Is Chaplaincy Training Broken? I Don't Think So: A Response to Kevin Massey

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In my previous life as a manager in the corporate world, we lived by the motto "if it ain't broke, don't fix it." It was a time when the quality of customer service was at its highest. While I do not think chaplaincy training is broken, I do join Kevin Massey in being hopeful that a formalized collaborative dialogue will ensue between chaplains who are certified by the Association of Professional Chaplains (APC) and clinical pastoral education supervisors who are certified by the Association for Clinical Pastoral Education, Inc., (ACPE).[1] The primary intent of this dialogue should be to assess the need for, and implement, appropriate changes to chaplaincy education that will enhance patient wellness and promote positive patient experiences, while providing the much sought after evidence that chaplaincy is, indeed, productive and cost effective. At some point this conversation could, and probably should, include administrators, patients/families, and representa-

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tives of the interdisciplinary care team such as nurses, social workers, and ethicists. Its focus should be on enhancing the patient experience. There is room at the table for all as we remind ourselves that our patients, the "living human documents" whom we serve, are our greatest teachers.

That said, as an ordained Elder in the United Methodist Church, who is endorsed by the Church and appointed by the Bishop of the North Georgia Conference to serve in extension ministry as a CPE Supervisor/chaplain in the Spiritual Care Department at a Level II trauma center in North Carolina, it matters a great deal to me how others perceive my role. Without this foundation I could not have become a board certified chaplain nor a CPE supervisor. Massey suggests an identity shift for chaplains to a *"healthcare professional with theological and religious training rather than as a theological or religious professional with a healthcare role."* I do not support this shift as it would tend to minimize my specialty of "caring for the soul" of the patient. Caring for the soul means building bridges between humanity and its objects of faith "in order to keep soul alive in times not hospitable to the soul."[2] I dare say, living in the crisis of being in the hospital in today's world is often not hospitable to the soul and particularly so in the absence of someone with spiritual discipline and expertise who can engage the inhospitality. When the chaplain becomes a healthcare professional, the patient loses their only hope for an advocate on the care team whose primary focus is not related to their body.

Chaplains are a lens through which needed care for a patient's soul, mind, and body can be discovered. They have a professional connection to the patient which engages a "mysterious power" on behalf of the patient, unlike that of other members of the care team. Chaplains see things, are made privy to situations, and capture experiences belonging to patients that persons who spend more time in offices than in patients' rooms may ever encounter. Is it important that the chaplains and the rest of the care team are able to communicate and comprehend data retrieved via their respective areas of expertise? Yes. Thus it is important for ACPE and APC to reflect on how chaplains are being prepared to embrace and excel in their healthcare role, while not losing connection with the *mysterium tremendum* from whence comes a spiritual professional's ultimate authority.

Massey suggests that *"chaplaincy training is broken and needs fixing"* and suggests a revision to the first year CPE resident curriculum. The capacity and ability to self supervise is crucial and process oriented, and cannot be learned by simply reading a book. The standards, objectives and outcomes of ACPE's Level I/Level II and Supervisory Education, when fully under-

stood and utilized, provide a framework for curricula that meet the needs of the students and the institutions they serve.[3] ACPE certifies that its CPE supervisors (barring any abnormality) can move from one accredited center to another, adapt and be productive and effective with care receivers, students, staff, and administrators. I suggest that Hospital Administrators consider financing a second year of specialized hospital residency, which would include modules on hospital administration, evidence-based research, etc., and leave the first year curriculum intact.

Massey remembers *"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."* If he indeed did begin the ACPE CPE supervisory process and did not complete it, it stands to reason that he might have reached a saturation point in his expectations that limited his learning. There does come the time in supervisory training where the scope of the Supervisory Education student's learning moves beyond the boundaries of the facility in which he/she is working. My educational theory asserts that CPE is an emancipatory educational process that results in transformative learning. ACPE certifies that its educators/supervisors are chaplains who understand caring for the soul and are transportable beyond acute care hospital walls, to community-based centers, military/veteran systems, university-based centers, psychiatric facilities, and even to parish-based centers, just to name a few. CPE Supervisors seek to ensure that students who engage CPE programs will be effective/productive chaplains for those they serve, wherever they may be employed. If, on the other hand, Massey's comment about an educational saturation point in his "supervisory process" referenced his residency experience, then I wonder if he experienced an identity shift and became a healthcare professional with minimal interest in "care of the soul" early in his educational process. There is always much to be learned about keeping the soul alive when all about you there is death and dying—brokenness abounds in unimaginable ways and so does the *mystery*.

Additionally, Massey's reference to the Davis (2010) article on the transformation of the healthcare system failed to note that Davis is most concerned about the usage of aggregated data to provide hospital personnel with tools needed to identify patterns and determine the effectiveness of treatments in order to determine "the intricate differences in how individuals respond to various treatments." Chaplaincy is not a treatment adminis-

tered via standard dosage designed to produce a cure in x number of days. We work with the living human document whose life experiences change every day. Thus caring for the soul is not an exact science *sans* mystery, and yet...we pray that medical treatments are.

Thank you, Kevin Massey, and other recipients of the Templeton Grant, for the research you have done. Hopefully, once your research is available, dialogue and collaboration between APC and ACPE will occur without premature judgment that could prevent such dialogue from being productive. No, chaplaincy education is not broken, but enhancements are certainly appropriate.[4]

NOTES

1. All subsequent references to CPE, CPE Supervisors, or accredited centers are related to ACPE, Inc.

2. Herbert Anderson, "Whatever Happened to Seelsorge?," *Word and World* 21, no. 1 (Winter 2001): 41. Also reference Teresa E. Snorton, "Ministry as Soulful Leadership: Implications for Supervision," *Reflective Practice* 27 (2007): 150–161.

3. Reference is made here to the diversity of "special projects" offered in numerous centers that have led to the broadening of professional chaplains; i.e., EMS chaplains, HIV/AIDS chaplains, palliative care chaplains, hospice chaplains; university and college chaplains. There are also CPE residency programs that culminate in a Masters Degree like the one offered at Virginia Commonwealth University, and inter-professional educational ventures like an End-of-Life curriculum that was offered for five years between the CPE program at Anderson, SC, Clemson University's School of Nursing, the Winthrop University's Master of Social Work program (George West). Or consider a new CPE resident program that has just started at Mass General that focuses on medical ethics, research literacy, and chaplaincy leadership. These are just a few examples of how the standards, objectives and outcomes which guide the CPE curricula allow for creativity and expertise when planned in collaboration with the ACPE accredited institution.

4. This response was written following conversations and collaboration with several CPE Supervisors in the Southeast, Southwest and Mid-Atlantic Regions of ACPE, Inc.