# Reflections on the Development and Future of Chaplaincy Education

**Alexander F. Tartaglia**

Since its inception, clinical pastoral education (CPE) has been a pivotal experience for religious leaders, either because they celebrated the survival of the experience or the experience had a transforming impact on the formation of their personal and pastoral identity. Over time, CPE has become a defining experience for the training and certification of healthcare chaplains. Recent conversation has generated debate as to whether CPE in its current composition is sufficient for the training of chaplains in a healthcare environment where evidence-based practice and patient outcomes are becoming the norm.[1]

Recent studies of Level II residency programs accredited by the Association for Clinical Pastoral Education, Inc. (ACPE) found that only eleven of some 200 centers included research literacy as a student learning outcome in their year-long curricula.[2] Research literacy, the lowest of three levels of research competence outlined by the standards of practice of the ACPE, refers to a chaplain's ability to critically read research findings and incorporate them into professional functioning. Research competence (collaborator with other professionals) and advanced research (investigator) are higher levels of involvement in the current healthcare context and typically call for more robust training.[3]

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Preliminary findings of a current study have found that less than half (six of fifteen interviewed so far) of the recently accredited (or re-accredited) CPE residency programs specifically address the twenty-nine professional competencies assessed for certification as a board certified chaplain (BCC).[4] Some of the supervisors at those centers indicated that CPE has a broader mission, namely, that the focus of CPE is to train providers in multiple contexts. Others were emphatic that they would never consider incorporating board certification competencies directly into the curriculum on the basis that evaluating students on those competencies would run counter to process education. Additionally, there was no consensus among the ACPE supervisors interviewed as to whether board certification as a chaplain should be required for authorization to train healthcare chaplains. In another recently completed survey of ACPE accredited residency programs, we found that only nineteen percent of those centers use an electronic medical record pastoral care documentation tool grounded in a published theoretical model.[5] Combined with the apparent lack of consensus among the pastoral care organizations, these findings contribute to the current environment where chaplains often sit on the periphery of the dialogue between spirituality and healthcare.

Nonetheless, CPE has an extensive history of preparing individuals for professional chaplaincy and has established itself as an accepted training program in hundreds of healthcare settings. CPE was conceived as a method of theological education by which persons learn the "art" of pastoral ministry through actual, supervised encounters with individuals in crisis. The practice emerged as an attempt to bridge the gap between the theoretical study of theology and the clinical encounter with persons experiencing human suffering.[6] Consequently, the founders of the CPE movement were characterized by Brooks Holifield as moral reformers concerned with reshaping the ethical sensibilities of theological education as well as professional leadership.[7]

Although CPE emerged as a reformation movement within theological education, my thesis for this paper is that within the current healthcare context a second moral reform is indicated. As such, I am proposing a curriculum model for chaplaincy training that draws upon the ethical assumptions underlying CPE, the historical development of the movement, and the contemporary healthcare environment that is calling for a new paradigm.

## ETHICAL ASSUMPTIONS

Historically, ethical methodology has been classified according to one of the modes of thinking that defines that which is considered normative. The three typological frameworks are traditionally referred to as deontological ethics, teleological ethics, and contextual (situational) ethics.[8]

Deontological ethics is preoccupied with the question, "What is right?" Appealing to some universal authority as its primary criterion for reflection and evaluation, this type of ethical discourse tends to take the form of principles, rules, or codes and emphasizes the content of an obligation. Teleological ethics in contrast is preoccupied with the question, "What is good?" Its appeal is to purposes, goals, and ends with an emphasis on the consequences and outcomes of a given action. Contextual ethics is that mode of ethical discourse that forces the 'right' and the 'good' to address a particular situation. Rooted in the view of the individual as participant who 'acts' under certain circumstances, contextual ethics recognizes 'choice' in all human conduct. By asking what is the 'fitting' thing to do within a situation, this approach appeals to personal freedom and guides action toward 'appropriateness.'

It is important to note that, standing alone, none of these approaches are sufficient. Rather, the most comprehensive and therefore most responsible normative stance incorporates all three modes. The task of ethics then becomes to develop a relative agreement among the diverse ethical pressures of the right, good, and fit in order to find that which can be ascertained as normative for a particular social system.[9] This most sound standpoint is defined as the "normative ethos."

