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In a Secular Spirit: Strategies of Clinical Pastoral Education

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Abstract. The Clinical Pastoral Education (CPE) model for the provision of spiritual care represents the emergence of a secularized professional practice from a religiously-based theological practice of chaplaincy. The transformation of hospital chaplaincy into "spiritual care services" is one means by which religious healthcare ministry negotiates modernity, in the particular forms of the secular realm of biomedicine and the pluralism of the contemporary United States healthcare marketplace. "Spiritual" is a label strategically deployed to extend the realm of relevance to any patient's "belief system," regardless of his or her religious affiliation. "Theological" language is recast as a tool for conceptualizing the "spiritual lens." Such moves transform chaplaincy from a peripheral service, applicable only to the few "religious" patients, into an integral element of patient care for all. Such a secularized professional practice is necessary to demonstrate the relevance and utility of spiritual care for all hospital patients in an era of cost-containment priorities and managed care economics.

Key words: chaplaincy, professionalization, professional ethics, religious pluralism, secularization, theology

Introduction

In this article, I argue that Clinical Pastoral Education (CPE), a training model for the provision of spiritual care in medical centers, represents the emergence of a secularized professional practice from a more religiously-based theological practice of chaplaincy. Further, I argue that the transformation of hospital chaplaincy into "spiritual care services" is one means by which religious healthcare ministry negotiates the secular realm of biomedicine and the pluralism of the contemporary United States healthcare marketplace. "Spiritual" is a label strategically deployed to extend the realm of relevance to any patient's "belief system," regardless of his or her religious affiliation (or lack thereof). "Theological" language is recast as a tool useful here for conceptualizing the "spiritual lens," itself similar to the psycho-social formulations of social work. These moves transform chaplaincy from a peripheral service, applicable only to the few "religious" patients, into an integral

element of patient care for all. In an era of constrained healthcare resources, US hospitals have been severely affected by the cost-containment priorities of managed care economics (Enthoven and Singer, 1996; Shortell et al., 1994). Consequently, a secularized professional practice is necessary to demonstrate the relevance and utility of spiritual care for all hospital patients, rather than restricting their applicability to explicitly religious patients.

Amidst the increase in biomedical knowledge and the accompanying advances of medical technology in the 20th century, one might well question the place of religion and spirituality in medical centers and the care of patients. Fundamental to the argument advanced in this article is a recognition of the history of the hospital-as-social institution that evolved from houses of Christian charity of early Byzantium, only assuming its identity as the "medical center" in the recent past.

> Until the late Middle Ages, religious personnel remained in leadership positions, staging ceremonies and participating in care giving. Spiritual care remained in the hands of priests, while physical nurturing became mostly the responsibility of religious and lay women because of the perceived domestic roots of these tasks. A medical presence in hospitals occurred only gradually, from consultants to salaried staff members during the Renaissance. (Risse, 1999, p. 7)[1]

The hospital began as a "house of God" – it is not spiritual concerns that are the new development there, but rather science and biomedicine. As Foucault demonstrated, in the West the birth of the clinic is rooted in the transforming power of sign and symptom and the accompanying conceptions of the individual and social body that made possible increasingly effective medical intervention (Foucault, 1973).[2] Only after the eighteenth century could hospitals become the "houses of Science" we know today as tertiary care medical centers.

Christian women expanded their healthcare ministry to the New World, following the waves of European migrants. As first settlements then cities sprang up, Christian hospices, clinics and later hospitals were established to serve the sick and the poor (Risse, 1999, p. 339).

In 1994, City Physicians Hospital,[3] a secular community-based non-profit facility in Northern California, was driven by the economic pressures of managed care to become part of a large, religiously-sponsored hospital management system (Robinson, 1996). While retaining some autonomy and its identity as a secular community hospital, City Physicians began operating in conversation with its counterparts in that system throughout the state. One of those institutional siblings was Incarnation Hospital, one of the earliest religiously-sponsored facilities in California dating back to the gold rush, operating only a few miles from City Physicians Hospital. As a Catholic

hospital, Incarnation has had Catholic chaplains as part of the hospital staff for many years and is considered a leader in chaplaincy training. At City Physicians, on the other hand, local clergy had visited patients as needed but the hospital has no tradition of chaplains on staff. In 1998 the CPE program at Incarnation was expanded to include City Physicians Hospital. This article emerges as part of a sustained ethnographic engagement with this hospital system.

Pastoral Care and Clinical Settings

The history of pastoral theology as an applied discipline follows the changing demographics and consequent sociopolitical developments of the US at the turn of the century that challenged the early understanding of "a Puritan nation founded on Christian [Protestant] principles" (Hemenway, 1996). The new professionalization of law and medicine helped to elicit concerns in the 1920s about what skills beyond liturgical practice were imparted in divinity schools that would equip ministers for their work with the faithful. As the fields of psychology and psychoanalysis bloomed in the US, ministers and seminarians embraced personality theorists like Erikson, Freud, and Murray (Capps, 1979). Pastoral psychology then joined with pastoral theology as the fundamental elements of pastoral care.

