number of people in the U.S. identify as religiously unaffiliated.[17] This trend highlights a central challenge for Catholic healthcare: balancing its sacramental identity with the broader spiritual needs of increasingly diverse patient populations. Although sacramental care remains an important component of spiritual care, many patients may primarily need skilled reflective listening, discernment, silent presence, and skilled mediation around goals of care. This distinction becomes clearer in the case of Sophia, introduced at the beginning of this paper as a patient newly diagnosed with breast cancer who is not a practicing Catholic. Sophia may desire compassionate spiritual support without sacramental care. For someone like Sophia, a professional healthcare chaplain could provide meaningful spiritual care.

At the same time, Catholic healthcare systems face increased strain to ensure sacramental care is available to the patients and residents who desire it. The 2015-2025 data from the Center for Applied Research in the Apostolate (CARA) show a steady decline in the number of priests, religious sisters and brothers, and only a slight increase in the number of permanent deacons.[18] (See Table 2).

Table 2. Summary of CARA Data on Catholic Clergy and Vowed Religious Status, 2015-2025

Year	Number of total priests	Permanent Deacons	Religious Sisters	Religious Brothers
2015	37,578	18,082	48,546	4,200
2020	35,513 (↓2,065)	18,036 (↓46)	41,357 (↓7,189)	3,801 (↓399)
2025	33,462 (↓2,051)	18,425 (↑389)	33,135 (↓8,222)	3,290 (↓511)

Source: The Center for Applied Research in the Apostolate (CARA), *2025 CHA/NACC Spiritual Care Survey* (unpublished survey report prepared for the Catholic Health Association and National Association of Catholic Chaplains, 2025).

While lay chaplains can administer some sacraments, priests are required to administer others. This creates a dilemma for a healthcare tradition that understands spiritual care as sacramental. As a result, spiritual care departments are hard-pressed to provide services that are essential to their mission. Catholic health ministries strive to provide access to sacramental rituals for Catholic patients and residents. These rituals, such as the Eucharist or Anointing of the Sick, carry great meaning for Catholics, especially in times of sickness or when facing mortality. Catholics often ask for them while in the care of a medical facility, and spiritual care departments in Catholic health ministries desire to provide them. Without adequate priest chaplain coverage, whether staffed or by community clergy willing to serve, access to sacramental rituals in the clinical care setting can be limited.[19] These limitations can significantly delay sacraments, in some cases to the point that patients may not receive them at all.[20]

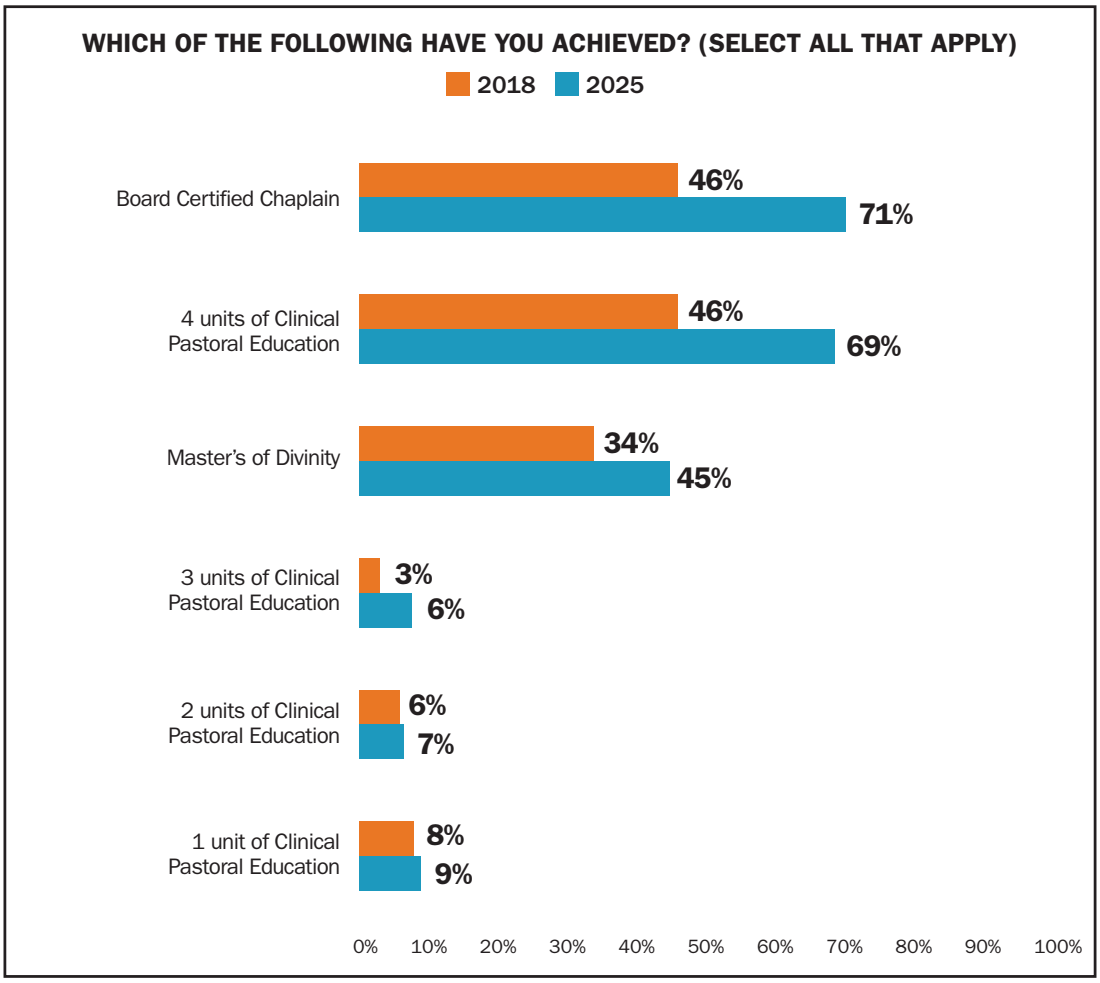
However, sacraments are only one dimension of spiritual care. Even in settings with limited numbers of priest chaplains, non-Catholic clergy can provide meaningful support beyond sacraments. As one chaplain said, “Spiritual care is always sacramental but not always based in the Sacraments.” Figure 3 shows the relationship between sacramental and spiritual care.