The twentieth-century shift in the direction of theological education (CPE) called for an evolution of the prevailing "normative ethos." Historically, traditional theological education was deontological in nature. It imparted theological truths of the tradition to students who in turn brought them to bear in understanding human nature and advising others of the proper behavior in the resolution of personal dilemmas. The methods and means of imparting truths were pedagogical, with the teacher as knower and the student as recipient of knowledge.

The introduction of CPE significantly altered educational methodology and, in the process, set the stage for "truth" to be subjected to the lens of experience and thus be considered changeable. The result was an ethical transition in the educational philosophy upon which CPE was founded, namely, a shift in the normative ethos to one informed by teleological factors

that focus on personal formation and skill development. The recommendations set forth in this paper suggest that the second moral shift is toward a situational focus in which the learning is increasingly defined by the clinical context.

## FOUNDATIONS OF CPE

William Keller, a Cincinnati physician influenced by the social gospel movement, was committed to bringing theological students out of the classroom and into communities to address the social challenges associated with poverty, discrimination, and family dysfunction. Keller was among the first to introduce the concept of "learning by doing" as a way of addressing the deficiencies in theological education inherent in three years of purely academic study.[10] Assigning students to community agencies under the supervision of clinical social workers, Keller brought a teleological perspective to clinical training aimed at improving the lives of others by transforming social systems. For him, learning to carry out the mission or socially redeeming work of the "church" rather than the personal growth of the learner was primary.

Not unlike Keller, Richard Cabot represented a reform that was similarly teleological in expression. Cabot, a Boston physician committed to health promotion, focused on professional competence and teaching theological students to respond appropriately to the needs expressed by the sick and the dying.[11] Cabot believed that students needed to practice theology where it was most needed, in personal contact with individuals in trouble.[12] Cabot and Keller both utilized the case study method to explore the stories of persons in need and to develop informed and compassionate responses to those needs. Distinct from Keller, Cabot's focus was on human growth, which he claimed to be the central goal of ministry, with healing professions addressing the emotional as well as the physical aspects of illness.[13] In these early days of clinical training, it was Cabot who took seriously the struggle experienced by pastoral care providers in talking with patients about personal problems.

The third reformer, often referred to as the "father" of CPE, was Anton Boisen. Boisen's focus was less on training students to provide pastoral and/or social services and more on understanding religious experience.[14] In 1925, as chaplain at Worcester State Hospital, Boisen used case studies

of mentally ill patients, so-called "living human documents," to help students reflect theologically. He wanted students to study mental illness as a way of understanding religious experience. Less interested in teaching pastoral skills, his primary aim was for his students to develop new theological truths.[15] Boisen's teaching was contextual in nature in that he sought to understand theologically the unique stories of individuals.

## DEVELOPMENMT OF CPE

As the CPE movement developed, it introduced a shift from "systematic" theology to what became known as "clinical" theology. This transition required being open to the observed rather than to the assumed religious experience of those in critical need. It required openness to the feelings and emotions as well as a willingness to explore the meaning of those emotions and their relationship to theological constructs. Clinical theology came to include ongoing dialogue between theory and experience as well as between concept and emotion, and it opened itself to new insights about the significant questions of living.

As evidenced by the slow changes in curricula, this evolution within theological education was initially met with resistance. It was not until 1931 that Andover Newton Theological School became the first seminary to employ a faculty member as director of clinical training. The conflict over the focus of clinical training within the movement itself led to an internal struggle. In New England, the group that eventually organized as the Institute for Pastoral Care primarily emphasized the cultivation of traditional pastoral identity. Preserving a distinctly "pastoral" orientation, they maintained a 'shepherding' perspective and the notion that clergy were "shepherds of the soul." Attention in New England was toward methodological innovation leading to skill development and competence as the basis for professional formation. The student-patient relationship was the locus of learning. This position was strongly advocated not only by Cabot but also by Russell Dicks, who practiced writing the dialogues of visits with patients immediately following the encounter. Dicks believed that the immediate recounting of visits provided the opportunity for self-criticism, self-evaluation, and self-improvement.[16] Thus, we have the birth of the verbatim as we know it today.