Clinical Pastoral Education is understood here as a form of theological education that takes place not exclusively in academic classrooms, but also in clinical settings where ministry is being practiced and theological knowledge of the human condition is applied to people in need. From some perspectives, the history of CPE is almost entirely a history of professional identities and associations (Hemenway, 1996).[4]

Religion, Chaplaincy and Spirituality in Hospitals

Throughout history, people have turned to religion to understand birth, death and the range of human experiences encompassed by illness and disease. Religious leaders have endeavored to provide meaning and a sense of order to these sites of critical concern, often contributing in ways beyond the limits of science and medicine. Religiously-sponsored medical facilities carry on that legacy and explicitly seek to meld the needs of the body with the needs of the spirit, or the soul, as their particular traditions inform them.

Hospitals and other healthcare organizations in the United States are subject to the standards of operation determined by the US Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Until the 1980s, the idea of "spiritual counseling" was only mentioned in standards of programs specializing in behavioral health care. Changes in 1987 moved

several such behavioral health care standards into hospital accreditation manuals in order to include psychiatric hospitals under the rubrics of general hospital accreditation.[5] In the last decade, the quality assurance movement helped shift the evaluation criteria from clinical pathway-specific applications (for example, cardiac care criteria as distinct from intensive care unit criteria) to more general categories of performance competency (for example, health outcomes) that could be understood and compared across departments. JCAHO restructured its standards to reflect this new focus on function and created comparative criteria like assessment, care, education, and performance improvement.

In conjunction with these changes, JCAHO developed standards for patient rights and organizational ethics in consultation with various bioethics organizations. The effect of this consultation is evident in the 1993 hospital manual that incorporates one specific standard from behavioral health: "the patient's right to spiritual counseling." But in 1995, "several pastoral-care-provider organizations" brought to JCAHO's attention that spiritual counseling was "too limited relative to what was being provided to patients in all hospitals. So the language was modified to focus on the patient's right to pastoral care and services – only one of these services being 'counseling.' " In late 1998, JCAHO adopted standards for spiritual care that were recently included in accreditation requirements for all hospitals. Though the new standards were articulated in terms of patients' rights, these accreditation requirements also serve to legitimize the need for providers of spiritual care to be actively involved in patient care – significantly, hospitals would now be evaluated on this resource – if they are to receive full accreditation.

CPE training is considered a form of graduate medical education under federal Medicare legislation. Consequently, hospitals and other medical facilities operating a certified CPE training program are eligible for financial reimbursements from Medicare funds.[7] The staff associated with CPE training programs, and the students receiving that training, provide spiritual care services that fulfill JCAHO standards. Thus a fully operational CPE program can be mutually advantageous, providing patient care, a revenue center for the facility, and a vehicle for clinical pastoral care experience for ministers needing that training.

Analysis

Clinical Pastoral Education is 'interfaith professional education for ministry.' It brings theological students and ministers into supervised encounters with persons in crisis. Within the interdisciplinary team process of helping patients, they develop skills in interpersonal and inter-professional relationships.[8]

There are two simultaneous agendas in operation within CPE: making spiritual care available to patients and improving the ability of theological students and clergy to minister in general. These agendas are complementary but not identical. The best spiritual care would arguably be provided by seasoned chaplains, rather than chaplains in training. In this way, spiritual care as a service to patients resembles graduate medical and nursing education: most hospitals serve as medical proving grounds for providers in training.

Language and the Spirituality/Religion Dichotomy

The distinctions between chaplaincy and spiritual care services revolve around the difference between "religion" as a social organization of belief and practice within a particular faith community (e.g., Roman Catholic, Methodist) and "spirituality" understood here as the "experiential integration of one's life in terms of one's ultimate values and meaning," without the institutional element connoted by "religion."[9] The differing histories of the two hospitals observed influence how pastoral care is understood and this is reflected in the titles of the respective departments. At the traditionally Catholic hospital, CPE is provided through the Chaplaincy Department, while at the traditionally secular community hospital, the CPE is based in the new department of Spiritual Care Services. This dichotomy may not necessarily hold elsewhere. I draw attention to this correlation here because my observations occurred at the particular moment when pastoral care provision was extended to a new community partner in a religiously-sponsored hospital system. It is also important to note that these hospitals are in California, one of the most secular parts of the US [Gallup, 1989, #633; Gallup, 2000, #718].

On several occasions, the CPE supervisors and their students commented that the term "spiritual care services" reflected the conscious deployment of language terms in an effort to make chaplaincy less threatening in an environment wary of being dominated by their new Catholic partners. One supervisor interpreted the resistance of one pharmacist to spiritual care:

> His was a very strong reaction against the whole institution of spiritual care in that *realm*, and I'm *sure* that if we were to sit down and have an honest conversation about it, that that would have to do with his negativity toward his own faith tradition, his, maybe some projections that he had about Catholics, because it's [the large Catholic system]. At the other two hospitals, there's been some anti-Catholic feeling, you know, they didn't want to have the Catholics come in and take over, umm, spiritual care. So it was very important to them that we had an interfaith group of people coming in [to City Physicians Hospital]. You know its

> hard to say we're evangelizing for the Catholic Church if, ah, we come in with a Buddhist, and a Methodist (laughter) and a Metropolitan Church person . . . . Its pretty hard to, you know, recruit for the Catholic Church if you're representing all these other faith traditions.

