

# Caring Connections

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



*Back to the Future: Chaplaincy, Pastoral Counseling and Clinical Education*

## 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.

## Scholarships

When the Inter Lutheran Coordinating Committee disbanded a few years ago, the money from the “Give Something Back” Scholarship Fund was divided between the ELCA and the LCMS. The ELCA has retained the name “Give Something Back” for their fund, and the LCMS calls theirs “The SPM Scholarship Endowment Fund.” These endowments make a limited number of financial awards available to individuals seeking ecclesiastical endorsement and certification/credentialing in ministries of chaplaincy, pastoral counseling, and clinical education.

Applicants must:

- have completed one [1] unit of CPE.
- be rostered or eligible for active roster status in the ELCA or the LCMS.
- not already be receiving funds from either the ELCA or LCMS national offices.
- submit an application, along with a financial data form, for committee review.

Applicants must complete the Scholarship Application forms that are available from Judy Simonson [ELCA] or Joel Hempel [LCMS]. Consideration is given to scholarship requests after each application deadline, August 15 and February 15. Email items to Judith Simonson at [jsimonson@aol.com](mailto:jsimonson@aol.com) and to Joel Hempel at [Joel.Hempel@lcms.org](mailto:Joel.Hempel@lcms.org).

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## Call for Articles

*Caring Connections* seeks to provide Lutheran Pastoral Care Providers the opportunity to share expertise and insight with the wider community. We want to invite anyone interested in writing an article to please contact the editors, Rev. Chuck Weinrich ([cweinrich@cfl.rr.com](mailto:cweinrich@cfl.rr.com)) or Rev. Diane Greve ([dkgreve@gmail.com](mailto:dkgreve@gmail.com)). This call is a regular item in each issue of *Caring Connections*, but we are particularly intentional as we invite articles for upcoming issues on the following themes.

**2016, No. 4 (Winter) “Prayer”** Do you have a pastoral experience in which prayer was an important component? Are you willing to write a reflection on prayer, or do you have a unique opinion about the use of prayer in pastoral ministry? We welcome your input.

**2017, No. 1 (Spring) “Zion XVI”** We plan to include transcripts of the major presentations from the conference. Do you have a reflection or opinion about the conference? Please consider writing an article for us. We want to hear from you!

**2017, No. 2 (Summer) “Ministry with Immigrants”** Are you involved in pastoral work that involves immigrants? Please consider writing about it and contact either Diane or Chuck for details.

## Editorial

**MOST ALL OF US** can recall the movie, *“Back to the Future II”*. While the film was set in 1985, “Doc” and Marty travel ahead in time to the year 2015. We now know that some of the predictions featured in that movie were surprisingly accurate — like widescreen smart TV’s. Others totally missed the mark — like “hydrators” and “hover boards”. When it comes to our attempts at gazing into crystal balls, that screenplay reflected a pretty typical batting average, one that would most likely hold true for any book or movie entitled, *“Back to the Future: Chaplaincy, Pastoral Counseling and Clinical Education”*.

As Scripture attests, human beings are obsessively future-oriented, eschatological beings. In addition to what we embrace from the past, present meaning is closely related to our anticipation of what lies just over the horizon. Whether the focus be on climate change, the economy, fashion, or the church, endeavoring to identify the kinds of needs, opportunities and trends the future might hold seems part of our DNA. It keeps us leaning ever forward.

Through a two-part, historical overview of Lutheran ministries in chaplaincy, pastoral counseling, and clinical education, the last two issues of *Caring Connections* set the stage for just such a gaze into the future. It’s our hope that readers found that history informative — even inspiring. The epilogue concluding Part II posed the questions, *“So, where are we headed? What now becomes of these longstanding ministries and spiritual care services in an ever-changing, postmodern world...?”* We quickly identified just a few emerging trends already upon us: population health management, evidence/outcomes/metrics-based care, outpatient and workplace ministries, and “e-ministries”. Those few barely whet the appetite.

Thanks to the five superb articles and two interviews comprising this issue, an entire buffet (or, for some of us Scandinavian Lutherans, “smorgasbord”!) is served up in the pages that follow. It’s one that could very well shape an initial screenplay for: *“Back to the Future: Spiritual Care and Clinical Education 2030”*. As you will quickly discover, all seven contributions are from seasoned, respected colleagues in the field. All bring unique perspectives/outlooks from unique vantage points. Collectively, their writing is marked by keen insight, candor and care. Given that this is the last time I edit an issue of *Caring Connections*, it has been a privilege to participate in setting the table for this sumptuous buffet.

I will greatly miss serving as co-editor of this special resource for those serving in ministries of spiritual care, counseling and education. Along with retirement from NYU Lutheran Medical Center, I’ve decided to step back from some other activities as well in order to give focus to a few of my own aspirations in teaching and writing.

What an enriching four-year journey this has been! I will especially miss the blessing of working with Chuck Weinrich — his mentoring, support, and unique brand of “holy humor”! Indeed, I hope readers continue to fully appreciate the

innumerable gifts they receive in/through this free journal: in addition to Chuck's many talents and steadfast leadership, the able guidance of the editorial board, the labors of those who have graciously contributed hundreds of articles, the caring and creative work of those who design and produce the copy and, ultimately, the invaluable nourishment of the journal itself. As my grandmother often reminded me, "Maybe it's an old cliché, but never forget that, truly, the best things in life are free."

With deepest gratitude!

Don Stiger

# The Future(s) of Lutheran Pastoral Counseling

Rev. Dr. Bruce Hartung

*Those were the days my friend  
We thought they'd never end  
We'd sing and dance forever and a day  
We'd live the life we choose  
We'd fight and never lose  
For we were young and sure to have our way.  
La la la la,  
Those were the days, oh yes those were the days <sup>(1)</sup>*

**FOR THE SPECIALIZED** pastoral care movement those were energized and optimistic days — those 1960's. The pastoral counseling movement was caught up in those days. Perhaps we thought that the human spirit could rise above the national traumas of three assassinations; perhaps we believed that the better angels of humankind could bring peace out of war or justice out of a political convention; perhaps we just thought that the combining of a deeper understanding of human psychology combined with the eternal force of God's action in Jesus could make the world a really better place; perhaps we were really beginning to grasp the notion of human wholeness and that the life of the Spirit of God was not limited to "church" on Sunday morning, but rather permeated all of life.

In 1959, as if to usher in the 60's, the Lutheran Institute for Human Ecology was formed with the definition: "the understanding and treatment of the human being as a whole person in light of his relationship to God, to his family and to the society in which he lives."<sup>(2)</sup> At the same time Lutheran General Hospital was begun in Park Ridge, IL as an outgrowth of Deaconess Hospital in Chicago. The American Association of Pastoral Counselors (AAPC) was founded in 1963; the Association for Clinical Pastoral Education (ACPE) was formed in 1967, bringing together four pastoral clinical groups, including specific denomination groups from the Southern Baptists and the Lutherans. The Ph.D. interdisciplinary Garrett Seminary and Northwestern University program in pastoral counseling was going strong (with a behavioral emphasis at Northwestern and a psychoanalytic emphasis at Garrett), and in 1967 both Larry Holst, the Director of Pastoral Care at Lutheran General and I, a 1967 graduate from Concordia Seminary, Saint Louis, were beginning students.

Lutheran names that became known to me were three, none of whom I had read at my seminary: William Hulme, author of many books over the years, but his "Lutheran Pastoral Care" article in the *Dictionary of Pastoral Care and Counseling* remains an outstanding summary work<sup>(3)</sup>, Fredric "Fritz" Norstad, whose article "The Hospital as a Healing Community" in *The International Review of Mission*<sup>(4)</sup>

set the overall tone for wholistic care, and Granger Westberg, experimenter with health clinics as an integral part of parish ministry and later a major pioneer force in the development of parish nursing. Westberg's biography *Gentle Rebel*<sup>(5)</sup> was just published in 2015 (and will soon be reviewed in the *Concordia Journal*).

In the Lutheran Church—Missouri Synod, the Wheat Ridge Foundation selected five parish pastors and paid for their entire graduate education in psychology (not me, by the way, but I did try to see if they would help me with funding, a “try” that failed); inter-Lutheran cooperation was flourishing; graduate programs in pastoral counseling were developing and expanding; the specialized pastoral care organizations were expanding and becoming more prominent; and Clinical Pastoral Education was becoming highly valued as an important component of theological education. Much of this, by the way, is documented in a more overall way by E. Brooks Holifield in *A History of Pastoral Care in America: From Salvation to Self-Realization*<sup>(6)</sup>, as well as in the brief Hulme article mentioned earlier.

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“...pastoral counseling will continue to insist that the life of the Spirit is not just to be seen in relief of symptoms or in treatment of disease.”

It is good to know from whence we came. It influences how I view my own walk and the development of pastoral counseling and the Lutheran version of it (if there is one), and it certainly influences my view of the future. Any way it is sliced, however, those were the days.

In the succeeding years I remained at Lutheran General Hospital at the Pastoral Psychotherapy Institute, moved to Syracuse, New York to be at the Onondaga Pastoral Counseling Center, then returned to Saint Louis as a denominational person (Director, Ministerial Health/Health and Healing Ministries) and then migrated to Concordia Seminary to teach and help in ministerial formation for over a decade. I was active for a significant piece of time at the organizational level of AAPC, and AAPC is the only clinical organization from which I have not retired as an active practitioner. I still have a deep need for what AAPC brings, as will become clearer later.

As I look back as a beginning place to looking forward I can make a clear prediction, though, about the future: it will likely not be what I predict, for my 60's perspective would never have seen what is today in a whole host of arenas. There will be unanticipated forces at work perhaps not even dreamed of in 2016 except in science-fiction novels. Yet I dare to have future hopes, and these I will share. In that sense they are not predictions at all, but rather hopes for the future of Lutheran pastoral counseling. Thanks to the editorial staff of *Caring Connections* for risking to give me this opportunity. But as the reader reads this, remember, or at least consider, pieces of those days that were.

***Lutheran pastoral counseling, and pastoral counseling in general, will focus on spiritual and psychological depth, resisting exclusive emphasis on (and compensation for) symptom-oriented treatment.***

In a counseling world that values evidence-based treatment and that also compensates according to symptom-relief, without devaluing the former, pastoral counseling will continue to insist that the life of the Spirit is not just to be seen in relief of symptoms or in treatment of disease (utilizing primarily a medical model), but also in the exploration of the deeper aspects of the psyche and a person's ongoing relationship with the Divine.

If Saint Augustine was correct, as I think he was, that a person's heart is not at rest until rest is found in God, then deep attention to both the inner world of a person and the spiritual walk of that person is crucial in the work of pastoral counseling.

This moves from a symptom-based practice of pastoral counseling to a whole-person practice, and prizes work that has a focus on insight, understanding, mindfulness and the life of the Spirit. This deeper orientation, looking beyond symptoms into the very being of the self in relationship to God and others, is a future for Lutheran pastoral counseling for which I hope.

The alternative future is that Lutheran pastoral counseling is consumed with almost exclusive attention to symptom-relief (a necessary goal as well) and how the Gospel attends to and meets these symptoms without attention to the broader and deeper aspects of spiritual life and formation as disciples of Jesus.

***Lutheran pastoral counseling, and pastoral counseling in general, will work to strengthen cerebral cortex thoughtfulness and right-brain hemispheric activity.***

Some years ago I (and several dozen others) was with the Director of the National Institutes of Mental Health. When he was asked what principal change he expected to occur between 20th and 21st century mental disorders, he quickly responded, "We will move from disorders of repression to disorders of impulse control". I have come to understand this to mean that we, having learned to experience more of what we think and feel, will develop less capacity to harness and utilize those thoughts and feelings in productive and useful ways. Rather, we will simply act them out. Practically, therefore, when I get angry at someone on the road I lean on my horn or cut them off, rather than reflect on my impatience. Similarly, when I am disappointed I see someone or something to blame (as in, "the devil made me do it") rather than explore the nature of my disappointment. When my spiritual life begins to wither some, I decide the preaching no longer nourishes me rather than seek a spiritual director to walk with me.

