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From the Bedside to the "Device-Side": Digitalisation and the Professionalisation of Healthcare Chaplaincy

Abstract: With the digitalisation of healthcare, patients spend fewer days in hospitals and clinics, and more time in outpatient care. This development confronts healthcare chaplains with profound changes in how, when and where they care for patients. Once present at the patient's bedside for days and weeks at a time, chaplains have begun to use new technologies to care for patients at any point of the continuum of care, and develop new, "device-side" models of care. In this chapter, we summarise our contribution to the field of digital spiritual care during the first phase of the URPP "Digital Religion(s)". We present the background, theoretical and methodological approach and main findings of our work, with particular attention to the emergence of telechaplaincy, and the encounter of telechaplains with Electronic Health Records (EHR) and increasingly comprehensive telehealth platforms. In conclusion, we expand and elaborate on the major challenges faced by researchers and practitioners in the emerging interdisciplinary field of digital spiritual care, and discuss the potential positive contributions of these digital religious practices for individuals, communities, and society in Switzerland and internationally.

Mit der fortschreitenden Digitalisierung des Gesundheitswesens verbringen Patient:innen weniger Tage in Gesundheitsinstitutionen und werden in wachsendem Maße ambulant versorgt. Diese Entwicklung konfrontiert Seelsorgende mit tiefgreifenden Veränderungen in Bezug auf die Art, den Zeitpunkt und den Ort ihrer Tätigkeit. Waren Seelsorgende früher tage- und wochenlang am Patientenbett anwesend, nutzen sie in zunehmendem Maße neue Technologien, um Patient:innen an jedem Punkt des Pflegekontinuums begleiten zu können, und entwickeln neue, geräteseitige („device-side") Unterstützungsmodelle. In diesem Beitrag fassen wir unsere Forschung zu diesem Thema während der ersten Phase des URPP „Digital Religion(s)" zusammen. Wir stellen den Hintergrund, den theoretischen und methodischen Ansatz und die wichtigsten Ergebnisse unserer Arbeit vor, mit besonderem Augenmerk auf die Begegnung von „Tele-Seelsorgenden" (Telechaplains) mit elektronischen Patientendossiers (Electronic Health Records, EHR) und zunehmend umfassenden Telehealth-Plattformen. Abschließend gehen wir auf die wichtigsten Herausforderungen ein, mit denen Forscher:innen und Praktiker:innen im entstehenden interdisziplinären Gebiet der digitalen Spiritual Care konfrontiert sind, und diskutieren mögliche positive Beiträge dieser digital-

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religiösen Praktiken für Personen, Gemeinschaften und Gesellschaft in der Schweiz und international.

1 Introduction

Across Europe and North America, health providers and the medical industry strive to implement digital health strategies (WHO 2020; 2021). In the course of this development, healthcare, once firmly centred in the physical location of the clinic, is distributed across a dispersed network of service providers and users connected through digital platforms. On the side of funding bodies, insurers and hospital administrators, the transition towards telehealth is incentivised by cost savings incurred by reducing the length of stay of patients at the hospital. For patients, remote care is hoped to improve quality of life, treatment adherence and outcomes, and reduce access barriers and treatment burdens such as cost of travel (Flodgren et al. 2015). For professional spiritual care providers, it fundamentally challenges how, when and where spiritual care providers perform their role: traditionally based at the patient's bedside, healthcare chaplains are increasingly faced with a new professional reality, where many aspects of care are no longer provided bed-, but "device-side".