CPE thus reforms chaplaincy as spiritual care using a language of "spirituality" rather than "religion" in order to defuse the tensions that accompany a denominational, or even religious, identity. CPE is challenged, on the one hand, to reduce denominational markers but also to rely on theological concepts and language to distinguish spiritual care from social work and psychology, two other fields represented on the interdisciplinary patient care team. CPE defines its realm of professional expertise most clearly in its approach to diagnostics of patient need.

Technology of Spiritual Assessment

The professionalism theme is pervasive in the chaplaincy discourse, but is most evident in the structure of the pastoral visit and the technology that has emerged to assess and minister to patients. I will lay out the strategies of CPE to demonstrate that pastoral concepts are applied both to patient care and to the development of the chaplain's professional identity. At these two hospital sites, the central element of chaplaincy technology is the spiritual assessment model which defines the chaplain's task through a summary of the whole person that is the patient. George Fitchett, a Quaker minister and leading authority on pastoral care, understands the interest in spiritual assessment as a natural result of the pressure "to document the contribution which pastoral services makes to patient care" exerted by the national implementation of diagnostic-related group (DRG) Medicare reimbursement strategies in the early eighties (Fitchett, 1993, p. 2). DRG payment systems required every hospital service provided to a patient be tied to a diagnostic category in order to be elegible for Medicare reimbursement; private payors soon followed suit. Fitchett argues that as this approach became the standard, it influenced providers to seek a diagnosis-based means of assessment that would justify pastoral care.

The assessment model used here is oriented toward ascertaining a person's core spiritual needs, which are broken down into three typologies: (1) self-worth, (2) reconciliation, and (3) meaning and direction. An individual may have characteristics of all these needs, but this approach to CPE maintains that the core spiritual need emerges in crisis and renders other character traits secondary concerns.

A person whose core spiritual need is self-worth will often talk about the experience of their illness or injury as an inconvenience to other people (family and friends, even health care providers). Such an individual will often

blame himself; for example, someone with injuries as a result of domestic violence may speak about the behaviors that provoked the abuser to strike out. A chaplain will seek to assist such a patient in recognizing the legitimacy of his own needs and inherent value as a person living in community with others.

A person whose core spiritual need is reconciliation will often attribute the cause of her illness or injury to others – family, co-workers or even "the system." Such an individual is often identified by nurses as the "difficult patient" who may have lashed out during attempts to assist the patient. Chaplains talk about a patient's need to be 'reconciled with self and other,' the family or community. A provider may recall an encounter with a substance abuser on repeated visits to the emergency room who rants about the economy as the source of her trouble and will resist acknowledging her own decisions around drugs or alcohol use. A chaplain would seek to encourage such a patient to recognize her own role in her predicament with an aim to taking steps to enact change and accept assistance from others.

The third typology is reportedly more infrequent relative to the other two core spiritual needs. A person with a core spiritual need for meaning and direction is often unclear about the source of an illness or injury, or how to make sense of it in the context of their particular life circumstances. Even patients who attribute the etiology of their illness to fate or biology (infectious agents) may express confusion or uncertainty about their experience or attempt to interpret implications for their life in general. Chaplains will seek to help such a patient interpret her experience and determine how she might move forward differently based on the meaning she gives to her crisis.

Proceeding from the medical diagnosis, staff comments and personal assumptions, the chaplain uses the framework of core spiritual needs to formulate an initial assessment of a patient as he walks into a patient room. The typologies are presented as a starting point to determine an initial attitude and approach so that chaplains have a starting point for dialogue. One CPE supervisor encourages residents to focus on the process as "mapping a life trajectory." Students starting the CPE program express concerns about what they first perceive as a "cookie-cutter" approach to spiritual care; however, they consequently report finding it a helpful tool that enables them to make the most of interactions constrained by daily patient volumes and limited staffing.

The assessment model is useful, the chaplains maintain, because it is more "holistic" than the biological framework that dominates healthcare, it focuses on patient growth, and it is efficient. By efficient, chaplains mean the model addresses both the drive to standardize spiritual care as a process, and the need to articulate what chaplains provide for patients in a way that can be summarized and communicated to other members of the interdisciplinary care team or

the patient's family. The concept of "holistic" care is an attempt to reference the chaplains' belief that individual persons are more than their physical body or mental processes, but that the uniqueness of an individual also connotes a transcendental element that different faith traditions may consider the spirit or soul. Popular culture, particularly in California, has also adopted the idea of the whole person/holistic care as a marker of the "natural" intervention that often accompanies alternative and complementary medical treatments, as well as wellness lifestyle trends.[10] The development of patient empowerment and medical consumerism that are the flipside of the managed care conversion may also contribute to the cultural backdrop against which CPE has emerged (Adler, 1999).[11] In hospital settings dominated by a biomedical worldview, CPE can represent itself as the holistic treatment of patients as persons; this approach is presented as being both responsive to patient/public demand and a unique attribute of spiritual care services, as opposed to other elements of the interdisciplinary care team.