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"Empathy emerges as a core value, intuition combined with thoughtfulness as a skill, and exploration of the inner world a necessary task."



Along with this diminishment of the capacity for and utilization of meditation, reflection and conversation-with-others about one's own experience and an increased tendency to act out more immediately on what one thinks and feels is also a move away from intuition and deeper empathic connection, characteristic of right hemisphere neurological work. Empathic connection with others becomes less valued.

Lutheran pastoral counseling will resist these acting-out trends and will foster, value and offer personally reflective work concerning the integrated and wholistic self. Empathy emerges as a core value, intuition combined with thoughtfulness as a skill, and exploration of the inner world (to borrow Anton Boisen's book title) a necessary task. This future hope for Lutheran pastoral counseling pairs well and congruently with the first hope, above.

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"...we are in a sea change and potential retreats to cultural encampments. This is a significant challenge for inter-Lutheran work as well as inter-church and inter-faith relationships."

***Lutheran pastoral counseling will maintain vital inter-Lutheran, inter-church and inter-faith relationships and conversations.***

The choices of Lutherans are relatively clear here. In the midst of the anxiety and cultural struggles that are so obvious (is a listing of struggles about sexuality, Biblical authority, exclusivity of Jesus as the road to salvation, spirituality without institutional religion and with whom do we pray publically necessary as beginning examples?), we are in a cultural sea change and potential retreats to cultural encampments. This is a significant challenge for inter-Lutheran work as well as inter-church and inter-faith relationships.

Lutheran pastoral counselors as well as others in the specialized pastoral care and counseling field, will stand their inter-Lutheran, inter-church and inter-faith relational and conversational ground. Our conversations, relationships and working together for the common good do not need to depend (although it would be nice!) on our agreement concerning these cultural changes. In this way Lutheran pastoral counselors continue the bridge-building movement of the 60's and reject the wall-building movements so evident in our current age.

Ongoing activity in organizations like the American Association of Christian Counselors (AACC, [www.aacc.net](http://www.aacc.net)) is an important small step as it maintains the inter-church (Christian) relationships. But are the necessary conversations and relationships limited to Christians? There are clear limits to the narrow "what is distinctively Lutheran about Christian counseling" conversation. That is why in my future the American Association of Pastoral Counselors (AAPC, [www.aapc.org](http://www.aapc.org)) or organizations like it are so important, because there clinical counseling discussion intersects with the broadest of folks in the inter-faith and, actually, inter-spiritual cultural.

All this builds on the first two future hopes.

The alternative future is, of course, increasingly limited conversations with those with whom we agree, and our professional conversations increasingly mirror the echo-chambers so characteristic of Facebook.

***Lutheran pastoral counseling, and pastoral counseling in general, will combine attention to the individual with deeper attention to the larger systems in which an individual lives.***

One of the early faults of the pastoral counseling movement and its individualistic and psychodynamic emphasis was its relative inattention to contextual forces and influences on the individual. Over the years, though, family systems work has been extended into a systemic analysis of organizations such as churches, businesses and even communities. Attention to social justice and socioeconomic factors began to work their way into the wholistic model. Indeed, we have learned that toxic systems can make individual people, even healthy ones, ill, and that healthy systems can aid in the recovery and healing of people who are ill.

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"Lutheran pastoral counselors... will become more social and economic justice advocates... robust advocates for systemic changes that will facilitate wellness."

Lutheran pastoral counselors, seeing the interaction between environmental systemic health and individual health, will become more social and economic justice advocates. Those Lutheran pastoral counselors who know how their clients got into spiritual, personal or interpersonal difficulty over time will see repetitive systemic patterns that, if addressed, would prevent or minimize the difficulties. Seeing how toxic environments facilitate illness should lead those who do pastoral counseling to be robust advocates for systemic changes that will facilitate wellness.

An alternative future is that Lutheran pastoral counselors stay confined to their office and do not venture out into the public square. Here, then, the counseling effort, as important as this effort might be, will be focused on personal adaptation, not systemic change.

***Lutheran pastoral counselors will balance a medical model (e.g. we will find out what is wrong and help you fix it) with a wholeness/wellness model (e.g. we will seek to discover that which is already healthy and help you maintain it, we will work together to do more and more healthy behaviors, and we will seek to prevent illnesses that are preventable).***

If 30%+ of the treatment of diseases paid for by Concordia Plan Services of the LCMS are for preventable diseases, should not Lutheran pastoral counselors be in the forefront of healthy behavior models? If healthy eating, sleeping and exercising

foster more efficient and imaginative work, should pastoral counselors not be taking initiative to teach folks about this and encourage their movements in this direction? If our wholeness is surrounded by what Gary Harbaugh used to call “faith hardiness”, should not Lutheran pastoral counselors actively engage people with whom they talk about their spiritual walk with a loving and caring Christ who has redeemed them and the whole world?

Turning in an exclusive passion in search of cure for an equal passion of discovering wholeness and wellness should characterize Lutheran pastoral counselors, and pastoral counselors in general, as they go about doing their vocation in this world. Prevention and wellness become as key a point of vocational activity as treatment and cure.

My hope in responding to the request from *Caring Connections* to offer this article is that it will help stimulate the reader’s reflections not only on the history and values from which he or she has come, but also how the future beckons them and what hopes they have and can help implement about the future.

I would love to have a dialogue about hopes and futures as they relate to Lutheran pastoral counseling. Perhaps *Caring Connections* can set that up. But, I am also available at [hartungb@csl.edu](mailto:hartungb@csl.edu).

Blessings on your 21st century walk!

*Bruce M. Hartung is Professor Emeritus of Practical Theology at Concordia Seminary, Saint Louis. Previously to joining the seminary faculty he was the Executive Director of the Commission on Ministerial Growth and Support of the LCMS. He is a past President of the American Association of Pastoral Counselors, and was the Executive Director of the Onondaga Pastoral Counseling Center, Syracuse, New York and, before that, the Director of the Pastoral Psychotherapy Institute (beginning as the Community Pastoral Counseling and Consultation Center) at Lutheran General Hospital, Park Ridge, Ill. He is married to Judy and together they have two grown sons, two grown daughters-in-law and five grandchildren.*

## ENDNOTES

- (1) Mary Hopkins, “Those Were the Days, My Friend” accessed through [http://www.lyricsfreak.com/m/mary+hopkin/those+were+the+days\\_20317307.html](http://www.lyricsfreak.com/m/mary+hopkin/those+were+the+days_20317307.html)
- (2) [http://articles.chicagotribune.com/1986-04-09/news/8601270666\\_1\\_patient-health-care-prenatal](http://articles.chicagotribune.com/1986-04-09/news/8601270666_1_patient-health-care-prenatal)
- (3) William E. Hulme, “Lutheran Pastoral Care” in Rodney J. Hunter, Editor, *Dictionary of Pastoral Care and Counseling* (Abingdon, 1990), 670–672.
- (4) Fredric M. Norstad, “The Hospital as a Healing Community”, *International Review of Mission*, volume 57, Issue 226, April 1968. 202–212.
- (5) Jane Westberg, *Gentle Rebel: The Life and Work of Granger Westberg, Pioneer in Whole Person Care*, (Memphis, Tenn.: Church Health 2015).
- (6) E. Brooks Holifield, *A History of Pastoral Care in America: From Salvation to Self-Realization*, Abingdon, 1983, re-released by Wipf & Stock, 2005).
- (7) Pieces of my thinking that influenced this article can be found in *Holding Up the Prophet’s Hand: Supporting Church Workers*, (Saint Louis: Concordia Publishing House, 2011) and *Building Up the Body of Christ: Supporting Community Life in the Church*, (Saint Louis: Concordia Publishing House, 2016).



## Interview with Rev. Dr. Stephen Bouman, Executive Director, Domestic Mission Unit, Evangelical Lutheran Church in America (ELCA)

**Interviewer: Don Stiger**

**June 20, 2016**

*Stephen Bouman presently is Executive Director of the Domestic Mission unit of the ELCA, in which he directs all the domestic ministry of the church body. He served over twenty years in parish ministry in New York City and New Jersey. He served as Bishop of the Metropolitan New York Synod of the ELCA from 1996–2008. He has written books on parish ministry, the response of the church to the September 11, 2001 attacks in New York, and immigration issues. His current book, *The Mission Table*, is being used in congregations and synods throughout the ELCA. He is the founder of the Diakonia lay training program. Stephen and his wife Janet currently live in Chicago. Children — Timothy, wife Erin, grandchildren John and Ruth live in Chicago. Jeremy, wife Sarah, grandchildren Sofia and Luke live in Omaha. Rachel lives in Chicago.*

**DON (D):** *Stephen, on behalf of Caring Connections, many thanks for your willingness to engage in this interview.*

*To begin...you and your unit work with a wide breadth of ministries throughout this church body. How do you see Ministries in Chaplaincy, Pastoral Counseling and Clinical Education (MCPCCE) involved in the future mission of the ELCA?*

**STEPHEN (S):** I see several places and points of significant involvement.

One, we are in the midst of a growing churchwide emphasis on wellness, including projects and programs supported by Portico, Lilly, and others. To have the direct involvement of a well-trained, well-qualified cadre of professionals like those in many of our MCPCCE ministries could be a huge gift to all engaged in ministry and to our hope of having rostered persons model for the church and each other healthy living in body, mind, and spirit. As such a cadre, I think MCPCCE could help immensely in shaping much of that for the future.

As you know, in the years I served as Bishop of the Metropolitan New York Synod, I used to meet regularly with those serving in these ministries. In fact, they were for me a kind of “kitchen cabinet” in the disaster response work that followed 9/11. I recall how we did “mutual CPE” together throughout that time. I regularly referred people to them for much-needed care and counseling.

In affirming that these ministries continue to be vitally necessary, I point to the church’s general outreach as well. The only place many people in this society may ever encounter a Bible is through the presence and ministry of an institutional chaplain. The most teachable moments in our lives continue to be those in which we are most vulnerable. We stare into our own mortality, with any number of ultimate issues and

serious questions stirring. To be connected to someone in one of these ministries is incredibly timely and important for so many people.

Further, I continue to lift up the particular importance of Clinical Pastoral Education (CPE) in the formation of rostered leaders in this church. In fact, I believe that connections with CPE need to be even stronger now. I say that because the ministerial identity of so many pastors and rostered leaders is changing. CPE remains a unique opportunity for taking a searching look at *what* you're doing in ministry, *why* you're doing it, and *how* you present yourself.

**D:** *Are you particularly referring to the projected need for future rostered leaders to be equipped to combine parish ministry with other creative forms of ministry in the public square?*

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"The only place many people in this society may ever encounter a Bible is through the presence and ministry of an institutional chaplain."

**S:** I'm referring not just to tent-making needs in the future. I'm referring to formation. The role is rapidly changing from that of "Herr Pastor" to "Rabbi" — that of one who can effectively meet people alongside the road in their spiritual journeys and effectively connect with them and minister to them.

