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Published online: 13 Aug 2018.

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Healthcare Chaplaincy as a Companion Profession: Historical Developments

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Chaplains, like professionals in a range of industries, have long sought to maintain and build occupational power by articulating their professional mandate and advocating for their work. I describe how leaders of the Association of Professional Chaplains and its predecessor organizations used multiple strategies to articulate and re-articulate their professional mandate between 1940 and the present to become a companion profession, one that comes alongside another without seeking to challenge its jurisdiction. I find chaplains seeking to develop an economic base, aligning interests across distinct segments of the profession and creating new professional associations, lobbying for legislative support, and offering their services in institutional voids. They further adopted the language of healthcare around questions of identity, charting, and accreditation and, chaplains used not just the frameworks but the methods of healthcare—evidence based research—to try to demonstrate their value. This history can help chaplains and chaplaincy leaders today to form a more comprehensive sense of their history and think more strategically regarding how to make the case for their profession going forward.

KEYWORDS Healthcare chaplaincy; professional jurisdiction; professional mandate

In July of 2016, the Spiritual Care Association hired the international law firm Akin Gump Hauer & Feld to lead advocacy efforts to promote spiritual care and further integrate it into the American healthcare system. The Association hoped the firm would lobby federal legislators and craft legislation that

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would enable spiritual care providers in healthcare to be reimbursed for their services (Wintz, 2016 July). While lawyers lobbying for chaplaincy or spiritual care may seem unusual, these efforts are actually not new. In the 1970s the College of Chaplains—an organization with a much longer history than the Spiritual Care Association—worked with a lobbyist in Washington DC to determine the major issues they faced and try to impact legislation. In 2006 the College of Chaplains, now named the Association for Professional Chaplains, launched *Healing Spirit*, a glossy news magazine intended to communicate the value and contributions chaplains make to healthcare organizations.

Healthcare chaplains, like professionals in a range of industries, have long sought to articulate their professional mandate and advocate for their work (Kronus, 1976; Freidson, 1984; Abbott, 1988). Chaplains began these processes aware that religious people and institutions have long histories in healthcare (Myers-Shirk, 2008; Fayard, Stigliani, & Bechky, 2016). Some of the ways they articulated their professional mandates reflect these histories, while others reflect new strategies including adopting the language of healthcare (including around accreditation) and trying to prove their expertise using the methods of healthcare. Rather than challenging other healthcare professionals for control over work, chaplains have been most unique in consistently naming as "work" those tasks that other professionals in the healthcare systems do not. They built their professional mandate by doing this new "work" and becoming a companion profession, one that comes alongside another without seeking to challenge its jurisdiction.

I focus on the Association of Professional Chaplains (APC), what is today the largest professional group of healthcare chaplains in the United States. Formally created in 1997, the APC represents the merger of the College of Chaplains and the Association of Mental Health Chaplains. The College of Chaplains was formed in 1968 out of the earliest professional group of healthcare chaplains formed in 1946 under the auspices of the American Protestant Hospital Association (Thomas & LaRocca-Pitts, 2006). Historically, and in the present, members worked in a range of healthcare organizations including hospitals, hospices, and other healthcare organizations. The APC today has 5,500 members.[1]

To learn how the APC and its predecessor organizations advocated for their work, I reviewed a broad range of archival materials. I focused primarily on notes and reports from Board meetings, including Annual Reports, to obtain a macro sense of how leaders were thinking about and advocating for their work. Recognizing the breadth of opinion within any professional association, I aimed to document the actions the APC and its predecessor organizations took—as organizations—to define who they were and to communicate those understanding to external constituents. I hope a chronological history of these efforts will enable chaplains and

chaplaincy leaders today to develop a vision that will increase awareness of the strategies their colleagues used in the past as they tried to more firmly establish the profession.

BEFORE 1960

As a distinct profession, healthcare chaplaincy emerged from efforts to change Protestant theological education in the 1920s, that is, to get students out of classrooms and into interaction with individuals in a range of contexts. It was not until the 1940s that some of the people who had completed Clinical Pastoral Education began to organize into a distinct professional group. These pioneers formed the first chaplaincy organization in 1946 through the American Protestant Hospital Association (APHA), which included a broad range of Protestant healthcare professionals. It was within this association that chaplains began to come together and articulate their professional mandates.