One CPE supervisor (Elise) promotes the unique perspective that pastoral care provides to patient care when she explains the division of labor in patient care to chaplain residents by drawing a pie chart. Elise argues that providers split the patient into physical and psycho-social elements, each addressed by different healthcare providers. The danger, she explains, is that without aligning CPE as a spiritual care practice, chaplains would only visit patients that other hospital staff had identified as particularly "religious":

> This is the problem. Chaplains," she explains, "get triaged into a tiny slice, the 'spiritual'. Nurses say, 'Oh yeah, this patient's kind of religious, so why don't you go see him, too?' Better to present our role as addressing the needs of the whole person, seen through a different lens. Physicians, nurses see the same patient but each through a different lens.

As she later explained to her interns:

> We are looking with a theological perspective. Why? In this setting, you need to have some theory to describe what you do. Without it you get discounted, and you end up charting with psychological rather than theological language. Without being able to articulate spiritual services, chaplains are relegated to only religious patients, and as an afterthought.

Elise's approach, then, is strategic: CPE casts the chaplain as a partner in holistic patient care, and it explains the difference in the CPE approach without minimizing biomedical perspective. Elise's comment highlights three distinct elements of concern for CPE and spiritual care providers. CPE seeks to articulate the legitimacy of providing spiritual care, its universal relevance to all patients, not just "religious patients," and the unique contributions of a theological perspective that are distinct from psychology. This last

concern has been a focus of considerable attention in the chaplaincy literature. Pastoral care specialists have critiqued the tendency in the 1970s to either ignore diagnosis altogether or only observe a psychological rather than theological diagnosis of a patient's condition (Fitchett, 1993, p. 1). Trainers challenged chaplains to transcend psychological theory and technique to fully integrate "the theological perspective in pastoral care and counseling."

The 'theological' here is explained in chaplaincy literature as concerning the tripartite ethical relationship with one's self, with the other, and with community that is the natural expression of one's existence in God's order. Muldoon and King maintain that in the modern hospital, spirituality increasingly refers broadly to "the experiential integration of one's life in terms of one's ultimate values and meaning" (Muldoon and King, 1995, p. 330). While CPE is defined as an "interfaith professional education for ministry,"[12] both instructors and students speak in the language of their individual faith traditions. For example, in the classroom, the supervisor's language reflects her Protestant background:

> We connect with the patient's inner spirit and bring encouragement. We bring a Witness of Love . . . . We find meaning to life, and taking it beyond . . . to the transcendent. We bring spiritual care. How do you define spiritual care? . . . Spiritual care is bringing the Gospel (good news/God) to the point of the person's needs. The focus on needs brings out the uniqueness of individual patients.

A good deal of CPE instruction addresses the challenge for each student to understand their work in terms of their own denominational experience and particular ministry's training, while balancing how to use neutral language in the care of patients. The emphasis on mobilizing "theological language" reflects the drive for these chaplains-in-training to assume the legitimate authority that comes with the particular expertise of ministry to deal with spiritual concerns. But CPE, at the same time, requires students to use their grounding in a specific faith tradition to address common spiritual needs more generally. Language is a powerful tool here. The authority that is invested in the use of a particular theological lexicon can also undermine a spiritual care provider's efforts to be interfaith, or at least, ecumenical.[13] For example, the label of "reconciliation" for the second core spiritual need of the spiritual assessment model that is used in this program carries a number of associations, depending on one's faith tradition.[14] The Protestant Reformed tradition (Presbyterian and Congregationalist) recognize reconciliation as God's renewing nature and the call to transform the world as responsible human beings: "God was in Christ reconciling the world to himself, no longer holding men's misdeeds against them, and that he has entrusted us with the message of reconciliation" (2 Corinthians 5, pp. 17–20).[15] Methodists might

understand the term in the historical context of reconciling congregations to the united denomination, or more recently, the controversy over homosexual persons. Roman Catholics often associate the term specifically with the sacrament of confession, the experience of penance which returns the penitent believer to God's grace. On the other hand, for people not raised in a religious tradition at all, reconciliation may connote ideas of restoring harmony, settling differences, or submitting to hardship, without the overlay of religious meaning.

The recent changes in accreditation standards increase the pressure upon chaplains and others involved in religious healthcare ministry to address the spiritual needs of non-Christians and atheists, just as healthcare in general must determine how to address the needs experienced by ethnically-diverse patient populations. Spiritual care services attempts to meet that challenge by contrasting the unique strengths of pastoral care to other disciplinary approaches.

Spiritual care providers deploy the spiritual assessment model as a way to initiate dialogue with patients and as a summary device to explain their perspective on patients' care needs to other members of the interdisciplinary care team. However, when CPE was first initiated at the community hospital, chaplains encountered resistance to their efforts to identify their role in patient care.

Challenges to a Chaplain's Authority

The following excerpt from an open-ended interview with one CPE supervisor reflects the initial resistance to spiritual care services at City Physicians Hospital.