**D:** *Given that, like most mainline denominations today, the ELCA remains more congregationally oriented — with parish ministry continuing to be normative — in the future, what, if any, special or unique influences do you envision potentially coming from these kinds of more specialized ministries?*

**S:** The first thing I would cite is that the name of our churchwide unit has been changed to the "*Domestic Mission Unit*", because congregational and synodical mission is limiting. In reality, we have become a network of networks in the church and will continue to grow out into such a model, such that the role of judicatories and denominations will not be cranking out programs as much as convening, nurturing and sustaining networks that have impact on the lives of people. For instance, in faith formation ... I would welcome a conversation with those in MCPCCE about how we can more extensively network you into other networks. I see already-existing networks like MCPCCE as being leaven for the whole loaf.

**D:** *That sounds great, and I would hope Caring Connections would serve as helpful leavening for that very purpose.*

**S:** Indeed.

**D:** *Given the serious "greying" of those serving in these ministries, as well as the considerable reduction in numbers of Lutheran CPE supervisors, are you concerned*

*about us being able to make such contributions in the future...perhaps even concerned about the long-range survival of these ministries?*

**S:** Many of us are getting a bit long in the tooth! But, we are always going to have persons reaching out to God in hospitals and other such institutions of care, persons needing counseling services and healing ministries in their lives. So, I don't see these ministries ever going away. We also need the kinds of servant leaders who can and do surf the interfaith world. MCPCCE persons do just that. We now live in a new interfaith matrix that requires extensive retooling. We will need those seasoned in MCPCCE to be able to report into the church and help the church in this regard. Once again, I think such ministries are an untapped resource when it comes to navigating such needs and trends.

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"I continue to lift up the particular importance of Clinical Pastoral Education in the formation of rostered leaders in this church."

**D:** *Given that the ELCA originally had a full-time staff position attending to these ministries, then half-time, then cut back even further for a while, do you think sufficient support will exist in the infrastructure of the ELCA to support those serving in these diverse ministries? What shape do you see that taking in light of continued budgetary and staffing constraints?*

**S:** What is everybody's responsibility can end up being nobody's. And, there has to be "a there there". We have responded to some hard lobbying from networks around child and family ministries and were able to create a half-time position which, again, networks with networks. Alongside Judy Simonson's position, I think it would serve us well to create something like that for these ministries as well; I see that as something necessary for the future. I also think Synods need to step up — to claim these ministries on their territories. By that I mean Bishops getting more fully oriented to the nature and importance of these ministries when they are elected, to actively honor these calls, meet regularly with all in MCPCCE on their turf, and take more primary responsibility in supporting them. These ministries need to be seen right on the ground, where they are lived out day-to-day.

**D:** *These same ministries have carried a number of names and references over the years, from "specialized pastoral care" to "ministries in specialized settings" and "institutional ministries". Over the last fifteen years or so, we have endeavored to more consistently reference them as "Ministries in Chaplaincy, Pastoral Counseling, and Clinical Education". Any thoughts as to what you feel is the most appropriate nomenclature?*

**S:** I think the name we now have and have been using in recent years — MCPCCCE — most clearly and inclusively names these ministries and immediately tells us what they are about. It names what “it” is. I would not change that reference and would see it continuing. Again, it specifically and clearly names who and what they are.

**D:** *Finally, reaching back to the ELCA Statement adopted in 2003, “Caring for Health: Our Shared Endeavor”, one of the adopted resolutions referred to the importance of recruitment and clinical preparation for these ministries. Do you think there is a robust spirit for that in the future, and will it be something pursued deliberately throughout the church?*

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“My life and ministry have been very blessed by those who practice the arts of chaplaincy, pastoral counseling, and clinical education.”

**S:** I don’t think it’s robust. For instance, are we at the ELCA Youth Gathering, in ways that encourage young people to consider these ministries as a possible vocational direction? Not that I’m aware of. We want that event to include more of a process for nurturing such vocations. Might there be more ways for youth and college students to do earlier internships and shadowing experiences in these ministries and at the same time bring colleges, universities and seminaries more into that conversation? I think we have to, a) make sure we visibly name these ministries and that they really get lifted up as we talk about church; that means leaders actively doing this. And, b) we have to be more intentional about a deeper bench for leadership.

**D:** *As I once again thank you for this interview and your responses, any final thoughts or reflections you might want to share?*

**S:** My life and ministry have been very blessed by those who practice the arts of chaplaincy, pastoral counseling, and clinical education. As mentioned earlier, I found our annual synodical MCPCCCE gatherings in metro New York to be one of the most stimulating meetings I attended every year. I noticed that the ordained folks serving these ministries always talked about direct connections to Word and Sacrament ministry, bringing unique and special insights to that. I would hear of the many ways that our pulpits, altars and fonts become so public through their ministries. I wanted them to feel the connection to the heartbeat of the church and that they are a major expression of its beating heart of hope in the world. That’s a vision I very much continue to hold. My final word is one of total gratitude to those serving in these ministries.

**D:** *Stephen, please know that we extend that same gratitude to you. Thank you so much for this time and all you’ve shared.*

# New Horizons for Spiritual Care

**Rev. Dr. Gary Gunderson**

**MORNING STAR** Baptist Church rests in a neighborhood of about 2,500 mostly poor and mostly black people wedged behind the athletic fields of Winston-Salem State University and I-52. This is one of the “hotspots” for high levels of charity care, which isn’t surprising given the sprawl of one-story bottom-rung apartments, long out of reach of public transportation, food stores and certainly any medical resources. The Associate Pastor, Charlotte Leach, was a second year CPE resident at Wake Forest Baptist Medical Center, with part of her placement being her church, where her husband, George, has been the Pastor. When I began working on this article I went over to witness the church’s community outreach day, which attracted 450 community members in searing 95-degree heat, and saw that nearly every member of the church was doing something (I personally favored the hot dog ministry!). The “healing rodeo” included everything from medical checkups to dedication of a new garden, with representatives of city, county and police (and our competing hospital!) taking the opportunity to mingle and be known.

Rev. Dianne Horton, another CPE graduate, is also an Associate Pastor in a creative ministry in one of the hospital’s ambulatory dialysis clinics. This began as a trial placement at the request of the Chief of Medicine, who noticed the atrocious and expensive readmission rates for dialysis patients. Those patients face a six to seven-year regimen, tethered to a machine two or three times a week, four exhausting hours each time, impossibly disruptive to them and those who love them. Rev. Horton moved into this space with a chaplain’s mind, seeking to understand and strengthen the psycho-social-spiritual relationships between all involved—the families, neighbors, physicians, techs and churches. As she opened eyes to the possibilities, many began to see ministry options. For example, the local chapter of the Masons adopted one of the clinics, providing blankets and snacks along with prayers and visits. Rev. Horton’s work caught the attention and stirred the imagination of the local Ministerial Association, which then appointed her their “minister of health.”

That kind of eye-opening resulted in her becoming the full-time chaplain at the Wake Forest hospital in Lexington—a town that used to have a furniture factory and not much else. Chaplains know how to talk to a patient wishing for their lost youth. Can a chaplain help a whole town find its future?

Spiritual specialists have been part of the healthcare industry for nearly as long as the modern hospital—about a century and a half<sup>1</sup>. This entire field, in which spiritual care is one part, is young and once again is going through radical changes

<sup>1</sup> There is a long history of entities called hospitals, going back to before Basil the Great, but I have trouble counting anything before Ignaz Semmelweis, who began efforts to get doctors to wash their hands in 1847 or, in the US, before the Flexner Report in 1900 established some educational standards for physicians.



in the economics and structure of the industry, which in turn accounts for about 18% of all economic activity in this nation. It is no wonder that those of us who have crafted our life pathway into and through these institutional settings find ourselves wondering what it portends for our profession and our lives.

Why are faith people involved in hospitals anyway? We owe our jobs to the peculiar blend of optimistic public faith and politics driven by confident industrial and scientific reason that caused many religious denominations to found hospitals. Even where you'd least expect it—North Carolina Baptists. In 1921 they saw that “this form of Christian service must not be removed too far from the churches ... As we establish and maintain a hospital system, it must not lead churches and Christians to relegate all responsibility and personal interest to the hospital. Church and individual interest will be aroused in cases, though they be subjects for the hospital, and the community nurse will be a part of the church community and hers will be as distinctly a Christian service as that of the pastor. So a proper conception of this mission of the hospital will put the local church in close touch with the community, in ministering to the afflicted and also extend its interest to the institution as well.” (Annual of the North Carolina Baptist State Convention 1921, (Richmond Press: Richmond, 1921), 121–123.) There were no chaplains; the whole *thing* was spiritual and caring.

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“Now we find ourselves thrown out of the clinical ‘garden’, not because of sin, but because of the success of science, which makes healthcare less likely to be futile...”

That century-old idea is an even better one today: hospitals as a component in a suite of approaches that can blend science with community strategies in order to advance the health and well being of the whole population. However, hospitals are not like healing spas, resorts in which one might spend a week or 10 days; they are more like rooms you rent for quick relationships lasting a few hours, maybe overnight, but at most only a couple of days. Today only about 20% of any hospital's patients spend the night. This is very disorienting for the niche of clinical pastoral education and the profession it serves. This field of clinical spiritual care has been attached primarily to the interior spaces of both the person/patient and the hospital itself. Now we find ourselves thrown out of the clinical “garden,” not because of sin, but because of the *success* of science, which makes healthcare less likely to be futile and thus less deadly (less than 3% of hospital patients die during their stay). And this is compounded by the successful array of outpatient and chronic condition management strategies involving pharmaceutical and home-oriented support that make hospitals less necessary. Or maybe we are being led *into* the garden where all the people live, going about their lives. This “outside” space is what hospitals call “population” health, where we are following Rev. Leach and Horton out of the hospital building's door and into the lives of people in the community.

Today the field of population health in the USA reflects three key bodies of thought, which themselves rest on a sprawling field with thousands of agencies, guilds, researchers and practitioners. It is helpful to see the broadest outline of the convergence we are experiencing today as it removes the walls from the places we call “clinical,” and draws us into the community.

**PUBLIC HEALTH.** The 1988 Institute of Medicine (IOM) document, *The Future of Public Health* (Health 1988), frankly confronted the disarray of public health and initiated a quarter century of laborious reforms in the structure, training and budget priorities of public health. This continuing movement within public health re-conceptualizes public health as a field in which there is a transformation of the interlinked community systems. This implies a body of competencies suited to transformation—not just maintenance—of those systems (Wright 2000). That competency map is *almost* religious. The Chicago School of Theology faculty, in dialogue with the Interfaith Health Program, developed a branch of this map including spiritual competencies for community transformation. Not surprisingly for the birthplace of CPE and Anton Boisen, the map suggests the relevance of reflective practice on a larger field of practice than the hospital corridor, specifically the community.

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“Most chaplains could think of ideas that would work more effectively with real people.”

**QUALITY HEALTHCARE.** Another 2003 IOM publication, *Crossing the Quality Chasm* (Institute of Medicine (U.S.) Committee on Quality of Health Care in America, 2001) played a similar role within healthcare organizations, laying bare the radical gap between optimal science and actual delivery by an organization of that science into patients’ lives. The report defined quality as having six aims: safety, effectiveness, patient-centeredness, timeliness, efficiency and equitability. The Institute for Healthcare Improvement, led by Dr. Donald Berwick, further sharpened this into a commitment to a more compact (and easier to remember) “triple aim.” All of those early goals rest squarely in the bio-medical model of health, with only slight mention of mental, much less, spiritual dynamics. While the IOM publication was eloquent about the complex nature of health institutions, there was no resonance for the spiritual strengths or weaknesses of an institutional capacity for change, such as that about which any CPE intern learns quickly enough.

