Surfing through a Sea Change: The Coming Transformation of Chaplaincy Training

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Mini-Symposium Summary

This essay introduces a mini-symposium that asks whether the preparation of future chaplains today anticipates sufficiently the emerging patterns of healthcare and the challenges of religious diversity.

The process of training chaplains has changed little over several decades. More recently, some involved in healthcare chaplaincy have perceived that new models are needed in forming, training, and evaluating chaplains. I am one person persuaded that other formats, models, and curricula could be proposed that may better match the needs of healthcare chaplaincy amidst the rapid changes also underway in healthcare in America. This essay will explore those alternatives and propose a conversation aimed at finding a hopeful new direction, incorporating traditions of chaplain training with new models of skills-based training and outcomes-oriented chaplain work.

Background

Clinical Pastoral Education (CPE) has formed the basis of chaplain training for decades. CPE has been a respected educational format that enables a learner through an action/reflection process to experience and practice ministry and reflect on growth and learning in both group and individual

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Reflective Practice: Formation and Supervision in Ministry
ISSN 2325-2855

settings. Most Christian and many non-Christian religious bodies require a unit of CPE for formal ministry, appreciating the value of CPE in forming mature well-prepared religious leaders.

Early in my time in seminary I experienced CPE as a process of collegial learning which helped me to feel that learning edges weren't inadequacies but rather places to continue to nurture and seek continuing collegial support. CPE helped me discern my gifts in ministry and energized my sense of vocation. CPE also helped me see the different styles, journeys, and talents of my peers as richness to be sought for further learning and growth.

It is from this background of appreciation and admiration for the process of CPE that I propose to explore areas where CPE may be lacking in emphasis and content, not for fault of its own emphasis and content, but because the further needs of training professional healthcare chaplains may lie elsewhere.

Changing Healthcare

The emergence of evidence-based medicine and patient-centered outcomes-oriented evaluation in healthcare is transforming the healthcare system in the United States.[1] The foundation of healthcare reform involves a shift from fee-for-service to fee-for-value. In the future, providers will not be rewarded for what they do, but rather for what comes of what they do. Medicine itself is struggling to confront variability of practice that isn't associated with variability of outcomes. This is a sea change in the institutions providing and evaluating healthcare.

The provision of spiritual care needs to be examined along with all other areas of healthcare. The field of chaplaincy must study itself to learn what measurable outcomes of its work can be found. If these outcomes can be identified as being associated with particular interventions or practice patterns, those interventions and practice patterns need to be scrutinized for an understanding of what mechanisms may underlie them and how those mechanisms can be replicated.

This research agenda for chaplaincy is barely underway now, but urgently needed. An exciting part of it is evident in the development of a Chaplaincy Research Collaborative, which has emerged following the capacity-building process of a generous grant from the John Templeton Foundation administered by the New York-based Healthcare Chaplaincy. I was

privileged to be a part of this opportunity and will describe later how this Collaborative can contribute to new paradigms of chaplaincy training.

Chaplains need intentional training in research methodology aimed toward becoming minimally research literate and, ultimately, research capable. Research literate chaplains can begin to translate insights and techniques of other supportive disciplines into chaplain practice. Research capable chaplains can begin to study chaplain activities toward demonstrating and comparing outcomes, ultimately to improve chaplain work and outcomes.

The Place of CPE in the Chaplaincy Research Agenda

The educational goals and outcomes of CPE weren't designed or intended to address the same needs and questions as that of evidence-based and patient-centered outcomes in healthcare. An attempt to re-apply CPE to address these needs, I believe, would be unjust to CPE. To prospective students inquiring online, CPE describes itself as:

> [I]nterfaith professional education for ministry. It brings theological students and ministers of all faiths (pastors, priests, rabbis, imams and others) into supervised encounter with persons in crisis. Out of an intense involvement with persons in need, and the feedback from peers and teachers, students develop new awareness of themselves as persons and of the needs of those to whom they minister. From theological reflection on specific human situations, they gain a new understanding of ministry. Within the interdisciplinary team process of helping persons, they develop skills in interpersonal and interprofessional relationships.[2]

The goals of CPE don't include surfacing enhanced techniques and practice patterns aimed at improving patient care outcomes. That fact is not any indictment of CPE. The goals of CPE focus primarily on the development of the student's pastoral identity. These goals are foundational to ministry formation and need to be preserved in the areas where they have such a strong heritage of esteem. This, however, implies that the process of CPE may be incomplete in relation to the larger question of training chaplains for professional careers in a changing healthcare context. Further, the emphasis on personal process that the CPE action/reflection model instills in students has probably made patient-centered outcomes-based thinking foreign to many chaplains. A needed shift of identity involves seeing a chaplain pri-

marily as a healthcare professional with theological and religious training rather than as a theological or religious professional with a healthcare role.