> One of the people in pharmacy ... wanted to have the nurse figure out whether the chaplain should be called, he didn't want to have the chaplain automatically called. Because he felt like that would be an imposition on the family to have a chaplain show up. And I wanted to have the chaplain automatically called, for the chaplain to make that assessment, not the nurse. Because I don't know what the nurse is basing her assessment on, but we can train the chaplains to make an assessment as to whether they're needed or not. So that we're in the position to decide whether spiritual care is needed or not, not the nurse.

Claiming expertise in matters spiritual is a marker of professionalization for chaplains and is an regular concern in the professional literature (VandeCreek, 1999). As the quote reveals, the intervention of the supervisor concerned identifying the expertise and competency of chaplains to assess a patient care situation and determine whether a patient could benefit from

a chaplain visit. The supervisor maintains that ability to make that assessment comes from CPE training and it is distinct from the training of other healthcare providers.

This excerpt suggests that, in practice, individual resistance to the establishment of spiritual care services at City Physicians Hospital reflects a reluctance to change procedures in patient care, accompanied by a misunderstanding about the purpose and character of how chaplains seek to provide care. Senior CPE staff have repeatedly commented that a good part of their task is to engage in administrative relations explaining the role of spiritual care providers in patient care, as much defining what they do not do as what their contributions may be: "we don't convert or evangelize; we do talk with patients about how they feel about their experience."

However, another supervisor explains how she sees that the cultural expectations of the character of religious leaders can sometimes work in the favor of spiritual care providers:

> A patient was about ready to be discharged from adult psych and was afraid of . . . an abusive situation at home, and they hadn't told anyone else. Now you would think they'd have told the social worker, the one that was planning their discharge, but they didn't. They told the chaplain . . . If a patient is used to confiding in a religious leader, because they have assumptions that religious leaders are gonna be non-judgmental and stuff, you know, loving and nurturing . . . they're in for a big surprise, but umm, by and large we're in a neutral role, and so, they, umm, patients kind of tell chaplains things . . . So a chaplain can go on an interdisciplinary team, and say, "they really want to go home, they're ready but they're afraid of this and that. So that's why you're getting a resistance about their making a decision about going to this place or that place."

The comments of senior CPE administrators during interviews constitutes, at some level, a form of "impression management,"[16] a clear effort to mobilize a convincing narrative asserting CPE as a professional patient care strategy and the situations recounted to me reflect that selectivity. In this case, the senior CPE administrators are participants in an institutional discourse seeking to legitimize spiritual care as an effective and worthwhile patient care strategy for this era.

This exchange also emphasizes a distinction between chaplaincy staff and priests or other ordained ministers in other settings. A chaplain or CPE staff is part of the care provided in the hospital setting; a chaplaincy visit is very different from the Christian sacrament of confession. Chaplains are challenged to draw this distinction when patients, and even staff, perceptions are colored by the popular idea of minister as confessor and the sanctity of confidentiality. Especially for patients who identify as Catholic, the CPE

student will explain he is not a priest, but will offer the services of the staff chaplain who is a priest and is available for the sacraments of confession and anointing (see below).

Popular perceptions of religion, or misperceptions, further reveal themselves when people resort to humor. In one such case, an interdisciplinary team harbors an unease about the domain of chaplaincy reflected in the joking exchange noted as follows:

> Nearly two hours later, as the care team prepared to disperse, the chaplain asked about the discharge of the last patient they had discussed: "How long is the stay?" The quick answer from nursing, "Forever, until you folks take him" was met with laughter and general amusement by everyone in the room. Smiling, the chaplain clarified, "I ask because I was wondering at Christmas, who would he go home to?" Again, the answer from nursing: "Home with the chaplains, since it'll be that season."

This moment of humor between the nursing staff and the chaplain highlights their working relationship. The nursing staff is sufficiently comfortable and familiar with the chaplain to suggest that when the medical care of a patient comes to an end, chaplaincy is best equipped to deal with dying and death. Accepting the retort good-naturedly, the chaplain presses her point about the discharge date, and again the nursing staff invokes the stereotyped religious domain of chaplaincy expertise: the burden of the Christian holiday falls on the chaplain. Humor often marks an underlying unease or discomfort in social interactions. Observations of clinical rounds reveals the growing edges of the professional relations between spiritual care service providers and their fellow members of the interdisciplinary care team – death and dying mark the traditional line where health care providers surrender their patient to the chaplain, whom they perceive as the figure equipped to deal with the end of life. But as chaplains become more regular participants in the every day care of patients, the disciplinary care team increasingly recognizes the utility of their perspective more broadly.

Discussion

At Incarnation Hospital, spiritual care staff are specifically trained to discuss both Durable Power of Attorney for Health Care (DPAHC) authorizations and Do Not Resuscitate (DNR) orders with patients and family on admission. This is routinely done at the first chaplain visit, but familiarity with the issues is often crucial during a crisis when a proxy might be consulted about care decisions. In the world of biomedical intervention, chaplains traditionally are

associated with palliative and end-of-life care. The archetypal scenario when physicians can "do nothing more" has nurses tending to the physical comforts of a patient and a chaplain called to counsel her through her fear of death and anxiety about things to come. Popular misperceptions of the Catholic tradition, for example, are rife with the idea that the appearance of clergy in a hospital ward signifies impending patient demise and the narrative restricts the role of the priest to conducting "last rites."

