Staff Chaplains as Educators
The Clinical Pastoral Education Program
at Virginia Commonwealth University

Alexander Tartaglia • Paula Ropelewski • Nancy Hauser • et al*

One department's evolutionary experience in the use of staff chaplains as educators in Clinical Pastoral Education is described. A comprehensive view of the dynamics inherent in this model also identifies its benefits and limitations. Input from ACPE supervisors, staff chaplains (clinical faculty), and CPE residents is included. Authors maintain that collaboration between supervisors and staff chaplains can enhance the learning experience of residents and contribute to an environment that promotes continual learning and challenges to supervisors and staff chaplains alike. They conclude that this model retains a healthy balance between education and service.

The program of pastoral care at Virginia Commonwealth University, which also encompasses Clinical Pastoral Education (CPE) is complex and somewhat unusual both structurally and educationally. Our department, the Program in Patient Counseling, is an academic unit within the School of Allied Health Professionals. Presently we have eight full-time faculty: three CPE supervisors, one of whom is also department chair and five clinical faculty/staff chaplains. A fourth CPE supervisor is a part-time staff member. Funding for these positions is supported through a combination of health system and university resources. The university provides educational space and academic resources. The health system authority provides clinical space and support. One position is grant-funded. In addition, the hospital funds seven stipended resident positions. All faculty and residents together serve as the health system's Department of Pastoral Care. In that context, clinical faculty and residents provide the majority of direct patient care. Formal education of residents and interns remains primarily within the scope of responsibility of supervisors. The academic chair also provides administrative oversight, serving as the director of pastoral care. This arrangement is formalized through a clinical, educational, research, and service agreement.

*See Authors' Note at end of article. Alexander Tartaglia, M. Div., BCC, ACPE Supervisor, is Associate Professor and Chair, Program in Patient Counseling at Virginia Commonwealth University and Director of Pastoral Care for the VCU Health System, Richmond, VA; Paula Ropelewski and Nancy Hauser are CPE Residents. Correspondence may be directed to Alexander Tartaglia, Box 980664, Richmond, VA 23298-0664; <atartagl@hsu.vcu.edu>
Within the university, the Program in Patient Counseling offers an Intern Certificate, a Graduate Certificate, and a Master of Science degree. The Intern Certificate program parallels the initial unit of CPE and teaches to Level I outcomes. The Graduate Certificate program parallels a three-unit CPE residency year and is focused on the outcomes of Level II CPE. Students in the M.S. program select either a chaplaincy certification/specialization track or a CPE supervision track. This degree teaches to the outcomes appropriate for the student's individual track. Clinical assignments are made within the Virginia Commonwealth University Health System (VCUHS). The CPE programs are accredited by the Association for Clinical Pastoral Education, Inc. (ACPE). Accreditation is held jointly by the university and the health system.

The Department of Pastoral Care provides 24-hour/7-day working coverage. Most chaplains work the day shift Monday through Friday. Two chaplains, one a clinical faculty member and one a rotating resident, work the evening shift. One chaplain, a clinical faculty member, works the night shift. Residents, in rotating 12-hour shifts, cover weekend and holiday hours. In addition, we have a defined backup system with residents serving as primary and faculty providing secondary backup. While they maintain designated clinical unit assignments, our use of CPE interns after hours is limited. All full-unit interns are required to complete eight 12-hour shifts. During the initial four shifts they are paired with either a faculty member or a resident. At that point, they are evaluated according to a clinical and knowledge-of-environment checklist. Once they have passed the checklist, interns are assigned to the remaining four 12-hour shifts in dyads with back-up coverage. On average, we have ten interns each summer and eight in each of the fall and spring academic semesters.

Faculty and residents share pastoral care coverage of the hospitals and clinics. Two of the clinical faculty serve in pediatrics. One is the primary chaplain for pediatrics, working predominantly in the intensive care inpatient arena. The second is dedicated to serving pediatric hematology/oncology patients primarily in the clinics. The fifth full-time clinical faculty member serves as the coordinator and team leader of our organ donation protocol providing concentrated pastoral services to families of neurologically devastated patients. One of the CPE supervisors serves two mornings per week as the chaplain to an off-campus ambulatory site. The other supervisors provide pastoral care on an as needed basis. Clinical faculty, residents, and interns have defined clinical responsibilities either established by clinical service or shift. Supervisors do not.