In the first phase of the URPP "Digital Religion(s)", the project "Digital Spiritual Care" has engaged with this development on several fronts. We set out to investigate chaplains' changing communication and documentation practices in electronic health records (EHR), explored the emergence of "telechaplaincy", and engaged in training and education necessary to prepare the next generation of chaplains for digital care environments. In the following, we provide a selective overview of this work. We begin with an outline of the background and current research in this field, and then turn to the theoretical and methodological basis of our work. We then present our main findings thus far and conclude with a brief look into future research priorities and the potential positive contributions of these digital spiritual practices for individuals, communities and society, in Switzerland and internationally.[1]

1 Terminological note: we understand "spirituality" as an umbrella term for religious and non-religious practices, experiences, beliefs, and attitudes that have a family resemblance through their reference to an ultimate concern. The inclusion of the "spiritual dimension" in healthcare, for which the term "spiritual care" has become established, is due not least to the terminological openness of these terms that transcend a duality constitutive of (Euro-American) modernity: the distinction between religious and secular (Bender and McRoberts 2012; Peng-Keller 2019; 2024b).

2 Background

What we currently refer to as "digital spiritual care" began to develop in the mid-1990s, as the internet became more widespread in Europe and North America. In German-speaking Europe, the first internet-based pastoral care services were launched in 1995. In Germany, a network of ecumenical telephone counselling centres launched an internet presence (Knatz 2022), while in Switzerland, Jakob Vetsch, a rural, technology-savvy Protestant pastor, together with an IT specialist, launched seelsorge.net, an ecumenical website for chat-based pastoral care (Winiger and Neuhold 2023b). The website later gained the support of the churches in Zürich and still exists today as a nationwide service supported by 30 volunteers. The success of chat-based pastoral care in the mid-1990s to early 2000s brought with it what may be described as a digital "renaissance" of written forms of spiritual care.

Through early chat services such as seelsorge.net, it may be argued, a supra-parochial social space emerged, characterised by a radically immediate and anonymous mode of interaction by which users, freed from communal identity factors – including confessional affiliation – began to discuss deeply meaningful, often shameful, life events. Parallel to the widespread adoption of dial-up connections and the concomitant development of "internet culture" (Porter 1997), pastoral care began to incorporate and develop milieu-specific sociolinguistic practices, and "emojis, punctuation marks or the choice of certain words" came to be "used as substitutes for non-verbal communication that would otherwise be expressed through body language." (Blackstein 2023, 74, 75; Knatz 2014). Several chat services of the mid-1990s continue in this manner, and still enjoy considerable popularity.

While church-financed chatroom-based pastoral services appeared early and were surprisingly popular, professional spiritual care providers employed in institutional and typically outpatient care have been comparably slow to adapt to digital technologies. This contrasts with many healthcare institutions, in which Electronic Health Records (EHR) software in recent years has evolved into increasingly comprehensive integrated telehealth platforms, which offer screening, appointment scheduling, virtual consultations, remote patient monitoring, as well as prescription "laboratory and diagnostic services, round-the-clock provision of mental health interventions, and real-time access to electronic health records. As more and more clinical activities move to digital platforms, the domain of influence of the traditional healthcare chaplain has begun to retreat. The Covid-19-pandemic accelerated this development. As healthcare chaplains were prohibited from visiting patients at the bedside, they were forced to adapt to quarantine restrictions and constructively engage with the digital infrastructure available at

their institutions (Byrne and Nuzum 2020; Vandenhoeck et al. 2021). In the course of this rapprochement, chaplains began to explore how to more closely integrate their work into their institutions' telehealth strategy.

3 Current Research and Debate

Thus far, little research has appeared which investigates the digitalisation of healthcare chaplaincy, and there have been no major public debates over the use of technology by chaplains. This is surprising because digitalisation plays a far-reaching role in the standing of healthcare chaplaincy in healthcare institutions.

The case of EHR exemplifies this point. In order for spiritual care providers to be recognised as healthcare professionals, they must use EHR software to care for patients according to their needs and treatment history, and document their interactions with patients intraprofessionally (with other spiritual care providers in the institution), and interprofessionally (with other members of the clinical care team). Clinical information systems have also become instruments of internal communication and coordination, replacing E-Mail as the medium through which clinical workflows are coordinated (Peng-Keller and Neuhold 2020).