In actuality, the situation is considerably more nuanced. Physicians and other providers are often not comfortable accepting the limits of their science and are rarely trained to counsel patients when physicians themselves often perceive the limits of their intervention as "medical failure" (Bosk, 1979; Ptacek et al., 1999). Chaplains, on the other hand, as people trained in religion and spirituality, are much more grounded in the inevitability of death as a universal human experience, and many faith traditions have specific rituals that are mobilized to address the uncertainties of the illness experience, as well as the last stages of life. For example, the inaccurate moniker "last rites" refers to the Catholic tradition's practice of viaticum, the sacrament of the last communion before death (Vaticana, 1997, p. 424). This is often confused with the more general sacrament of healing, the anointing of the sick, that can be administered on request to any individual confronting any stage of illness (Vaticana, 1997, p. 417). In popular images of religious care, the anointing of the sick, which invokes the compassion of Christ in the care of the patient's illness, is often eclipsed by last communion.[17]

The hospital policy that allocates the responsibility for discussing DPAHC and DNR issues to the spiritual care providers capitalizes on the expertise that chaplains have talking with patients about the uncertainties of illness and the possibility of death. But, like the humorous banter at the close of the care team's patient rounds, this task allocation underscores a deeper social ambivalence toward the relationship of religion in medical settings that is played out in the language and interactions concerning death and dying. This may even represent a secularization of "last rites," where the original religious function of ministering to a patient's needs at the end of life is transformed into a medico-legal administrative process. It also reflects the denominational history of a Catholic identity in this facility; at City Physicians Hospital, where CPE is much more conscious of the need to be interfaith in its approach, even with the hospital's own administration, chaplains are not responsible for discussing DPAHC and DNR.

However, the policy at Incarnation Hospital resonates strongly with the professionalizing ethic at work in CPE. Spiritual care providers have identified a unique area of competency and connected it to a realm of authority over an administrative technology, a readily recognizable task in keeping with

the overall medical mission of the hospital. In California, where hospitals are required to inform patients of their right to appoint a proxy and determine advance directives, chaplains absorb an administrative task into their repertoire as a function of their secularization. Not all patients have religious needs, but all patients need to be informed of their rights and CPE training equips chaplains with the skills to be the appropriate conduit of that information given the medical uncertainty that surrounds it. In this respect, the reluctance of other provider disciplines to manage adverse outcomes seems to work in the favor of spiritual care services.

The idea of professionalization as an element of secularization takes place against a much broader discussion of secularization as a dynamic societal force and theorists remain divided on its nature, the scope and implications of such a master process (Sherkat and Ellison, 1999).[18] I use secularization here to make reference to a broad arena within which religious persons and institutions retain a semblance of their own religious identity and character but engage in some modification to navigate the challenges of existence in the broader society.[19] That broader society may be ostensibly *de jure* secular or *de facto* secular as a result of the interaction of multiple religious persons and worldviews acting in the same public sphere, that is, pluralism.[20]

Developing Pastoral Identity

A significant part of the CPE paradigm is about the growth, not just of patients, but of chaplain residents themselves, the development of a chaplain's pastoral identity and, thus, his or her individual ministry. The year is defined by goals and objectives drafted repeatedly, regularly shared and compared with colleagues. Becoming more aware of her calling, the CPE student improves her ministry to patients. By improving that ministry, she discovers her pastoral identity. Working effectively as part of a unit's interdisciplinary care team means claiming your pastoral identity during those interactions. In the Christian words of one supervisor, "What are your gifts and graces for this work?" Not hiding his light under a bushel, a CPE student explicitly participates in a cycle of guidance and self-examination, self-knowledge and confession.

This aggressive program of professional development applied to pastoral care distinguishes CPE students from the more traditional approaches of the staff chaplains.[21] According to CPE supervisors, the staff chaplains of Incarnation Hospital engage in a ministry of presence that is about being a witness to the patient's experience. It is consequently a different approach to pastoral care; for example, staff chaplains generally will not talk about the spiritual assessment model. Staff chaplains follow a more adjunct model of care that stems from their religious vocation within a Catholic institution.

Their ministry of presence is more about compassion than the intervention of CPE, a training model explicitly constructed as an integrated part of the interdisciplinary care of a biomedical institution. That interdisciplinary context demands that CPE graduates demonstrate applied expertise, defined by both language and method, that warrants their professional authority as a legitimate component of the patient care team. In meeting that demand, the professionalization of CPE connotes a necessary secularization driven by the closer collaboration with biomedical rationales. As CPE graduates move on to permanent clinical positions, the composition and thus style of hospital staff chaplaincy will continue to change.

Conclusion

CPE is a means to establishing chaplaincy as a codified method of patient care that, rather than being purely revelatory or intuitional, is a routinized and systematic process that can be taught, evaluated and its providers tested and certified. The JCAHO accreditation is a two-prong phenomenon for chaplaincy. By making spiritual care a requirement for hospitals, chaplaincy gains the legitimacy it needs to command authority and resources. But the only way chaplaincy could become a JCAHO standard was to be recast as "spiritual care services," a non-denominational, more importantly "non-religious," patient care strategy. Consequently, CPE represents a secularized model of one aspect of religiously-motivated healthcare.