In addition, the department provides considerable leadership in the health system. We provide primary staff support for the health system's bereavement program. Departmental members are either chair or co-chair of the Ethics Committee, the Patient Rights and Organizational Ethics Committee, the Organ Donation Committee, and the Decedent Affairs Committee.

Historical use

It strikes us that, when viewed historically, the use of clinical faculty as educators with residents is a rather recent phenomenon. Nonetheless, we have some well-established practices that were consistently identified by supervisors, clinical faculty, and residents.

CPE has been present at the Medical College of Virginia since the late 1950s; the residency program was introduced soon after. For much of the his-

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Virginia Commonwealth University (VCU) is an urban research university with two campuses approximately three miles apart. The west campus houses the majority of undergraduate programs as well as graduate schools of social work, engineering, humanities, and the life sciences. The east campus houses the schools of medicine, nursing, allied health, pharmacy, and dentistry. It is also the location of the Virginia Commonwealth University Health System's Medical College of Virginia Hospitals and Physicians (VCUHS), a 741-bed teaching hospital and related specialty clinics. The health system serves as the major trauma and referral center for central Virginia and provides medical care for over 30 percent of the state's indigent patients.
tery of the department, there has been a clear delineation between academic and clinical responsibility. The faculty (CPE supervisors) focused on education, while residents and interns performed clinical service.

Staff chaplains have been present since 1985 when the first pediatric oncology chaplain was hired. In 1990, a second chaplain was hired. It wasn’t until 1993 that both were integrated into the department as clinical faculty. Until that time they worked rather independently of the education program. A third clinical faculty member was added in 1997 and two more in 1999. The intentional use of clinical faculty in the educational mission of our residents has evolved as the department has grown.

- Clinical faculty are always included in the interview process with prospective residents. Intentionally, their focus is to help assess pastoral competence and to identify personal characteristics appropriate for success in a high stress clinical environment.

- Clinical faculty are widely used during orientation for new residents and interns. Their knowledge of the clinical setting as well as organizational protocols involving chaplains is a critical asset for both supervisors and CPE students. They remain available to residents as resources, providing information on the clinical environment throughout the program.

- Each clinical faculty member brings to the department proficiency related either to a clinical specialty or a theoretical expertise. As such, supervisors make regular use of clinical faculty for didactic presentations. Periodically, they are invited to join clinical seminars when residents present case material related to a specialty area.

- One of our clinical faculty teaches two semester-long academic courses for residents, one in clinical ethics and the other in professional ethics.

- Clinical faculty regularly serve as mentors for residents who are completing required projects. For example, clinical faculty are presently serving as mentors for residents specializing in trauma care and pediatrics. Two others are sharing mentorship of a resident who is facilitating the development of a new Interfaith Committee for the health system.

Viewed historically, clinical faculty were added to a department comprised predominantly of residents. We remain curious about the dynamics of other departments that have added CPE to a staff chaplain model. One interesting aspect of this is that the addition of clinical faculty was the direct result of the positive contribution of residents over the years. Quality resident care helped sell the value of pastoral services and the need for continuity of presence to hospital staff. On the other hand, the advent of clinical faculty impacted the CPE program by elevating the level of competence demanded by the clinical environment. It was this phenomenon that contributed to the decision to limit after-hours responsibility for interns.

**Surveys**

Evaluation of the use of clinical faculty in designed ways always has been a part of our program evaluation process. We began devoting more attention to the relationships in preparation for our recent ACPE site visit. Thus, the faculty eagerly voted to participate in the development of this article in collaboration with the residents who willingly agreed. The primary authors developed separate surveys for all three groups to prompt reflection and facilitate participation. Participants were free to focus on particular elements of the survey and to make additional comments as necessary. Two residents elected to focus on development of this article as their summer project for our class in pastoral care management and leadership. Three full-time supervisors, five clinical chaplains, and eight residents (two of whom recently graduated from the program) completed surveys. Shared primary authorship was offered to anyone who elected to write a significant portion. It was understood that everyone who participated would be acknowledged as a contributor to the article.