The documentation of spiritual care using EHR software helps clarify to colleagues what chaplains do, what their contribution to patient well-being is, and helps to assess whether their interventions are effective. Outcome measures, such as the Patient-Reported Outcome Measure (PROM) have been developed to this end, and are premised on the availability of reliable and comparable data (Snowden and Telfer 2017). With the expansion of EHR software from its original purpose of data collection into comprehensive telehealth platforms, digital competencies become the foundation of a care provider's ability to contact and care for patients. Thus, while digitalisation itself is not subject to significant debate in the professional community, the ability of chaplains to proficiently use EHR software is closely linked to their professional standing and thus partakes in a larger, ongoing debate over whether chaplains should be understood either as an external (usually volunteer or church-financed) service provider, or a professional member of staff internal to the organisation and intrinsic to the clinical care team (Peng-Keller 2024a).

Without access to EHR and the institution's wider telehealth platform, patient care is becoming increasingly difficult, and since access to medical records is subject to strict legal requirements, the access of chaplains to an institution's digital infrastructure in turn depends on whether it is recognised as an independent profession in the health care system. In this sense, the digitalisation of healthcare

forces chaplains to professionalise, and ultimately concerns the current and future status of their profession as an integral part of holistic, patient-centred healthcare.

4 Theoretical Basis and Methodology

Beginning with its roots in the Clinical Pastoral Education of the 1920s, and the pioneering efforts of Anton Boisen (1876–1965) and Richard C. Cabot (1868–1939), chaplaincy has been shaped by theology, psychotherapy, social work, educational theory, and medical ethics. Interdisciplinarity remains a central hallmark of spiritual care, both in practice – where chaplains ideally work closely as part of an interprofessional care team – and as a field of research, which brings together health psychologists, practical theologians, anthropologists, nursing scholars, psycho-oncologists, palliative care physicians and a host of other disciplines. Research on digital spiritual care contributes a further dimension to this interdisciplinary moment: located at the intersection of healthcare, digitalisation, and spiritual care, it adds the field of Information and Communication Technology (ICT) to the research and practice of healthcare chaplaincy. This intersection ranges from computer linguistics, which can provide a quantitative understanding of religious and spiritual language use in digital spaces (Winiger et al. 2025b) to the work of Human-Computer-Interaction researchers on chaplain's participation in online communities (Smith et al. 2021) or the exploration of virtual reality as a tool for spiritual (self-)care (Winiger, 2024b; Pirker and Pišonić, 2022), and the multifaceted work of scholars of digital religion on topics such as digital mourning practices (Frick, 2023).

Building on this long tradition of inter- and transdisciplinary collaboration, we have engaged with digital spiritual care through a combination of social anthropological methods and a hermeneutical approach rooted in practical theology. We have also closely worked with colleagues in nursing studies, computer linguistics and communication studies. In addition to a series of case studies and qualitative analyses, we surveyed the Swiss general population, the population of the Canton of Zurich, and the Swiss community of healthcare chaplains regarding their experiences with and attitudes towards digital spiritual care, and conducted a study of language use related to religion and spirituality on X (formerly Twitter) (Winiger et al. 2025a). To bring this work into dialogue with healthcare chaplains, and since 2022, we have cooperated with the U.S.-based *Transforming Chaplaincy* initiative, to host a Telechaplaincy Community of Practice, which brings together researchers, practitioners, and managers of chaplaincy departments in Europe and the U.S. to discuss current developments in the field (see www.telechaplaincy.io).

5 Main Findings

In the following, we summarise our findings in two areas: the emergence of telechaplaincy, and the encounter of telechaplains with EHR software and increasingly comprehensive telehealth platforms.