In the early years, chaplains drew on the remarks of chaplain Russell Dicks presented in a lecture he delivered at the annual meeting of the American Protestant Hospital Association in 1939. Speaking to the gathering of Protestant clinicians and hospital administrators, he described what chaplains do, seeing as work those things other healthcare professionals did not. Chaplains, he argued, are not ministers conducting rituals at the bedside but people interested in patients' physical recoveries and their spiritual growth. A chaplain, Dicks explained, "knows that in suffering and stress, people are either thrown back or else they gain confidence in the fundamental nature of things, and it is the chaplain's hope to steady them in any way he can during such stress" (Dicks, 1940).[2]

Early members of the chaplains' professional group worked with colleagues in the APHA on an educational campaign to help others understand their role. Focused on the Protestant hospitals that belonged to the association, these efforts were intended to convince mostly Protestant hospital administrators of the importance of having an adequate religious program for their institutions. In 1940 and again in 1945, the American Protestant Hospital Association adopted statements, "Standards for the Work of the Chaplain in the General Hospital" that delineated how to appoint and work with chaplains. Numerous articles in the *Bulletin of the American Protestant Hospital Association* during these years focused on religious work in hospitals. The Association of Mental Health Clergy was also emerging during these years with connections to the American Psychiatric Association where they similarly worked to educate psychiatrists (Aist, 1996). It was through public statements and educational

campaigns before 1960 that chaplains named as their work aspects of patient care not otherwise seen as work by their colleagues in healthcare.

EXPANDED COLLABORATION IN THE 1960S AND 1970S

The strategies chaplains used expanded from public statements and educational campaigns in the 1960s and 1970s as the health care industry began to grow exponentially (Starr, 1982). Chaplains continued to make statements about the value of their work, to name it, and to educate healthcare professionals. They also began to collaborate with secular healthcare organizations. Their audiences expanded from members of the APHA to those affiliated with a range of secular healthcare organizations. As chaplaincy departments grew across the country, the Chaplains' Division of the APHA worked with the American Hospital Association (AHA) to convene a committee that in 1961 published a pamphlet entitled, "Essentials of a Hospital Chaplaincy Program" intended for all of its member hospitals. Expanding from their traditional Protestant base, this committee included Catholics and Jews and the resulting document emphasized the importance of providing "ministry" to "all patients in conformance with their faith and expressed desire for counseling," of having clergy coordinate with health teams, and of facilitating "close working relationships with all religious groups in the community and the hospital" (Essentials of a Hospital Chaplaincy Program, 1961). The AHA also worked with the APHA to design a brochure, "Model Guide for a Hospital Chaplaincy" (Plack, 1961).

The APHA partnered with the AHA throughout the 1960s and early 1970s making a range of statements that advocated for chaplains. In 1967 the American Hospital Association published a Statement on Hospital Chaplaincy, which called chaplaincy programs a "necessary part of the hospital's provision for total patient care" and asserted that qualified chaplains, adequate facilities, and the support of other staff were "essential in carrying out an effective ministry for patients" ("Statement on Hospital Chaplaincy," 1967, pp. 14-15). Not only did this statement say that chaplaincy care is important, but it encouraged hospitals to provide an economic base and bolstered the profession by distinguishing how the work of chaplains is distinct from than that of local clergy. In 1970, the American Hospital Association published a Manual on Hospital Chaplaincy and also established a standing committee to continue to advocate for chaplaincy.[3]

Some of this advocacy work was facilitated by regular meetings of the Inter-Organizational Consultation that started early in the 1960s. This group, which met at the headquarters of the American Medical Association in Chicago, included representatives from the American Medical Association, the American Protestant Hospital Association, the American

Hospital Association, the United States Catholic Conference (which over-saw the National Association of Catholic Chaplains after it was formed in 1965), and the Rabbinical Council of America.

