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*An Inter-Lutheran Journal  
for Practitioners and  
Teachers of Pastoral Care  
and Counseling*



# CARING CONNECTIONS

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# THE PURPOSE OF CARING CONNECTIONS

*Caring Connections: An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling* is written by and for Lutheran practitioners and educators in the fields of pastoral care, counseling, and education. Seeking to promote both breadth and depth of reflection on the theology and practice of ministry in the Lutheran tradition, *Caring Connections* intends to be academically informed, yet readable; solidly grounded in the practice of ministry; and theologically probing.

*Caring Connections* seeks to reach a broad readership, including chaplains, pastoral counselors, seminary faculty and other teachers in academic settings, clinical educators, synod and district leaders, others in specialized ministries, and—not least—concerned congregational pastors and laity. *Caring Connections* also provides news and information about activities, events, and opportunities of interest to diverse constituencies in specialized ministries.

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# Editorial

“CPE should be recommended but not required for either ordination or seminary graduation.”<sup>1</sup>

That single sentence, drawn from a Report on Theological Education in the New Lutheran Church to the Commission for a New Lutheran Church, worked like a cattle prod back in 1987. The Lutheran Church in America, the American Lutheran Church and the Association of Evangelical Lutheran Churches were in the process of coming together as the Evangelical Lutheran Church in America (ELCA). In swift response to that report the Association for Clinical Pastoral Education (ACPE) and the Department of Specialized Pastoral Care and Clinical Education of the Lutheran Council-USA (LCUSA) worked with denominational representatives from the groups mentioned above, as well as officials from the Lutheran Church-Missouri Synod (LCMS), to convene a Symposium on CPE and Lutheran Theological Education. That meeting took place November 21-23, 1987, in New Orleans, Louisiana. I was one of almost 60 people present at that critical moment in Lutheran/CPE relations.

Lutherans had been closely involved with CPE since the early 1940's. Chuck Hall, first Executive Director for ACPE, noted in his paper presented at the Symposium that “the official entry of Lutherans into the CPE movement helped facilitate a long period of dialogue which eventuated in an inter-denominational inter-faith organization, the Association for Clinical Pastoral Education (ACPE) in 1967.”<sup>2</sup> So, this suggestion that CPE only be recommended, not required, for Lutheran seminary students needed to be addressed and explored. That's what happened in the Big Easy.

The exploration revolved around a concern that the CPE process was being abusive, particularly to women and people of color, with the result that it was being seen as a white, male learning style, and therefore not mandatory for those who didn't fit those categories. I remember being struck by the fact that at the Symposium Joan Hemenway, a non-Lutheran supervisor, was called upon to identify women's issues in CPE, since at that time there were

no female Lutheran supervisors. Also, Cameron Byrd, a non-Lutheran African-American supervisor addressed multicultural issues, since there were no non-Caucasian Lutheran supervisors either.

The immediate outcome of the Symposium and clearing of the air around these concerns was that the ELCA did continue to require, not just recommend, CPE for seminary students. The LCMS chose to continue making CPE an option, usually on a student-by-student basis. However, Lutherans have maintained a close relationship with CPE ever since.

Vivid evidence for that deep involvement can be found in the articles included in this issue of *Caring Connections*. Shawn Mai describes his process of becoming a student in the CPE supervisory process. John Schumacher shares his development of a CPE Residency in a hospice setting, in hopes that it might help others think of doing something similar. Bill Dexheimer Pharris offers practical help for developing clinical records that CPE students can learn to use more quickly, with the result that they become effective team workers in less time than before. Steve Arnold gives his testimony on CPE helping him make a professional and personal transition in his life and career. Diane Greve stirs the pot by asking if there is a need for more Lutheran supervisors...and 21 other questions in her article! Kevin and I hope you will enjoy reading and reflecting on these articles as much as we have.

How are you at writing letters to the editor? I've often wanted to do so, but seldom followed through. We at *Caring Connections* want to invite you to write to us if you have reactions to any pieces we have included in this issue or future issues as well. Send your comments to [Kevin.Massey@elca.org](mailto:Kevin.Massey@elca.org).

How are you at writing book reviews? I've never been moved to write one, but I value highly the efforts others have made, whether that's in *Time*, *Christian Century*, or *Currents in Theology and Mission*. We welcome your offer to be a reviewer, and if you have published a book and would like it reviewed here, please contact us as well. Use Kevin's address, as given in the prior paragraph.

If you have not already done so, we hope you

## Call for Articles

*Caring Connections* seeks to provide Lutheran Pastoral Care Providers the opportunity to share expertise and insight with the wider community. We would like to invite anyone interested in writing an article to please contact the editors, Rev. Kevin Massey and Rev. Chuck Weinrich.

Specifically, we wish to invite articles for upcoming issues on the following themes.

Fall 2008 “Spiritual Care in Long Term Care and Rehabilitation”

Spring 2009 “Disaster Relief and Pastoral Care”

Summer 2009 “The Role of Forgiveness”

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#### Notes

<sup>1</sup> “Report on Theological Education in the New Lutheran Church to the Commission for a New Lutheran Church,” ACPE Records, RG 001, Box 350, Folder 21, Archives and Manuscripts Department, Pitts Theology Library, Emory University

<sup>2</sup> “Historical Influences in the Development of Clinical Pastoral Education” Chuck Hall, ACPE Records, RG 001, Box 350, Folder 21, Archives and Manuscripts Department, Pitts Theology Library, Emory University

# My Journey in Becoming a CPE Supervisory Student

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Looking back, I'm grateful for the learning I experienced in the parish and also in my first years as a chaplain.

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Like most ELCA seminarians, I took CPE initially because it was a requirement for my ordination as an ELCA pastor. The summer after my first year of seminary I drove from St. Paul, Minnesota to Wichita, Kansas to fulfill my requirement at Wesley Medical Center.

That summer unit was transformational as it introduced me to the action/reflection model of learning, and the process sharpened my call to specialized ministry. Before finishing seminary in 1992, I completed a four-unit CPE residency in Colorado that led me to consider CPE supervision as a possible vocation in ministry.

Were it not for the ELCA requirement of serving in the parish to be certified for specialized ministry in the ELCA, I would have pursued supervisory education at that juncture in my ministry. Looking back, I'm grateful for the learning I experienced in the parish and also in my first years as a chaplain.

In my first call out of seminary, I served a large urban congregation in Minneapolis, Minnesota, where pastoral care continued to be my focus in ministry. I served that parish for five years and learned about ministry as a parish pastor. These years of my ministry have informed me in my supervision with students about life in parish ministry.