5.1 The Emergence of Telechaplaincy as a Field of Research and Practice

As suggested by a recent review of current developments, telechaplaincy practice has developed much more quickly in North America than in Europe (Winiger 2024c). A major finding is the relative lack of practical initiatives in Europe, and the struggles faced by a few notable pilot projects. This discrepancy may be explained in part by different degrees of integration of chaplains into healthcare institutions, and a comparably slow rate of telehealth adoption in Europe. Early pioneering projects in chat-based chaplaincy, as described in the introduction, remain active, but have not kept pace with the emergence of chaplaincy as a healthcare profession (Winiger and Neuhold 2023b). In Germany, more recent projects, such as the "Ankerplatz" of the Evangelical Church of Germany (Winiger and Neuhold 2023a) or the "Krankenhausseelsorge im Chat" by the Evangelic-Lutheran Church of Northern Germany, have met with considerable obstacles. A survey of Swiss healthcare chaplains suggests that the European professional community is generally sceptical towards digitalisation (Peng-Keller and Winiger 2024), which contrasts with findings from a representative survey of the Swiss population which showed that 25% of patients wished the creation of a digital chaplaincy service (Peng-Keller et al. 2024, 9, for the canton of Zurich see Winiger et al. 2025b). Recent special issues in *Spiritual Care* and *Praktische Theologie* suggest the emergence of a German-language literature on this topic, but new forms of chaplaincy appropriate to digital care contexts are as yet only "partially developed" (Haußmann et al. 2023, 87).

In the U.S., "telechaplaincy" and related terms such as "virtual chaplaincy", "online chaplaincy", "e-Chaplaincy" and "digital spiritual care" have circulated in the chaplaincy literature for years, and telechaplaincy has been practised since the mid-1990s with formalised telechaplaincy programmes appearing in the early 2000s (Sprik et al., 2020, 1276). In this context, we have found major healthcare organisations such as Ascension, Mercy, Baylor, Scott & White Health and the Veteran's Health Administration to have well established telechaplaincy programs (Winiger 2023b; 2023a; 2024a). As shown by a thematic analysis of a major international conference on telechaplaincy held in 2022, chaplains are increasingly

challenged to deliver spiritual assessment, treatment planning, patient care and outcome measurement through digital means, but often have not received any training and improvise their work to the best of their ability (Winiger and Sprik 2023). A widely shared consensus on how to conceptualise this field is lacking in both the European and North American context, and major training programs accrediting organisations thus far have been slow to update professional standards and educational curricula.

Following the seminal distinction between "religion online" and "online religion" (Helland 2000), we have found two types of professional practice in this field. The first, "spiritual care online", refers to chaplains who use digital means to communicate with patients and the public. Their institution's websites, mobile apps and digital platforms are understood primarily as a place to advertise existing chaplaincy services, rather than as a medium for patient encounter through which new models of care may arise. Often, a phone number for patients to contact a chaplain is listed next to office hours and a number for emergencies. The care provided in this case is typically similar to traditional chaplaincy, with the notable difference that contact is made through the internet. Though Helland's typology was developed in the 1990s and the approach of religious actors to digitalisation has evolved in several waves since (Campbell 2023), this remains the most common form of digital presence by healthcare chaplains.

Drawing on Helland, a second variety may be identified, which we refer to as "digital" or "online spiritual care". It describes a form of spiritual care emerging in predominantly digital work environments, in which many or most of the chaplain's activities are conducted using digital means. As Helland argued, for practitioners of online religion, "the Internet is not some place 'other' but recognised as a part of their everyday life" (Helland 2005, 12). Similarly, in the provision of online/digital spiritual care, the digital is not a separate sphere occasionally engaged for specific purposes, but the constitutive fabric connecting care provider and recipient. Spiritual care provided in chat rooms described above, and on social media sites such as Instagram – often by pastors or religious influencers – are exemplary.