**HEALTHCARE BUSINESS.** Meanwhile, inside the management of healthcare organizations the work of Dr. Michael Porter of the Harvard School of Business, drew a compelling map of the future with sharply focused medical service lines, organizational consolidation, and cost-driven bundles of care offering greater value for payers (and, presumably, patients). His book with Elizabeth Teisberg, *Redefining Healthcare*

(Porter and Teisberg 2006), addressed those leading the healthcare enterprises—not policy makers or, much less, chaplains. Porter and Teisberg insist that systems act like *systems*, concentrating procedures in the regional sites specialized enough to have high volume, and thus the highest efficiencies. In practice this meant, for instance, closing OB or cardiac surgery at small hospitals, driving specialized care to the hub, or even to the competitor. In real human institutions those decisions are excruciatingly painful. In this foundational work, however, Porter and Teisberg never mention anything or anyone outside the walls.<sup>2</sup>

Bundles are entirely bio-medical in design, wrapped around episodes of care with little attention to the long cycles chronic conditions demand. The IOM *Quality of Health Care* report had a whole chapter on healthcare organizations as complex adaptive systems with quality as an emergent “systems property.” Porter and Teisberg have less patience and greater hope for the role of rationality, discipline and, of course, financial incentive.

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“CPE must learn new methods of prophetic engagement on behalf of the poor and those poor in spirit.”

Because this approach is so highly regarded among the leadership of the institutions in which CPE is practiced, it is worth noting the *weaknesses* of the work in the context of our discussion here. Because it is aimed at managing large organizations, it tends to be unsophisticated about the human, social, and community context that lie around and sometimes under those organizations. Because of its focus on financial incentives and simple rationality, it tends to miss the benefits of human complexity and the practical roles of altruism and spiritual resilience. Most unfortunately, it never includes the poor in the economic model of healthcare, as if they can be externalized somewhere or another. Most chaplains could think of ideas that would work more effectively with real people. And most chaplains have had the experience of being undervalued in the identical way that Porter overlooks the entire field.

All three of these major currents are visible in the documents of the Affordable Care Act (ACA) and its closely related policies dealing with the accountability of the non-profit component of health systems. The ACA legislation is a highly negotiated and compromised *mélange*, and its *implementation* is even more chaotic at state and county levels, where healthcare actually happens. ***The law has dramatic implications for any aspect of spiritual care and CPE related practice.*** Ezekiel Emanuel sketches seven major areas of fundamental change: the end of insurance companies, VIP care for the chronically and mentally ill, the emergence of digital medicine, closure of 1,000 hospitals, the end of employer-sponsored health insurance, the end of healthcare cost inflation, and the transformation of medical

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<sup>2</sup> Porter's new work on the Social Progress Index goes in a quite different direction, well in range of the concepts discussed here. It will be interesting to see if the healthcare executives, still tuned to his earlier work, will follow this work, too. See <http://www.socialprogressimperative.org/data/spi>

education (*Reinventing American Healthcare*—2014). These developments radically alter the landscape in which spiritual care has grown and give it a new identity as a component in a field now in the process of changing.

**CREATIVE CIVIL SOCIETY.** While these three fundamental currents have been driving deep change within the field of health, even more fundamental change has been surging within faith, non-profit and non-governmental organizations. As health is now finding its way to consider populations, not just patients, it is beginning to notice that it has backed into a wildly creative ensemble of work under way at the community level. This “movement of movements” reflects many contributing streams, notably community organizing built on Saul Alinsky and others, new urbanism largely driven from city planning for the “built environment,” ecological and food organizations, and a wide array of new roles and programs within and between faith organizations. This last component is the one with direct overlap into the fields of healthcare and public health, especially the thousands of “faith community nurses,” many adjacent caregiving roles, and multiple adaptations of the Memphis Model’s hundreds of connected health congregations. There is an entire ecology of roles across the spectrum of the paid, the unpaid and the semi-paid. Many of these are tuned to the same core *charism* of chaplains (“it’s not about me”). As both healthcare and public health are drawn out of their contained environments and into real complex human communities, they find themselves in a tumult of creative work, relevant to their goals, but impossible for them to control. Ironically, the entire field of spiritual professionals began on the outside and in complexity; but, over a few decades, have found our way inside as guild-oriented, institutional colleagues. We may be closer to the door from where we can see the community and sometimes we even offer our training to enhance the skills of pastors with CPE training. But the community mostly sees our hospital ID badge, not our history.

“The challenge of CPE is whether it can reflect on the practice of innovation—the expression of the energy of creative freedom—to help the places, neighborhoods and, yes, even our healthcare systems, find their life.”

As a field and as a community of practitioners, CPE must learn new methods of prophetic engagement on behalf of the poor and those poor in spirit. The opportunity is found where it always has been, in critical reflection on the journey of life, and the way in which powerful privileged institutions and professionals lend their privileges in order to advance the lives of others. The fact is that we are embedded in institutions that absorb vast resources in the name of health, but do not deliver adequate mercy, much less justice. Why? The entire enterprise of modern healthcare has been constructed on a conceptual scaffolding organized around death and disease. Part of this is very good. But the privileges accumulated in the name of that good have obscured a great deal of science, some of it arcane, but most of it obvious,

that can prevent and relieve suffering at a far less crippling economic cost. In 1986 The Carter Center and the Centers for Disease Control found that roughly two thirds of all deaths before age 65 were preventable, based on what we already knew. Who was in a position to implement that knowledge? Not, for the most part, hospitals, doctors, or even public health departments. Rather, it was the social nodes in society, beginning with the most obvious and ubiquitous: 300,000 faith congregations. A few years later, The Carter Center and the Park Ridge Center convened “The Churches’ Challenge in Health” which, with support from the Robert Wood Johnson Foundation, set off a long stream of learning focused on raising up transformational leaders and developing a body of logic that blossomed in Memphis as the vast hopeful sprawl of the Congregational Health Program and its nearly 600 covenant partners. That stream is now bearing even more creative fruit in the learning group called Stakeholder Health ([www.stakeholderhealth.org](http://www.stakeholderhealth.org))—dozens of healthcare systems learning their way into communities.

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“...it is common to see large scale ‘population health management’ schemes designed with little or no provision, much less integration, of the factors closest to the mind of CPE and spiritual care professionals.”

What does any of this have to do with CPE or spiritual care or *even spirit itself*? To answer that question one needs a new idea of Spirit itself. The International Religious Health Assets Program has done fundamental work in this field, most recently into the role of spirit as an asset in the lives of younger men in highly violent communities, comparing Memphis and a township in Cape Town, South Africa. The whole study is rich and relevant. In order to even do the research at all it was necessary to abandon the customary linguistic shell of religion, faith and spirituality to go to the foundations of humanity. African and Chinese speak of spirit as energy (*sriti* or *chi*). Kant understood the basic human capacity as creative freedom, which expresses *sriti* or *chi* as the drive to create (what could be more close to the image of God?). This creative freedom is not just inside one human at a time, but in a people, a body, a social entity like a neighborhood or a human institution created at one point of time that could be recreated for another. The challenge of CPE is whether it can reflect on the practice of innovation—the expression of the energy of creative freedom—to help the places, neighborhoods and, yes, even our healthcare systems, find their life.

It always struck me as a sad curiosity that the genius which Anton Boisen released into the lives of so many patients and practitioners of spiritual care did not have a more enduring transformational effect on the institutional logic of the organizations in which that care was provided. It is, of course, impossible to run an accredited hospital without competent and diverse spiritual care. But it is quite possible to design and deploy tens of millions of capital and operational dollars without giving a passing thought to the psychological, social or spiritual dynamics of

the patients or their healing prospects. Even in the most obviously relevant patients—vulnerable patients marked by being eligible for both Medicare and Medicaid—it is common to see large scale “population health management” schemes designed with little or no provision, much less integration, of the factors closest to the mind of CPE and spiritual care professionals. How could we speak of managing the lives of humans from the distance of our computer consoles, dispatching this and that intervention through caregiving drones? The fact that this can be proposed and implemented in 2015 marks not only the failure of those of us in positions inside these institutions today, but of the weakness of the movement over past decades.

Part of the weakness of our movement is that we have not, across these decades, developed more nuanced and persuasive descriptions of how the spiritual dynamics affect the journey of the patient into, through and out of the care environment in a way that would cast light on the financial costs of the poorly attended psycho-social-spiritual aspects of that journey. The likely expensive failure of most population health management schemes in the next few years will—if evaluated carefully—be largely due to these, not bio-medical, causes. These failures will occur outside the constrained clinical workplaces of most chaplains and thus be as much out of their sight as of their hospital colleagues working up in finance. Indeed, while the chaplains may have more imagination about these outside-the-walls issues, they are no more present to the patients once they are discharged from the acute treatment facility than if they were surgeons. Surgeons are the iconic pinnacle of hospital care, but today many of them now work in same-day surgical centers, while almost all chaplaincy is confined to the overnight patients. If the surgeons have figured it out, surely, we can too.

The future of spiritual care in the age of population health looks more like Reverends Leach and Horton, utterly comfortable and trained within the critical care units of hospitals, but equally as comfortable, competent and reflective amid the complex dynamics in the intensive environment of one troubled community at a time.

*Rev. Dr. Gary Gunderson is an ordained American Baptist minister who serves as Vice President for Faith and Health at Wake Forest Baptist Medical Center. His responsibilities include spiritual care, Clinical Pastoral Education, 32 counseling centers, and guiding community health strategy for the 19-county service area. He is Professor of Public Health Science in the Wake Forest University School of Medicine and Professor of the Health of the Public in the School of Divinity. Gary is known for more than two decades of creative work in the field of faith and public health — initially at The Carter Center and Emory School of Public Health, then in Memphis, Tennessee. Gary currently serves as Secretary of Stakeholder Health, a learning group of more than 50 healthcare systems convened in working collaboration with the White House and the Department of Health and Human Services.*



## Interview with The Rev Bart Day, Executive Director, Office of National Mission, The Lutheran Church Missouri Synod (LCMS)

**Interviewer: Joel Hempel**

**July 7, 2015**

*As executive director of the LCMS Office of National Mission, the Rev. Bart Day's primary responsibility is the implementation of the policies of the LCMS Board for National Mission, which directs the domestic ministries serving congregations and schools through the Synod's districts. This work includes 17 programmatic ministries (including Specialized Pastoral Ministry) that support the districts, congregations, schools and workers of the Synod in their witness, mercy and life together. During his time at the LCMS International Center, Bart has also served as interim chief mission officer (2014-2015); he currently serves as interim executive director for the LCMS Office of Pastoral Education. Bart and his wife, Julie, have six children. They are members of Hope Lutheran Church in St. Louis.*

**JOEL (J):** *Rev. Day, thank you for taking the time to meet with me!*

**BART (B):** Thank you. I am pleased to do this interview with you. I have a great deal of respect for Specialized Pastoral Ministry (SPM).

**J:** *Among all of the other issues that you deal with, where and how do you see SPM involved in the mission and ministry of our church body?*

**B:** To begin with, I have to admit that SPM is too often forgotten or marginalized due to other programs and ministries that draw attention in the church. However, SPM does have a special place in caring for people in various contexts outside of congregational life. It is easy to overlook SPM due to its size compared to congregational ministry. But when we are ministering to the changing culture, SPM is on the front line of the opportunity to share the Gospel more so than parish ministry.

**J:** *Realizing that the LCMS is congregationally oriented, what positive influence from these specialized pastoral ministers (institutional chaplains, emergency services chaplains, pastoral counselors, clinical pastoral educators) do you foresee in the future of the LCMS?*

**B:** Specialized pastoral ministers are underutilized in their ability to train and equip those in congregational life. We need to find a way to promote and encourage the intersection between those in SPM and those in parish ministry. I think parish pastors are looking for or need to be looking for the skills to connect with culture. Specialized pastoral ministers have those skills.