Administrators and practitioners in religiously-sponsored healthcare facilities regularly emphasize the need to maintain their religious ministry and ensure it is not lost amidst the economic drivers of healthcare. In this respect, establishing "spiritual care services" also requires constructing a discourse of contemporary relevance, a convincing narrative within the institution, that can preserve a space for modern religiosity – rendered less threatening and more universal by the label "spiritual" – and yet respond to the hostile cost-containment climate that demands every hospital service justify its continued utility. Moreover, the transition to a practice conceptualized as generically "spiritual" rather than affiliated with a particular denomination addresses the problem of serving diverse patient populations. CPE training seeks to incorporate spiritual care providers into the biomedical setting by identifying specific areas of expertise linked to roles and tasks required by the bureaucratic ethos of contemporary healthcare institutions and standardizes a "spiritual methodology" that can contribute to an interdisciplinary care process. This legitimating strategy retains a religious perspective in a healthcare system dominated by the secular biomedical worldview.

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Notes

[1] See also Sigerist, H.E. (1936).

[2] A more detailed discussion of Foucault's concept of biopower would also note the resonance between his idea of pastoral power and the contemporary rationale underlying pastoral ministry (caring for persons) that chaplains and other ministers practice. I reference Foucault here, not to deploy a power/knowledge or other analytic strategy, but rather to point to the historical institutional transformation that his genealogical approach laid out.

[3] The names of the facilities where my research was conducted have been changed to protect those who provide and seek medical care on their premises. People's names and other identifying features have been similarly changed. Where identifying elements are significant to the analysis, efforts have been made to retain plausibility within the narrative while still protecting individuals and the institutions where they work.

[4] Clinical Pastoral Education is a national program of training and accreditation with its own history that is beyond the scope of this article. For those interested, I recommend Hemenway 1996 as a recognized account. Except where indicated, subsequent references to CPE refer to the particular configuration I observed at Incarnation Hospital and that was then expanded at City Physicians Hospital.

[5] Recent reports regarding the control of standards in psychiatric hospitals have raised substantial questions about the efficacy of JCAHO review. It remains to be seen how this will impact the evaluation of patient care services in the hospital industry.

[6] Carole Patterson, Deputy Director, Joint Commission Dept. of Standards. Personal communication, July 1999.

[7] The Association for Clinical Pastoral Education, Inc. is nationally recognized as an accrediting agency in the field of clinical pastoral education by the U.S. Department of Education. Some religious groups also have their own independent certifying bodies; for example, the National Association of Catholic Chaplains (NACC) accredits chaplains in competencies specific to that faith and creed.

[8] Adapted from "What is Clinical Pastoral Education?", a document developed and written by one informant, a Roman Catholic priest, submitted to his presiding bishop regarding the priest's training as a CPE supervisor.

[9] For a more general treatment of spirituality in healthcare, see Muldoon, M. and King, N. (1995), which draws heavily on Schneiders, S. (1986).

[10] Perhaps this use of "holistic" reflects a similar tendency with regard to "spiritual." Both casual conversation and general surveys throughout the US frequently indicate that many

Americans consider themselves "highly spiritual" but not "religious." In these cases, spirituality would seem to reflect a greater individualization rather than participation in an organized religion.

[11] For discussion of this market trend and its relation to patient behaviors see Adler, S.R., et al. (1998), and Adler (1999).

[12] ACPE brochure, "Professional Education for Ministry: a guide for students interested in CPE." The same language is repeated in the brochure for CPE training at Incarnation Hospital.

[13] My informants have noted that this is itself tenuous ground. Interfaith refers to a range of faiths, for example, Buddhism to Judaism to Eastern Orthodox Christian. Ecumenical on the other hand, derived from the Greek, implies the inclusion of all *Christian* denominations, what a traditional Roman Catholic might refer to as 'non-sectarian'. A Reform Jewish CPE student noted in conversation that CPE easily manages to be ecumenical, but interfaith is a challenge that programs nationwide continue to confront. Spirituality, neither ecumenical nor interfaith, for providers and patients who do not identify with any organized religion, constitutes an even greater challenge.

[14] I thank Kirsten Linford-Steinfeld for suggesting this example and for taking time to comment on my research in the midst of her own theological and pastoral studies.

[15] See Vaux, K.L. (1984), and Smylie in Numbers, R.L. and Amundsen, D.W. (Eds) 1986.

[16] Reissman, C.K. (1993) *Narrative Analysis*, Vol. 30, Newbury Park: Sage Publications., discussing Labov.

[17] In the Catholic tradition, sacraments of anointing and confession can only be administered by an ordained priest. On the other hand, the communion wafer must be blessed by a priest, but can be administered to a Catholic patient by any other Catholic. Thus, those CPE students who are Catholic need not be ordained to offer communion to patients.