We have proposed the term "telechaplaincy" to refer to a specialised form of online/digital spiritual care specific to professional, most often medical, care settings. In analogy to the WHO's definition of telehealth, we understand telechaplaincy as "the delivery of spiritual care where patients and providers are separated by distance. Telechaplaincy uses ICT [Information and Communication Technology] for the exchange of information for spiritual assessment, care for spiritual distress and injuries, research and evaluation, and for the continuing education of spiritual care professionals." (Winiger 2023b, 2). Although telechaplaincy is most widely established in healthcare and particularly outpatient care,

other fields, such as port-, community- and prison chaplaincy, may also use telechaplaincy. Phone-based telechaplaincy is the most common (Sprik et al., 2022), and has relatively recently developed from conventionally phone-based care to embrace video calls and other technological means. In healthcare, telechaplaincy has begun to emerge as a subspecialty of professional practice, as evidenced by the production of guidelines by professional associations, and the creation of new positions such as "Director of On Demand Spiritual Care" (Ascension) "Director of Spiritual Care Innovation & Transformation" (Mercy) or "Manager for Innovation in Spiritual Care" (Baylor, Scott & White Health).

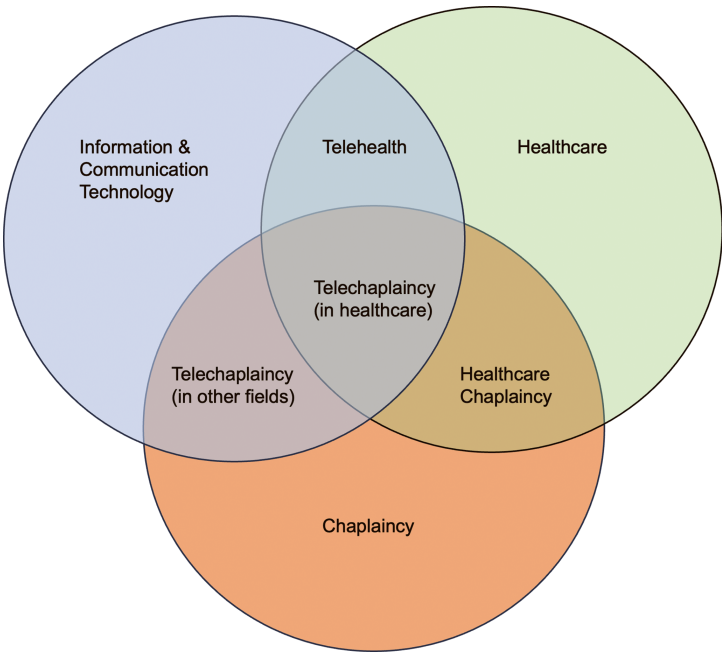

Figure 1: Telechaplaincy as a specialised form of digital spiritual care at the intersection of information and communication technology, healthcare and chaplaincy.

Telechaplaincy is accompanied by a change in some fundamental premises of clinical pastoral education (CPE) as developed in the 20th century. Whereas chaplains have traditionally cared for homogenous patient populations hospitalised for relatively short periods of time, telechaplaincy is premised on longer-term patient-provider relationships, as telechaplains use digital means to remain in contact with patients for periods of time exceeding the duration of a typical hospital

stay. Though medical advances may have shortened patients' hospital stays, chaplain encounters are no longer contingent on a visit to the hospital but can be arranged by a button on a mobile device at any point on the continuum of care, lowering the threshold of access, and shifting from a supply- to a demand-driven model of care. Rather than lying in bed wearing a hospital gown awaiting visitation, patients can arrange a video call on-demand with a chaplain at a time and place of their choosing, and in the dignity of their private dress. Moreover, patients decide the degree to which they remain anonymous – through turning off the camera in a video call – or disclose themselves – by sharing with the chaplain their home, relatives, and pets on camera. What is described in social psychology as the "online disinhibition effect" may manifest in digital settings in forms of self-disclosure that normally only occur after a long time in direct accompaniment (Suler 2004).