Financial pressure from third party payers in the early 1970s likely led chaplains to do some of their first organized lobbying in Washington DC, joining examples of other healthcare professionals who tried to establish professional mandates through legislative efforts. The Chaplains' Division of the American Protestant Hospital Association—renamed the College of Chaplains in 1967—passed a resolution to "utilize the Washington resource, Ken Williamson, in every way possible to determine the crucial issues we face, to make an impact on legislation, and to keep the membership informed" (p. 2).[4] Letters from individual chaplains to the leadership of the College at this time emphasized how pressure from third party payers threatened their jobs making this lobbying essential.[5]

Financial pressures throughout the 1970s may have also led chaplains to begin to more explicitly mirror the language of the healthcare system. While Halpern (1992) identifies the ways lower status professionals in healthcare have tried to align their interests with those of dominant groups, this mirroring is different as it represents chaplains' efforts to frame and articulate their importance in the language and frames currently accepted in healthcare organizations. A Committee on Allied Health met at an Annual Meeting of the College of Chaplains in the 1970s to consider the language of "allied health professionals" as a way of framing their work. Rather than calling themselves chaplains, committee members asked, could they gain traction and credibility by becoming allied health professionals. The consensus of the committee was yes; "clergy education could well fit into the structures of allied health education." Subsequent robust debate, however, led this frame to be rejected. While such a re-framing might have led chaplains to more firmly become members of the healthcare team—and therefore lead them toward greater job security—critics argued that this would happen at the cost of medicalizing the profession in name and content.[6]

A related debate began in the 1970s regarding whether chaplains should have access to patients' medical records and/or make chart notes about their visits. At issue was the boundary and identity question of whether chaplains were clergy members or health care professionals working as part of a team. In the mid-1970s, the General Council of the American Hospital Association approved a set of recommendations designed to give chaplains—but not local clergy—access to medical records, effectively making them part of the healthcare team.[7]

In another mirroring effort, the College of Chaplains also began to consider research in the 1960s and 1970s primarily for internal constituents. The College convened a Research Committee at their Annual Convention in 1969, and later they formed a Joint Council for Research in Pastoral

Care.[8] Research, leaders suggested, was a way of showing that "the professional chaplain is here to stay and that the College is determined to offer him the best and most up to date resources it can muster in order that his ministry might be effective and healing."[9]

CONTINUED FINANCIAL PRESSURES AND THE JOINT COMMISSION IN THE 1980S

Members of the College of Chaplains continued to mirror some of the language of the healthcare system in the 1980s as well as to name their work in formal statements and collaborate with a larger number of chaplaincy groups, secular healthcare, and social service organizations. In new efforts, they attempted to mirror the regulatory practices of healthcare as an advocacy strategy by first lobbying the Joint Commission that sets regulations for healthcare organizations, and when that was not successful, created their own regulatory organization. The College also continued to encourage chaplains to mirror the charting practices of healthcare colleagues in the hopes that they might eventually be a part of financing through diagnostic resources groups (DRGs).

The College of Chaplains named their work in the 1982 publication, "Rationale for Professional Institutional Chaplaincy." Published as a brochure intended to be shared broadly the information was organized in response to the questions, "Why a theologically educated and ecclesiastically endorsed ministry? Why a certified ministry? Why a paid ministry? Why a ministry to all faiths?" In addition to again making the case for their work, this brochure emphasized the services chaplains provide to *all* rather than only to members of their own faith groups was strong. "The certified, ordained chaplain has a theological understanding of people as people rather than as denominational people" (p. 13).

The College of Chaplains continued to collaborate with the National Association of Catholic Chaplains and the Association of Clinical Pastoral Education as well as the National Association of Jewish Chaplains. It was during the 1980s that these groups began to try to work collaboratively and convened their first joint gathering, Dialogue88 in Minneapolis. Intended to bring segments of the profession together to foster greater understanding, approximately 1,800 people gathered for the meeting and the Council on Ministry in Specialized Settings (COMISS) was born at its close to build cooperation and communication.[10] While relationships with the American Medical Association and American Hospital Association continued during these years, and new ones were formed with the Homes for the Aging Division of the APHA and the National Hospice Organization, they were secondary to intra-chaplaincy relations.[11]