[18] On-going debates in the sociology of religion can be very rich. However, as an anthropologist, I remain skeptical of more recent trends arguing for a paradigm of rational choice theory based on claims of "new methodological rigor" and "empirical analysis." See Warner, R.S. (1993), Young, L.A. (1997).

[19] I cannot address in this article the extent to which "secularization" in this sense might reflect an American continuation of the particular classic social transformation Weber ascribes to the schism of the Protestant sects from the Catholic Church that coincided and complemented the rise of European capitalism. Future work will consider shifts in religiously-sponsored healthcare more directly from this perspective.

[20] This understanding of secularism/secularization benefits from a discussion by H.T. Englehardt of seven senses of secularity, specifically: (1) the secular as a morally neutral framework (as opposed to a Church-derived value system, like sin/redemption) through which believers and non-believers can collaborate one with another; (7) secularization as the process by which a culture's or a society's sense of the religious or the transcendent is transformed into an immanent, worldly province of meaning in Engelhardt, H.T. (1991). While these two senses of "the secular" do not map precisely what I think my fieldwork has engaged, they provide a frame of reference to position my observations within a broader theoretical context.

[21] Staff chaplains are to be distinguished from CPE students and educators. They are long-standing Catholic men and women religious (brothers and fathers, sisters) whose service in this case pre-dates the CPE program. They often have extensive experience in chaplaincy but are not trained in CPE, a key distinction with regard to method.

References

Adler, S.R. (1999) Complementary and Alternative Medicine Use Among Women with Breast Cancer. *Medical Anthropology Quarterly* **13**(2), 214–222.

Adler, S.R., McGraw, S.A. and McKinlay, J.B. (1998) Patient Assertiveness in Ethnically Diverse Older Women with Breast Cancer: Challenging Stereotypes of the Elderly. *Journal of Aging Studies* **12**(4), 331–350.

Bosk, C. (1979) *Forgive and Remember: Managing Medical Failure*. Chicago: University of Chicago Press.

Capps, D. (1979) *Pastoral Care: A Thematic Approach*. Philadelphia: Westminster Press.

Engelhardt, H.T. (1991) *Bioethics and Secular Humanism: The Search for a Common Morality*. London/Philadelphia: SCM Press/Trinity Press International.

Enthoven, A.C. and Singer, S.J. (1996) Managed Competition snd California's Health Care Economy. *Health Affairs* **15**(1), 40–57.

Fitchett, G. (1993) *Spiritual Assessment in Pastoral Care: A Guide to Selected Resources*, Vol. 4. Decatur GA: Journal of Pastoral Care Publications, Inc.

Foucault, M. (1973) *The Birth of the Clinic: an Archaeology of Medical Perception*, 1994 edition. New York: Vintage Books.

Hemenway, J.E. (1996) CPE from a Historical Perspective. *Inside the Circle: A Historical and Practical Inquiry Concerning Process Groups in Clinical Pastoral Education*: *Journal of Pastoral Care Publications*.

Muldoon, M. and King, N. (1995) Spirituality, Health Care, and Bioethics. *Journal of Religion and Health* **34**(4), 329–349.

Numbers, R.L. and Amundsen, D.W. (Eds.) (1986) *Caring and Curing: Health and Medicine in the Western religions Traditions*. New York: MacMillan Publishing.

Ptacek, J.T., Fries, E.A., Eberhardt, T.L. and Ptacek, J.J. (1999) Breaking Bad News to Patients: Physicians' Perceptions of the Process. *Support Care in Cancer* **7**, 113–120.

Risse, G. (1999) *Mending Bodies, Saving Souls*. Oxford: Oxford University Press.

Robinson, J.C. (1996) Administered Pricing and Vertical Integration In The Hospital Industry. *Journal of Law and Economics* **39**, 357–378.

Schneiders, S. (1986) Theology and Spirituality: Rivals, Strangers, or Partners. *Horizons* **13**(2), 257–264.

Sherkat, D.E. and Ellison, C.G. (1999) Recent Developments and Current Controversies in the Sociology of Religion. *Annual Review of Sociology* **25**, 363–394.

Shortell, S.M., Gilles, R.R. and Anderson, D.A. (1994) The New World of Managed Care: Creating Organized Delivery Systems. *Health Affairs* **13**(5), 46–64.

Sigerist, H.E. (1936) An Outline of the Development of the Hospital. *Bulletin of the History of Medicine* **4**, 573–581.

Spradley, J.P. (1970) *You Owe Yourself a Drunk: An Ethnography of Urban Nomads*. Boston: Little Brown.

VandeCreek, L. (1999) Professional Chaplaincy: An Absent Profession? *The Journal of Pastoral Care* **53**(4), 417–432.

Vaticana, Libreria Editrice (1997) *Catechism of the Catholic Church*. New York: Image Doubleday.

Vaux, K.L. (1984) *Health and Medicine in the Reformed Tradition: Promise, Providence, and Care*. New York: Crossroad.

Warner, R.S. (1993) Work in Progress Toward a New Paradigm for the Sociological Study of Religion in the United States. *American Journal of Sociology* (50), 1044–1093.

Young, L.A. (1997) *Rational Choice Theory and Religion: Summary and Assessment*. New York: Routledge.