While serving in the role of congregational minister, I dealt with group dynamics, issues of self-care, clarity regarding call, understanding self and others, development of pastoral theology, as well as learning how to differentiate and appreciating difference. Following my five years of parish ministry I served for two years as a hospice chaplain. I began developing more expertise in specific areas of ministry, i.e. end of life care, spiritual assessment and pastoral approaches.

In 1999 I was called to be the Director of Spiritual Care for Walker Methodist Health Center, a non-profit senior health care organization that served seniors through a variety of living options and long-term care in Minneapolis. During the first couple of years we began utilizing CPE interns, through placement agreements, to help cover some of the clinical needs in our 488 bed long-term care facility. Providing clinical coordination for these students reconnected me with my decade-old dream of becoming certified as a CPE supervisor. I began exploring the possibility of working through my



certification process while continuing to serve in my current position.

The Fairview CPE Center in Minneapolis had begun a model of supervisory education that sought to train students in supervisory CPE who were based in the community. This was a perfect fit for me. Fairview designed the program with a peer

*I've come to appreciate what Lutheranism values in recognizing differences and being open to the process of questioning.*

group component that met for didactics, presentations, and group reflection once a week. I have completed all of my supervision of CPE students in my facility through placement agreements and contracted supervisors. This arrangement has proven to be of great benefit not only for me, but also for my organization.

Through my training process I have experienced a deepening of my sense of call as an ordained Lutheran pastor. Underlying my supervision with students is my eighth grade Lutheran catechism question, "What does this mean?" I have felt a renewed affection for Martin Luther as I've wrestled

with the issue of grace for myself in my certification process, and as I've come to appreciate what Lutheranism values in recognizing differences and being open to the process of questioning. As I have come to a deeper understanding of my own formation and competence as a pastor and supervisor, I am learning how to walk with seminarians and pastors as they move through this important process as well.

*Rev. Shawn R. Mai is an ACPE Supervisory Candidate at Fairview CPE Center in Minneapolis, Minnesota.*



# Models for CPE Residency at Rainbow Hospice

The benefit for the spiritual care program has been the rich experience of interacting with students.

*There is a great deal of interest in hospice care among people entering CPE residencies and also thinking beyond residency to employment possibilities. The perception is that growth in inpatient chaplaincy positions has slowed or stopped, whereas hospice seems to be a “growth industry” where new pastoral care positions continue to open. Not surprisingly, CPE programs, responding to student interest, are exploring ways to incorporate a hospice experience in their residency programs. This article describes the history of clinical pastoral education at Rainbow Hospice and in so doing suggests some models that might be replicated in other settings.*

## Hospice Residency as a Concurrent Clinical Experience

Rainbow Hospice has had a connection to clinical pastoral education since its beginnings more than 25 years ago. Lee Joesten, then a chaplain and CPE educator, and now Vice President for Mission and Spiritual Care at Advocate/Lutheran General Hospital (A/LGH), provided pastoral support to Parkside Hospice, a small inpatient program within the Lutheran General Health System. This hospice soon merged with two other local hospices to form Rainbow Hospice. Among Lee’s other duties was responsibility as Rainbow’s first chaplain. When Lee took on more administrative duties, he was replaced at Rainbow by Will Wagner, another chaplain and CPE educator at A/LGH. In addition to the pastoral support they themselves provided, Lee and Will allowed interested residents to carry a small hospice case load in addition to their clinical assignments at the hospital. I was allowed that privilege during my residency in 1991-92, while at the same time serving rotations in gerontology and addictions. My maximum hospice caseload was two patients at any given time, but the experience was enough to ignite my passion for this work.

By 1993 Rainbow Hospice had grown sufficiently to support a full-time staff chaplain, the position for which I was hired and subsequently called by the Metropolitan Chicago Synod. We continued the practice of inviting interested residents to experience direct patient care, and I served as the clinical site consultant for A/LGH. The strength of this relationship was the opportunity to allow residents a brief exposure to end-of-life care at no cost and with



minimal administrative complications. However, the weaknesses were becoming more evident. A three-month rotation through hospice on a very part-time basis usually meant that by the time the resident was oriented and ready to visit patients, the rotation was nearly over. Once oriented, the resident had to deal with scheduling and travel. The majority of Rainbow Hospice patients are “in the field”, living at home or in the long term care facilities where families or LTC staff serve as the primary

*My maximum hospice caseload was two patients at any given time, but the experience was enough to ignite my passion for this work.*

caregivers. The resident had to block out time away from hospital responsibilities, and then travel, sometimes a significant distance from A/LGH, in order to visit the hospice patient. With the resident’s limited availability and the problem of patients’ short lengths of stay, residents frequently complained that the new patient assigned had died before the resident had opportunity to make an initial visit. There is one former resident who to this day swears he never saw a living hospice patient



except for those he met when shadowing other disciplines during orientation. Perhaps the greatest weakness of this extremely part-time rotation was that it denied a resident the very heart of hospice - the opportunity to become an integral part of the interdisciplinary team.

### Hospice Residency as a Specialization

In the late 1990's, when increasing census and the changing commitments of Rainbow's second staff chaplain opened the possibility of hiring a part-time staff chaplain, we instead began to explore a different model for clinical pastoral education in hospice. With the support of Lee Joesten at A/LGH and Pat Ahern, Rainbow Hospice's Executive Director, we created a contractual agreement whereby a resident would be assigned to Rainbow but receive CPE credit from A/LGH. Candidates applying for the A/LGH residency who expressed interest in hospice were given an opportunity to meet with me as a part of their interview team. The candidate selected for residency works at Rainbow as his/her clinical setting, participates in on-call at A/LGH for experience in acute care, and receives supervision with his/her resident peers at A/LGH. Initially, the resident's stipend, along with benefits for which he or she was eligible as a part-time Rainbow employee, was paid directly by Rainbow Hospice. However, when it became clear that A/LGH, a much larger health care institution, could offer the resident a richer benefit package for the same cost, the resident was moved to the A/LGH payroll and Rainbow was billed by A/LGH for the cost of stipend and benefits.

The benefits of this model are clearly evident. For the hospital the additional resident adds a new clinical perspective to the peer group and another pastoral professional to serve in the on-call rotation. The value of this model is reflected in the A/LGH decision to replicate this residency model with a local Lutheran Social Service nursing home and another Advocate hospital. Neither of these programs is able to fund a full CPE residency program on its own.