*J: I appreciate you recognizing that! Thank you! As the executive director for the Office of National Mission, you have oversight responsibility for many ministry areas and departments within the Synod. As you think about SPM, do you have any concerns?*

**B:** I do have concerns. Specialized pastoral ministers are not in the relative safety of parish ministry. There are many cultural and legal changes occurring, as seen in the recent Supreme Court decision about same sex marriage. It continues to become more challenging to live out our beliefs and remain true to our identity as well as to share the Gospel. There will be increasing attempts to censor conservative Christians who are faithful to their confession and church body. I'm concerned that federal- and state-run institutions may not hire LCMS chaplains or promote them as readily. For their sake and for the sake of the Gospel, that concerns me. Serving outside the safety net of the church proper, our specialized pastoral ministers may have to take the brunt of the church's interface with a hostile world.

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" . . . I have to admit that SPM is too often forgotten or marginalized due to other programs and ministries that draw attention in the church."

*J: You say that with passion, Bart! I truly appreciate your empathy! I also appreciate the substantial commitment the LCMS has made in providing resources for SPM. Do you anticipate any shift in SPM support in the immediate future? That is, will the mercy arm of the LCMS continue to support SPM?*

**B:** The LCMS will continue robust support of SPM! Now is not the time to stop. Indeed, we need to find creative ways to foster vigorous recruitment of men and women to these vocations. I know you are already working on this!

*J: Many of our colleagues in SPM are retiring and dying. What must we do to insure that others will be following in the path of chaplains, pastoral counselors and clinical pastoral educators?*

**B:** The Synod needs to be intentional with a long-term strategy to identify, train and equip men and women for SPM. Without the Synod doing this at a high level, SPM will die. We need to be intentional in speaking well of SPM and working to identify those with the aptitude and calling for this unique and most valuable ministry. Part of this intentionality is reaching out to those who are struggling with vocation, who recognize they may not fit in congregational ministry and/or the congregation can no longer afford to support them. In some of these cases there are men and women out there who would serve well in SPM, but they don't know about the opportunity or how to proceed to get the necessary training and credentials. We need to provide



substantial funding for training. We need to put the dollars on the table.

**J:** *(Smiling) I'm glad we're having this conversation! In the past, we have been identified as Specialized Pastoral Care (SPC), Ministries of Chaplaincy, Pastoral Counseling, and Clinical Education (MCPCCE), and currently as Specialized Pastoral Ministry (SPM). Quite frankly, we have struggled with how best to identify and represent who we are in a few words. Do you have any thoughts about what we should be called?*

**B:** I'm glad you asked. I do have thoughts about it. I do not believe Specialized Pastoral Ministry is the best way in the Missouri Synod to represent who you are as a group. There are a sizable number of people in our church body — rostered and lay people alike — who assume that the word “pastoral” describes only men who are ordained. As you know, we have recently seen this in the reaction to a couple of published articles. I also know you agree that we need to foster clear communication.

“When we are ministering to the changing culture, SPM is on the front line of the opportunity to share the Gospel more so than parish ministry.”

**J:** *I certainly can't disagree. It is a challenge to find a few words that capture who we are in our diversity and not create misunderstanding. Some time ago we decided to hold on to the word “pastoral” and not refer to ourselves as specialized **spiritual** caregivers because “pastoral” has been more traditionally viewed as Christian. But I understand what you are saying. Perhaps we need to go back to the more cumbersome wording the ELCA has retained: “Ministries of Chaplaincy, Pastoral Counseling, and Clinical Education.” I'll bring it to our SPM Advisory Committee to get their input.*

*Finally, as you know, the LCMS has had a three-year goal of recruiting 136 international missionaries. This grew out of a convention resolution. What are your thoughts about SPM working toward a resolution (and/or ONM Board policy) that would direct the church body to recruit ministers and seminarians intentionally for specialized pastoral ministries and to encourage Recognized Service Organizations (RSOs) to hire/call trained and endorsed specialized pastoral ministers?*

**B:** That is not a bad idea! But first we have to dispel the questions that surface in some quarters of our church body whether men and women in SPM can continue serving in these pluralistic contexts and remain faithful to our Christian confession and Lutheran identity. After we address those concerns, we can take it to the convention floor. We need a broader conversation in the Synod about what SPM does and how specialized pastoral ministers function faithfully in their ministerial tasks. If assurance can be given, then we can go after that kind of Synod-driven recruitment and support.

On the one hand, the Synod loves the fact that we are out there on the fringes of culture, living out and proclaiming Law and Gospel. On the other hand, it is concerned about the pressures from government that infringe on our RSOs and chaplaincy. Because human need is so great and brokenness is so evident, and because the divine call has been granted to chaplains and pastoral counselors, our specialized pastoral ministers live and work on the edge and are able to do that faithfully. I know this is true, but we need to communicate that regularly. We need to be clear that if the church wants to be represented in the world of cultural challenges and government pressure, it will be a little messy. Ministerial decisions have to be faithful to the Synod's doctrine and practice while at the same time they need to be applied in very unique contexts. SPM will not look like congregational ministry. The Synod has to be able to embrace that.

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"The LCMS will continue robust support of SPM!...  
We need to provide substantial funding for training.  
We need to put the dollars on the table."

The LCMS wants and needs to be engaged in the Kingdom of the Left, interacting with Caesar on a daily basis. We need to have a voice regarding religious freedom, Christian morality, and ministerial practice in this realm. We do not want the rest of the world or other denominations and religions speaking for us. We need to own our identity as Lutherans and live it. Either we acquiesce to everyone else, or we remain bold and engage the world outside of the church. I say SPM needs to be very much a part of the intentional movement into culture, into the Kingdom of the Left!

*J: Thank you for those powerful words of encouragement. Before bringing this interview to a close, do you have any other thoughts or concerns about SPM that you care to offer?*

**B:** We need to lift up specialized pastoral ministers and praise and thank God for them! We need to thank those who have served for a long time with little recognition. We need to make sure they are healthy and well. We also need to encourage them not to give up. We need them to recruit those who are younger and mentor them to take over. Our seasoned specialized pastoral ministers are the most powerful recruiting tools we have in the Synod. I pray that they will look around and take note of those who may be waiting for our Lord's nudge into SPM.

# The Coming Transformation of Chaplaincy Formation and Certification

**Rev. Kevin Massey**

*(This article is based on a plenary speech delivered on April 13th 2016 at the 3rd Annual Caring for the Human Spirit Conference, sponsored by the Health Care Chaplaincy Network in San Diego California.)*

**I HAVEN'T BEEN INVOLVED** in health care as long as many of you. I transitioned from parish-based ministry to health care chaplaincy in the late 1990's. In that time, somebody or other has always been saying the same things — that health care is precipitously changing, and that in those precipitous changes, chaplaincy is under significant threat of vanishing. Somebody has been saying that for years.

Here's an example: a predecessor of mine at Advocate Lutheran General Hospital, Larry Holst, wrote the following in the book *Hospital Ministry* in 1985:

*“There will be fewer hospital chaplains around in the future. At least there will be fewer of them doing what they now do. This decline will not occur because of chaplain’s incompetency or because of the public’s disillusionment with their services. The decline will have nothing to do with chaplains. It will occur because there will be fewer hospitals, fewer occupied hospital beds, briefer hospitalizations, and reduced reimbursements for health care in the future. We have reached a point in America where hospitals are providing more health services than the public can afford. Shrinking reimbursements will accentuate internal competition for reduced budgetary dollars. As a non-revenue producing department, chaplaincy will find itself at a distinct disadvantage.”<sup>1</sup>*

That's what Larry wrote in 1985, and Larry turns out to have been very prophetic about it, because that actually describes the shape of change in health care that is happening. There will be fewer hospitals, fewer occupied hospital beds, briefer hospitalizations, because we are in the middle of a transformation of how health care in the United States of America is financed.

We are moving from a fee for service system to a capitated population health based payment system.

What this means is that hospitals used to get paid for doing things, and unsurprisingly this meant hospitals did more things. We are moving to a system where hospitals will get paid a flat fee for covering a person or a group of people, and the incentive for the hospitals will be to keep people healthy and avoid them being hospitalized, and when they need health care, they will receive that at the lowest level of acuity possible.

Here's what we foresee in my organization, Advocate Health Care. In 2015, Global capitation payment rates were at 26% of our payment, but fee for service of one type or another was still 73%. But right now is when all that changes because by 2020 we calculate that 70% of our payment will be from one form of capitation arrangement or another.<sup>2</sup>

That will be the trend for all of our institutions. And it will mean more outpatient care, more care by persons called mid-level practitioners, advance practice nurses and physician assistants. Fewer people will be in hospitals, and that means eventually there will likely be a smaller number of larger hospitals.

.....  
"...for the first time the nature of the change actually could call for growth in the field of health care chaplaincy."

That could mean fewer hospital chaplains, but I don't think it will. I think that the specific role that chaplains serve will come to be seen as more crucial and necessary than it is now.

What population based health care will require of every health care provider, chaplains included, is demonstration that the interventions they perform contribute to specific outcomes, which in turn contribute to high quality health care.

That is a paradigmatic change for everyone in health care, chaplains included, but I think that something different and special about this paradigmatic change is that for the first time since people have been predicting the eventual downfall of chaplaincy, for the first time the nature of the change actually could call for *growth* in the field of health care chaplaincy. So I'm not going to say that health care chaplaincy is under any threat of vanishing, I'm going to say, on the contrary, that the exact nature of the paradigmatic changes underway in health care are going to cause and bring about growth, expansion and increase of appreciation for health care chaplaincy. But not health care chaplaincy as it has for many decades been practiced. taught, trained, certified and understood.

I'm going to describe important ways I see emerging how health care chaplaincy will change, but I will also share that the essential core of what health care chaplaincy really does will remain as strong as it has ever been, and that the things that I think will change, including the ways that chaplains are formed, the ways we identify when someone is ready to work in which contexts, those things, even if they are decades old, aren't essential to what health care chaplaincy is. I see strength, resilience in health care chaplaincy that is above and beyond any of the structures and systems we have ever built up attempting to promote it.

Before I now back up and describe what is going on in health care right now and what that means to health care chaplaincy, let me tell you a story illustrating that last point, that health care chaplaincy has at its core a power and strength. By the way, any stories I will share here involving patients and patient care have been appropriately fictionalized and anonymized to protect the privacy of any persons

involved in the actual events, but they do convey the underlying meanings that unfolded.

Some years ago, I was working a night shift as chaplain at a Chicago emergency room. A young man was shot to death. His brother came to the hospital looking for him and was given the sad news that his brother had died. This young man released blood curdling screams of rage, anger and grief. He wept bitter tears, he sobbed with huge heaves. I reached out my hand to comfort him and he pushed me away screaming, “Don’t you touch me, leave me alone!”

We sat in the little room where the young man just sat and cried. As I sat with him, he cried and cried for an hour. Finally, at one moment he took a couple of deep breaths. He took his face out of his hands, looked up at me and said, “So your job is to sit with people when something like this happens?”

I said, “Yeah.” He said “Boy, your job sucks!”

And then he said, “Hey I’m really sorry I pushed you. This is the worst day of my life, but I can’t imagine what it would have been like if I at least didn’t have somebody to sit here with me.”

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“Could there be markers, measures, formats, and approaches to fostering those conversations that are better than others?”

So I ask you to reflect, what did the chaplain really do in that story?

The chaplain said practically nothing. The only overt gesture of support the chaplain tried, namely to reach out his hand to provide compassionate touch, was forcefully rejected. Another chaplain could have given this young man more space, and that could have been the right thing to do, too.