The College also looked to the Joint Commission with renewed interest in the 1980s as a new way of mirroring the norms of their healthcare contexts. They first lobbied for standards around chaplaincy and spiritual care that they thought would name and protect their professional jurisdiction through regulation. "The problem," a special joint committee of the American Protestant Hospital Association and College of Chaplains at the time reported, "has been that the Joint Commission on Accreditation of Hospitals has consistently refused to consider the recognition of chaplaincy in its survey of hospitals" (p. 2).[12] While these representatives and others hoped that the Joint Commission would require chaplains—creating an economic base by mandating their positions through policy—this did not happen. Efforts to teach chaplains to conduct spiritual assessments, which developed during the 1980s, were another mirroring effort likely loosely tied to regulatory efforts as chaplains who could "assess spirituality" fit more easily into healthcare parlance.[13]

Frustrated by the Joint Commission's refusal to require healthcare organizations to have chaplains, representatives of the College of Chaplains took questions of regulation into their own hands in the late 1980s starting the Joint Commission on Accreditation of Pastoral Services and Education (JCAPS). The strategy, made explicit at this time, was that pastoral care departments could be voluntarily reviewed and accredited by JCAPS that might increase their status and importance.[14]

As in earlier years, the College did some state and federal lobbying in the 1980s and focused on public education bringing their cause and advocacy directly to the people they served. The APHA, itself facing demise as its member hospitals secularized, brought concerns about cost containment to the Carter Administration and the College of Chaplains lobbied state governments that were cutting chaplaincy positions in mental health hospitals.[15] The College and APHA worked with their shared lobbyist to raise ceiling levels for Medicare reimbursement of hospice services and address other issues.[16] The College also worked on their communications strategy trying to broaden their audience from healthcare administrators to others.[17] They also began to look at research in a new way, less as a symbol of professionalism and more as a tool that might help them advocate for their work.

CONTINUED FINANCIAL PRESSURES AND EFFORTS TO COLLABORATE IN THE 1990S

The sense of urgency that members of the College of Chaplains felt continued into the 1990s as financial pressures mounted and healthcare became increasingly evidence-based and bureaucratic. Changes in reimbursement,

broadening constituents, the changing nature of the work, and other factors led chaplaincy positions to be threatened during these years.[18] The APHA closed and the College merged with the Association of Mental Health Chaplains to become the Association of Professional Chaplains (APC) in 1998. The APC continued to try to work with other professional chaplaincy organizations and continued to mirror the norms of healthcare through increased attention to research and other healthcare efforts such as "quality assurance."

As in the 1980s, most of the APC's collaborative energy focused on working with other chaplaincy organizations, but they ultimately failed to align all of these segments of the profession. A second collaborative conference took place in Milwaukee in 1994 with the theme, "A Call to Partnership: Shaping Pastoral Care for the 21st Century." While some believed a single professional organization for chaplains would be more efficient and effective in training and advocating for the field, others felt strongly about elements of their personal histories, identities, and religious traditions reflected in the current institutional arrangement and did not want change.[19] Conflict over this question clouded advocacy efforts. The Board adopted a statement in 1996 called Vision 2000 stating that by the year 2000, a new inclusive organization will be operational.[20] Leaders met at the end of the decade to draft the mission, values, and vision for such a group.

Collaborations with nonchaplaincy organizations in healthcare continued in the 1990s on a smaller scale. Educational pamphlets co-produced with the American Hospital Association were a thing of the past, although APC representatives did work with the American Association of Retired Persons (AARP) to draft guidelines for pastoral care in long-term care, as well as with representatives of the National Mental Health Leadership Forum and the American Association of Homes for the Aging.[21] The mirroring efforts that are present in the APC's work lobbied the Joint Commission and then were internally accredited through JCAPS, which continued into the 1990s as did some state and federal advocacy.[22] Nationally, lobbying mainly took place through the National Interfaith Coalition, a group the APC joined in the late 1990s.[23]

Research also continued as a mirroring strategy during the 1990s, shifting from a blurry role to a clearer advocacy role. Early in the decade, chaplain researcher Larry VandeCreek worked on a few small research projects, but a committee report from 1994 made clear that the role for research was fuzzy. "The Council [of the College] has struggled with how to utilize a research committee. Feelings have varied … .We hope to more clearly define this role" (p. 4).[24] VandeCreek looked for research-oriented colleagues outside of chaplaincy and started attending conferences and connecting with leaders in the developing spirituality in healthcare movement (Cadge, 2012). In 1996, he wrote in a report to the College,