For a hospice the resident provides the pastoral care support of an additional part-time chaplain and, in our case, extended Rainbow's commitment to be a primary resource for professional end-of-life education in the metropolitan area. For the student, it is the opportunity to specialize, functioning for a full year as a hospice chaplain.

Most often, the resident reports a sense of being accepted and affirmed by the team as its chaplain by the end of the first quarter. By the end of the second quarter, the question is "Will you have a job opening at the end of my residency? I don't want to leave." The overwhelming majority of our residents have continued in hospice care. Of the eight A/LGH residents who have served at Rainbow, four are serving hospices. Two were hired by Rainbow Hospice. One is serving a hospice in Missouri, and another, a hospice in Oregon. Two of the residents are serving in

church-related continuum of care facilities which include significant end-of-life care. The current resident is interviewing with another hospice program for employment at the conclusion of her residency.

The benefit for the spiritual care program has been the rich experience of interacting with students. The residents have brought racial, ethnic, and religious diversity to our staff. They have offered significant gifts. As an example, the work of the first resident, a gifted musician, was certainly one factor which influenced administration to open the door for the addition of a music therapist to Rainbow's spiritual care staff. The residents have also helped a

*Above all, ... I take delight in  
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staff of board-certified chaplains to stay connected to the action/reflection model of learning and to the value of sharing verbatims and case studies.

### Hospice Residency as a Clinical Rotation

After the Advocate residency was well established, Rainbow Hospice turned to our second affiliated health care system. Resurrection Health Care is a large multi-site Roman Catholic health care system, accredited by the National Association of Catholic Chaplains and the Association for Clinical Pastoral Education. Initially we offered the Advocate model, but we soon found that it did not meet RHC's needs. It was their preference to rotate residents through their various health care settings and to offer Rainbow Hospice as one clinical option. However, we were concerned that even if hospice were the sole clinical responsibility for the resident, a quarter did not provide sufficient time to orient and fully integrate the resident into the hospice experience.

Our impasse was solved in the fall of 2007 when Rainbow Hospice opened The Ark, a 15 bed inpatient unit. The Ark offered a number of advantages over the field for short term resident placement. At The Ark, there is less concern that the orientation prepare the resident to work independently in the field. The Rainbow Hospice Ark resident is surrounded by mentors from every discipline and can continue to orient even as he or she begins patient care. In The Ark the resident is more quickly recognized by staff as the chaplain because, unlike the field teams serving homes and long term care settings, The Ark staff has frequent opportunities to observe the chaplain at work. In The Ark, the resident is also more quickly integrated into the team, simply because of the close working relationship that develops among the inpatient staff members.

Through the good offices of Pat Ahern,

Rainbow's Executive Director and Bob Bulger, Senior Vice President for Mission, Resurrection Health Care (RHC), a relationship was established for clinical pastoral education at The Ark. RHC provides the resident's stipend, at no cost to Rainbow Hospice, as well as the resident's peer group and clinical supervision. In turn, The Rainbow Hospice Ark's staff chaplain serves as the mentor to the RHC resident, and I serve on RHC's CPE Professional Advisory Board. Because The Ark is one clinical option among many for the residents, Rainbow is not guaranteed a placement each quarter. Therefore, when a resident is assigned, we have chosen to use the resident as a supplement to the pastoral support available to the patients, families, and staff at The Ark, and have not included the position in our staffing plan.

The first RHC resident was assigned to The Ark in February, 2008. He and the staff chaplain worked well together in initiating a pastoral care program for our new clinical setting. When the resident completed his program and the staff chaplain unexpectedly resigned, we were happy to hire the resident as the new staff chaplain serving The Ark.

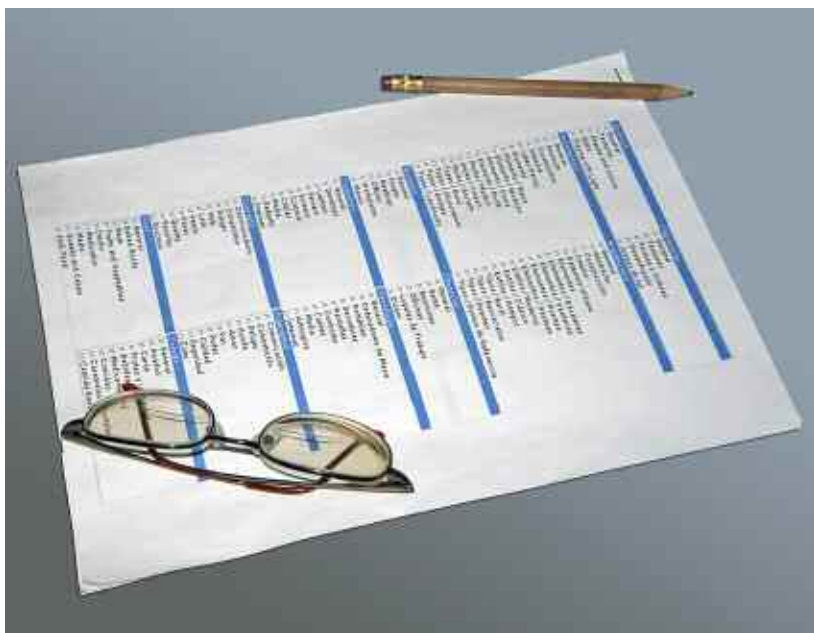
Personally, the experience of integrating clinical pastoral education in hospice has been one of the delights of my 15-year tenure at Rainbow Hospice. I have appreciated the opportunity to stay connected to the CPE process, and I am deeply grateful for the collegiality extended by the clinical pastoral educators at A/LGH and RHC. We have truly enjoyed a partnership which deepens the relationships among our institutions. I look forward to continued cooperation with both health care systems and new opportunities we might identify for educating pastoral care practitioners in the unique world of end-of-life care. Above all, I am grateful for the residents who have elected to serve in residency with us and I take delight in the care they continue to provide as they offer dignity and hope to those who live with loss and end of life.

*John E. Schumacher, BCC, is an ELCA ordained clergy called by the Metropolitan Chicago Synod to serve as manager of Spiritual Care and Healing Arts. He currently supervises a staff of chaplains, music therapists, and massage therapists. John can be contacted at [jschumacher@rainbowhospice.org](mailto:jschumacher@rainbowhospice.org). Rainbow Hospice is a community-based not-for-profit hospice serving metropolitan Chicago since 1981. It is affiliated with two-faith based health care systems, Resurrection (Roman Catholic) and Advocate (ELCA & UCC).*

# Checklists for Chaplains: Navigation Tools for Meaningful Chaplaincy Practice

Our hope is that the navigation tools we provide might serve to help our colleagues fly free and land safely onto the grounds of meaningful chaplaincy practice.