This chaplain sat with the young man while he wept. He had learned somewhere along the way in his training that sometimes there is nothing to say. Sometimes even trying to say something isn’t helpful. People need a human presence to witness their cry of lament.

Chaplains have a purposeful presence that is more than just being in the room, it is a purposeful accompaniment with someone who may be in a moment of deepest terror and grief, but that someone is not alone in it.

Here’s a quote that may summarize that:

*“It is better to be silent and be there, than to speak and not be there.”*

When do you think that piece of wisdom was coined? It sounds very “chaplain-y” doesn’t it?

Well, it was Ignatius of Antioch<sup>3</sup> who lived in the first century of the Common Era.

I share that mainly to underline that we didn’t just recently invent spiritual care. We haven’t recently even really improved it. The deep core of what it means for humans to comfort each other and support each other draws upon ancient human tradition, spanning every culture, every faith group.

At the core of what health care chaplaincy is and does is providing people with the opportunity in times of struggle, grief, and uncertainty to journey with

someone who can kindle hope, nurture meaning and help someone connect that meaning to their own personal cultural and spiritual values, dreams and traditions.

At the core of what health care chaplaincy is and does is a comfort with ambiguity and uncertainty, making space for questions without necessarily looking for answers. Seeking the Both/And rather than settling on an Either/Or.

*That* is what I see as the pivotal role for hospital chaplains [and for all spiritual care providers for that matter] in this transforming medical model.

Here's why. There remains a powerful misalignment in the United States of America between people's actual personal, cultural and spiritual values that would inform the nature and type of health care they would wish to receive and the care that they actually receive.

For example, 7 in 10 Americans say they would prefer to die at home, but only 25% of Americans actually do.<sup>4</sup>

Another example: in a recent study<sup>5</sup> published this last January in JAMA with Ezekiel Emanuel as corresponding author, the United States had about double the rate of patients with intensive care stays in the last 180 days of life when compared to six other developed countries, And each of these countries has a better life expectancy than the United States.

Obviously, intensive care saves the lives of specific people at specific times. But, when looked at across the whole population, that isn't extending life. We aren't really having our lives extended by the volume and type of health care we receive.

As it turns out, people don't really even want it. It just happens to so many people because realistic goals of care and people's values about their care, just don't get discussed correctly, and in a timely way. That is the specific gap driving a portion of the misaligned health care that we provide.

Careful advance care planning, before a time of crisis, is what is required to meet this need.

The Institutes of Medicine report, "Dying in America," defines advance care planning as "the whole process of discussion of end-of life care, clarification of related values and goals, and embodiment of preferences through written documents and medical orders."<sup>6</sup>

This means that the actual health-care advance-directives documents people may complete are not as important as the conversations people have with others about their values and wishes regarding their health care.

Conversations about values and goals, that's what we chaplains do! Chaplains are particularly suited for this in our ability to navigate and nurture those conversations, especially our ability to enter into the ambiguities of life and values.

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"CPE may be ill-designed to deliver the techniques, skills, and advanced competencies needed to work in professional chaplaincy."

The misalignment of people's wishes and values about the care they want and the care they actually receive is a symptom of Either/Or Thinking. Until recently, our health care delivery system did everything possible, such as high utilization of intensive care until it did nothing or little.

Both/And thinking, the thought underlying palliative care, means that people can receive meaningful appropriate care, aligned with their values, even curative care, yet also realistically and regularly reexamined for its achievable goals.

And chaplains can help those conversations happen.

But here's the question: chaplains are good at helping align someone's care plan with their values. OK, but what does that mean? All chaplains? Doing anything? Saying anything? Trained anyway? Certified anyway? I don't think so.

.....  
"...simulation taught me something that no other format of chaplain training had ever taught me."

Could there be markers and measures and formats and approaches to fostering those conversations that are better than others? Are there ways that somebody like a chaplain could demonstrate that they really are skilled at fostering those conversations? Does our present system of training, screening, and certifying chaplains guarantee that the successfully certified chaplain is skilled at doing these things and thus can guarantee to the health care community that they can be entrusted with this pivotal role?

I think not. I think that we have so much variation in the way we train health care chaplains that we can't guarantee it. And I think that the way we certify chaplains suffers from the same problem.

I have spoken and written in a number of venues about improving the process of training and forming persons for providing spiritual care. A few years ago I wrote the following in the *Journal of Reflective Practice*:

*"It needn't offend proponents of Clinical Pastoral Education...to suggest that the contribution CPE can make in the formation of professional chaplains is limited and mismatched. Any single educational format is limited. CPE has an important role to play in the earlier formation of persons for ministry. At the same time, it may be ill designed to deliver the techniques, skills, and advanced competencies needed to work in professional chaplaincy."*<sup>7</sup>

I have always clarified that the focus of my efforts on this topic is not that there is anything specifically incorrect about what we as a field currently do in the personal and professional development of spiritual care providers, but rather that this preparation is incomplete in this emerging health care world that calls for objectively measurable outcomes and evidence-based practice. The preparation has to afford some evidence of guarantee that the chaplain can do the things health care of the future needs chaplains to do.

I mentioned earlier that at the core of what health care chaplaincy is and does is a comfort with ambiguity and uncertainty, with making space for questions without

necessarily looking for answers, with seeking the Both/And, rather than settling on Either/Or.

So, it is ironic that when it comes to this question of skills-based, outcomes-oriented health care chaplaincy, and the pre-existing traditions of training chaplains through clinical pastoral education as it is currently formulated, everybody seems to have gotten into Either/Or camps.

I'll confess that I've found myself falling into this thinking at times too, so I commit myself to striving for a Both/And on how I see chaplain formation, training, certification, and continuing education. Please read everything I will share about improvements I would like to challenge us to make as spoken in a spirit of Both/And.

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"Until we unify how we talk about what we do and why, we are diluting our impact."

So, when I call for something additional to complement clinical pastoral education to guide health care chaplains in being able to guarantee that we have the competencies we are being called on to have, what are those additional things?

Three important elements that I think are lacking in chaplain training and certification, as presently practiced, are:

1. An emphasis on incorporating the perspective of the recipient of care into the training and educational process.
2. A systematic way to observe objectively what a chaplain actually does in the critical interactions that are so pivotal in the outcomes that need to be affected during the certification process.
3. A normative, shared language of our interventions and hoped for outcomes.

First, how could we incorporate the perspective of the recipient of care into our training? One format for trying to meet this need is something that has been incorporated quite sparingly in chaplain training and certification, namely simulation.

Here's a definition of a simulated patient in health care.

*"a simulated patient (SP), also known as a standardized patient, sample patient, or patient instructor, is an individual trained to act as a real patient in order to simulate a set of symptoms or problems. Simulated patients have been successfully utilized for education evaluation of health care professionals"*<sup>8</sup>

Lex Tartaglia<sup>9</sup> has published on the use of simulation in his CPE program at Virginia Commonwealth University. I have heard of a few other places it has been tried, but it is still quite rare in chaplain circles.

We are in the middle of a two-year funded project incorporating simulation in chaplain education at my site. This project is being led by Rev. Marilyn Barnes, who is a terrific chaplain in addition to having amazing organization and research skills. We are hoping to incorporate simulation as a permanent format in our CPE program.



Here's a scene from inside the simulation lab at the University of Illinois at Chicago, an institution that is a national leader in simulation in health care education.

UIC's simulation lab has a number of cameras in each mock patient room, so that after one has had an encounter, you can objectively re-assess what actually happened, what was actually said.

The simulated patient actor is trained not only in how to effectively portray a patient with a specific diagnosis or having a specific experience, but the simulated patient actor is also trained in how to assess the role performance of the learner, and give useful feedback in what was helpful or not in every aspect of how the patient experienced the encounter.

I had the opportunity last summer in our project to be the chaplain in a simulation scenario. Allow me to tell you an eye opening experience I had in it. It underlined for me the importance of addressing the absent element of incorporating the patient perspective into our training.

I visited a simulated patient who was portraying a lightly injured trauma victim. The patient was awake and alert but in the scenario he was refusing to cooperate with staff on his treatment. Staff have asked the chaplain to speak with the patient because he isn't cooperating in his care, and he is refusing to give an emergency contact name. This worries the staff because if he worsens, we wouldn't be able to find his loved ones.

So I visited with the patient. You know those times working as a chaplain when you feel like you did good work ... when you know you made a real difference? Well, frankly I did a really good job in this scenario. I helped the patient feel more accepting of the care he was getting, he gave me the name and phone number of somebody to call and let them know he was in the hospital. I did a great job.

After the simulated encounter, then there is the feedback session with the simulated patient. He gave me good marks, he mentioned how my way of talking was very calming to him, how I managed to establish rapport with him, and that it put him more at ease and made him decide to share an emergency contact name. Wow, I was feeling great, because the simulated patient was really affirming my work.

But then he said, "Now let me share a piece of feedback for you: do you know that on two occasions during the encounter you were talking with me at length with your back to me?" I thought, "What? I didn't do that." I asked him, "Are you sure?" He said "Yes, When you came in to the room, you were foaming in with the sanitizer foam, and you spoke to me for about 30 seconds with your back to me. Then when you were writing down my wife's name and phone number, you turned around and were writing on your clipboard and then you kept talking to me that way for



another 30 seconds. When you watch the video tape you'll see it."

So when the simulation day was all done, and the videos were downloaded to the project website, I could look at the video. It happened exactly like the patient described. Here's a screen shot of the very talented and affirmed chaplain. The patient is clearly trying to talk to the chaplain and the chaplain is talking, but his back is to the patient.



University of Illinois at Chicago

Now is this something that I frequently do when visiting patients? I don't know. But I did it then, and that is something important to know and be aware of: monitoring my person and position when visiting patients.

I'm an experienced chaplain, and simulation taught me something really important about improving my clinical work. But my point here is that simulation taught me something that no other format of chaplain training had ever taught me.

One way that chaplain training as currently practiced could have contributed to that specific improvement was dual patient visits with a supervisor, where she could have spotted me doing this and shared it with me. Maybe your training included more frequent and sustained dual visits with a supervisor giving feedback. Mine did not. Dual visits were something that happened once or twice near the beginning of training, and I suspect the norm is not for frequent and sustained dual patient visits.

The mainstay of CPE process continues to be the verbatim. The verbatim has the benefit of being a vehicle students can use to share with their supervisor and their student peers their experiences in clinical ministry for feedback, growth, and learning. Yet the verbatim has a principle drawback of being self-reported, self-interpreted information that is recorded sometimes hours, even days after the actual events and thus may or may not reflect what actually happened in an encounter.

This is a widely recognized part of CPE process.

One CPE handbook available online instruct students writing verbatims in this way:

*"Only provide the most critical aspect of the conversation under reflection. It is understood that you will not be able to remember a conversation word for word, but try to restate what you remember, as best you can. What you remember is significant regardless of whether it is literally what was said or done."*<sup>10</sup>

All of that is true. Verbatims focus on the learner's experience and perspective; they are not intended to provide the perspective of the recipient of the care. What a student presents in a verbatim is significant, even if it is not literally what was said and done.

The Both/And perspective is that while what the student remembers is significant regardless of whether it is literally what was said and done, the perspective of the

recipient of care and what that person experiences, and some reflection on what WAS literally said and done, are also very *important*. Both/And. CPE, as presently practiced, doesn't explore both aspects.

How a person is experienced by others in group and individual supervision is said to be a sufficient proxy for how someone would be experienced by patients. Similarly, how a candidate for certification is experienced in the board certification interview is sufficient proxy for how someone would be experienced by patients. But I suggest that isn't a sufficient proxy.