Most importantly, perhaps, the bedside appears to be losing its mythical status as the sole mainstay of healthcare chaplaincy, as chaplains develop "device-side" models of care and work with patients to create new, non-local sacred spaces at the interstices of private and institutional spheres. Once limited to support and fellowship found in the surrounding area – often, the local church – they create supra-parochial communities of fate. Initiatives such as the "Finding Our Way Through Grief" program at Dartmouth-Hitchcock Medical Center (Ashton and Klassen-Landis 2023), or "Walking with Wisdom" at Niagara Health in Ontario, Canada (Siolkowsky 2023) are instructive of how telechaplains – once, as the name suggests, defined by their patronage of a physical chapel – now use new technologies to redefine how and where they care for patients.

5.2 Telechaplains and the Platformisation of Healthcare

A notable aspect of the digitalisation of healthcare is the introduction of digital platforms into the professional reality of healthcare chaplains. The term "platform", coined in the 1990s to describe a hardware architecture based on modular components, has since the turn of the millennium been adopted by firms such as Uber, eBay, Facebook, and Tinder to describe a business model premised on multi-sided markets in which the platform operator extracts value from interactions between users (van Dijck, Poell, and de Waal 2018). The "platformisation" (Eisenegger 2021) of the healthcare industry has been driven by U.S.-based companies, persistent advocacy by the World Health Organization, and substantial investment by Ministries of Health, particularly in the UK and Scandinavian countries, which have adopted many features and ideological tenets of the IT industry.

In the course of this development, vendors of EHR software such as Epic Systems, McKesson and Cerner have expanded into increasingly comprehensive tele-

health platforms. Epic, one of the most widely used EHR systems, began to offer solutions for outpatient care, population health management, financial operations, data analytics, virtual visits, and patient monitoring, among others (Epic Systems 2024). Like platform operators in other industries, Epic has positioned itself as the foundation of a highly integrated ecosystem connecting patients and care providers by turning its business model from a vendor of individual software products into a provider of the very digital infrastructure on which the healthcare sector operates.

In the public sector, national digital health strategies vary widely in breadth and scope (WHO 2023). Beginning in the mid-2000s, discussions of digitalisation at the WHO's World Health Assembly led to the passing of resolutions urging Member States to draw up long-term strategic plans for digital health services, develop IT infrastructure, introduce appropriate regulatory frameworks, and ensure standardisation and interoperability (WHO 2005; 2013; 2018). In 2020, the organisation endorsed the *Global Strategy on Digital Health*, which laid out a comprehensive 5-year plan to promote the development of national digital health systems (WHO 2020; 2021). Central to this structure is the notion of healthcare infrastructure as a "platform". Like its private-sector counterparts, this is conceptualised as a common infrastructure for information exchange on which other digital health applications and systems build upon. As explained in a detailed handbook authored by WHO and the International Telecommunication Union, the "concept of the DHP [Digital Health Platform] emerged from a recognition that most digital health progress thus far has arrived in the form of individual applications and information systems. [. . .] A system-wide approach to application and architecture design that emphasises the development of an integrated and interoperable whole is far better than a piecemeal approach that results in fragmented and isolated digital health tools" (WHO and ITU 2020, vii). Noting that health-related apps used on mobile computing devices are replacing traditional visits to healthcare clinics, the handbook states, "patients receive messages about health education and reminders of appointments and medication schedules, clinicians engage in telemedicine, and users monitor health indicators, such as blood pressure and exercise data. These health apps are moving the point of care out of the doctor's office and to the patients themselves" (WHO and ITU 2020, 10).

Among public health systems, the NHS' digital health strategy illustrates this. The NHS has rapidly expanded its digital infrastructure, which now includes platforms for collaboration, clinical supervision, data exchange, training and education, and a comprehensive patient-facing mobile phone app set to become the "front door" to the NHS (Benger 2022). For healthcare chaplains, who often have only recently begun to engage with EHR software (and in some cases continue to