*Orientation of new CPE (Clinical Pastoral Education) students and staff chaplains into key technical/logistical aspects of the work of chaplaincy—charting, on-call protocols, interdenominational and interfaith religious protocols, etc.—has become increasingly complex in many hospital environments due to various reasons. If students are expected to function as unit chaplains with only a short period of time for orientation, all the tasks and protocols that must be learned can prove overwhelming and get in the way of a positive CPE experience. At University of Minnesota Medical Center (UMMC), Fairview (Minneapolis, MN, U.S.A.), staff chaplains and CPE supervisors in the Spiritual Health Services department have developed training tools for a system of clinical coordination, which involves a mentoring relationship between staff chaplains and CPE students, coordinated by CPE supervisors. The tools are designed to help students and new staff chaplains orient into their clinical work as smoothly and painlessly as possible. The writer will describe two training tools used by chaplains at UMMC, Fairview: a comprehensive charting manual, and a set of protocol worksheets to guide on-call ministry. Other chaplaincy departments might find elements in these training tools adaptable to their own context.*



had been found to be the result of pilot error, the U.S. Army Air Corps

...came up with an ingeniously simple approach: they created a pilot's checklist, with step-by-step checks for takeoff, flight, landing, and taxiing. Its

*If students are expected to function as unit chaplains with only a short period of time for orientation, all the tasks and protocols that must be learned can prove overwhelming.*

In his December 10, 2007 article in *The New Yorker*, "The Checklist," Atul Gawande writes about Dr. Peter Provonost, a critical care specialist at Johns Hopkins, and his fervent mission to implement the use of simple checklists to improve outcomes in intensive care units. The idea of using checklists to improve outcomes is of course nothing new; Gawande comments "...house movers, wedding planners, and tax accountants figured (this) out ages ago." However, this seemingly obvious way of making sure complex tasks are carried out correctly has not always been readily accepted by professionals in vocations like medicine, where one mistake could result in very poor outcomes, even death.

Gawande points out that research on the effectiveness of checklists has its origins in the area of aircraft safety. In the 1930s, responding to a number of disastrous accidents during flight training that

mere existence indicated how far aeronautics had advanced. In the early years of flight, getting an aircraft into the air might have been nerve-racking, but it was hardly complex. Using a checklist for takeoff would no more have occurred to a pilot than to a driver backing a car out of the garage. But this new plane was too complicated to be left to the memory of any pilot, however expert. With the checklist in hand, the pilots went on to fly the Model 299 a total of 1.8 million miles without one accident.

In describing the use of checklists by physicians and nurses on intensive care units, Gawande concludes that

...the checklists provided two main benefits...first, they helped with memory recall, especially with mundane matters that are easily overlooked in patients undergoing more drastic events...A second effect was to make explicit the minimum, expected steps in complex processes... Checklists established a higher standard of baseline performance.

The reader might be thinking “I understand what all this has to do with physicians, nurses, and airline pilots, but what’s the connection with chaplaincy?” My response would be that any chaplain working in a modern medical facility faces similar challenges. JCAHO (Joint Commission on Accreditation of Healthcare Organizations) regulations, HIPAA (Health Insurance Portability and Accountability Act) guidelines, the increasing need for a multi-cultural/multi-faith approach, emphasis on interdisciplinary care with all the attendant charting requirements, and the almost ubiquitous use of computers for charting and staff communication all add up to more stress on the job. In this increasingly complex healthcare environment, the implementation of checklists and other appropriate tools or guidelines could alleviate much of that stress, freeing chaplains to be more present to patients.

#### Chaplain orientation/clinical coordination

The role of **clinical coordinator** is described as follows in the Fairview CPE Handbook:

*As part of their learning process, students will be assigned to Clinical Coordinators who are staff chaplains...The Clinical Coordinator’s role is to offer students:*

**Orientation** to their particular clinical area;

**Mentoring/consultation** related to the acts of ministering; and

**Overall management** of students’ ministry efforts in their clinical areas including feedback and evaluation.

Staff chaplains are paired with either intern or resident chaplains. In the beginning of the student’s CPE experience they meet together at least once a week. Students often “shadow” staff chaplains in a few visits, and when ready are shadowed by the staff chaplain. The first few weeks of clinical coordination are focused on the learning of many tasks necessary to do the work of a chaplain: charting; getting to know staff on the patient care unit; and becoming familiar with sacramental ministry guidelines, inter-faith protocols, infection control issues, referral and on-call procedures, etc. As the student becomes more comfortable doing routine and not so routine tasks, the clinical coordination sessions become more of a time to reflect on particular cases, focus-

ing more on clinical issues than supervisory ones. Clinical coordinators are in close contact with the student’s supervisor, and participate directly in evaluation of the student’s clinical skills.

Over the last ten years our clinical coordination model has constantly evolved, and during this time staff have developed numerous training tools/protocols as consensus about “best practice” has been clarified. There is a continuous feedback loop revising these tools in real time. If a student or

*Having a checklist of all necessary tasks, in the order they need to be done, helps to free up the student ... to pay more attention the actual art of pastoral care.*

staff detects a problem or inefficiency, or suggests a new way of doing something, it is discussed in staff meeting. If the consensus is for change in a protocol, it is implemented as soon as possible. This process has resulted in the development of two sets of training tools that have proven particularly useful: our “Charting for Chaplains” manual, and a set of on-call protocol worksheets.

#### “Charting for Chaplains” training manual

Back in 1989, when I started a previous job in Chicago as a Global Mission advocate for the Evangelical Lutheran Church in America (ELCA), I had to learn Microsoft Word (before the Mac-like Windows operating system existed). I was relieved to learn that I didn’t have to attempt to wade through the official Microsoft Word instruction book; along with having access to my own computer I was given a simple in-house manual that explained pretty much everything I would need to know to do my job, point by point, key by key. Nothing more, nothing less. Each task was described starting at the beginning, walking the user through all the necessary actions to arrive at the desired outcome, using clear, jargon-free English to describe the task. I don’t recall the name of the person who wrote this manual, but I am sure she or he saved the organization countless hours and many dollars that would have been spent on time needed for hundreds of people to learn to use their computer, if they would have had to rely on the original, almost incomprehensible computer manuals. With this custom-made, streamlined manual, no classroom sessions were needed for teaching the basic tasks; it was a comprehensive and efficient *self-teaching* tool.