As a professional group we must be involved in and follow these events carefully and critically. Much of the interest focuses on "spirituality" (by whatever definition) rather than religious belief and practice as chaplains tend to think of it. Ambivalence about clergy is evident and literally no attention is given to theological concerns. Most researchers and many who attend these conferences do not understand the depth and subtleness of pastoral training involved in becoming certified chaplains. Do not assume that the results of all of this will be friendly to our institutional ministry (p. 37).[25]

By the end of the 1990s, VandeCreek and colleagues were actively pushing chaplains to pay more attention to research as a tool for improving their own work and as a strategy for the profession. Such research, VandeCreek and colleagues argued,

are becoming so relevant that chaplains who ignore them will increasingly be thought of by these professionals as uninformed. Continued neglect of these results will imply that the knowledge base of pastoral care is out of date and other professionals will begin to regard chaplains as incompetent. Thus, we must find ways to integrate the research results of others into their clinical practice (1998, p. 16).[26]

Evidence-based practice had become the norm in healthcare requiring that chaplains, if they wanted to be taken seriously as healthcare professionals, find a way to engage with research and use it as an advocacy tool for the profession. By the end of the decade, projects loosely connected to the APC focused on patient assessment, screening, and performance improvement measures. In contrast to earlier in the decade, a leader in 1999 wrote, "It is our belief that professional chaplaincy is better served in representing its value to healthcare administrators and other healthcare professionals with hard data rather than soft data" (p. 13).[27] Bench-marking and performance improvement workshops were integrated into annual APC meetings. As with research, the association increasingly used the language of healthcare during the decade setting up a Quality Assurance Task Force in the 1990s to help members apply Joint Commission's Quality Assurance measures to their work.[28]

CONSENSUS STATEMENTS AND FAILED COLLABORATIONS, THE 2000S

By the 2000s, almost all of the APC's advocacy efforts were inwardly focused on efforts to articulate chaplains' role and specify relationships

among the professional chaplaincy organizations rather than strategically communicate those roles to others. They continued to try to align interests within the broader field of professional chaplaincy, without success. At the start of the decade the leaders of the APC collaborated with the leaders of the other professional chaplaincy organizations to write a "White Paper Consensus Statement on Chaplaincy in North America." Led by chaplaincy researcher Larry VandeCreek and Larry Burton, this document described who chaplains are and what they do. As in earlier decades, it named their work trying to show how by caring for people's spiritual and broadly existential issues they did work not seen as such by others in healthcare. Published on behalf of the main professional chaplaincy organizations, the authors hoped it would become the basis for widespread advocacy (Chaplains, Education, Education, Chaplains, & Chaplains, 2001). These organizations subsequently published common standards in training, education, ethics, and ways of registering complaints—again, out of the hope that these efforts would help to align interests among chaplains and help colleagues in healthcare see and understand chaplains' work.

Alongside these efforts a new organization, a Council on Collaboration, was formed that changed its name to the Spiritual Care Collaborative in 2006. Intended as a professional association that would help groups work together, member organizations including the APC paid one dollar for every dues paying member. The organization was intended as a "collective voice to promote the highest standards of professional practice and to advance the field of professional spiritual care" (p. 32).[29] The Spiritual Care Collaborative hosted a well-attended conference in 2009, but by the end of 2010, the group had dissolved, a fatality of internal tensions and a lack of clarity of how such an organization might continue to advocate for the profession as a whole.[30]

While efforts to create a single advocacy organization for healthcare chaplains were the focus during the 2000s, the APC did continue some of their own advocacy efforts. They expanded their Council of Liaisons to include the American Red Cross that led to a partnership that brought chaplains into disaster relief efforts.[31] The mirroring evident in efforts to lobby the Joint Commission continued which seemed to increase understanding among chaplains.[32] The APC also sent their new glossy magazine *Healing Spirit* to CEOs, managers, directors and Human Resources Departments where people actually make decisions about the size and scope of pastoral care departments in 2006.[33]