Beyond CPE

It needn't offend proponents of CPE to suggest that the contribution CPE can make in the formation of professional chaplains is limited and mismatched. Any single educational format is limited. CPE has an important role to play in the earlier formation of persons for ministry. At the same, it may be ill designed to deliver the techniques, skills, and advanced competencies needed to work in professional chaplaincy.

Many CPE centers offer chaplain residency programs. These are usually one year long stipended positions during which one provides spiritual care in a medical setting while earning three or usually four units of CPE. Greater development and standardization of curriculum among these programs is needed. The curriculum needs to make knowledge of research methodology a standard preparation of chaplaincy.

Obviously an objection to adding elements and themes to a curriculum is that there is limited time in a program to cover everything and to add something means something has to be diminished. This is evident. I remember perceiving an incongruence at some point in my own supervisory process where the classic elements that make up a CPE unit had reached an educational saturation point, yet the process just continued on with more of the same elements of group reflection that seemed increasingly disconnected to the work actually happening in the medical center. There is a saturation point that is reached with what CPE can deliver in terms of its formational process.

A specific and significant drawback of CPE that can be associated with this saturation point is the lack of a true progression of beginning to intermediate to advanced learning. CPE has a basic Level I Unit, which this writer enjoyed one summer during seminary. Beyond a basic Level I Unit, there is a theoretical Level II. This is only theoretical because students frequently experience CPE units where some students are in Level I and some are in Level II, based on having had a previous unit. The standards of the two types of units are even written together as identical in the CPE standards:

> A *unit of CPE (Level I/Level II)* is at least 400 hours combining no less than 100 hours of structured group and individual education with supervised clinical practice in ministry.[3]

The students at Level I and Level II in the same unit experience the same didactic presentations and work in the same clinical contexts. While some elements of advanced practice may be expressed in the individual supervision of a Level II student, this doesn't significantly change the experience.

Undiscovered beyond Level I and Level II is when and how a student can internalize the Action/Reflection model and self-supervise without the assistance of a group and a supervisor. Since the majority of participants of CPE never take more than one unit, theoretically that should be a deliverable outcome of Level I. It is not. One Level I outcome is described in standard 309.10 as "to develop students' abilities to use both individual and group supervision for personal and professional growth, including the capacity to evaluate one's ministry."[4]

A Level II outcome goes a little further and in standard 312.9 reads "demonstrate self-supervision through realistic self-evaluation of pastoral functioning."[5]

An outcome from a unit of Supervisory CPE, for students in the process of becoming CPE supervisors goes yet farther in standard 315.4 reading "self-supervises own on-going pastoral practice."[6]

CPE needs further laddering of its levels of units and needs to re-design the goals to concentrate on rapid acquisition of the Action/Reflection model to self-supervise and then move on to the acquisition of techniques and skills in pastoral ministry. Minimally, the self-supervision goals of Level II should become those of Level I and those of Supervisory CPE should become Level II. As it is, the structure of CPE itself only delivers the same territory over and over again—and importantly, that territory is centered on personal formation, not on professional competence. What is needed is a progression in the Action/Reflection CPE model to reach a stage of self-supervising before this saturation point is reached. CPE itself may not be designed to do that. Again, I am not eschewing CPE for not doing something it should, I am simply challenging the use of CPE as the appropriate vehicle to deliver something that is still missing.

Models of Technique Training

What is missing is specific training on techniques and procedures in the delivery of healthcare chaplaincy and the exploration of how specific techniques and practice patterns can deliver improved patient outcomes. This includes minimizing self and personal practice in favor of demonstrated

practice patterns associated with improved patient outcomes. While the field of chaplaincy is far from discovering these outcomes, a platform in which they can be taught and explored will be needed. This will mean teaching chaplain performance quite differently than CPE currently does.

Uniformity and consistency in clinical practice is already an educational goal for a number of healthcare disciplines. An important element in medical school training is the acquisition of clinical skills through practice with standardized actor patients. Simulation training and standardized patients is actually nearly universal in medical education yet absent in CPE.[7] An important exception to this absence is a 2010 piece describing the effectiveness of simulation in chaplain training.[8] Areas of interaction by chaplains that could benefit from simulation include initial visiting, advance directives, facilitating family meetings, and caring for persons at time of death.

A number of other formats and models of techniques training could be adapted to chaplain training. Communication training for healthcare professionals presently includes approaches such as ONCOTALK[9] and VitaSmarts' "Crucial Conversations."[10] These approaches teach communication through scripting and conversational formatting that assist learners to gain facility in talking about difficult topics.