In the mid-90s I completed a CPE residency and subsequently was hired as a staff chaplain at the University of Minnesota Hospital and Clinics in Minneapolis, Minnesota, which merged with Fairview Riverside Hospital. The merged entity was

named Fairview-University Medical Center, which later became University of Minnesota Medical Center, Fairview. When I first joined our department, just before the merger, we were in a situation of crisis and transition so my training was a bit haphazard and piecemeal. We had only one staff chaplain and three residents covering the whole hospital for a good part of my residency year, yet my initial on-call training consisted of a one-hour tour of the hospital with an outgoing resident. With no written protocols provided, I had to depend on the notes I took during the tour. As for training in computer charting (we used a program called EMTEK), someone showed me how to log on, access patient charts, and write a note, but again nothing in writing. I did eventually get my hands on an in-house computer charting manual, but it was poorly written and primarily nursing oriented, covering way more than what was pertinent for chaplains.

There was no user friendly, streamlined manual available for use in our department as had been provided in my previous job, so I asked the one staff chaplain in our department to show me the basics, which I wrote down in a notebook. After that I learned new aspects of the program either by trial and error or by asking for help from staff in other disciplines. I kept a detailed journal of how to do all these actions necessary for chaplain charting. Slowly a manual of sorts took shape, first scrawled on pieces of paper or in my notebook, later transferred to my own computer files. Eventually I pulled together all my notes and checklists into a training document I called *Charting for Chaplains*.

In the more than ten years I have been a staff chaplain at UMMC, Fairview, I have seen this hospital setting becoming more and more complex, with a higher level of acuity. We are a major CPE site – three units a year, one unit as short as ten weeks. Up to 4 residents and 18 new interns cycle through our program each year.

Student chaplains are expected to function within a matter of weeks as unit chaplains, and when on-call they need to know how to perform all tasks pertinent to chaplaincy on any patient care unit in this large (800+ bed), quaternary care hospital. They are expected to use all forms of computer and paper charting properly.

**Charting for Chaplains** has become the core computer training document used to orient all of our CPE students, both interns and residents, as well as all new staff chaplains. It contains instructions not only for technical computer tasks, but also explains our philosophy of charting, how to write progress notes, how to manage patient information, etc. The introduction to the manual states its basic premise:

*This manual has been prepared for the use of chaplains at the University of Minnesota Medical Center, Fairview, and pertains to most types of charting and other information management on the patient care units. Understanding how to use*

*and contribute to patient charting is a fundamental part of effective pastoral care in a hospital setting. In this manual you will find step-by-step procedures for accessing and writing chart notes in ways that are appropriate for chaplains. It is meant to be a self-explanatory teaching tool, thus there is a certain amount of repetition from one section to another.*

Charting for Chaplains has undergone many revisions, as we regularly incorporate corrections or suggestions from students and staff. Sometimes the changes are major, for instance when we changed from the EMTEK charting system to FCIS (Fairview Clinical Information System).

## *Understanding how to use and contribute to patient charting is a fundamental part of effective pastoral care in a hospital setting.*

During the first week of student orientation, we have a 2 ½ hour training session with new CPE students. The training takes place in one of our hospital computer labs. The first half of the training is called “Charting 101” and is a basic introduction to various concepts of charting: *why* we chart, *when* we need to chart, some legal aspects, and how to write a basic progress note. We do a role-play of a chaplain visit and then write a chart note together as a group. The second half of the session is hands-on training at the computers. As the teacher, my computer screen is shown on a large overhead screen so everyone can see what I am doing. I review all the basic functions of our computer charting system (which are explained in detail in our *Charting for Chaplains* manual), first showing each function myself with students simply observing, and then having the students do it themselves. There is no expectation they will leave this session having mastered all the tasks; it is simply a way of giving them a first experience of doing everything, to familiarize them with the particular actions required to accomplish various tasks.

Students are given copies of *Charting for Chaplains* for further reference, and are encouraged to contact their clinical coordinator or any other staff chaplain if they ever get stuck in their computer charting. Tasks are described in a very literal, even redundant manner, geared for the anxious learner. The following example, taken directly from the manual, illustrates this principle:

### **This is how to write your DIAP note:**

1. Open the patient’s chart in FCIS
2. Select **Documents** tab
3. Click **Document Entry** button at bottom of window, or **Enter Document** button on toolbar. The **Document Entry Worksheet** screen appears.

4. Place cursor in box under “Content of” (it will change to “Searching for”).
  5. Type an “s” in the box under “Searching for”. A list appears below which includes **Spiritual Health Services Progress Note**.
  6. Double click on **Spiritual Health Services Progress Note**. **Free Text Entry** screen appears.
  7. Click in the large empty space, then use **Acronym Expansion** to produce a DIAP template.
- To use “Acronym Expansion”:**
- a. Type the letters **diap** (small case)
  - b. Press the **space** bar.

The following will appear:

SH PCU

Focus:

D:

I:

A:

P:

pager 899-#### (your pager number will appear)

(EPA and other routine referrals may be submitted to Spiritual Health Services at 3-3572 or as an FCIS order for a Spiritual Health Services consult. Routine referrals are picked up intermittently from 8a-5p, 24/7 and responded to within 24 hours. For urgent needs, the on-call chaplain will reply to a page from the switchboard or an FCIS “stat” order within 10 minutes.)

8. After the letters “PCU” in the first line, type in the patient care unit on which the visit took place. (For example, if the visit happened on 6C, it will be: SH PCU 6C)
9. Write your note by entering text for Focus and DIAP in the appropriate places.
10. When you have finished your note, click the Submit button at bottom.
11. Enter your password and click OK (or press “enter” key).

You will now be returned to **Document Entry Worksheet**. To exit, click **Close** button.

Concrete, literal thinkers especially need reassurance that what they have done at each step along the way is correct before they can move on to the next action. Reducing the anxiety of the process of charting frees students and new chaplains to concentrate on the more important context within which they are charting.