Figure 3. The Relationship Between Spiritual and Sacramental Care

Workforce and Demographic Challenges

The scale and changing demographics of Catholic healthcare creates significant challenges for spiritual care departments. According to recent annual data from the Catholic Health Association (CHA), Catholic healthcare systems include more than 600 Catholic hospitals and 1,600 long-term care and other health facilities across all 50 states, accounting for nearly 4.5 million admissions and 99 million outpatient visits. A recent spiritual care survey led by CHA, The National Association of Catholic Chaplains (NACC) and CARA found a large increase between 2018 and 2025 in the number of chaplains who completed four CPE units and are board-certified. (See Table 3). This reflects both elevated standards and increased professionalization in our chaplain workforce.

Table 3. CARA/NACC Survey Comparison of Educational Training 2018 and 2025



Source: CARA, *2025 CHA/NACC Spiritual Care Survey*.

The data also show greater diversity in 2025 than in 2018 across race, ethnicity, and religion. This highlights the importance of collaboration among chaplains from different faith traditions, as well as the need for education on the unique aspects of Catholic spiritual care. (See Table 4). These workforce changes are occurring alongside broader demographic shifts in the United States. Pew Research Center continues to show that people in the U.S. increasingly identify as "spiritual" but religiously unaffiliated.[21] These changing patterns of belief must shape how we provide spiritual care, how chaplains are educated and supported, how healthcare staff are trained to recognize spiritual needs, and how spiritual care must mirror the needs of the specific communities it serves.

Table 4. CARA/NACC Survey Comparison of Gender, Age, Race/Ethnicity, and Religion of Respondents from 2018 and 2025

	2018	2025
Gender		
Female	56%	53%
Male	44%	46%
Other	–	1%
Mean Age	59	57
Race/Ethnicity		
White/European American	84%	70%
Black or African American	8%	11%
Asian, Native Hawaiian, or other Pacific Islander	2%	6%
Hispanic or Latino	3%	5%
Native American or Alaska Native	<1%	1%
Other	3%	1%
Prefer not to say	–	3%
Religion		
Catholic	72%	56%
Protestant or Christian	22%	32%
Orthodox Christian	–	<1%
Unitarian	<1%	<1%
Jewish	<1%	1%
Buddhist	<1%	<1%
Other	5%	4%
No religious affiliation	–	1%
No response	–	7%

Source: CARA, *2025 CHA/NACC Spiritual Care Survey*.

At present, however, only limited data exists to assess the extent of spiritual and sacramental needs or the capacity of the current workforce to meet them. As spiritual care becomes more professionalized and patient populations become more diverse, healthcare systems will need better ways to measure and track unmet spiritual needs, evaluate the prevalence and effectiveness of CPE programs,[22] and assess the impact of spiritual care interventions.

Financial and Organizational Challenges

In addition to personnel shortages, financial and organizational challenges exist. Spiritual care departments are not revenue-generating and often labeled as "value-based." According to the CARA survey cited throughout this paper, leaders of spiritual care departments identified budgetary and resource constraints as their biggest challenges. This, in turn, negatively affects chaplain pay scales and discourages those who feel called to chaplaincy.[23]

One of the most critical challenges facing healthcare chaplaincy is the continued failure to recognize chaplains as clinical professionals. As members of interdisciplinary care teams (IDTs), chaplains should have parity with other clinical roles (social work, speech therapy, mental/behavioral health, etc.). Such positions receive compensation that reflects both years of specialized education and clinical training to prepare them as professionals on IDTs. Historically, chaplains have been, and continue to be, paid at rates similar to masters-level clergy, whose compensation does not account for the 1200 hours of clinical and educational preparation required of chaplains for board certification.[24] To date, national salary benchmark data does not reflect chaplains' contributions to patient outcomes and their increasingly integrated role in IDTs.[25] While some CHA-member ministries have transitioned spiritual care professionals to clinical status with corresponding job codes, a broad adoption is needed across Catholic healthcare.

Part Three:
Toward a Rebirth of the Clinic

Addressing the aforementioned challenges will require coordinated action across Catholic healthcare systems. Mission leaders, sponsors, executive leadership, spiritual care leaders, and chaplains each play distinct roles in shaping how spiritual care is enacted in healthcare settings. The following sections examine how these stakeholders can collaborate to strengthen spiritual care and preserve its centrality within Catholic healthcare.

Mission Leaders and Sponsors

Mission leaders and sponsors function at very different levels, but they share a commitment to the spiritual health and Catholic identity of their organizations. The role of the mission leader emerged relatively recently in Catholic healthcare. Historically, religious sisters embodied the mission through their presence and leadership. Much of the mission was cultivated through their witness and naturally woven into the organization's culture and priorities. With the decline of the sisters and an increase in lay ministry, the need to articulate and integrate mission more intentionally became clear. Making the mission explicit and ensuring it remains central to the ministry's identity and operations are key responsibilities of today's mission leaders. CHA has standardized expectations through the Ministry Identity Assessment (MIA), which highlights the mission leader's role in championing spiritual care to sponsors, boards, executives, and staff. [26] The mission executive should also work to promote awareness of chaplaincy as a vocational choice through partnerships with internal departments (e.g., human resources, marketing, communications) and external partners (e.g., schools and universities, local faith groups, and organizations).