I don't know whether or not I used to occasionally or even frequently speak to patients with my back to them, but the verbatim process could never have assisted me in unveiling that and working on improving my performance, because I could only share in a verbatim something of which I was at least dimly aware. Nothing in my board certification process could ever have unveiled it either.

I'll admit it could be scary for all of us chaplains to learn exactly how others perceive us, but the perspective of the recipients of our care is crucial to providing the best, most sensitive care. Let's build that into our training process.

The next element I would like to describe is how we could more specifically include objective observation of competency into training and certification.

Let me start with one element that we could borrow from the way some other disciplines are being evaluated in the both/and training process, namely "Developmental Milestones."

These are behavioral descriptors for the role performance of a discipline. What follows is an example of Developmental Milestones<sup>11</sup> in use for the training and evaluation of internal medicine residents. This shows how a learner in the earlier stages of training performs in a number of different interactions that must be demonstrated. The important thing is that the learner is evaluated by direct observation of the behaviors, not by self-report or submitted documentation. And it

18. Responds to each patient's unique characteristics and needs. (PROF3)				
Critical Deficiencies			Ready for unsupervised practice	Aspirational
Is insensitive to differences related to culture, ethnicity, gender, race, age, and religion in the patient/caregiver encounter	Is sensitive to and has basic awareness of differences related to culture, ethnicity, gender, race, age and religion in the patient/caregiver encounter	Seeks to fully understand each patient's unique characteristics and needs based upon culture, ethnicity, gender, religion, and personal preference	Recognizes and accounts for the unique characteristics and needs of the patient/ caregiver	Role models professional interactions to negotiate differences related to a patient's unique characteristics or needs
Is unwilling to modify care plan to account for a patient's unique characteristics and needs	Requires assistance to modify care plan to account for a patient's unique characteristics and needs	Modifies care plan to account for a patient's unique characteristics and needs with partial success	Appropriately modifies care plan to account for a patient's unique characteristics and needs	Role models consistent respect for patient's unique characteristics and needs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments:				

includes the feature of growth from not knowing how to demonstrate a behavior all the way to demonstrating it the way necessary to be the professional.

I would like to commend a recent study published this last January in the *Journal of Pastoral Care and Counseling*. Rev. Dr. Judy Ragsdale is the corresponding author of a piece entitled “Behavioral Outcomes of Supervisory Education in the Association for Clinical Pastoral Education: A Qualitative Research Study.”<sup>12</sup>

Judy and her co-authors have made a great contribution to improving how clinical pastoral educators are formed. Specifically, they share in their study that the content of Level I and II CPE and Supervisory education itself needs to include the content of spirituality and health, as well as the evidence based work about patients’ use of spirituality that our interdisciplinary colleagues already expect we are imparting (but aren’t really) in a systematic way.

Judy and her co-authors share a set of Developmental Milestones that better demonstrate how supervisors seeking certification meet the expected competencies of certification. They have a fantastic list that translates supervisory education outcomes into behavioral descriptors.

* Cultural/Religious/Spiritual Awareness:			
Scale	Rating	Definition	Notes
5	Excellent (could not be better)	The chaplain demonstrates awareness of cultural/religious/spiritual needs of the patient/family member/care team member in the encounter. The Chaplain Learner effectively incorporates these needs into the care of these person(s).	
4	Very Good (little room for improvement)		
3	Good (Solid chaplain; room for improvement)	The chaplain demonstrates awareness of cultural/religious/spiritual needs of the person(s) in the encounter; however the chaplain does not effectively incorporate these needs into care the care of these person(s).	
2	Fair (Significant improvement is needed)		
1	Poor (Major weakness in this area)	The chaplain does not demonstrate awareness of cultural/religious/spiritual needs.	

In the simulation project I described, we have also developed objective scoring systems for an observer to employ, showing the extent to which a chaplain performing a specific critical interaction is being successful, complete, and accurate. Here is an example of one element developed in that project. The chaplain is observed and rated for the extent to which the chaplain can assess spiritual and cultural needs and incorporate them into the care of the patient.

The important difference between how we currently assess competence and behavioral descriptors and developmental milestones is that these are observed *objectively*. This can be done during simulation or by a supervisor shadowing a learner, but they are not self-reported.

We can develop these descriptors around specific competencies and perhaps assembled into groups portraying successful outcomes in specific critical interactions, such as fostering conversations about spiritual, personal, and cultural values and wishes about health care. Developing them and using them in both chaplain training and certification would provide evidence that the chaplain is able to do the things we need chaplains of the future to do.

Finally, still lacking in our efforts to portray objectively observable competencies that result in successful outcomes, is a normative language for what we do and what we hope for its outcomes.

Being able to describe and claim those elements in a way that other members of the health care team can understand and, even better, refer or request has been a struggle for chaplains.

Lacking a normative language means that our interdisciplinary colleagues don't really know what we do and why we do it. That is partly because we describe the same things in many different ways; or, sometimes we describe different things the same way.

Some of you may have heard of the Advocate Chaplaincy Taxonomy<sup>13</sup> that I was privileged to work on a couple years ago. Health Care Chaplaincy and the John Templeton Foundation generously funded six projects to study a variety of topics in health care chaplaincy. My organization was fortunate to be chosen for one of those six projects.

What we did was use a mixed-methods approach to identify a normative language for health care chaplaincy: a normative list of interventions and outcomes that chaplains can all use to describe what we do and what results from what we do. If we all used the same list and used the same language, others in the world of health care chaplaincy would come to recognize what we do.

The Advocate Chaplaincy Taxonomy			
Intended Effects	Methods	Interventions	
Aligning care plan with patient's values	Accompany someone in their spiritual/religious practice outside your faith tradition	Acknowledge current situation	Facilitate closure
Build relationship of care and support	Assist with finding purpose	Acknowledge response to difficult experience	Facilitate communication
Convey a calming presence	Assist with spiritual/religious practices	Active listening	Facilitate communication between patient and/or family member and care team
De-escalate emotionally charged situations	Collaborate with care team member	Ask guided questions	Facilitate communication between patient/family member(s)
Demonstrate caring and concern	Demonstrate acceptance	Ask guided questions about cultural and religious values	Facilitate decision making

Establish rapport and connectedness	Educate care team about cultural and religious values	Ask guided questions about faith	Facilitate grief recovery groups
Faith affirmation	Encourage end of life review	Ask guided questions about purpose	Facilitate life review
Helping someone feel comforted	Encourage self-care	Ask guided questions about the nature and presence of God	Facilitate preparing for end of life
Journeying with someone in the grief process	Encourage self-reflection	Ask questions to bring forth feelings	Facilitate spirituality groups
Lessen anxiety	Encourage sharing of feelings	Assist patient with documenting choices	Facilitate understanding of limitations
Lessen someone's feelings of isolation	Encourage someone to recognize their strengths	Assist patient with documenting values	Identify supportive relationship(s)
Meaning-Making	Encourage story-telling	Assist someone with Advance Directives	Incorporate cultural and religious needs in plan of care
Mending broken relationships	Encouraging spiritual/religious practices	Assist with determining decision maker	Invite someone to reminisce
Preserve dignity and respect	Explore cultural values	Assist with identifying strengths	Perform a blessing
Promote a sense of peace	Explore ethical dilemmas	Bless religious item(s)	Perform a religious rite or ritual
	Explore faith and values	Blessing for care team member(s)	Pray
	Explore nature of God	Communicate patient's needs/concerns to others	Prayer for healing
	Explore presence of God	Conduct a memorial service	Provide a religious item(s)
	Explore quality of life	Conduct a religious service	Provide access to a quiet place
	Explore spiritual/religious beliefs	Connect someone with their faith community/clergy	Provide compassionate touch
	Explore values conflict	Crisis intervention	Provide Grief Processing Session
	Exploring hope	Discuss concerns	Provide grief resources
	Offer emotional support	Discuss coping mechanism with someone	Provide hospitality
	Offer spiritual/religious support	Discuss frustrations with someone	Provide religious music
	Offer support	Discuss plan of care	Provide sacred reading(s)
	Setting boundaries	Discuss spirituality/religion with someone	Provide spiritual/religious resources
		Ethical consultation	Respond as chaplain to as defined crisis event
		Explain chaplain role	Share words of hope and inspiration
		Facilitate advance care planning	Share written prayer
			Silent prayer

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Note one of the items at the top, “Aligning care plan with the patient’s values”. That is the item I am convinced is pivotal for health care chaplaincy of the future.

Some organizations have already adopted the language into their electronic medical records. What chaplains can use the list for is indicating the things they did, interventions and methods, and aiming toward what they hoped to accomplish in doing that, which the list calls intended effects.

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“There are spiritual care providers from myriad faith traditions, with countless different ways of being prepared, trained and educated for providing spiritual care.”

Here is an example:

“Aligning care plan with patient’s values” is the intended effect.

“Explore cultural values” is a method.

“Ask guided questions about cultural and religious values” is an intervention.

You can assemble the items in many different ways. For example, those same interventions and methods could be used to achieve a different intended effect

You could ask guided questions about cultural and religious values and explore cultural values as interventions aimed at “Faith Affirmation” or “Preserve Dignity and Respect”.

Until we unify how we talk about what we do and why, we are diluting our impact. You are invited to download and use the chaplain taxonomy.

You can download it at this website <http://www.advocatehealth.com/chaplaincyresearch>. It is free for use and we ask that, if you wish to incorporate it formally into a system of documentation, contact us so that we can talk about standards we ask for keeping the list consistent.

In summary: there are three elements that, added to the way we form, train and certify chaplains, will guide the field of health care chaplaincy into being counted on to do the things that we need to do. First, incorporating the perspective of the recipient of care into the way we are trained. Second, adopting objective observation and behavior demonstration of the role of chaplain into the certification process. Third, use of a normative language to describe what we do and what we hope to achieve from it.

These elements I believe, when added to how we currently train and certify chaplains, will help us emerge, amidst the changes happening right now in health care, as trusted health care professionals who can capably assist patients in aligning their own cultural, spiritual and personal values into their care.

One reason I am very excited about the Spiritual Care Association announced this spring (<http://www.spiritualcareassociation.org>), is that it recognizes that spiritual care is about far more than hospital chaplains. There are spiritual care providers from myriad faith traditions, with countless different ways of being prepared, trained and educated for providing spiritual care. They all long for further development, tools, curricula and contexts to connect and share ideas. But they also have much to offer to other providers

of spiritual care. The Association will enable different kinds of spiritual care providers to learn and teach from numerous models of providing care.

Spiritual care providers from these various faith traditions can also learn to improve their skills and help people talk about their values and goals in health care. Faith communities may even be a better place to talk about values and goals in health care, rather than in hospitals where the conversations take on more stress and anxiety.

The association is also proposing to design elements of competency examination that mirror what I see regarding our future needs. For example, I welcome the opportunity to take the test they are proposing on chaplaincy foundational knowledge. If I find that I don't command all of that propositional knowledge base, it wouldn't mean I'm a bad chaplain; it would mean someone is helpfully pointing out areas of knowledge that will be useful to me in improving my clinical practice.

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"I believe all of us who provide any form of spiritual care, in hospitals, in nursing homes, in clinics, in houses of worship, all of us, what we do is never routine or ordinary. It is extra-ordinary."

I believe that all the organizations, systems and structures in the United States that have been involved in training, educating, and certifying chaplains can welcome open exchange of ideas, concepts and models for formation in providing spiritual care.