### On-call protocol worksheets

On-call duties at UMMC, Fairview can prove quite daunting to the novice chaplain, and even to a seasoned pro. There is an on-call chaplain available to all patient care units 24/7. Weekdays from 8 a.m. to 5 p.m. we have 2 chaplains on-call, one for each

campus of the hospital (UMMC functions as one hospital on two campuses in close proximity, separated by the Mississippi River). The weekday chaplain continues to be responsible for chaplain duties on his or her unit, but also acts as back-up in emergencies to all units without a chaplain due to illness, vacation, or involvement in seminars, meetings, or projects. From 5 p.m. until 8 a.m. and for 24 hours of each weekend day, one on-call chaplain covers all pastoral care emergencies for both hospitals and responds to all trauma pages generated by our Emergency Department. We have strict protocols governing response times. One of our two Catholic

*As a staff, we want every student to do as well as he or she is capable. We want the technical tasks to be as stress-free as possible.*

priest chaplains is on-call exclusively for emergency sacramental needs; the primary on-call chaplain is responsible for assessing these needs. Given the high level of acuity in our hospital, on-call duties can be very demanding, even during the weekdays, when other chaplains are present in most units.

As normal day to day operations of the hospital have become more complex, on-call ministry has followed suit. In order to fulfill all the demands of this ministry, there are dozens of tasks that need to be attended to, in the proper order: responding appropriately to emergency requests (that sometimes occur in multiples simultaneously), triaging situations that could wait until a later date, charting all visits, referring on to the appropriate unit chaplain for follow-up, responding to trauma pages, leading worship service, etc. When I first came to UMMC, Fairview 13 years ago, my orientation to on-call consisted of a quick tour of the facilities and a short description of the tasks involved, then I was on my own.

This “sink or swim” philosophy might engender some good material to discuss in CPE, but we have decided that patient care would suffer too much. Thus, our own versions of “the checklist” emerged. We have developed detailed worksheets for on-call duties that take nothing for granted. Even a reminder to make sure one’s pager is turned on is included. Every necessary task is described in chronological order from the beginning to the end of the day in a checklist format. Space is provided for making note of all referrals, with reminders to pass on pertinent information to the appropriate unit chaplain. Four different worksheets are provided (University Campus weekday, Riverside Campus weekday, Saturday, and Sunday), since each of these scenarios has a different set of tasks that need attention.

All this paperwork might sound like micromanagement at its worst, or that we are demanding uni-



formity in pastoral care styles from CPE students, but positive feedback from students and staff chaplains says otherwise. It appears that having a checklist of all necessary tasks, in the order they need to be done, helps to free up the student to be able to pay more attention to the actual art of pastoral care. It helps them not only to focus on patient and family needs, but to function right from the start as a colleague to the other chaplains, be they staff, residents, or interns, and to provide pastoral presence to hospital staff.

## Common principles

These protocols and training tools pay close attention to issues of editing and translation:

*Editing* instructional materials may at times mandate paring down the material, or when needed, adding to it. More often than not, teaching manuals include much more than a learner needs to know for a particular facet of their job, making it very difficult to wade through all the material to identify those sections that are essential at any given time. For teaching tools to be effective, one needs to edit the material down to what is needed for a particular job or task, nothing more, nothing less. It is important that each task described be “self-contained,” that is, very little previous knowledge is assumed necessary to be able to do it properly. Each description starts at the beginning and walks you through every action, point by point. Redundancy is not necessarily a bad thing when it comes to writing how-to manuals, as many users enter in at the precise point of information they need at that particular moment.

*Translating* materials involves making sure the reader/learner will have no question whatsoever about what he/she is to do. Every action must be described in unambiguous, clear, precise, very concrete language. This is especially important if the resource is to qualify as a self-teaching tool. For someone not familiar with the jargon, certain published teaching materials, for example, computer manuals, can seem to the layperson like they were written in a foreign language. Translation into clear everyday English is essential.

## Conclusion

I gain great satisfaction from seeing others do well at their tasks. As a staff, we want every student to do as well as he or she is capable. We want the technical tasks to be as stress-free as possible. If there is going to be major stress for chaplains, whether students or staff, better that it come from substantive issues relating to pastoral care or personal growth and integration, which can be dealt with appropriately for students within the CPE group learning process, or whatever structures are available to support staff chaplains.

We believe that the heart of the CPE experience is pastoral care. The orientation materials I have

described are not meant to be “rules” that attempt to clone a department of like-minded chaplains. Our goal is not unity of pastoral care styles or approaches. The goal is complete transparency as to the “bottom line” of what is expected of chaplains to be able to function as part of an inter-disciplinary team. At their best, these protocols are a snapshot of our department’s consensus on best practice, a structure that fosters an environment where chaplains are all clear about what their colleagues expect of them and regulations require of them.

Returning full circle to where I began this article, I’ll relate the metaphor of flying to our experience as chaplains, especially as it connects to CPE. We don’t want students to crash and burn, thus the checklists were developed to help guide their takeoff, ascent, and landing. Once the student is in the air and feels safe, she or he can improvise a bit, using his own intuition, going deep into her own experience and unique skills, but always paying attention to the need for good communication with those down on the ground who can see the big picture. They can feel free to speed up, slow down, go into a steep dive, maybe even a barrel roll—but they will be no good to themselves or the patients they serve if they crash. Our hope is that the navigation tools we provide might serve to help our colleagues fly free and land safely onto the grounds of meaningful chaplaincy practice.

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## Notes

Readers interested in obtaining copies of the training tools described in this article (*Charting for Chaplains* manual, On-call protocol worksheets) may request them from the author at [bdexheil@fairview.org](mailto:bdexheil@fairview.org).

# Reflections on CPE and the Transition to the Third Age

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A new understanding of aging views the process as opportunity and fulfillment.

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The other day someone was talking with me about what he called the downward spiral of aging. I invited him to frame that statement differently by talking about the upward spiral of aging. Perception will often define reality and old concepts of aging can begin to define how the reality of aging is approached. The old understanding of aging dealt with deficit and loss. Aging was seen as a declining process that required changes in behavior and attitudes that began to isolate the aging person. A new understanding of aging views the process as opportunity and fulfillment.

New and progressive thinking has developed as the result of a 12-year study by Dr. William Sadler. Sadler's research indicates that we will live an average of thirty years longer than our forbearers of 1900. He calls this our "30-year life bonus" and uses "The Third Age" to signify a new period of life not possible for previous generations. Sadler identifies four periods or "ages" of life:

**1ST AGE = PREPARATION:** Our First Age prepares us for life. In the early years we develop skills we need to support our Second Age independence...

**2ND AGE = ACHIEVEMENT:** In Second Age we earn a place in the adult world of responsibility. Our focus here is on security, belonging and status...

**3RD AGE = FULFILLMENT:** Third Age begins as advancement becomes less important. Wisdom and self-awareness bring new ease with others and with our selves. Freed from the responsibilities of family and career, we can create our Third Age so it truly becomes, "THE BEST IS YET TO BE!"