Catholic healthcare was founded by religious orders devoted to caring for the poor and vulnerable. Over centuries of work, they developed a legacy of ingenious operational structures. They were accountable to local bishops and the Holy See for Catholic identity and mission. As membership in these religious orders wanes, we see a new generation of sponsors who exercise this accountability through new canonical structures described as "ministerial juridic persons." Their role, like that of their predecessors, is primarily spiritual; thus, they, along with board members, carry a unique responsibility to uphold Catholic identity and spiritual care through governance. Ultimately, it is up to these sponsors to ensure vital spiritual care. However, because the sponsor role is still developing, it is key to assess their understanding of both the importance of spiritual care and their sense of responsibility for it.[27]

How can mission leaders and sponsors ensure that quality spiritual care is accessible and sustainable?

1. ADVOCATE FOR SPIRITUAL CARE RESOURCES

Salaries: Average chaplain salaries are significantly below those of their mission, formation, and ethics counterparts with Master's degrees. Chaplains, who are deemed "non-revenue-generating" according to business standards, are more vulnerable to budget cuts. This contributes to poor staffing ratios and burnout. Chaplains arguably have the least control over their schedules; they are often required to cover emergencies around the clock, 365 days a year. Compared to other healthcare ministry roles, chaplains are the most readily available resource for answering staff, patient, and caregiver needs. Just salaries are necessary to sustain quality spiritual care.

CPE: To support CPE internships and residencies and attract vocations to chaplaincy, new funding and additional resources are needed. Earning a Master's degree (e.g., M.Div.) is costly; CPE and certification require a significant time commitment that is difficult to balance with full-time employment.

2. ENSURE THE VIBRANCY AND PROFESSIONALISM OF SPIRITUAL CARE SERVICES TO MEET THE UNIQUE NEEDS OF PATIENTS, RESIDENTS, FAMILIES, AND ASSOCIATES

The ERD imperative to provide spiritual care for all people invites us to strengthen our collaboration with the increasing number of BCC from other denominations and faith traditions. This includes listening and learning from one another and providing respectful formation in the distinctive theological and sacramental dimensions of Catholic healthcare.[28] It is key to identify which organizations or leaders are best positioned to guide these conversations and help shape sustainable models of spiritual care for the future.

3. PROMOTE SPIRITUAL CARE LITERACY

Mission leaders and sponsors who are knowledgeable about spiritual care research are better equipped to advocate for spiritual care with executive leaders and boards whose operational decisions are often guided by data rather than theological frameworks.

We invite mission leaders and sponsors to engage Church leaders in understanding the current literature that addresses the growing pastoral crisis surrounding sacramental care in healthcare settings. Relevant data sources, such as the CARA/NACC survey and the Pew Religious Landscape Study, are important resources that highlight spiritual care needs and the spiritual care workforce, improving hiring practices for better alignment. Key questions that need attention include:
How might Catholic healthcare systems expand the role of qualified, Catholic board-certified chaplains to meet broader spiritual care needs while reserving sacramental ministry for priests and deacons? When qualified non-Catholic chaplains are available for leadership roles, how should Catholic health ministries navigate the tension between competency-based hiring and the need to maintain Catholic leadership requirements in spiritual care?[29] What is a mission leader or sponsor's responsibility in ensuring the ministry's commitment to Catholic identity by recruiting and retaining highly qualified spiritual care leaders? What tensions emerge when requirements related

to Catholic affiliation limit the selection of candidates with the strongest leadership qualifications and professional expertise?

We invite mission leaders and sponsors to engage with these threats to spiritually integrated care and reverse the downward trend.

CRITICAL QUESTIONS FOR MISSION LEADERS AND SPONSORS

1. What is my comfort level discussing spirituality and spiritual care in strategic planning? With Church leaders? What would improve my confidence?

2. In what ways do I ensure the "vibrancy and professionalism of spiritual care services to meet the unique needs of patients, residents, families, and associates"?[30]

3. What can mission leaders and sponsors do to ensure that our budgets both reflect our spiritual care priorities (CPE, salaries) and incentivize a sustainable spiritual care workforce?

4. In what ways can my role support or hinder the accessibility of spiritual care to staff, patients, and families?

Executive Leadership

We live in a time when our sector is characterized by multiple stressors: healthcare worker burnout and shortages, financial uncertainty, reimbursement challenges, pushes for greater efficiency with fewer resources, and increased use of AI and virtual care. In this environment, spiritual care—as a form of attention to how we find meaning, purpose, and connection—is not only important; it is integral to patient, caregiver, and staff well-being.

The benefits of spiritually integrated care, as embodied by the pioneers of Catholic healthcare, are now increasingly supported by scientific research. A growing body of evidence points to measurable benefits for patient well-being, health outcomes, and quality of care. A landmark systematic review examining more than 15,000 studies across a 22-year period identified spiritual care as a best practice in patient-centered healthcare.[31] Other experts have gone further, arguing that spirituality should be understood as a social determinant of health because of its demonstrated effects on both individual and public health outcomes.[32] Recognition of spiritual care is also beginning to emerge at the institutional level. The Centers for Medicare and Medicaid Services (CMS), for example, approved Healthcare Common Procedure Coding System (HCPCS) codes to track spiritual care interventions.[33]

Spiritual Care and Patients

Studies show that patients desire spiritual care[34] and, unsurprisingly, its provision is associated with higher patient satisfaction scores and improved hospital reimbursement.[35] Patients with cancer and other acute or chronic illnesses often face incredible physical, psychological, and spiritual suffering.[36] Remarkably, recent research suggests that spiritual care can enhance life satisfaction even in the midst of serious illness.[37]

Spiritual Care, Caregivers and Healthcare Workers

Because caregivers of patients with serious illness often turn to religion and spirituality for support, they should have access to professional healthcare chaplains.[38] Evidence supporting this need continues to grow. The Spiritual Care Assessment and Intervention (SCAI) Framework, for example, demonstrates that chaplain interventions significantly improve the well-being of ICU healthcare surrogates. The framework has also been recognized by the National Institutes of Health.[39] By alleviating suffering for patients and families, spiritual care may also reduce some of the emotional and moral burden experienced by healthcare workers (HCWs).