As a tool for articulating and communicating the value of chaplaincy to non-chaplains in healthcare, research continued to grow in importance during the 2000s. Reflecting on the need for research-informed practice to be the core of professional chaplaincy in practice and advocacy, John Gleason called the absence of a robust body of research and interest in it among his colleagues a continued "elephant in the room" even as interest slowly grew.[34] While chaplains were not suddenly more interested in

research in the 2000s, efforts to promote that knowledge among chaplains as a tool they needed to advocate for themselves with others in healthcare was increasingly assumed. Chaplain researcher George Fitchett and colleagues developed patient/family satisfaction tools and considered efforts to bench-mark and utilize questions in routine hospital surveys. The APC spoke, for the first time, about ensuring that trained chaplains can identify best chaplaincy practice and began to hold webinars to help chaplains learn of recent research findings.

EVIDENCE BASED CHAPLAINCY? THE 2010S

This continued emphasis on research and the importance of making chaplaincy or spiritual care evidence based continued into the 2010s, as did the ways in which chaplains mirrored the language of healthcare to make the case for their profession. Regular webinars sponsored by the APC continued to help chaplains learn about relevant research. Chaplain researcher George Fitchett offered a five-part introduction to research webinar for members and a number of related research efforts, including one grant supported effort to include chaplains in palliative care research supported by another professional organization, the Healthcare Chaplaincy, were launched. The APC clearly stated in 2013 that one of their goals is to help members "become research literate," which involves "providing access to scholarly articles and research on our profession."[35] The APC also recently established a Joint Research Council to promote research and its application among a range of chaplaincy organizations.

In their use of research as a tool for education and advocacy, chaplains continued to reflect the norms of healthcare (Timmermans, 2003; Timmermans & Kolker, 2004). Drawing on the language of "standards of practice" from the medical discourse, the APC also developed and then accepted Standards of Practice for Professional Chaplains in Acute Care in 2010 and worked on such standards for other areas including Hospice and Palliative Care. The APC also encouraged chaplains to submit to the national office "best practices" reflecting emphases on best practices among other healthcare colleagues.[36] Efforts to work with the Joint Commission continued with new efforts to convince the Joint Commission to require board certified chaplains in healthcare organizations.[37]

While there have been some efforts to collaborate with other professional chaplaincy organizations since 2010, the APC has shifted its focus back to trying to advocate for itself through work with secular healthcare organizations including the Red Cross. The APC has also been emphasizing individual advocacy in recent years or the importance of individual chaplains advocating for themselves. "Advocating for our profession begins with each one of us on a daily basis," the APC president wrote in March 2011.[38] Workshops about how

to advocate were planned for annual meetings, and examples of the ways chaplains can do advocacy work within their institution were mentioned in several subsequent newsletters. As in the earliest days of the profession, a recent APC president called on his colleagues to claim their place at the table, "When do we proclaim our place at the table instead of waiting to be invited from the child's table to the grown-up table?" The difference today is that for this president, "evidence-based support for our programs and positions" is a central part of claiming that place.[39]

CONCLUSIONS

Chaplains, like professionals in a range of industries, have long sought to maintain and build occupational power by articulating their professional mandate and advocating for their work (Kronus, 1976; Freidson, 1984; Abbott, 1988). In healthcare, these efforts have taken multiple forms between 1940 and the present as chaplains tried to articulate their professional mandate. It is both changes in the training and role of clergy related to the emergence of chaplains as a distinct professional group and changes in the structure and organization of healthcare that influenced the negotiations between chaplains, healthcare organizations, and local clergy central to this case.

Chaplains and chaplaincy leaders today need to remember that from its earliest years the Association of Professional Chaplains and its predecessor organizations used multiple strategies to articulate and re-articulate their professional mandate. Chaplains sought to develop an economic base, align interests across distinct segments of the profession, and create new professional associations, lobby for legislative support, and offer their services in institutional voids. In none of these strategies, however, did chaplains compete with others inside of healthcare organizations for professional turf or jurisdiction. While such turf disputes may take place at the micro level in the individual healthcare organization, at the national level chaplains sought to define themselves as a group that brings something extra. They named their work and realized their ability to bring an awareness of the religious, spiritual, and broadly existential issues that influence patients' experiences to the healthcare system work that colleagues there did not. It may have been easier for chaplains to attempt to come alongside other healthcare professionals as a companion profession or one not competing for professional turf, because they had an outside other, local clergy, from whom they continually tried to differentiate themselves.