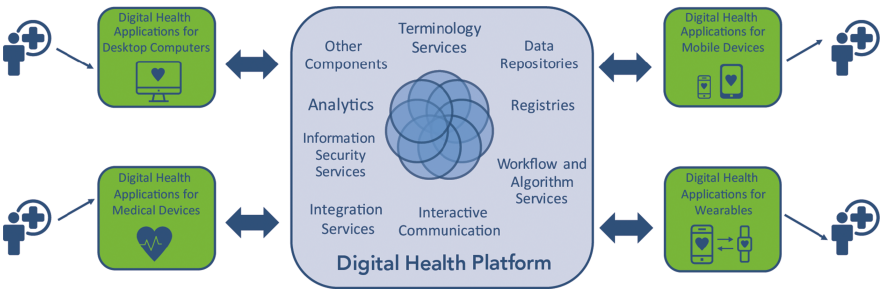

Figure 2: Interaction of digital health platforms with external applications and users (WHO and ITU 2020, 12). Reproduced with permission.

refuse its use), this is a daunting development. How does a chaplain meet a patient as they arrive, petrified of a looming diagnosis perhaps, for an appointment with their physician – if said front door is a metaphor for a smartphone app? As the point of care moves out of physical into digital clinical space, chaplains are challenged to move with it. We have found telechaplains to respond to this development in two ways: firstly, by attempting to assimilate into their institution's platform by proactively engaging staff responsible for technical development and support. The Community Support feature available to patients of Baylor, Scott & White Health on the MyBSWHHealth app, or TeleSpiritual Health, an employee benefit of Providence Health & Services offered through its Choose Well platform, exemplify this (Choose Well 2024; Winiger 2024a). Secondly, we are observing the emergence of specialised chaplaincy platforms such as spirituwell, eHeart, CareNote, and MyInspiration (CareNote 2024; Kelly et al. 2024; Nissen 2023; spirituwell 2024). We use the suffix "2.0" to distinguish telechaplaincy provided through such platforms from earlier, predominantly phone-based forms of remote care, and emphasise the differences in care which arise in this context.

Where patients interact with patients through a platform, for instance, chaplains may construct them as "users", which connotes a hierarchically flat, instrumental relationship. As with other technological interfaces, platform users may in turn expect an immediate response to user inputs, signified by the term "on demand" popularised by video streaming platforms such as Netflix. Indeed, the notion of "on demand" care has entered professional chaplaincy discourse through platforms such as spirituwell, and in at least one case frames the chaplaincy department of a major healthcare system. As critics have noted, platformisation is often accompanied by the flexibilisation or "uberisation" of labour: the commodification and precarisation of employment, and the emergence of a deregulated "gig economy". Particularly in care labour, platformisation may be deeply concerning for workers (Kluzik 2022; Rodríguez-Modroño, Agenjo-Calderón, and

López-Igual 2024; Tandon and Rathi 2021). It remains to be seen whether institutions use platforms to outsource chaplaincy to external providers and reduce the number of staff chaplains, or introduce a user pays model. Further research is needed to understand how spiritual care changes when provided through digital platforms.

6 Conclusion and Future Research

The developments described in this article will likely continue to gain importance in the coming years, driven by a demographic and epidemiological transition towards elderly and chronic care, which threatens to exceed the capacities of conventional healthcare infrastructure, and calls for an increase in outpatient care. The opportunities that they bring for healthcare chaplaincy are considerable. Against this background, the obvious challenges and limitations of telechaplaincy are important to consider. We have identified a host of issues at the level of individual care providers, organisations, and patient populations, as well as regulatory and economic risks, changing chaplain core competencies, and concerns over new barriers to access (Winiger 2023b; Winiger and Sprik 2023). In the following, we expand and elaborate on these points, considering our future work in this field and the potential positive contributions of these digital religious practices for individuals, communities, and societies in Switzerland and internationally.

First, and perhaps foremost, is the danger of a digital divide (van Dijk 2006). Telechaplaincy reaches its limits with people living with access barriers due to disability. Despite the advantages of a digital model of care, there are still many situations in which the opposite is true, or in which a combination of digital and conventional care is appropriate. Hybrid forms of care are likely to become increasingly common in the field of spiritual care in the future. “Device-side” care may not be a replacement, but an expansion of the chaplain’s reach, used particularly for patient populations who are underserved by conventional means. Telechaplains must be educated to reach across digital divides to ensure patients living with cognitive impairments, economic hardships and other access restrictions to technology continue to receive spiritual care.