**4TH AGE = COMPLETION:** This is a time to experience successful aging, the last stage of life on this plane. Growing to our full potential in Third Age prepares us for this completion.<sup>1</sup>

The movement into Third Age is a transition that can be either welcomed or feared, depending upon one's perspective.

Those of us who work with people transitioning into the Third Age will most times work from the perspective that this is the time to review where one has been and to reframe the future to complete all that is yet to be. Rather than viewing this process as a time of loss, we view it as a time to look to the future with joy and anticipation.



Participation in the Clinical Pastoral Education (CPE) process was part of my intentional process into the Third Age. At the age of 59, I reviewed where I had been and then assessed where I was. I was able to make some decisions about my life that began a reframing process designed to enrich my Third Age experience. I found that while I had enjoyed my time in teaching and administration in

*I came to understand how my own life issues impact patient care, and then I began to realize that these same issues impacted all of my relationships.*

higher education, it was now time to move on and into something with more teaching and pastoral care. My adult life has been filled with a great deal of out-of-sequence periods of illness and death and I began to realize that my gifts lent themselves to situations of care and support.

After a series of circumstances I decided to take a year long sabbatical from administration and teaching to enter the CPE process. In the reframing of my life, my goal was to begin the process of becoming certified as a chaplain so that in

“retirement” I could serve as a chaplain in a nursing home or hospice center.

Honestly, I approached CPE with a bit of arrogance. I had done parish-based ministry and I had ministered to the sick and dying of my own family; I entered CPE to earn the credential for what I felt I already knew. Well, I was in for a whole series of surprises. My time of “reframing” became one of the most powerful experiences of my life as I began to realize what it meant to walk with people along the way. Through the CPE process I experienced a reframing and renewal that was both painful and renewing. The CPE process helped establish a healthier framework for my move into the Third Age.

I expected to be entering CPE as the “old-timer.” I was pleasantly surprised that in my first CPE group there was another 50-year-old person in addition to me. In my second CPE unit, I wasn’t even the oldest person. The youngest member of our group was in the mid-forties range and the oldest was in the mid-sixties. What a rich experience. Here were people in my general age category also in the process of reframing through the CPE experience, with the intention of moving into a new expression of service. I will never be able to experience CPE as a twenty-year old, although I was truly blessed by the insights of the twenty year olds in the group, but I can say that my experience at this current age was made that much the richer for me because of my life experience.

The CPE experience turned out to have multiple layers of giftedness. I was, in fact, led to reframe my understanding of pastoral care to be much more inclusive. I came to understand how my own life issues impact patient care, and then I began to realize that these same issues impacted all of my relationships. From the reframing that resulted within the CPE experience I feel that I have developed a clearer sense of authenticity, with avenues in place for future growth. My peers have told me that they have observed my teaching style, my ministry style, and even my lifestyle change as I have gone through this reframing process in CPE.

Life in the Third Age becomes a process of building off of the past in order to leap into the future. As I reflected upon the issues of my life, I was able to see many of the things that enhanced my life and I began to see many of the things that held me back in life. I discovered that because of issues in my family of origin I was not always able to be fully present with certain people. I particularly became somewhat distanced and not fully present with those who struggled with addiction. Through a number of encounters with patients and the feedback that I received in the verbatim process, I have grown tremendously in my ability to be much more present for people with addiction issues. What this allows me to do is to travel “lighter” on the journey into the future, and, by traveling lighter I can walk more authentically with those around me. I have learned

how to recognize the “excess baggage” that I have carried from various life experiences and have learned ways to either release the baggage or, at least, move it out of the way in my work with people.

So, as I progress in the Third Age of life, I continue to explore service as a chaplain. I will continue to do some teaching, but the goal that I have is to serve as a chaplain in an institutional setting. CPE was described by one of the leaders in CPE as a place for those in transition. I really agree with this statement. CPE has helped me and supported me during my transition into the Third Age.

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*Dr. Arnold completed two units of CPE in the Fairview system assigned to the University of Minnesota Medical Center-Fairview site.*

#### Notes

<sup>1</sup> <http://www.thirdagecenter.com/whatis3rdage.htm>

# Do We Need More *Lutheran* CPE Supervisors?

What differentiates a Lutheran CPE supervisor from any other CPE supervisor?

I often hear from other Lutheran supervisors that we need more Lutheran supervisors. The numbers would show that when ACPE was formed in 1967, there were many more Lutheran supervisors than we have today. In 1988 we had about 150 Lutheran CPE supervisors. Today, we have about 50, with many retiring or dying each year. So, understandably, we want to recruit more Lutherans into CPE supervision. But why?

From 1949-1967, when the Lutherans were certifying pastors as supervisors and chaplains through the Lutheran Advisory Council, the number of Lutheran supervisors grew. The process was challenging. The camaraderie was evident. Lutheran identity was integral. One reason given for the formation of the Lutheran Advisory Council was concern about the perceived scarcity of pastoral theological education in CPE at that time. Then, in the 1940's, the Board of Social Welfare of the LCMS began a plan for the creation of a clinical pastoral program under Lutheran auspices for Lutheran seminarians. Lutherans have long been a confessional movement rooted in theological inquiry. I find myself wondering, do we believe we need more Lutheran supervisors in ACPE in order to continue the mission of the Lutheran Advisory Council?

When the ELCA was formed, the decision was made to require one unit of CPE (or equivalent experience) of all persons seeking ministry of word and sacrament. Yet, since then, the number of Lutheran CPE supervisors has dropped to a significant low. Do we want Lutheran seminarians taking CPE with a Lutheran supervisor? Does it matter today? I asked one of the current Fairview summer CPE interns who is an ELCA seminarian whether he was encouraged to look for a Lutheran supervisor and he was a bit baffled by the question. No one had brought that up to him.

I want to be clear that I, personally, do not believe that it is necessary or even useful educationally for Lutheran CPE students to have a *Lutheran* supervisor. After all, ACPE supervisors are required to abide by the ACPE Code of Professional Ethics that state, "approach the religious convictions of a person, group and/or CPE student with respect and sensitivity; avoid the imposition of their theology or cultural values on those served or supervised (ACPE Standard 100)." Besides, engaging a supervisor of another theological perspective can create an educationally beneficial dissonance that contributes to differentiation and appreciation of difference. It is the task of students to integrate their own theological heritage into their theology of pastoral care.