Research shows that direct chaplain interventions increase social support and mitigate harm to HCWs, who face a high risk of moral injury and burnout.[40] HCWs may turn to chaplains to assist

with difficult medical decisions and mediate communication between families and the clinical team.[41] For example, a patient with stage IV metastatic cancer may confide in a chaplain that they do not want aggressive treatment; they may feel the side effects take away from meaningful time with family, but worry about disappointing their caregiver. Chaplains can help clinicians share information in ways that support patients. This support can alleviate fears and facilitate advance care planning.[42] It may also prevent unwanted, expensive, and perhaps non-beneficial care, while reducing moral distress for healthcare staff.[43]

Spiritual Care and Strategic Goals

Spiritually integrated care can also enhance an institution's broader strategic goals. For organizations seeking Joint Commission accreditation, chaplains are well-equipped to assist with standards related to "Patient Rights and Responsibilities." These include respecting patients' "cultural and personal values, beliefs, and preferences" and their "right to religious and other spiritual services."[44] Spiritual care also aligns closely with the new Medicare Age-Friendly Health Systems initiative, particularly its emphasis on the "4Ms": What Matters, Medication, Mentation, and Mobility.[45] Because chaplains are trained to facilitate conversations about meaning, values, and beliefs, they play an important role in helping patients and caregivers articulate what matters most in decision-making during illness.

How can executive leadership ensure that quality spiritual care is accessible and sustainable?

1. CREATE A CULTURE OF SPIRITUAL CARE LITERACY

Because spiritual care is not a peripheral service but an essential dimension of whole-person care, spiritual care literacy should be a priority for healthcare leadership and all members of the interdisciplinary team. Evidence-based programs such as the Interprofessional Spiritual Care Education Curriculum (ISPEC) pair chaplains with interdisciplinary team members to enhance the collaboration needed for quality spiritual care.[46] When all staff—from nurses and doctors to patient registrars and environmental services personnel—know the signs of spiritual distress and how to refer individuals to a chaplain, they can help provide timely care.

2. SUPPORT THE HIRING OF QUALIFIED CHAPLAINS

The Impact of Professional Spiritual Care is a resource developed by five leading professional chaplaincy organizations to guide healthcare systems in hiring well-qualified chaplains.[47] Qualified chaplains must be skilled at identifying and responding to the spiritual needs of diverse patient populations while honoring the beliefs, values, and preferences of the individuals they serve. They must also be able to adapt to evolving models of healthcare delivery (e.g., telechaplaincy)[48] and to identify spiritual needs of both those affiliated with specific religions and the growing population of those unaffiliated.[49] Finally, like other clinical professionals, chaplains must be skilled at creating

care plans and spiritual interventions that are tailored to individual needs. High-quality spiritual care, therefore, depends on access to professionally trained, board-certified chaplains who hold graduate-level theological degrees and have completed accredited CPE training.[50] Ensuring access to CPE training is essential to sustaining the future of spiritual care.

3. ENSURE APPROPRIATE STAFFING

Staffing levels must account for the fact that spiritual or moral distress can strike patients and staff at any time, day or night. The presence of a chaplain is arguably more important at night or on weekends. During those times, administrative support is lean, and fewer resources are available. Staff may also have greater availability to take advantage of chaplain support.

While staffing ratios affect the quality of spiritual care, recommendations vary widely. CHA has developed a useful staffing tool for acute care settings, based on adjusted patient days and full-time equivalents (FTEs), to help leaders determine whether they are adequately staffed.[51] However, further research is needed to align staffing with spiritual care needs.

In conclusion, the provision of quality spiritual care is a best practice from every vantage point. Beyond improving patient and caregiver quality of life, it increases satisfaction with care, strengthens staff resilience against burnout, and contributes to the overall effectiveness of our healthcare ministries. Executive leaders are well-positioned to ensure that quality spiritual care is both accessible and sustainable. Only when we prioritize hiring board-certified chaplains, maintaining adequate staffing ratios, ensuring fair compensation, and supporting a culture of spiritual care awareness can we reliably provide quality spiritual care.

CRITICAL QUESTIONS FOR EXECUTIVE LEADERSHIP

1. *What experiences have shaped my understanding of spiritual care and chaplaincy as a Catholic health leader? What education would enhance my growth?*
2. *What is my comfort level with discussions about spirituality and spiritual care in strategic planning? What would improve my confidence?*
3. *How does the current budget reflect my ministry's commitment to spiritual care as essential to Catholic identity? What dedicated resources does my health ministry offer to support spiritual care literacy and access to quality spiritual care? Are they adequate?*
4. *In what ways can my role support or hinder the accessibility of spiritual care to staff, patients, and families?*

Spiritual Care Leaders and Chaplains

As we encourage executive leadership and other stakeholders to reflect on their understanding and relationship with their spiritual care departments, it is equally important for chaplains to do the same. In recent years, spiritual care leaders and researchers have made progress in deepening an understanding of spiritual care and in making the case for chaplaincy across the profession. Abundant research is available on topics such as spiritual care assessments, documentation, and collaboration between chaplains and other allied health professionals.[52] The question then becomes how spiritual care leaders and chaplains use this research to improve their practice and illuminate the value of spiritual care in their particular organizations: To what extent are chaplains aware of quality improvement processes and outcomes assessment?