In addition to defining as work those tasks other professionals in the healthcare system do not, chaplains utilized two additional strategies. First, chaplains adopted the language of healthcare around questions of identity, charting, and accreditation and tried to explicitly make their case in those

terms. While Timmermans and colleagues have shown medical norms such as clinical practice guidelines diffusing across healthcare professions in studies of standardization, this case is one of the first to show groups on the edges of healthcare organizations utilizing norms from the center as the forms through which to articulate their value and professional mandate (Timmermans & Kolker, 2004). Second, chaplains used not just the frameworks but the methods of healthcare—evidence based research—to try to demonstrate their value. While research began as a tool, chaplains thought were would help them appear as professionals; it has become more a part of the way current leaders of the Association for Professional Chaplains try to articulate their value.

Beyond the strategies themselves, this case reminds current chaplaincy leaders of the importance of thinking about the audience for their claims. Early audiences of Protestant administrators expanded, as hospitals secularized and the American Protestant Hospital Association weakened, to include a broader more religious diverse group of hospital administrators. By the 1980s, the Joint Commission was a central focus of the College of Chaplain's advocacy efforts—a focus that continued through the 1990s and then became less central. Other professional chaplaincy organizations became the central audiences in the 1990s and 2000s, as efforts to collaborate and potentially form a single organization took much of the association's energy.

While increasing bureaucracy, changing financial structures and moves toward becoming more evidenced based were some of the changes in healthcare that influenced these different audiences; demographic, religious, and other factors in the American context also played a role. The decision-makers who could influence chaplains' economic base shifted over time from hospital executives to national regulatory bodies to more diffuse groups. This work of advocacy, perhaps like that of other caring professions, is difficult in the complex American healthcare context that remains fluid. As in the earliest years, chaplains in healthcare are still trying to, in their words, get a seat at the "grown up's table," showing sociologists of the professions, healthcare, and religion how they have absorbed notions of assessment, regulation, and evidence-based research and are likely to continue to mirror the norms of their contexts in the future. They are more likely to have success in this endeavor if they remember and learn from their history.

NOTES

1. The Association of Professional Chaplains (APC) is one of four major professional chaplaincy organizations today with the others being the National Association for Catholic Chaplains (founded in 1965); Neshama: Association of Jewish chaplains (founded in 1990); and the Association for Clinical Pastoral Education (founded in 1967), which mostly focuses on training.