Meanwhile, in New York where the Council for Clinical Training emerged, the dominant metaphors were derived originally from Boisen and strongly promoted by Helen Flanders Dunbar. Drawing extensively from theories of the psychology of religion, crucial attention was riveted on the drives and impulses of the personality.[17] The New York group promoted a more psychodynamic approach to learning, reframing the focus of pastoral care from advice-giving to emotionally freeing patients to think about and find resolution for their own problems.[18] When shifting to supervision, the focus became helping theological students to understand their own emotions and to develop a psychological understanding of those to whom they ministered.[19] The locus of learning was the supervisor-student relationship. The ethical focus "ends" became freedom rather than formation, with healing as "liberation of the self" and the image of the clergyperson as "physician of the soul."

This ideological discrepancy accompanied the formative years of CPE, with the education vs. therapy debate continuing to the present. Those who accented education defined the goals of CPE in terms of ministry to be performed, with personal change and emotional growth of the chaplain as secondary to pastoral formation. The therapy advocates viewed professional understanding and role development, as well as the quality of pastoral functioning, as byproducts of self-understanding and personal maturation.[20] The ethical norms (oughts) were essentially teleological ones: professional authenticity vs. authentic personhood, professional vs. personal identity, vested authority vs. personal authority. While the internal tension within the pastoral care movement had strengthened and expanded the task of supervision, it drew energy away from what was happening in the medical establishment and deterred the development of chaplaincy as a clinical profession. Formation and freedom became the primary foci and dominant ethical drivers at the expense of developing metrics for measuring effective pastoral care or agreement on quality standards for chaplains. Even now most professional chaplains would struggle to define those metrics, instead working under the assumption that they know quality care when they see it. One could argue that CPE has come to justify the lack of scientific rigor under the guise of "intuition."

## LEARNING MODELS

The movement to establish a new normative ethos for theological education did not exist in a vacuum. A significant factor concurrent with this shift was the changes in educational philosophy emerging from pragmatism. These educational reforms are highlighted by the work of John Dewey.[21] Grounded in the ideas of Charles Pierce and William James, Dewey set about critiquing current theories of how a state of "satisfaction" could be achieved and maintained by deception. Dewey suggested three methods of achieving a state of satisfaction that impeded learning: (1) the "method of tenacity" whereby one clings to beliefs merely because they are comfortable, (2) the "method of authority" in which one appeals to tradition or power (it has always been done this way, or doing it "my" way), and (3) the "a priori method" based on intuition or what "feels" right or wrong or "I'll know it when I see it." In response to these purported stances toward "knowing" or "learning," Dewey proposed the "scientific method" centered on "control" (ability to influence the environment), "public test" (experimentation), and further objective tests (repeated experiments where one could come to reasonable proof or consensus). For Dewey, *how to think* was as important as *what to think.* For Dewey, experience was the beginning and end of education and the process of learning determined the product.[22] The cycle of learning follows the scientific method that is ongoing and progressive. It is, if you will, the action-reflection model, which includes movement from concrete experience to observation and reflection on that experience to formulation of new concepts in conjunction with existing theories and finally to testing those new concepts. Taken in these terms, the ends of education are not fixed. Rather, they are changeable and can be modified in relation to shifting environmental conditions (in CPE we claim that learning is transferrable). Therefore, the chief ends of education must be stated in terms of processes rather than static states: the promotion of reflective behavior, the promotion of growth and health. Education then becomes its own end—teach the person to fish rather than give the person a fish.

The influence of Dewey's theory of education has been a hallmark of CPE and remains closely tied to theorists who have continued to inform the movement. The educational theorists embraced by many CPE supervisors are still linked to Dewey's lineage, such as Malcolm Knowles's self-directed learning (andragogy) and Parker Palmer's devotion to teachers and learners as partners. Others, like Chris Argyris and David Schon, have in-

troduced reflective concepts such as "double-loop learning" and "espoused theory vs. theory in use." More recently, bell hooks has focused on "engaged pedagogy."