**Survey content**

The intentional use of clinical faculty in the training of residents, described in the previous section, was consistently identi-
fied in the survey results. The CPE residents who participated in the survey readily indicated that they received valuable clinical education and support from the clinical faculty at the VCUHS. These faculty members provide orientation to hospital units and protocols, offer mentorship for learning projects, and give guidance and consultation on pastoral care issues. The surveys identified additional dimensions of clinical faculty involvement in the education of residents:

- Residents are able to observe professional pastoral caregivers active in the clinical environment to which they can compare and contrast their clinical skills.
- Clinical faculty serve as spiritual role models. In particular, it was noted that the residents were able to witness first hand how these chaplains live out their faith through their work in the hospital.
- Clinical faculty are experienced as key members of the support system for the residents. It was repeatedly noted that their availability for debriefing and problem solving in difficult, critical incidents was invaluable.
- Residents identified the willingness of clinical faculty to share experience, theoretical understanding, and professional resources informally as a very important component in the education of the residents.
- Residents reported that they appreciated and enjoyed a spirit of collegiality with clinical faculty.
- Residents thought that because the clinical faculty were in the field, they could help with integrating the chaplain's position into the health care team and building interdisciplinary relationships, especially with physicians. This stands in contrast to the supervisors, whom the residents tend to see as the providers of the theory and technical skills of pastoral care.
- Residents appreciated the presence of clinical faculty in seminars, especially when they made themselves vulnerable by presenting their own clinical material.

The clinical faculty reported a similar list of contributions to the education of the CPE residents. It is of significance to this investigation that both groups saw the role of clinical faculty in much the same light. There were some noted differences however.

- Clinical faculty indicated a personal goal to provide more didactic experiences for the students. They felt that residents could indeed benefit from more theoretical and practical expertise in their areas of specialization. Time constraints and demanding workloads were identified as deterrents to accomplishing this goal.
- Clinical faculty noted that association with the education of residents has significantly enhanced their ministry skills as educators and mentors. As such, they have expanded their professional identity to include those dimensions. They expressed interest in furthering these skills through more formal teaching opportunities.
- Concerning their relationships with the CPE supervisors, clinical faculty concurred that the educational program would significantly benefit from more involvement of the supervisors in the clinical setting.

There were similar responses concerning the role of clinical faculty in the observations made by supervisors. The supervisors see these faculty members as mentors, valuable assistants to the debriefing process, and providers of clinical expertise and resources for specialized ministry. Theirs is a role that is complementary, collaborative, and supportive of the supervisors who offer technical theory and facilitate integration of personal and professional identity and functioning.

- In the opinion of the supervisors, clinical faculty provide a realistic glimpse of what it is like to be a chaplain in the health care system. They name the skills necessary for success in health care ministry. They become sounding boards for vocational discernment. They model styles of interdisciplinary functioning.

There are a few differing expectations of clinical faculty identified by supervisors:

- Clinical faculty explain their role as mentors, providers of clinical expertise and re-
sources, and assistants to any debriefing process. However, supervisors view the role of clinical faculty in an even more expansive way—as catalysts for resident growth, specifically around personal growing edges. This is particularly evident when clinical faculty are open with residents about their own vulnerabilities.

- Supervisors look to clinical faculty to model styles of leadership and to demonstrate creative opportunities for understanding the breadth and depth of pastoral care.

**Primary limitations and benefits**

Unclear role expectations and communication problems appear to contribute to the limitations noted by each group of participants. We have noted those most often identified.

- When supervisors and clinical faculty have different philosophies on student learning or standards of pastoral care, residents can get caught in the middle. Residents often utilize both sets of faculty for feedback and can feel conflicted when differing opinions on the resolution of clinical issues are received. The impact on education can be confusion, immobility, or taking the easier, and often more secure, path.

- Supervisory interventions with residents are not always within the purview of clinical faculty. Gaps in communication or respect for student privacy sometimes leave clinical faculty unaware of resident growing edges and the applicability of supervisory feedback on pastoral functioning.

- Mentorship provided by clinical faculty is inconsistent. Workload demands require clinical faculty to prioritize their commitments in favor of ministry to patients, families, and staff. In addition, service responsibilities by clinical faculty vary, with only two clinical faculty assigned to units also serviced by residents.

- Our department experiences tension between supervisors and clinical faculty over supervisors’ attention and participation in the delivery of service. Residents can receive mixed messages regarding priorities and balancing of professional responsibilities.