2. These points were later articulated in "Standards for the Work of the Chaplain in the General Hospital," written by Russell Dicks and adopted by the American Protestant Hospital Association in 1940 and again in 1950.
3. The APHA also continued to do its own thing during these years, which included printing "Guidelines for Evaluating Pastoral Care Services" and distributing these materials to 7,000 hospitals (Report, College of Chaplains, 1979).
4. College of Chaplains, Annual Report, 1973.
5. These letters, written in 1973, were from Daniel DeArment and Kenneth Burnette to Fred Powers respectively. They are located in the archives of the APC.
6. (Billinsky, 1973). This talk was given as the third annual Russell Dicks Memorial Lecture. See, also, the College of Chaplains Book of Reports, 1972, meeting of the "The Committee on Allied Health."
7. The committee concluded that "(1) that chaplains commensurate with their authority and responsibility should have access to medical records (2) that chaplains might make entries containing both factual and observational information in medical records, (3) that visiting clergy not a part of hospital staff should not have access to medical records and (4) that effective recording in medical records is by definition brief without sacrificing necessary factual information" (Crittenden, 1977).
8. This is document in materials from the College of Chaplains Annual Convention in 1969. There was also a paper published in The Tie in 1969 titled "The Hospital Chaplain as a Researcher" and a bibliography of research relevant to chaplaincy compiled by Herman Cook.
9. (Reid, 1972).
10. Annual Report of Dialogue 88, Book of Annual Reports. College of Chaplains, March 11–15, 1989.
11. Council for Public Concerns, Book of Annual Reports, College of Chaplains, March 20–23, 1983; Book of Annual Reports, College of Chaplains, March 25–28, 1984; Book of Annual Reports, College of Chaplains, March 3–6, 1985.
12. Report of the Joint APHA/College of Chaplains Task Force on Chaplaincy Evaluation. Instituted by APHA and the College in March 1982.
13. Executive Committee Report, Book of Annual Reports, College of Chaplains, March 1–4, 1981; Executive Committee Report, Book of Annual Reports, College of Chaplains, March 20–23, 1983; Executive Committee Report, Book of Annual Reports, College of Chaplains, March 25–28, 1984; Executive Committee Report, Book of Annual Reports, College of Chaplains, March 11–15, 1989; Executive Committee Report, Book of Annual Reports, College of Chaplains, March 11–15, 1989. Reports indicate that the Spiritual Assessment Workshop developed out of work with the Hospice Accreditation Program of JCAHO.
14. Smith, Kermit. "Trends in Health Care and Their Implications for Chaplains." College of Chaplains, May 3, 1984.
15. Council on Government Relations, Annual Meeting, American Protestant Hospital Association, March 10, 1980; Executive Committee Report, Book of Annual Reports, College of Chaplains, March 1–4, 1981.
16. Council for Public Concerns, Book of Annual Reports, College of Chaplains, March 3–6, 1985.
17. Council for Public Concerns, Book of Annual Reports, College of Chaplains, March 20–23, 1983; Book of Annual Reports, College of Chaplains, March 3–6, 1985; Book of Annual Reports, College of Chaplains, March 14–18, 1987. Book of Annual Reports, College of Chaplains, February 27– March 2, 1987. Public education was also considered by a Think Tank of the College in July 1984 which led to a donor drive for financial support.
18. 1990, Memo to Arne Jensen, Executive Director, College of Chaplains.

19. Report of the President, Book of Annual Reports, College of Chaplains, February 12–17, 1993.
20. 1996 Board Statement, "Vision 2000."
21. Book of Annual Reports, College of Chaplains, February 24–28, 1990.
22. July 17, 1990 letter from Arne Jessen, Executive Director, College of Chaplains to Dennis O'Leary MD, President of the Joint Commission for the Accreditation of Healthcare Organizations.
23. Book of Annual Reports, Association of Professional Chaplains, 1998.
24. Committee on Standards, Education, Research and Professional Development, Book of Annual Reports April 30–May 1, 1994.
25. Book of Annual Reports, Association of Professional Chaplains, 1998.
26. Annual Report of Research Committee, Association of Professional Chaplains, 1998.
27. Annual Report, Association of Professional Chaplains, 1999.
28. Report of the Quality Assurance Task Force. "Quality Assurance and Improvement. A Guide to Developing Continuous Quality Improvement Plans in Pastoral Care," 1992.
29. Annual Report, Association of Professional Chaplains, 2007.
30. (S. K. Wintz, 2010).
31. (Roberts & Ashley, 2008).
32. It is also interesting to note that in 2003 JCAPS changed its name after being asked to do so by attorneys for the Joint Commission who thought the name was too similar to that of the Joint Commission. Collaborations with the Joint Commission included working on publications in 2004 and 2005.
33. Annual Report, Association of Professional Chaplains, 2006. In one additional public education example the APC worked with PBS/Bill Moyers to share news of the four-part program "Death in America." The APC was a promotion partner but, despite their work to the contrary, program produces ignored the role of professional chaplains in the videos. Book of Annual Reports, Association of Professional Chaplains, 2000.
34. (Gleason, December 3, 2008).
35. APC News, July 2013.
36. APC News, July 2010.
37. In 2013–2014: A task force was formed with representatives from APC and the National Association of Catholic Chaplains, the Association for Clinical Pastoral Education, the COMISS Network and the National Association of Veterans Affairs Chaplains.
38. March 2011, Presidential Column, APC ENews.
39. APC ENews, June 2010.

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