While CPE embraced the principle focus on experiential learning, two things that the profession is seeking to recapture in the training of chaplains fell to the background. For one, the shift in education came at the expense of the scientific method associated with learning as a research enterprise. In addition, the preoccupation with how learning occurs took precedence over what needed to be understood about healthcare and the role of the chaplain in order to succeed in the ever-emerging clinical context.

## NEW FOCUS

The shift in educational methodology had a parallel in the restructuring of medical education. Responding to the findings of the 1910 Flexner Report, medical education was expanded to incorporate a more robust clinical component. Physicians began to be trained in a more scientific manner, with medical faculty more focused on research. In addition, medical schools (now reduced in number) were given control of clinical instruction in hospitals.

The significance of this transition for the development of chaplaincy is that while the medical establishment increasingly focused on what became known as "evidence-based practice," CPE clung to professional formation and educational methodology. The early stages of healthcare chaplaincy did not follow the route of medical education. Rather than affiliating with the institutions where they would practice, chaplains were more tied to religious organizations that were primarily concerned with congregational life. The result was that chaplains found themselves on an island between two of the three historic professions but embraced by neither.

In many instances, chaplains were local clergy who volunteered their time. Additional chaplains were often assigned to hospitals by different religious groups without any coordinated effort. While these arrangements afforded access to patients, accountability to hosting organizations was minimal, resulting in increased marginalization, limited credibility, inconsistent practice, and a lack of integration. The phenomenon has consequences to this day as chaplains continue to find their place within healthcare institutions.

Another factor worth noting is that while the "founders" are credited with the emergence of clinical pastoral education and while CPE has be-

come the defining experience in the training of chaplains, none of them saw their goal as training chaplains for healthcare. The first glimpse of that goal came in 1939 when Russell Dicks outlined his considerations for the requirements of effective hospital chaplains:

- Hospital chaplains must remain connected to hospital staff caring for patients.
- Hospital chaplains must have a plan based on the severity of patient illness, patient need, and clarity about which patients should be visited.
- Hospital chaplains should be accountable to hospital personnel.
- Hospital chaplains should keep records of their visits.

Dicks shifted the perspective on chaplains away from the provision of religious rituals to the promotion of patients' physical recovery and spiritual health. While Dicks set out the first standards of practice for hospital chaplains, the evolution of the profession seemingly failed to follow.[23] The fact that consensual professional standards did not re-emerge for the profession until 2009, eighty years later, is a telling statement about the place of chaplaincy in the emerging pastoral care movement.

## FUTURE STEPS

The debate over whether CPE in its current configuration is sufficient for the training of healthcare chaplains remains critical. The movement from "learning objectives" to "learning outcomes" in CPE is a shift in a positive direction. However, ACPE has not developed any consensus metrics on what constitutes evidence that a student has met these outcomes. Furthermore, there is little correlation between CPE learning outcomes and the standards of practice for professional chaplaincy. Limited research has been conducted on the measureable changes in student learning resulting from CPE training.[24] More study needs to be conducted if CPE is to develop evidence-based practice for the use of CPE to train chaplains; without it, determination of student competence typically falls to the personal evaluation of a single supervisor.

The balance to this primacy of the supervisor-student relationship is a return to the shared value of those served—patients and families. Despite increased attention to spiritual care and the growing availability of chaplains in healthcare organizations, fundamental problems persist. As Wendy

Cadge reports in her book *Paging God*, healthcare institutions continue to face limitations in adequately addressing the spiritual needs of patients. [25] Cadge references the 2009 study of Balboni et al. indicating that seventy-two percent of patients with advanced cancer report not having their spiritual needs supported by the medical system.[26] This statistic becomes more significant alongside numerous studies where those who report having those needs met experienced a higher quality of life. [27]

What are some key areas needing attention that might promote further development of health care chaplaincy as a clinical profession? The first is the need to arrive at consensus on professional standard definitions, particularly that of the "role" of the chaplain. The profession has redefined itself as providing "spiritual" rather than "pastoral" care. While this change is quite entrenched, there is no uniform definition of spirituality and thus no uniform definition of spiritual care. The closest attempt at this was the Archstone project, which has had limited circulation within the profession.[28] Second, despite the clear expectation that a fundamental standard of practice for chaplains is to conduct spiritual assessments, there are no commonly held metrics or accepted components or content elements for such assessments.[29] Third, there are no established criteria for prioritizing patient visitation or for determining which patients should be seen by a professional chaplain. Responding to deaths and traumas is common in developed scopes of service. Yet, a number of pastoral care departments have no established scope, and only limited numbers of departments are either attached to protocols or have tactical plans regarding visitation.[30] This is a significant efficiency issue in a cost-conscious healthcare environment.