Embracing the Spiritual Care Clinical Role

The concept of chaplains as clinicians and spiritual care specialists has gained more visibility in recent years. At the same time, chaplains may resist clinical practices such as documentation, assessments, and the collection of metrics, especially if these were not covered in their training. However, chaplains in healthcare settings must recognize organizational culture as a requirement for board certification (Competency OL3).[53] Healthcare chaplaincy training should emphasize the importance of navigating institutional healthcare culture—specifically, understanding that values and best practices (e.g., quality improvement, documentation) support person-centered care. As Kevin Massey, a leader in spiritual care says, "A needed shift of identity involves seeing a chaplain primarily as a healthcare professional with theological and religious training rather than a theological or religious professional with a healthcare role."[54]

Chaplains within Catholic healthcare are called to provide care that honors the dignity of the whole person. Just as Jesus used parables to reveal deeper truths, chaplains use stories to help foster understanding. By documenting patients' stories in the clinical record, chaplains enable the entire care team to recognize, honor, and build upon the care provided. At the same time, demonstrating value of spiritual care and ensuring that it remains available to all, stories must be paired with metrics. Chaplains must be willing to meet clinical peers where they are, by using their language. To be midwives in the "rebirth of the clinic," chaplains must see themselves as valuable members of the clinical team rather than as outsiders.

Strategy and Leadership from within Spiritual Care

Embracing their role on the clinical team is important for spiritual care professionals, and they must prepare themselves to be leaders. Catholic health founders looked ahead to meet the needs of those in their care; chaplains need to think strategically to ensure that spiritual care remains integrated with

organizational culture. While spiritual care managers and directors are required to understand these dynamics, staff chaplains should also be familiar with their ministry's strategic goals and have a basic understanding of organizational structures. Chaplains are leaders of spiritual care, whether official or unofficial.[55] As such, they carry a vital responsibility to nurture and mentor less experienced chaplains so that they can fully and confidently step into these leadership roles.

Effective chaplaincy leadership requires strong partnerships with others who share responsibility for sustaining the mission of Catholic healthcare. Among the most important of these partners are mission leaders and colleagues involved in ministry formation. Chaplains are already accustomed to serving as relational bridges between patients, families, and interdisciplinary care teams. These same skills can also bridge spiritual care and mission.[56]

CRITICAL QUESTIONS FOR SPIRITUAL CARE LEADERS AND CHAPLAINS

1. *How effectively do I model and promote documentation, assessment, and accountability as core chaplaincy practices that demonstrate spiritual care's contribution to a patient's plan of care?*
2. *How is spiritual care aligned with the health ministry's strategic goals and integrated into the organizational culture?*
3. *What opportunities exist for collaboration between spiritual care and mission in my setting? How can I support this collaboration?*

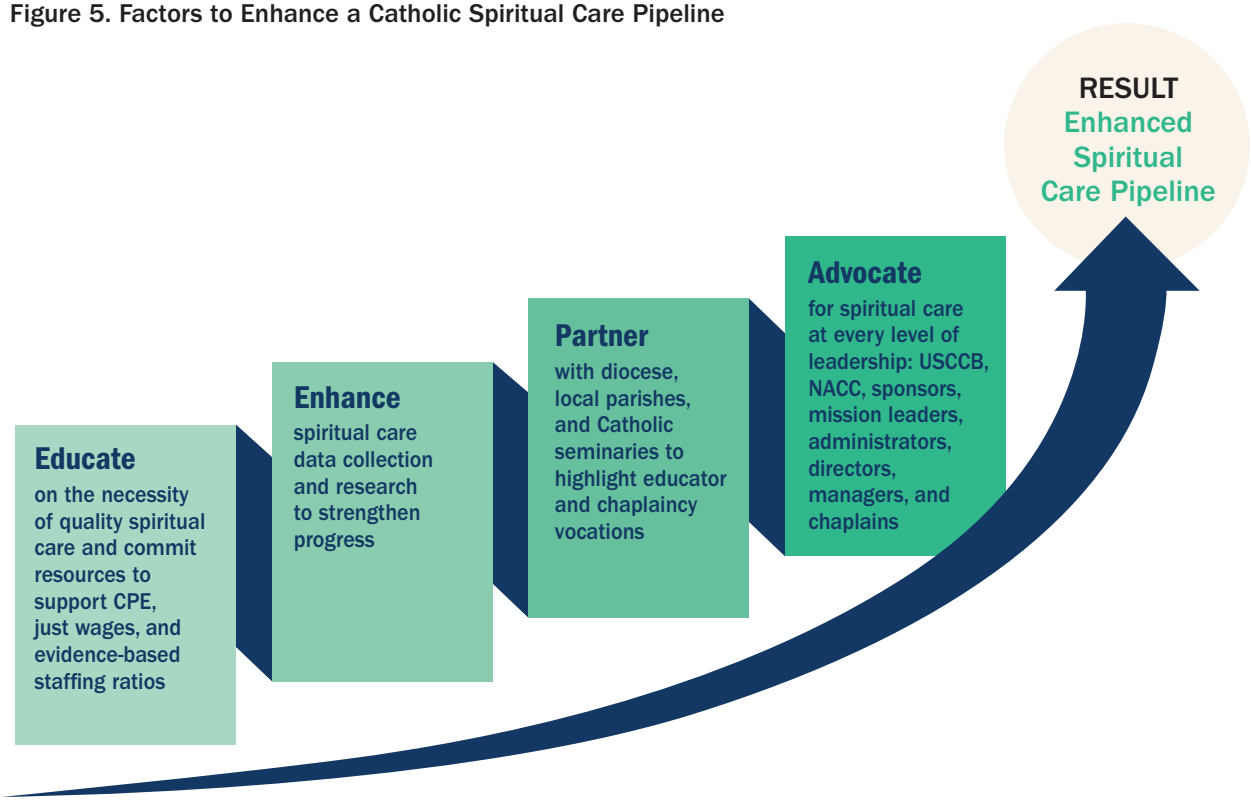
Conclusion

Spiritual care in Catholic healthcare is at a crossroads. It is deeply embedded in the foundation and history of Catholic healthcare. Still, both internal and external challenges have placed spiritual care departments in the precarious position of being both necessary and under-supported. This paper offers important insights to further the conversation across Catholic healthcare about the challenges facing spiritual care. These conversations are key to ensuring a future in which spiritual support for patients, their families, and clinical staff contributes to human flourishing.