- At times, residents feel constrained by clinical faculty. Premature interventions by clinical faculty can leave residents feeling undermined, threatening their autonomy and authority. In some areas, staff will bypass residents and go directly to faculty for assistance in problem resolution.

- Tension can exist for residents when they feel overshadowed by clinical faculty. A noted stressor for residents is the burden they place upon themselves to function at the same level of clinical competence as experienced chaplains.

- Within the clinical areas shared by faculty and residents, tension can result from unclear expectations and division of responsibilities.

- Clinical faculty can model poor self-care, creating tension within a resident’s own ability to value self-care. Residents experience a double message when this occurs, learn to care for yourself and place the needs of the organization above your own.

There tends to be, however, a greater degree of benefit experienced when clinical faculty are involved in the resident’s educational journey. In addition to aspects noted previously the following were highlighted.

- Generally, clinical faculty readily affirm the contributions by residents to the delivery of pastoral care service. Residents truly feel that support.

- Clinical faculty tend to be more sensitive to resident stressors displaying an awareness of the emotional impact of providing pastoral care in our environment. They provide the majority of debriefing for residents during stressful and critical events. In addition, they often will advocate for residents with supervisors.

- Clinical faculty offer their expertise as active pastoral care givers to which students are able to compare their own clinical skills.
• The blended model of using clinical faculty and residents contributes to an atmosphere that promotes learning and professional development by all parties.

• As noted in the surveys, the resident experience is enriched by the expertise in specific clinical areas, hospital protocol, and professional behavior modeling provided by clinical faculty. Much clinical insight is imparted through didactic presentations by clinical faculty, providing the opportunity for residents to practice their ministry more effectively.

• Residents are encouraged to see a variety of theological perspectives and methods of applying theology to practice. They also get to witness the application of faith to practice through the shadowing of clinical faculty.

• When supervisors and clinical faculty work well together, residents experience an integrated pastoral care team mutually beneficial to one another with respect and regard for one another’s function in the teaching-learning clinical environment.

• Since clinical faculty have more opportunity to observe residents within the clinical setting, they often provide valuable feedback for supervisors to incorporate into their teaching.

All agree that the collaborative efforts of clinical faculty and residents contribute to a high level of pastoral care from which the patients, their families, and the other hospital staff benefit tremendously. The educational program cannot help but benefit as the students get a firsthand opportunity to see good pastoral care in action and to implement these skills into their own ministry and pastoral identity. Clinical faculty cannot help but benefit from an environment that values learning, encourages risk and experimentation, and seeks to integrate theory and practice in ministry. Supervisors benefit from the challenge of clinical faculty to remain current with a changing health care environment that demands expanded knowledge and skill.

Analysis: themes and insights

Ambivalence

What have we learned? What can we carry forward? What challenges continue to present themselves? In reviewing the contribution of the three components of our program a number of themes stand out.

Peership

The department is faced with power and authority imbalances. It appears that residents seek and expect peership with clinical faculty but not so much with supervisors. Residents want to be treated as equals in the clinical environment. They tend to seek autonomy and want to establish their own authority. However, they can confuse being equal with having the same responsibility or doing the same thing. Curiously, when residents become stressed and the clinical demands are high, their hostility becomes directed at the clinical faculty. This occurs even though the clinical faculty cover the majority of the most critical patient care areas most of the time. Further, residents rarely get angry toward the supervisors who do little clinical coverage. Perhaps it feels safer. Residents are not alone in this. The parallel is that the clinical faculty share some of the same angry feelings toward the supervisors. The supervisors want to make use of clinical faculty effort to support their teaching but do not offer to share a comparable effort toward supporting patient care. Of course, all of this occurs dynamically even though position descriptions clearly delineate responsibilities.
Resident issues even as personal/professional learning issues arise in the clinical setting.

Production versus process

The tension within this theme appears to primarily affect the relationship between clinical faculty and supervisors. Clinical faculty tend to be more focused on work getting done, and supervisors on learning occurring. Supervisors have a tendency to treat failures or mistakes by residents less as problems and more as learning opportunities. Clinical faculty primarily focus on professional competence, whereas supervisors tend to focus foremost on professional identity and development. This tension is endemic to CPE, which by definition is an educational methodology charged with teaching clinical competence. While everyone would agree that these are both/and not either/or issues, the differences in philosophical emphasis do create tensions when it comes to resolving certain pastoral care dilemmas with residents. One clear example of this is a sense of urgency in getting problems addressed that tends to be greater for clinical faculty than for supervisors.