Fourth, there are few established spiritual pathways for caring for specific patient populations that have been exposed to ongoing evaluation. The development of spiritual pathways assumes knowledge of particular disease processes and of the impact the diseases can have on the emotional and spiritual lives of persons with those diseases as well as of the interventions to address the human suffering associated with them. Such pathways will need to be outcome-driven.

Fifth, the conversation will need to shift away from what "chaplains do" to what healthcare organizations do and how the chaplain's role can serve that mission. After all, patients come to hospitals for medical care, not spiritual care. This will mean partnering with our healthcare colleagues to develop organized strategies to promote health and address the needs of patients and families. Sixth, regular examination of the standards of pro-

fessional practice is necessary to ensure that their adaptation parallels the advances in healthcare delivery. Finally, we will want to continue to move toward becoming a research-informed profession supported by evidence-based practice that is defined and characterized by the use of scientific findings to inform assessment and intervention in the spiritual care of persons.[31] This will include developing best practices emerging from collaborative research and performance improvement.

As chaplaincy moves to embrace these changes, we will be able to realize the shifting paradigm for the profession from the earliest days when chaplains represented religious communities operating "in response to individual sin" to the paradigm that came to dominate CPE training—building genuine relationships with patients and demonstrating empathic listening—to the more recent model described by Jack Gleason as "outcome oriented chaplaincy."[32]

## RECOMMENDATIONS FOR TRAINING

This brings us to the need to explore a learning/training model for the education of healthcare chaplains. Figure 1 is a visual attempt to capture the reflections in this paper. It is offered as a variation from the traditional action-reflection model. As with any educational model, we would begin with the expected outcomes. What knowledge and skills need to be learned? What methods should be employed in imparting those learning outcomes? Then we would ask what structures would need to be put in place to maximize the opportunity for such learning. In 2000, the Department of Patient Counseling at Virginia Commonwealth University received approval by the State Council on Higher Education in Virginia to offer a Master of Science degree that was compliant with ACPE standards. The development of the curriculum for this degree was an initial step in forming an academic and clinical program designed to support learning specifically for healthcare chaplains. In addition to the employment of traditional methods embedded in CPE, the curriculum design required students to embrace a theological and psychological stance from which they operate and reflect. It also added specific content components such as clinical ethics, leadership and management in chaplaincy, process improvement methodology, and an introduction to research literacy.[33]