Figure 4. Contributors to Strengthen Accessible Spiritual Care

Catholic healthcare is currently confronting several significant pressures, including sustaining the chaplaincy pipeline, ensuring adequate sacramental coverage, providing just compensation, and supporting adequately resourced spiritual care departments. We encourage each stakeholder group to reflect on these concerns with their teams — including executive leadership — using the discussion questions provided in each section. Even amid these realities, there is reason for hope. Shared responsibilities for spiritual care (see Figure 4) can help strengthen the future chaplaincy workforce (see Figure 5) and sustain spiritually integrated care within Catholic healthcare. Throughout its history, Catholic healthcare has demonstrated resilience in responding to changing needs, and the future of spiritual care will likewise depend on collaborative leadership and shared commitment.

Figure 5. Factors to Enhance a Catholic Spiritual Care Pipeline



Executive Summary

The main concern of this paper is the importance of spiritual care as part of Catholic identity and a strategy for whole-person care, demonstrating its effectiveness for patients and healthcare workers by multiple studies. These studies also show that spiritual care enhances the patient experience and may contribute to both reduced costs and lower burnout among clinical staff. Despite the need and desire for spiritual care, internal and external factors limit its availability.

Spiritual care is rooted in the healing ministry of Jesus Christ, which, over the centuries, evolved into many forms of institutional care. Quality healthcare recognizes healing is holistic — body, mind, and spirit. The Catholic tradition and the ERDs that guide Catholic healthcare insist upon the care of the spirit. Chaplains are professionally trained clinicians who provide holistic spiritual support to patients, residents, and staff regardless of one's faith tradition. As trusted members of the interdisciplinary team, chaplains attend to the whole health of persons and teams through spiritual interventions, meaning-making modalities, and sacramental provision to those who are Catholic.

External challenges to effective spiritual care include the predominance of a secular, clinical model of healthcare that tends to marginalize the spiritual. Internal challenges include a lack of awareness of chaplaincy as a vocational choice, low compensation, a lack of commitment to CPE programs, and a reluctance to recognize chaplains as full-fledged members of the care team. The limited availability of priest-chaplains is a significant problem for pastoral care in the sacramental Catholic tradition.

Upholding a commitment to strengthen the quality of spiritual and pastoral care across Catholic healthcare requires collaboration among key stakeholders, including mission leaders, sponsors, executive leadership, spiritual care leaders, and chaplains themselves.

We have summarized specific suggestions for each of these groups in Table A1.

Table A1. Upholding Our Commitment to Strengthen Spiritual Care

Role	Responsibilities
Mission Leaders	✦ Advocate for resources to ensure quality spiritual care is accessible 24/7 for patients, caregivers, and staff ✦ Prioritize spiritual care in organizational decisions ✦ "Ensure the vibrancy and professionalism of spiritual care services to meet the unique needs of patients, residents, families, and associates"[58] ✦ Model and promote spiritual care literacy
Sponsors	✦ Hold executive leadership accountable for the problem of unmet spiritual care and workforce shortages, and ensure CPE accessibility ✦ Advocate for institutional changes that could advance and enhance a pipeline of qualified Catholic spiritual care professionals ✦ Ensure just compensation and adequate resources so that quality spiritual care is accessible and available to all who need it
Executive Leadership	✦ Promote spiritual care literacy and integration of spiritual care leadership in organizational decisions ✦ Support the hiring of Board-Certified Chaplains, accessibility of CPE and certification support for those already hired ✦ Ensure adequate staffing and compensation for quality spiritual care
Spiritual Care Leaders and Chaplains	✦ Embrace spiritual care as a clinical role (documentation, assessment, quality improvement, best practices) ✦ Track and provide data to tell the story of how chaplains impact patient and staff outcomes ✦ Educate on the role of the chaplain and promote spiritual literacy at every level ✦ Partner with interdisciplinary teams and align with organizational strategic initiatives ✦ Uphold Board Certification standards

Notes

[1] Tracy A. Balboni, Tyler J. VanderWeele, Stephanie D. Doan-Soares, et al., "Spirituality in Serious Illness and Health," *JAMA* 328, no. 2 (2022): 184–97, https://doi.org/10.1001/jama.2022.11086.

[2] Gael Charbonne, Juan Linares, Kevin Gill, and Harvey Hahn. , "Spirituality: The Missing Pillar of Whole-Person Care," *Primary Care Reports* 32, no. 1 (2026): 1–9.

[3] Christina M. Puchalski, Betty Ferrell, Rose Virani, et al., "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference," *Journal of Palliative Medicine* 12, no. 10 (2009): 885–904, https://doi.org/10.1089/jpm.2009.0142.

[4] Balboni et al., "Spirituality in Serious Illness and Health."

[5] Spiritual distress is "the inability to experience and integrate meaning and purpose in life, often to the point that it impairs holistic healing, reciprocation in supportive relationships, and the acceptance of current circumstances." Ascension Health's On-Demand Spiritual Care Team adopted this definition of spiritual distress from Fabiana C. Dos Santos et al., "The Impact of Spiritual Care Delivered by Nurses on Patients' Comfort: A Propensity Score Matched Cohort Utilizing Electronic Health Record Data," *International Journal of Medical Informatics* 183 (2024): 105319, https://doi.org/10.1016/j.ijmedinf.2023.105319.

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[7] George Fitchett, Kelsey White, and Kathryn Lyndes, eds., *Evidence-Based Healthcare Chaplaincy: A Research Reader* (Jessica Kingsley Publishers, 2018).

[8] Puchalski et al., "Improving the Quality of Spiritual Care."