Accountability

To those of us who understand the dynamics associated with the clinical rhombus, tensions around accountability seem even more pressing in a model like ours. Clinical faculty accountability is focused primarily on the delivery of pastoral services and responsiveness to staff in the health care environment. Supervisors’ accountability is focused primarily on the learning goals of students and the use of the clinical environment as a context conducive to resident professional and personal development. Residents often find themselves caught in the middle with shifting priorities, often torn by transitioning from providing clinical service to advocating for their own learning and the reflective time required to attend to it. Turning off all pagers during seminars has helped, but not eliminated, this dilemma. The program chair is charged with facilitating an environment with a creativity that promotes the “both/and” tension. Having dual lines of administrative accountability, the university and the health system, complicates this.

Communication

Our inquiry once again highlighted the fact that the successful incorporation of clinical faculty in the education of CPE residents is clear and consistent communication around expectations, roles, and boundaries. Gaps in communication create confusion, misunderstanding, and mistrust that jeopardize a positive learning environment. Communication between supervisors and clinical faculty helps preserve resident honesty and integrity in facing tough issues. The same communication offers residents a more comprehensive approach to resolving clinical dilemmas.

Postlude

Having summarized our collective thoughts and insights, did we still want to share them? Did we want to risk exposing our vulnerabilities and growing edges? After some discussion, we concluded that the answer had to be yes. Our commitment to process really drove us. Will our use of clinical faculty in the educational process continue to evolve? This exercise has reinforced our commitment to make it so. The expectations for clinical competence in our environment demand it. Residents and future employers as consumers of our education programs will insist on it. Our hope is that this exercise will continue to focus and energize our department to improve what we have started and to seek new ways to utilize our composite expertise in educating CPE residents.

Authors’ note

The following also contributed to this article: Faculty of Virginia Commonwealth University – Jim Bonomo, M.Div., Instructor and Chaplain; Maryne Cain, Th.M., Assistant Professor and ACPE Supervisor; Ann Charles-Craft, M.Ed., M.Div., Instructor and Chaplain; Ken Faulkner, M.Div., M.A., Assistant Professor and Chaplain; Stephanie Hamilton, M.Div., Instructor and Chaplain; Alma Hassell, M.Div., Instructor and Chaplain; Robert A. Young, Jr., D.Min., Associate Professor and Assistant Chair, ACPE Supervisor; CPE Residents at VCU Health System – Roxanne Cherry, M.P.S., Stephen Coleman, M.Div., Tim Ford, M.A., Jennifer Steele, M.Div., and former CPE Residents Link Elmore M.Div., M.S. and Bambi Willis, M.T.S.
VUCHS Survey – Guidelines for Reflection

Supervisors
1. How do you use staff chaplains in your supervision?
2. What are expectations for the use of staff chaplains in the training of residents?
3. What are the assets and liabilities of using staff chaplains for chaplaincy training?
4. What are the specific benefits to the education of the residents?
5. How would you rate the overall delivery of pastoral care using both staff chaplains and chaplain residents vs. using one or the other?

Staff Chaplains
1. What academic assistance do you provide to the residents?
2. What clinical support do you provide to the residents?
3. What limits the overall effectiveness of your ministry while you are supporting the residents?
4. What strengths do you find in your own ministry by supporting the residents?
5. What are your particular concerns in working with the residents?
6. What model of didactic/clinical training do you incorporate in working with the residents?
7. What model of didactic/clinical training would you like to see incorporated in the learning of residents?
8. How would you describe the collaboration between yourself and the supervisors?
9. Is there anything else you would like to add to this inquiry?

Chaplain Residents
1. Do you receive academic and clinical support from staff chaplains? Yes__ No__
2. What academic and clinical support do you receive?
3. How has your ministry been strengthened through the support of staff chaplains?
4. How has your ministry been limited by the support of staff chaplains?
5. What model of didactic/clinical training would you like to see incorporated for use by staff chaplains to support your learning experience?
6. What has been the most profound contribution by a staff chaplain to your residency?
7. What growing edges do you see in the relationship of staff chaplains and chaplain residents?
8. Comment on your views concerning the contribution of the collaboration of the staff chaplains and supervisors to your education.