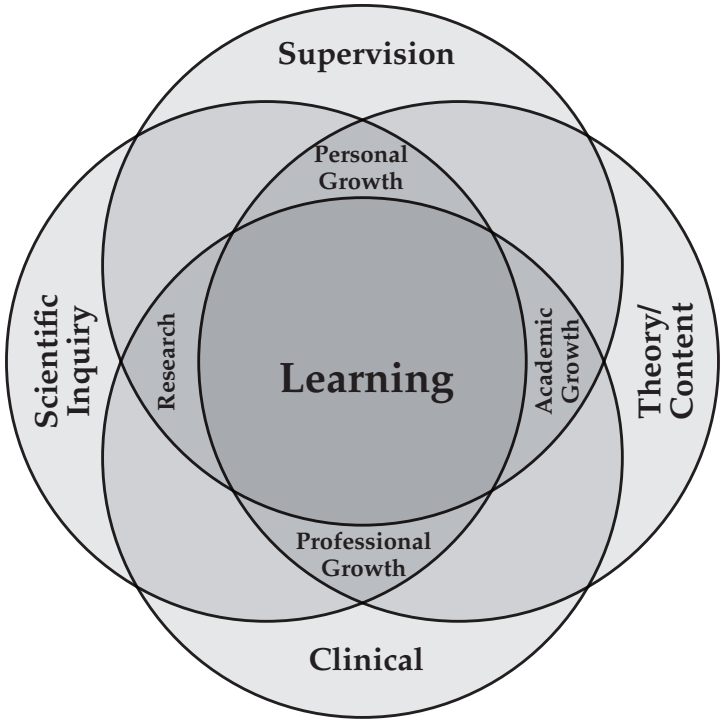


**Figure 1**. Learning Model Undergirding the Proposed Chaplaincy Curriculum

Richard Cabot called for the "clinical year" as fundamental for reforming theological education. His purpose was to ensure that clergy developed pastoral and professional competence. Not until 1961 was a 24-week clinical training recommended as a requirement for chaplain certification.[34] Only later did a full year of clinical training become the standard for certification as a chaplain. My first recommendation would be that training for chaplaincy move from a one- to a two-year timeframe beyond the graduate degree in theological education. Table 1 provides an outline of a proposed two-year program of chaplaincy training.

**Table 1. Outline of a Proposed Two-Year Curriculum for Training Chaplains**

| Curriculum Framework | Year 1 | Year 2 |
|---|---|---|
| Learning Environment | Facilitating Conditions that Promote Learning<br>Environment Built to Support Outcomes<br>Supported by Teleological Ethical Assumption | Exploration of Richness of Clinical Context<br>Environment Exists to Support Outcomes<br>Supported by Integrated Ethical Assumptions |
| Learning Outcomes | Peer Learning<br>Pastoral formation<br>Pastoral Competence<br>Aligned with ACPE Outcomes<br>Pastoral Identify and Personal Authority | Demonstrated Professional Peerships<br>Aligned with BCC Competencies<br>Focused on Standards of Professional Practices<br>Establishing Professional Identify and Authority |
| Supervision | Traditional CPE Model<br>CPE Supervisor as Primary Instructor<br>Learning That Is Personal<br>Defined by Supervisor/Student Alliance<br>Theory in Use vs. Espoused Theory (Argyris)<br>Thinking Reflectively | Multiple Teacher Model/Content Experts<br>CPE Supervisor as Coordinator<br>Supervision in the Healthcare Context<br>Use of Clinical Educators<br>Facilitation of the Use of Available Resources<br>Learning as a Collaborative Effort<br>Intentional Use of Theory<br>Thinking Critically and Creatively |
| Teaching/ Theory/ Content | Introduction to Critical Content<br>Pastoral Care Theory<br>Claiming a Theory: Theology and Personality<br>Use of Verbatims<br>Group Process: Personal and Peer Functioning<br>Leadership Theory<br>Bio-Medical Ethics: History and Theory<br>Care of the Dying<br>Videotaping<br>Social and Cultural Factors in Pastoral Care Relationship<br>Bringing Resources to Seminars | Content Driven by Clinical Context<br>Disease and Disease Processes<br>Assessment/Intervention<br>Comprehensive Case Studies<br>Case Study Method<br>Regular Participation in Rounds<br>Assume an Administrative Task<br>Organizational Theory<br>Ethics Committee/Grand Rounds<br>Death and Bereavement Studies<br>Complicated Grief<br>Social and Cultural Factors Impacting Delivery of Healthcare<br>Bringing Students to Significant Educational<br>Events |

| Curriculum Framework | Year 1 | Year 2 |
|---|---|---|
| Service/ Clinical Practice | Participation in Meaningful Ministry<br>Focus on Caring for the Individual<br>Genuineness and Empathic Listening Paradigm<br>All CPE Programs<br>Person-Centered Care | Demonstrating Competence of Meaningful Ministry<br>Focus on Caring for the Organization<br>Assessment/Intervention/Outcome Paradigm<br>Caring for Groups/Compassion Fatigue<br>Leadership Opportunity<br>CPE Programs Accredited for Healthcare Chaplaincy<br>Patient-Centered Care |
| Scientific Inquiry/ Research | Engage Curiosity<br>Introduction to Research Basics<br>Research Resources: Databases<br>Developing Literature Reviews<br>Introduction to Performance Improvement | Commitment to the Scientific Method<br>Participation in Inter-Professional Journal Clubs<br>Participation in a Research Activity<br>Develop a Single Case Research Study<br>Participation in Improvement Initiative<br>Focus on Evidence-Based Practice |