[9] Gary B. Ferngren, *Medicine and Health Care in Early Christianity* (Johns Hopkins University Press, 2009).

[10] Dozens of editions of these handbooks were published in many languages from roughly 1350 to 1800. For one example, see St. Robert Bellarmine, *The Art of Dying Well*, trans. John Dalton (Richardson and Son, 1847; repr., Sophia Institute Press, 2021).

[11] Daniel P. Sulmasy, *The Rebirth of the Clinic* (Georgetown University Press, 2006), 21. He describes this reborn clinic as a "biopsychosocial-spiritual" model of care. Refer to chapter 8 of the same title for further reading. See also Daniel P. Sulmasy, "A Biopsychosocial-Spiritual Model for the Care of Patients at the End of Life," The Gerontologist 42, no. 3 (2002): 24-33.

[12] Sulmasy, *Rebirth of the Clinic*, 17.

[13] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 7th ed. (United States Conference of Catholic Bishops, 2025).

[14] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, directive 10: "A Catholic health care organization should provide pastoral care to minister to the religious and spiritual needs of all those it serves. Pastoral care personnel—

clergy, religious, and lay alike—should have appropriate professional preparation, including an understanding of these Directives."

[15] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, directives 16-17.

[16] White, Kelsey B., Shoou-Yih Daniel Lee, J'Aime C. Jennings, Seyed Karimi, Christopher E. Johnson, and George Fitchett. "Provision of Chaplaincy Services in U.S. Hospitals: A Strategic Conformity Perspective." *Health Care Management Review* 48, no. 4 (2023): 342–51. https://doi.org/10.1097/HMR.0000000000000382.

[17] Pew Research Center, *2023-24 Religious Landscape Study (RLS) Dataset*, https://doi.org/10.58094/3kwb-bf52.

[18] Thomas P. Gaunt, and Michal J. Kramarek, *Spiritual Care Ministry in Catholic Health Care*, CARA Special Report (Center for Applied Research in the Apostolate, Fall 2019), 3-7; David Lewellen, "How Can Systems Better Support Catholic Chaplaincy?," *Health Progress* 104, no. 2 (2023), https://www.chausa.org/news-and-publications/publications/health-progress/archives/spring-2023/how-can-systems-better-support-catholic-chaplaincy; Julia Greenwood and Mary L. Gautier, *Trends in the Life and Ministry of Religious Sisters in Latin America*, CARA Special Report (Center for Applied Research in the Apostolate, 2018); and Pew Research Center, *2023–24 Religious Landscape Study*. All cite the declining number of priests as a major concern. Although discussion of the Veterans Administration (VA) falls outside the scope of this paper, the issue is particularly severe there. The VA is one of the largest employers of healthcare chaplains, but only priests are permitted to serve as Catholic chaplains because only priests can provide all sacramental ministries. Catholic deacons and lay chaplains, regardless of training or expertise in spiritual care, are not permitted to serve as Catholic chaplains within military or VA systems.

[19] Michal J. Kramarek, Thomas P. Gaunt, Mark M. Gray, Felice M. Goodwin, A. Marco Garcia, Michael J. Defelice, *Spiritual Care Survey: A Report for the Catholic Health Association of the United States and the National Association of Catholic Chaplains* (Center for Applied Research in the Apostolate, 2019), 64, 137-38, 146, 149, 152, 159.

[20] Center for Applied Research in the Apostolate, *Spiritual Care Survey Report 2019*, 5.

[21] Pew Research Center, 2023-24 *Religious Landscape Study*.

[22] The complexities of CPE fall beyond the scope of this paper. The ongoing conversation in Catholic healthcare on this topic should ask: Is quality CPE accessible enough for the professional, ethically aligned workforce we desire in Catholic healthcare?

[23] Kramarek et al., *Spiritual Care Survey*; Lewellen, "How Can Systems Better Support Catholic Chaplaincy?" According to a 2018 chaplain compensation study commissioned by NACC, CHA, and the Association of Professional Chaplains (APC), the national median salary for chaplains below the rank of manager was $58,500.

[24] U.S. Bureau of Labor Statistics, "Occupational Employment and Wages, May 2023: 21-2011 Clergy," accessed April 29, 2026, https://www.bls.gov/oes/2023/may/oes212011.htm.

[25] Mark Gray, Jill Fisk, and Erica Cohen Moore, "National Survey Highlights Trends and Obstacles to Professional Spiritual Care in Catholic Health Environments," *Health Progress* 107, no. 1 (Spring 2026), accessed April 29, 2026, https://www.chausa.org/news-and-publications/publications/

health-progress/archives/spring-2026/national-survey-highlights-trends-and-obstacles-to-professional-spiritual-care-in-catholic-health-environments.

[26] Catholic Health Association, "Ministry Identity Assessment" (2020), accessed March 26, 2026, https://www.chausa.org/member-center/ministry-identity-assessment.

[27] In many cases, sponsors and board members serve in dual roles. Their shared responsibility for governance of Catholic identity must include access to adequate spiritual care for patients and associates. Appropriate formation regarding the sponsor's responsibility for spiritual care is needed, as is accountability from the ministry to the board or sponsor body and then to the Holy See.

[28] Dagmar Grefe, *Encounters for Change: Interreligious Cooperation in the Care of Individuals and Communities* (Wipf & Stock, 2011). Grefe proposes a three-part model of spiritual care consisting of an "outer circle" of common human experience, a "middle circle" of interconnected spiritual practice, and a "center circle" of particular spiritual practice. Sacramental ministry falls within this innermost circle. This model provides a helpful framework for understanding how spiritual care can remain grounded in Catholic sacramental identity while functioning within increasingly diverse chaplaincy teams.

[29] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, directive 22: "For the sake of appropriate ecumenical and interfaith relations, a diocesan policy should be developed with regard to the appointment of non-Catholic members to the pastoral care staff of a Catholic health care institution. The director of pastoral care at a Catholic institution should be a Catholic; any exception to this norm should be approved by the diocesan bishop."