A very hopeful form of techniques training has surfaced with the study I earlier referenced, which was performed in my healthcare system last year. From a generous grant from the New York-based Healthcare Chaplaincy provided by the John Templeton Foundation, we conducted a study entitled "Toward a Taxonomy of Chaplaincy Activities." In this study, we explored chaplain language and thought preferences in describing chaplaincy work. Categories of items that included both granular activities and outcomes emerged. The full inventory of items that surfaced in the study will be forthcoming in another publication. In preliminary testing of the items, chaplains found that the items can be assembled into pathways of chaplain work that include tangible actions and intended effects of chaplain work.

Three groups of chaplain residents at two different institutions have been introduced to the Taxonomy and have found it a fresh and inviting set of terminology around which to describe their care. Further practice with students using the inventory to both describe their care and prescribe outcomes and interventions around medical and spiritual needs promises to be an exciting new element in case studies, verbatim, and group work.

Re-designing Chaplain Residency

This writer believes that there may be greater intransigence amongst CPE supervisors themselves on broadly changing chaplain residency training than actually exists in the ACPE standards. The standards governing what constitutes a unit of CPE are written intentionally broadly to leave plenty of room for differences of style and pedagogical philosophy. This breadth can also be applied to designing new group experiences to be employed in addition to the traditional CPE experiences such as verbatim presentation. While the standards are helpfully broad, they do present in their simplicity a dichotomy of educational activity and clinical practice that is itself an unhelpful concept.

Therefore I propose introducing a unit of Chaplain Residency CPE, distinct from Level I and Level II, that includes a third category of educational experience that bridges and unifies action and reflection.

I propose Chaplain Residency CPE as "at least 400 hours combining no less than 50 hours of structured group and individual education with supervised clinical practice in ministry and no less than 50 hours of experiential training in clinical techniques."

Another mismatch in the process of chaplain training is the requirement by the Association for Professional Chaplains that candidates for chaplaincy possess four units of CPE. However, the practice of most residency years is to award four units of CPE, in addition to one unit for admission, totaling five units for many students.

Rather, a chaplain residency year should require a basic Level I unit as an entry requirement. Then the residency year should include three additional units, one Level II unit, followed by two Residency units. This would also give more time in the yearlong curriculum to meaningfully explore the complex healthcare context, time usually unavailable because of the need to clock 100 hours of group and individual supervision time per unit for four units.

A re-designed curriculum would surface the full inventory of chaplain-associated knowledge that would be imparted through a variety of pedagogical techniques. The successful student would master the body of propositional knowledge and be able to capably demonstrate this mastery. One could envision a healthcare chaplain competencies test through which a chaplain candidate would demonstrate mastery of this propositional knowledge of chaplaincy intended effects

While the Association for Clinical Pastoral Education certifies CPE centers, there is no actual accreditation process for Chaplain Residency programs. No standards exist for what should constitute a residency, how many units of CPE it should include, or what measurable outcomes should accompany successful completion of a residency. The Association for Clinical Pastoral Education and the Association for Professional Chaplains would do well to collaborate on a uniform structure of chaplain training incorporating such adjustments.

Conclusion

This essay is intended to be part of a wider conversation unfolding on this topic. The conversation has emerged from time to time and has been bolstered by contributions such as that of Dr. Wendy Cadge in *Paging God*.[11] Other elements of this conversation include a speech George Fitchett gives this year at the annual conference of the Association for Clinical Pastoral Education. Additionally, George Fitchett and I will make a presentation at the annual assembly of the Association of Professional Chaplains entitled, "Chaplaincy Training is Broken: Let's Fix It." We hope to enliven a conversation that will be hopeful, fruitful, and respectful—even as it must also be daring, risky, and challenging.

This conversation must soberly confront that previous models and philosophical approaches to training and formation are at stake. Defensiveness and intransigence are predictable, but not inevitable, responses to this confrontation. I believe an optimistic approach of meeting to mutually build a new approach specifically to professional chaplain training would enable these inter-related disciplines to thrive through these changes.

NOTES

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4. Ibid., 309.10.

5. Ibid., 312.9.

6. Ibid., 315.4.

7. *Wikipedia: The Free Encyclopedia*, "Simulated Patient," accessed January 24, 2014, http://en.wikipedia.org/wiki/Simulated_patient.

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9. Vital Options, *ONCOTALK®: Improving Oncologists Communication Skills*, accessed February 12, 2014, http://www.oncotalk.info/.

10. Vitalsmarts®, *Resource Center*, "Crucial Conversations: Tools for Talking When Stakes are High," accessed January 24, 2014, http://www.vitalsmarts.com/crucialconversations/.

11. Wendy Cadge, *Paging God: Religion in the Halls of Medicine* (Chicago: University of Chicago Press, 2012).