A second issue concerns the legal requirements for interprofessional communication and documentation: telechaplaincy is only possible where chaplains are part of the treatment team and spiritual care is recognised as a clinically relevant task by healthcare institutions. Due to the technical complexity of medical information exchange and regulatory restrictions regarding the storage and exchange of patient data, “stand-alone” platforms built by churches or entrepreneurs usu-

ally operate outside the routine workflows of healthcare institutions. Particularly in highly differentiated regulatory environments such as Switzerland, where laws and regulation differ in each of its 26 cantons, legal aspects pose a significant hurdle. For instance, who qualifies as a healthcare professional ("Gesundheitsfachperson") is determined by both national and cantonal law, and regulates who may be granted access to the national EHR system currently in development. In the future, this will be explored in collaboration with legal scholars working in the URPP "Digital Religion(s)".

The use of virtual reality and artificial intelligence, both by patients and healthcare providers, is also raising new questions for chaplains. What role can immersive simulations play in the simulation of clinical incidents, the development of empathy and the holistic care of patients (Pirker and Pišonić 2022; Young 2022)? What does it mean for chaplains when chatbots like ChatGPT are used to ask existential questions and seek spiritual support (Singler 2024)? Whatever the answers to these questions: chaplains, educators, researchers and indeed society at large must critically examine these practices to ensure they make a positive contribution to society. We have begun to explore these questions in the first funding phase (see e.g. Winiger, 2024b), and will continue to explore their implications for spiritual care.

With the growing specialisation of healthcare, the need for healthcare chaplains to engage in interdisciplinary research and practice has become inevitable. Healthcare chaplains speak and document their interactions with patients using the conventions, vocabulary, and registers appropriate to a professional medical setting, and rapidly "code switch" depending on the religious and cultural context of those they care for (Cadge and Sigalow 2013). For telechaplains, it is critical to acquire what has been referred to as "digital literacy" (Dobson and Willinsky 2009). In this case, digital literacy includes the ability of spiritual care providers to proficiently communicate with patients, relatives, and caregivers in digital work environments, and liaison with technical development– and support staff to ensure spiritual care is integrated into the institution's digital workflows. In some health systems, such as Baylor, Scott & White Health, Digital Spiritual Care teams have been created for this purpose, and individual chaplains have trained to receive Epic certification to improve exchange between spiritual care staff and Epic support staff (Winiger 2024a).

Finally, the success of the chaplaincy profession in responding to the technological developments outlined here may depend on developing a critical stance towards the journalistic and academic hubris of technological determinism. The mystification of technology as a distant power with the capability to radically and irrevocably steer the course of society, both toward the better and the worse, has reached new heights amidst the popularisation of generative AI, and is used by

corporations to make a case for the market value of their products and services. Technological hype and counter ("criti-")hype (Vinsel 2021) is also widespread in the healthcare sector (Petersen 2019), where claims regarding the "disruptive" potential of digital health underwrites the supposed transformative might of the IT industry and its financial and intellectual acolytes (cf. Matusiewicz et al., 2018). As scholars of Science and Technology Studies have long argued, however, technologies are not causes, but artefacts, of social processes (Pinch and Bijker 1984). Digital health does not make the telechaplain, just as the steam-mill did not give rise to the industrial capitalist. Put differently, the rarely questioned claim that technologies have specific "effects" or "impacts" on social actors is a theoretically profoundly flawed and politically ill-advised characterisation of chaplains' relationship with technological change (cf. Grint and Woolgar, 1997). Rather than viewing themselves as latently disenfranchised subjects of technological effects, telechaplains may be more usefully understood as creative agents who enact – appropriate, repurpose and (co-)produce – digital technology in the interest of holistic, patient-centred care.

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