[30] Catholic Health Association, Mission Leader Competency Model (2026), 12, https://www.chausa.org/docs/default-source/mission/mission-leader-competencymodel_booklet_2020_singlecolumn__lr_finalforwebsite10292020.pdf?sfvrsn=9877f1f2_5.

[31] Balboni et al., "Spirituality in Serious Illness and Health."

[32] Katelyn N. G. Long, Xavier Symons, Tyler J. VanderWeele, et al., "Spirituality as a Determinant of Health: Emerging Policies, Practices, and Systems," *Health Affairs* 43, no. 6 (2024): 783–90, https://doi.org/10.1377/hlthaff.2023.01643.

[33] Association of Professional Chaplains, "What New HCPCS Codes Mean for Chaplains," accessed February 1, 2026, https://www.apchaplains.org/what-new-hcpcs-codes-mean-for-chaplains/.

[34] Association of Professional Chaplains, "Impact of Professional Spiritual Care"; Beth L. Muehlhausen et al., "Patients' and Loved Ones' Expectations of Chaplain Services," *Journal of Health Care Chaplaincy* 28, no. 3 (2022): 350–64, https://doi.org/10.1080/08854726.2021.1903734. See also Katherine M. Piderman et al., "Hearing and Heeding the Voices of Those with Advanced Illnesses," *Journal of Palliative Care* 35, no. 4 (2020): 248–55, https://doi.org/10.1177/0825859720928623.

[35] Joshua A. Williams et al., "Attention to Inpatients' Religious and Spiritual Concerns: Predictors and Association with Patient Satisfaction," *Journal of General Internal Medicine* 26, no. 11 (2011): 1265–71, https://doi.org/10.1007/s11606-011-1781-y. See also Deborah B. Marin et al., "Relationship Between Chaplain Visits and Patient Satisfaction," *Journal of Health Care Chaplaincy* 21, no. 1 (2015): 14–24, https://doi.org/10.1080/08854726.2014.981417.

[36] Gary Kwok et al., "Spiritual Needs and Satisfaction with Life: An Exploration of Mediating Pathways," *Supportive Care in Cancer* 33, no. 12 (2025): 1020, https://doi.org/10.1007/s00520-025-10105-8. See also Alan B. Astrow et al., "Is Failure to Meet Spiritual Needs Associated with Cancer Patients' Perceptions of Quality of Care and Their Satisfaction with Care?," *Journal of Clinical Oncology* 25, no. 36 (2007): 5753–57, https://doi.org/10.1200/JCO.2007.12.4362.

[37] Petra J. Sprik, Heather Vanderstelt, Charles Valenti-Hein, Joseph Denton, and Deadra Ashton, "Chaplain Interventions and Outcomes in Outpatient Settings: A Scoping Review," *Journal of Health Care Chaplaincy* 30, no. 4 (2024): 306–28, https://doi.org/10.1080/08854726.2024.2357042.

[38] Michael Mercier, Jane Maglio, Khaldoun Almhanna, and Dana Guyer, "Spiritual Care for Adult Patients with Cancer: From Maintaining Hope and Respecting Cultures to Supporting Survivors–A Narrative Review," *Annals of Palliative Medicine* 12, no. 5 (2023): 1047–58, https://doi.org/10.21037/apm-22-1274.

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[43] Jonathan Rauch, "How Not to Die," *Atlantic Monthly*, May 1, 1993. The article discusses the "momentum of medical maximalism" and the importance of "the conversation" in preparing for death. Both themes have spiritual implications and suggest an important role for the spiritual caregiver.

[44] Joint Commission, "Standards," accessed May 13, 2026, https://www.jointcommission.org/en-us/standards.

[45] Institute for Healthcare Improvement, *Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Care Practices* (Fall 2022), https://forms.ihi.org/hubfs/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf.

[46] Christina Puchalski et al., "Implementing Quality Improvement Efforts in Spiritual Care: Outcomes from the Interprofessional Spiritual Care Education Curriculum," *Journal of Health Care Chaplaincy* 28, no. 3 (2022): 431–42, https://doi.org/10.1136/esmoopen-2018-000465. See also Chaplaincy Innovation Lab, *Mainstreaming Spiritual Care in Healthcare Organizations* (2025), accessed May 2, 2026, https://chaplaincyinnovation.org/wp-content/uploads/2025/02/White-et-al.-

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[50] NACC and APC share board-certification standards. See National Association of Catholic Chaplains, "Board Certified Chaplain," accessed March 22, 2026, https://www.nacc.org/certification/board-certified-chaplain-bcc.

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[52] Rebecca Johnson, M. Jeanne Wirpsa, Lara Boyken, et al., "Communicating Chaplains' Care: Narrative Documentation in a Neuroscience-Spine Intensive Care Unit," *Journal of Health Care Chaplaincy* 22, no. 4 (2016): 133–50, https://doi.org/10.1080/08854726.2016.1154717 ; Christina M. Puchalski, Betty Ferrell, Rose Virani, et al., "Interprofessional Spiritual Care in Oncology: A Literature Review," *ESMO Open 4*, no. 1 (2019): e000465, https://doi.org/10.1136/esmoopen-2018-000465; Sprik et al., "Chaplain Interventions and Outcomes."

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[56] Spiritual care often serves as one of the most visible expressions of mission within Catholic healthcare. For this reason, chaplains should work closely with mission leaders to help integrate spiritual care more fully into the life and culture of healthcare institutions. This connection between spiritual care and mission leadership has deep historical roots. Religious sisters not only provided holistic, whole-person care but also frequently served as operational leaders of hospitals and health systems. Their example demonstrates that spiritual care providers have long played important roles in shaping both ministry and institutional leadership within Catholic healthcare.

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