Let me close with another story that shows the value chaplains can have: A patient came into the intensive care unit in critical condition, unable to make or communicate any decisions about care. The patient had a friend who came to the hospital, claiming that the patient had named this person as the agent of Power of Attorney for Health Care, that they were lifelong friends and that the patient had no other family. In a search of the medical record, they found a scanned copy of the Power of Attorney for Health Care form, which had indeed been completed by the patient, naming this specific friend as the agent of Power of Attorney for Health Care. The person who shared this story with me noted that I had been the chaplain who had assisted the patient in completing the form and witnessed the document. This had happened over 10 years ago.

I think that advance directive was one of the countless advance directives I have helped patients with over the years. Helping that patient fill out that form at the time probably felt like the most routine and ordinary thing that I did that day, because that is a really routine and ordinary thing for a chaplain.

But, over ten years later, that routine, ordinary thing was crucial in helping a patient have care aligned with the patient's values and having the person the patient trusted make those decisions. It wasn't routine or ordinary at all; it was a crucial moment.

I believe all of us who provide any form of spiritual care, in hospitals, in nursing homes, in clinics, in houses of worship, all of us, what we do is never routine or



ordinary. It is extra-ordinary. Every day we are aligning people's care with their values, every day we are preserving dignity and respect, promoting a sense of peace, journeying with people in grief, building relationships of care and support. The future of chaplaincy rests in continuing to develop the profession of caring for the human spirit.

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## Endnotes

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- 2 Data presented at 34th Annual JP Morgan Health Care Conference, San Francisco, California, January 11, 2016.
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# The Future Has Passed By: Reflections on Lutheran Theological Education and Lutheran Specialized Ministry

**Rev. Dr. Leonard Hummel**

**IN HIS 2011 ARTICLE**, “The Future Has Arrived: Changing Theological Education in a Changed World,” Daniel Aleshire, the president of the Association of Theological Schools, first commented, “I know that [the title] doesn’t make much sense; the future is always arriving, isn’t it?” but then proceeded to unpack the meaning of his title in way that makes complete sense.

*[At] this moment in time in the church and theological education ... it is as if the future has moved faster than the present and the sun has risen in the east before it has set in the west. Theological schools in North America are at an unprecedented time in their history—a future has arrived and they are struggling to catch up with it.*<sup>1</sup>

When I was invited to offer notes and comments to *Caring Connections* regarding the future of Lutheran theological education and the significance of that future for ministries in pastoral care, counseling, and clinical education, the announcement of the establishment of a new school of theology through a consolidation of Philadelphia and Gettysburg Lutheran Seminaries had not yet occurred. To be sure, the shape that this new school will assume is not now completely clear. But one thing is certain: the creation of this entity means a shaking of foundations throughout all of Lutheran theological education in the United States. And it means that the future not only has arrived but is quickly passing by.

What will abide both as these two seminaries become one and also throughout Lutheran theological education as it undergoes concomitant reformation will be the training of rostered leaders (pastors, deacons and ministers by any other name) for specialized ministry—since the call will remain for the church to find ways to hand over the gospel to the world in unique and focused ways. What will change is that, not only will those seeking to serve in specialized ministries of chaplaincy and religious social service be challenged to find new opportunities to hand over the gospel to the world, but also that all theological students will be educated to develop specialized ways of engaging in professional ministry.

Indeed, all eight ELCA seminaries now are laser-like focused on training their students to become “public religious leaders” whether they will serve that public in congregations or through other forms of ministry. For example, Luther Seminary aims for its graduates to assume roles in “Christian Public Leadership.” At the Lutheran School of Theology at Chicago, the goal is “Leadership for a Public Church.”

Trinity Lutheran Seminary forms “leaders for Christ’s church at work in the world.” And at university-affiliated Divinity Schools, many Lutheran theological students are developing competencies in subjects such as health-care and law so that they may take on related specialized ministries.

Another trend reflected in the new candidacy manual for rostered leaders of the ELCA will be more competency-based training. Therefore, seminarians will be accustomed to assessing themselves and being assessed by others according to the metrics of demonstrable outcomes—as many in specialized ministry have been doing for some time. Similarly, more graduating seminarians will carry with themselves carefully compiled portfolios of their activities, accomplishments, and achievements.

In sum, both the blessings and shortcomings (if not sometime curses) brought on by the technical rationality that shape these educational/professional processes and now already direct much specialized ministry will be common throughout all ministries.

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“Many current specialized ministers in the LCMS and ELCA may be good examples for the new crop of theological students for learning how to be faithful to Christ by sometimes using the language of faith and sometimes not doing so.”

I have used the term “handing over the gospel to the world” several times to describe the heart of ministry. By this term, I mean a process of ministry that is congruent with I Corinthians 11:23, wherein the root-word *paradidomi* is employed to signify both the handing on of gospel tradition and also the betrayal of Jesus. Accordingly, I suggest a handing over of gospel to the world at the risk of losing control over the gospel is the very way the good news gets out to the world for the sake of the world. Since the gospel exists for the sake of the world—and not for those who minister in its name or even for the sake of the gospel itself—specialized ministry informed by an empathic theology of the cross may sometimes refrain from using the language of faith with some people and in certain circumstances. Many current specialized ministers in the LCMS and ELCA may be good examples for the new crop of theological students for learning how to be faithful to Christ by sometimes using the language of faith and sometimes not doing so.

Out of empathy for the world and as the church seeks new ways to be faithful to the gospel, we can expect varieties of electronic media and highly novel methods to shape the very architecture of seminary training. As these new ways of forming public ministers are sought after and adopted, we must also hope, pray—and work for—continuity with the traditional demand in Lutheranism that ministers be learned persons in the humanities, the sciences and theology itself. We may pray that the “specialized” in specialized ministry may come to signify that all seminarians have been selected for their rich talents for the special work of ministry. We may also pray that those talents will be cultivated and nurtured by the best theological educators—since the church is called to offer only the best to the world. For the sake of the future

that has already arrived, we must hope, work and pray that God will richly bless Lutheran theological education for the sake of the world.

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## Endnotes

1 Daniel O. Aleshire, "The Future Has Arrived: Changing Theological Education in a Changed World," *Theological Education* 46 (2011): 380.

# Thoughts on the Future of Lutheran Ministries in Pastoral Care, Counseling and Clinical Education

Rev. BJ Larson

**I SPEND MOST** of my time on the future of spiritual health in my organization, Fairview Health Services, so I commend this issue's focused intention. My purpose in writing is to offer reflections on the future of Lutheran specialized pastoral care ministry from the vantage point of a Lutheran organization that is — in the not too distant future — actually merging with the University of Minnesota Physicians and Clinics (UMPC). This is, of course, if all the votes have gone through positively by the time you read this article.\* If this is the case, the name “Fairview” will go away — after more than a hundred-year history — and we will become one with UMPC, with a new name yet to be determined. Fairview, which had its roots in Lutheran congregations and committed to serve the neighbor, Norwegian or not, will soon cease to exist in name, while the scaffolding and structures will be reformed in union with UMPC into one integrated academic health system. How's that for a reformation in modern day? And you might ask, “What does this reformation have to teach us, specifically from the perspective of spiritual health and clinical pastoral education”? To that end, I'd like to suggest that living out our mission today in health care calls for community partnerships in education and service, a courageous willingness to let go of what's been and trust in what will be, as well as a commitment to love of the neighbor — no matter what faith they hold or other diverse expressions of humanity they embody.

Fairview and UMPC agree that we exist to “heal, discover and educate” for longer, healthier lives, according to our mission statement. We also agree that, to be good stewards of the resources we have been given means that we can do more together; and, we can do it better for less cost if we join as one. That is, of course, easier said than done, and I'm sure we will have squabbles along the way; however, we are called to live into our new identity with trust in our roots and a commitment to the common good that we share. Too many people in our communities suffer because of the zip code in which they reside and the lack of a health care system that effectively partners with them and empowers them to become healthier in their own backyards. How we actually improve the health status of all communities we serve, not just through money, will be at stake in our new future together.

And while it is true that we have leaned into faith in our endeavors as a spiritual health department since our beginning; today we are called to wisely use the resources of other disciplines and research methodologies to demonstrate our unique contribution in ways that those who speak other languages can appreciate more fully. It is our Pentecost of another day drawing upon our Lutheran theological roots! I

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\* see addendum

hear a reverberation in notes from a brief survey oral history of ACPE (Association of Clinical Pastoral Education) in 1944 which put forth a similar spirited declaration: “We dare no longer delay the fuller fusion of faith and life, of doctrine and practice, of knowledge and skill” (Daniel Sandstedt, historical survey document, 1944).

Spiritual health departments that serve and educate today are called to be of the highest quality, not relying on past influence or just the leaders who “get what we do” and “why CPE is so important.” Today

we can actually make a case for the difference our services make to patients, particularly in areas such as oncology and adolescent behavioral health, for example, which have led to growth in new contexts. Our CPE residents and interns get to be part of the health care team in the

various clinical contexts in which they practice and learn how not to go it alone as a parish pastor disconnected from other local experts in the community. In fact, this fall, as a part of a research grant with ACPE, we will have our first outpatient chaplaincy CPE unit with students from United Seminary in Minneapolis, whose degree preparation is concentrated in interfaith chaplaincy. Students will not only be serving the patients in a new, state of the art, outpatient facility, but they will be researching what matters to these patients in terms of their spiritual care. Additionally, the CPE supervisor of record for this unit will be conducting a national survey of CPE programs and curriculums to identify best practices for educating CPE residents about outpatient chaplaincy. Finally, we have more chaplains deployed today in outpatient settings, including virtual environments responding to spiritual care needs of patients, family members and the health care professionals themselves who struggle to be resilient in such a rapidly changing environment.

Finally, from an organizational lens, our current reformation is underway with the Fairview Association, representing seventy-eight Lutheran congregations. The delegates recently gathered for the annual meeting on Syttende Mai (May 17 – Norwegian Independence Day) to hear what is happening with the planned merger and voice their hopes and fears for the future. While the most palpable loss is letting go of the name “Fairview”, since identity is so important for both its longevity and its community shaping effect, this community affirmed the future and a new proposed charter of an interfaith health collaborative “to bring diverse faith communities and other mission-aligned, community-based organizations together ... to advance our common mission of healing, health and wholeness.” (draft document). Besides the frontline work these community partners do every day where it matters, now this new group, will also select two members of the patient experience and community council. With both presence and action, voice and vote, the impact of the faith community and

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“...to live out our mission today in health care calls for community partnerships in education and service, a courageous willingness to let go of what’s been and trust in what will be, as well as commitment to love the neighbor.”

service-driven organizations, combined with the educational fervor of the university and its partners, is seeking to embody a more robust love of neighbor and ensure the health of our communities for the future.

This is a bold vision and reformation in the context of health care, the faith community, and the neighbors around us. And I hope it is more than a preacher's tale I'm spinning, because this really matters to a lot of people and to the common good of our local communities and our state endeavor in the educational intersections with public health, community health and health care professionals. May it be so! And when we don't get it right, which our theology reminds us will happen in spite of our best intentions, we are still accountable for what we do and what we don't do. Because of organizations like Fairview — and yours — we will be given another opportunity each day to rise, to let go of what we're hanging on to, and to be changed in love of the neighbor, poured out in commitments “to heal, discover, and educate for longer, healthier lives.” Whether the mission statement of your organization reads this way or not, we have this common purpose in the reformation of health care and specialized pastoral care ministries right where we are serving today. May it be well with you today, and may we find more and more ways to partner together in education and service, to be courageous in letting go, and to love our neighbors as ourselves.

**ADDENDUM:** *Fairview announced in July that it will not be merging with University of Minnesota Physicians into one organization, as had previously been hoped. However, the affiliation agreement remains in effect in a dynamic, collaborative environment — with both challenges and opportunities. Therefore, the premise of this article remains; that is, how we change and grow, while still moored by mission and vision in our true grounding.*

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