So, do we need more *Lutheran* supervisors? When I was in my supervisory education process, I was encouraged to "get out of my Lutheran ghetto" and have supervisors who were not Lutheran. For the same reason, I earned my MA in Religious Leadership at a UCC seminary, where I studied with

*Engaging a supervisor of another theological perspective can create an educationally beneficial dissonance.*

faculty and students from many Christian and some non-Christian, non-theist faith traditions. This educational formation for supervision has been helpful to me as a CPE supervisor. For example, my most recent intern group consisted of a Buddhist priest, a liberal Catholic, an LCMS minister, an ELCA seminarian, a retired Salvation Army officer and a Kenyan Methodist.

Before we can answer the question, "Do we need more *Lutheran* supervisors?" I wonder if we need to ask, "What do we need from our Lutheran supervisors? Is it just a good thing to have more Lutherans on the CPE supervisor list? Is it that we want a Lutheran presence in ACPE to be a liaison back to the churches? What responsibility do supervisors today have toward the religious institutions and church bodies? And what responsibility do institu-

tions and the church bodies have toward “their” supervisors? How are our Lutheran supervisors pastoral theological educators of and for the Lutheran expressions of the body of Christ? What can we offer one another as we move into the 21st Century?”

Maintaining a Lutheran Christian identity in an inter-faith world is not easy, and while it may not always be necessary, what then makes each of us distinct? In his article, “Ferment and Imagination in Training in Clinical Ministry,” (*Pastoral Care and Counseling: Redefining the Paradigms*, Nancy J Ramsay (ed.) Abingdon Press, 2004) Loren L. Townsend, Professor of Pastoral Care and Counseling in Louisville, Kentucky, writes,

Over the past two decades, training for clinical ministry has been reshaped as educators responded to cultural and sociopolitical contexts....*Chaplains have revised their identity away from religious connections that define care as an extension of particular religious communities* (italics mine). Its replacement resembles a medical specialty—chaplains are those practitioners who treat the spiritual dimension of patients through a set of competencies independent of ordination, religious commitments, or faith community. This change, now an ACPE policy, assures a future for hospital chaplains. It also shifts training priorities away from pastoral formation and toward learned competencies for professional practice. While this change is important to survival, it is critical that chaplains and pastoral theologians maintain conversation to evaluate effects and interpret this new identity in a theological context (p.130).

If, as Townsend posits, many chaplains, and I would add many clinical pastoral educators, have shifted their identity away from religious connections through which they see their ministry as an extension of their faith community, I would ask how has that also happened to the Lutheran chaplains, pastoral counselors and clinical educators?

We are required to be endorsed by the Lutheran church for our ministry as CPE supervisors in order to be certified supervisors. Being endorsed requires being rostered for public ministry. As supervisors, we need to “maintain good standing in our faith traditions (ACPE Standard 102.1).” The Inter-Lutheran Coordinating Committee for Ministries of Chaplaincy, Pastoral Counseling and Clinical Education (ILCC-MCPCCE), supported by both LCMS and ELCA, offers various venues to remain connected to our Lutheran identity, including *Caring Connections*, triennial Zion Conferences, annual Lutheran breakfasts at cognate meetings. While these may strengthen the Lutheran identity of those who avail themselves of these opportunities to connect with other Lutheran supervisors, is this enough?

Am I a supervisor who happens to be Lutheran in affiliation and tradition? Or am I a Lutheran supervi-

sor, called and sent by the ELCA and LCMS to serve the church as a clinical pastoral educator?

What differentiates a Lutheran CPE supervisor from any other CPE supervisor? How do our church bodies support our identity as one called and sent to serve as CPE supervisor? In good Lutheran paradox, we are both grounded in the church and serve institutions that employ us and certify us. We are Lutheran and we work in an inter-faith context. We want to be partners in this inter-faith educational ministry.

*I would like to see the church recognize the incredible asset that these Lutheran supervisors are to the church.*

I don’t know if we really need more supervisors who happen to be Lutheran. But I believe the Lutheran churches need more Lutheran supervisors. What if we who are ELCA were called through the ELCA Church Council as theological educators of the church and connected through Lutheran Seminaries as adjunct faculty? What if we asked one another to remember our Lutheran theology as foundational for our supervision? What if Lutheran supervisors came together at Zion Conferences for a peer review around our Lutheran identity in supervision? While I don’t have clear answers, I would call for dialogue with the church bodies and the CPE supervisors around these questions.

ACPE needs more supervisors. Toward this end, the Fairview CPE Center, Minneapolis, a member organization of Lutheran Services in America (LSA), has designed supervisory education that will allow more flexibility and intentionality in forming people for supervision. We have a grant from Thrivent to assist with tuition costs for supervisory education students. We allow students to continue to minister in their own context concurrent with supervisory education (see the related article by Shawn Mai). In the fall, we will have three supervisory students who are Lutheran, two of whom are from Norway.

I would like to see more *Lutheran* supervisors. And, I would like to see the church recognize the incredible asset that these *Lutheran* supervisors are to the church. This mutual accountability to one another may draw more Lutherans into supervisory education. And that could strengthen the theological thread within the ACPE movement.

*Deaconess Diane Greve was certified by the ACPE in 2000 as a CPE Supervisor and manages the Fairview CPE Center in Minneapolis. She currently serves on the Inter-Lutheran Coordinating Council for Ministries of Chaplaincy, Pastoral Counseling, and Clinical Education (ILCC-MCPCCE). Diane has been a consecrated deaconess of the Lutheran Deaconess Association, Valparaiso, Indiana since 1972.*

## New and noteworthy

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### Give Something Back Scholarship

The next deadline for this joint Lutheran scholarship fund is August 15th. The awards will then be made in November. Scholarship funds are awarded to individuals seeking ecclesiastical endorsement and certification/credentialing in ministries of chaplaincy, pastoral counseling, and clinical education. The fund has a corpus of \$146,896.44 with grants totaling \$6000.00 per year (\$3000.00) semi-annually.) More information and application forms are available on both the ELCA and LCMS web-pages.

### Zion XIV Conference

Preliminary planning has begun for the Zion XIV conference to be held in 2010. Thanks to the efforts of Reverend Bryn Carlson and Reverend John Fale, the Vocation and Education Unit of the ELCA and LCMS World Relief and Human Care are committing the necessary seed money to make this conference a reality. More information about the conference will be shared in future editions of *Caring Connections*.



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## Recent and upcoming events

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### Inter-Lutheran

October 10-11      Inter-Lutheran Coordinating  
Committee meets in St. Louis,  
Missouri

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