"A call for some coordinated effort by APC and ACPE:" A Response to Tartaglia's Proposal on Chaplaincy Education

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Because I was a chaplain/CPE supervisor in a small psychiatric hospital for the first ten years of my career, I supervised only summer intensive and extended introductory units of clinical pastoral education (CPE). At the end of those ten years, I transitioned to a large medical center with a CPE residency program. I was certain that as an Association for Clinical Pastoral Education, Inc. (ACPE) supervisor I should offer different and distinct experiences to the residents depending on their learning needs.

For those seminary students who were participating in a summer intensive program, CPE was part of their theological education. Much more attention was paid to the difference between systematic theology and clinical theology and to pastoral identity formation. For those community clergy or lay people who participated in an extended introductory unit of CPE, it was more of a continuing education experience. Pastors often used the twenty-

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six-week unit for consultation around parish issues; lay people would test out scriptural stories and conversational styles. Both groups gained new understanding of their personhood.

When I arrived at the Carolinas Medical Center and began to supervise CPE residents, professional development and identity formation were emphasized as well as pastoral identity as a member of an interdisciplinary team. My responsibility was to prepare students to be clinically proficient professional chaplains for the marketplace. I believed that I was to prepare students to be certified by the Association of Professional Chaplains (APC). Since I functioned within a medical center, I was certified by both ACPE and APC. I was amazed several years later to learn that although they functioned within a medical institution and supervised residents, other ACPE supervisors did not think of themselves as being professional chaplains. Even though they supervised CPE residents within a medical institution, they believed that they only did theological education. They stated that they did not train chaplains.

In his article, Dr. Tartaglia suggests that the CPE experience is theological education and also very much a professional training educational modality. I wholeheartedly agree with him. Tartaglia postulates that "CPE emerged as a reformation movement within theological education" and that now another reformation movement is needed. I also concur with him on this point. I have had the honor and privilege to serve as president of both APC (2011-2013) and ACPE (currently). In both organizations, I have participated in conversations about being "relevant" in today's world. While both organizations have their individual missions and tasks they must perform, each understands the need to keep their "eyes on the prize" of being relevant. Both groups have recently reviewed their internal processes and governance structures. Since I have been a part of these conversations, I agree that it needed to be done. Yet it may be only the first step in remaining relevant. The second and third steps may push us outside our comfort zones.

The author suggests—and I fear—that both APC and ACPE have become too narrow in their mission and limited in their approach to the education and training requirements needed for healthcare chaplains in the future. The impact of the Affordable Health Care Act and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Act on medical centers where many APC chaplains are employed and ACPE centers are located has created intense uncertainty within our profession. I have concerns for the future of all professional chaplains and educational sites

because of these new realities. Responding to these challenges is going to take some coordinated effort by APC and ACPE. Tartaglia lays out some suggested steps that would move both APC and ACPE in a direction that he thinks would bring sustainability to both organizations. It is this vision that I would like to address in the rest of my response.

I was interested to read Tartaglia's discussion of the restructuring of medical education in 1910 toward "evidence-based practice." Medical education moved to a scientific basis and research became a valued platform for growing the profession's successful outcomes. Meanwhile, as Tartaglia points out, CPE and healthcare chaplaincy (and, I would add, seminaries) continued to invest in "professional formation and educational methodologies." One hundred years later, APC is facing not only the question of how to make certification more robust but also a more insidious assault on the profession—the proliferation of seminaries abandoning the 90-hour Master of Divinity (MDiv) for a 72-hour degree program, with some seminaries even offering a 60-hour MDiv. This included seminaries beginning to offer MDiv degrees in chaplaincy with no clinical experience beyond shadowing a chaplain required. CPE was not even on these seminaries' radar.

Both APC and ACPE are concerned about this educational shift, and both have struggled to find the best way to counteract it. APC dropped its requirement of a 90-hour MDiv to the 72-hour level. At the same time, many ACPE-accredited centers dropped their curriculum requirements from a four-unit residency to a three-unit residency, which means they lost at least 100 curriculum hours of educational offerings (this is the case at the center where I practice).

If this slide in professional development continues, both APC and ACPE—who offer what I believe is a quality product—may find themselves becoming irrelevant in the marketplace, much like the handheld devices marketed by Blackberry became irrelevant after Apple introduced the iPhone. Both of these older, more established organizations are being challenged by younger professional organizations who state that they can both educate and certify professional chaplains. How APC and ACPE engage these groups that have less stringent requirements will determine our futures.

I am encouraged by the steps laid out by Tartaglia in his sections entitled "Future Steps" and "Recommendations for Training." I believe he is offering a vision that is worthy of careful exploration by APC and ACPE. He shares what he has been able to accomplish at the Department of Patient

Counseling at Virginia Commonwealth University. This is certainly encouraging. I wonder how this might be replicated within a seminary. If conversations were to begin among APC, ACPE, and others, I wonder who should be involved. Should it be various state governmental structures, the United States Department of Education (USDOE), denominational structures or endorsers, seminaries, the Joint Commission, and/or Medicare (CMS)?

Acute care/teaching hospitals are eligible for Medicare Part B's Nursing and Allied Health Education reimbursement by virtue of providing essential education to nursing and allied health professionals on their campuses. ACPE-accredited centers within these institutions are eligible to receive that reimbursement due to their recognition by CMS and the USDOE. Since 2003, CMS has reimbursed the training of CPE students/residents who are taking four units of CPE because of their interest in chaplaincy and spiritual care. CMS set this four-unit limit (or cap) on reimbursement because APC requires only four units of CPE to become board eligible and to enter into the profession of chaplaincy. The limitation imposed by CMS puts the onus on APC and ACPE to work collaboratively for more outcome-oriented training modules and to move away from a one-size-fits-all mentality. It may be time for a substantive conversation within ACPE as to what a year-long residency offers. Are there no differences between a summer intensive unit, an extended unit, and a residency unit? Alternatively, is the residency that is done within an acute care/teaching hospital designed with an educational focus that takes into account APC's required competencies for board certification?

Finally, I think we are research-starved. The type of research suggested by Tartaglia would assist in building best practices. Research, both qualitative and quantitative, would assist chaplains in proving what we claim—that we have a positive impact on patient lengths of stay, patient satisfaction, and quality of life at the end of life. We chaplains love to tell the story, but some measurements would help shore up our reality. We need to be educating in the areas of biomedical ethics, conflict resolution, end-of-life conversations, and research literacy; many now are doing so. We also need to be better integrating the APC Standards of Practice into our curricula. Tartaglia suggests increasing the training to 18 to 24 months. I believe that 24 months is a more realistic timeframe in a modern healthcare setting.

I appreciate the call by Tartaglia for those of us who are certified by APC and ACPE to move from the warm cozy spot that Russell Dicks described in 1939. Most certainly, those of us who are leaders in APC and

ACPE need to heed his call. Dicks was a visionary then, and Tartaglia is today. I give the article by Dicks to my students and ask them to guess what year it was published. Many think it was published in the 1990s, some in the 2000s, but none in 1939. We (APC and ACPE) need to continue to up our game and follow Tartaglia into a practice that is designed to meet the criteria needed in 2015 and beyond.