*Year 1*

The first year's focus in this model corresponds to the current outcomes of CPE, namely, formation, reflection, and competence following the standard introduction to clinical practice. Learning that is purposeful and informed involves both environment and outcome. Responsibility to establish an environment whereby the student can achieve the learning outcomes begins with the educator, who in this context is the CPE supervisor. The emergence and development of CPE has focused on the supervisor as the guide to help the learner achieve his/her own purposes. The supervisor is the catalyst in the learning process and is responsible for creating an environment that facilitates learning. This requires sufficient space for students to explore new opportunities and to identify and test previously held assumptions about ministry, as well as their ability to "practice" what they "espouse" about it. The supervisor will need to promote an environment where differences are respected and failures tolerated. While the supervisor defines the structure in which learning occurs, considerable content emerges from the needs and purposes of the learners.

The early founders of the CPE movement focused more on the medium than the message, more on the process of learning than the content of the lesson. The teaching component of supervisory practice is critical if students are going to learn the theory needed to maintain a rigorous action-reflection model that integrates new learning into current theories of operation. Here, learning is content-driven and students are exposed to what will later need to be mastered. The third component of this learning model involves clinical practice. Experiential learning occurs through active involvement in a clinical context. The clinical setting, as the locus for students to encounter physical and existential suffering, is the core of the profession. Living human documents, patients and families, are both the recipients of care and the subjects from whom we learn. The clinical context provides the setting in which students test their professional identity, struggle with personal and professional authority, and explore their place within a professional community.

What about the fourth component—research—in the first year? This is where Dewey once again becomes relevant. Here, students would pay intentional attention to the scientific method. The role of the supervisor is to promote a posture of curiosity. Why didn't something work, or why did it work? If I offered an intervention that worked for one patient, why didn't it work for another patient? Students would also be introduced to basic research language.

*Year 2*

Progressing to year two comes with the student's commitment to embrace the richness of the environment (the clinical context) in order to achieve the learning outcomes associated with certification. As such, the role of the supervisor or teacher changes dramatically. While the supervisor would be responsible for the curriculum, the clinical context would be the locus of instruction. Shadowing, observation, peer evaluation, and reflection would replace verbatims. Case studies would be comprehensive reviews that incorporate not only the immediate crisis but a detailed study of the illness and its impact on the patients and significant others. Supervision in the second year would include program oversight by a certified CPE educator within a multiple teacher model. The experts would come from within the healthcare field, and chaplain trainees would learn in an inter-professional setting along with other healthcare students. CPE supervisors would

collaborate with certified chaplains who would provide direct mentoring in the clinical setting.

In this model, clinical service and practice would shift from caring for the individual to learning how to care for the organizations where chaplains work. This would enable learners to embrace opportunities to practice group leadership skills.

Finally, there would be more active and engaged participation in research activities. Students would demonstrate research literacy and have the opportunity to move toward research participation. Students would learn some basic application of research methods as well as research vocabulary to enhance their consumption of relevant literature. Participation in activities such as inter-professional journal clubs would enable chaplain trainees to explore opportunities for collaborative process improvement, research, or the exploration of best practices.

Clearly there are challenges to this model. Adding another level of accreditation to ACPE programs that wish to train healthcare chaplains will require compromises in order to establish a standardized curriculum through a joint effort among groups such as the ACPE and the Association of Professional Chaplains. Getting students "to the job" will take longer. This might provide an opportunity to re-evaluate the need for three versus two years of theological education. Perhaps the entire clinical training could collapse into an intensive eighteen months, if all eighteen months were completed in a chaplaincy-track accredited program.

## CONCLUSION

The CPE movement was a reform in theological education that moved the normative perspective from deontology to teleology. While there is considerable consensus that learning in CPE is transferrable, the contextual aspects of what needs to be learned and delivered require continued attention. While learning how to learn is an art to be developed, knowledge that is contextually relevant is essential. Learning about healthcare, the culture of healthcare organizations, disease processes, and the emotional impact of diseases on the human spirit is critical. The ethical reformation lies before us.

**NOTES**

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