Before Your First CPE Unit

A Friendly Guide to Chaplaincy and Clinical Pastoral Education



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AI tools assisted in the preparation of this book. The author reviewed and revised all content and is responsible for it.

The stories in this book are composites. Names and identifying details have been changed so that no real person can be recognized.

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A Word Before We Begin

If you are holding this book, you are probably standing at the edge of something. Perhaps you have been accepted into your first unit of Clinical Pastoral Education and are waiting for it to begin. Perhaps you are still deciding whether chaplaincy is for you, or simply curious what this work involves. Wherever you stand, my hope is the same. By the last page I would like you to feel less anxious, more welcomed, and readier to begin, without any pretense that a book can do what only CPE itself can do.

A word about the stories in these pages. What the people in them feel and face is real, drawn from decades of actual patients, families, and students. But they are composites, their names and details changed and blended so that no real person can be recognized. The confidences people share in hospital rooms are sacred, and I have kept them.

There is one exception, and it may be among the more useful things in this welcome. A few years ago, a documentary called *A Still Small Voice* followed a year of our chaplaincy residency, from a resident's first uncertain visits through the exhaustion and the growth of a full year of CPE. I appear in it as one of the educators. I mention it here and return to a few of its moments through the book, because it offers something no book can. It lets you watch real CPE happen, on real faces, before you begin. If you would rather see the work than only read about it, the film is worth finding.

Now, to the work.

Getting Started

CHAPTER 1

Filling Out Your CPE Application

This chapter is for the reader who has not yet applied to CPE, or who is partway through an application and would like a steady hand through it. If you have already been accepted, you are welcome to move ahead to Part One, though a few pages here may still be worth your time.

The word application comes from a Latin verb, *applicare*, which means to attach or to fold something toward. That is a fair description of what you are actually doing. You are beginning to fold yourself toward this work, and the form in front of you is where that begins. I have read a great many of these applications from the other side of the desk, and I can tell you that the form is less forbidding than it looks, and that the anxieties it stirs are usually the wrong ones.

Finding a Program

Before there is an application, there is a choice of where to send it. In the United States there are more than two hundred programs accredited by the ACPE, the main accrediting body for CPE, which you will hear more about in the chapters ahead. The ACPE keeps a directory on its website that lets you filter by state, by the kind of unit you want, and by how it is delivered, including programs offered partly online. It is worth spending time there rather than applying to the first program you find. Programs differ in their settings, their schedules, and their character, and a unit that fits your life and your hopes will serve you better than the nearest one.

If you are weighing an intensive summer unit against an extended one spread across a year, the chapters ahead describe both, and it helps to know which shape suits you before you apply.

The Application Itself

Most ACPE programs use a common application, which you can download from the ACPE website and fill in on your computer. I would download it early, read the whole thing before you write a word, and give yourself more time than you think you need, because the questions ask you to reflect, and reflection does not hurry.

A handful of principles matter more than any single answer.

Answer the question that is actually asked. The prompts are more specific than they first appear, and a reviewer can tell when an applicant has written around a question rather than into it.

Show that you know yourself, including your limits. The application asks about your strengths, but it is not looking for a person without weaknesses. It is looking for a person who can see their own, because self-awareness is the raw material of everything CPE will teach you. An honest word about where you struggle tells a reviewer more than a page of accomplishments.

Be yourself rather than an impressive version of someone else. Reviewers read many applications, and they can feel the difference between a real person and a performance. You do not need to sound like a chaplain yet. You need to sound like you.

Let yourself be a little vulnerable. This is not an invitation to bare every wound, but the willingness to write honestly about something that cost you is exactly the disposition this work asks for. An application with no soft edges reads as guarded, and

guardedness is the very thing CPE will spend a unit helping you set down.

And finish the whole thing. Answer every section, attach what is asked for, and leave no gaps for someone to wonder about. Completeness is its own form of respect for the people reading.

You may notice that these are not tricks for getting in. They are the beginnings of the very practices CPE exists to grow: honesty, self-awareness, and the courage to be seen. The application is your first small rehearsal of them.

What the Application Asks

The particular questions are revised from time to time, so treat what follows as a map of the territory rather than a line-by-line key and always answer the version in front of you. But the heart of the application has stayed steady for years.

It asks for your personal history. Who are the people who formed you, the family you come from, the relationships that matter now, the mentors and the losses and the turning points that made you who you are? This is usually the longest section, and applicants often find it the hardest, not because it is complicated but because it asks for honesty about one's own life. Write plainly. You are not composing a memoir. You are helping a stranger understand the person who will walk onto the floors.

It asks for your spiritual development. The story of your religious and spiritual life, where you began, how it has changed, the experiences that shaped it, and how you came to sense a call toward this kind of service. Traditions differ, and the reviewers know that. They are not checking your answers against a creed. They are trying to understand the spiritual person you are and how you have come to this doorway.

It asks for your work history. Here you can be brief and factual, a resume or a summary of where you have worked and what you are doing now. This is the one section that wants information more than reflection.

It asks you to describe a helping incident. You will be asked to write about a time you cared for another person, ideally in something close to the form CPE calls a verbatim, a remembered account of an actual conversation, with what was said on both sides and what you noticed and felt. A later chapter explains the verbatim in full, so do not worry if the form is unfamiliar now. If you have done CPE before and have a recent verbatim, you may be able to use it. For most first-time applicants, this is simply a chance to show, in one real example, how you are with a person who is struggling.

And it asks for your impressions of CPE. What you understand the training to be, why you are seeking it, whether it is required of you or freely chosen, and what you hope to learn. If you have read this far into this book, you already have more to say here than most applicants do. Say it in your own words.

The remaining sections are administrative. There is usually a modest fee, sometimes none, and the amount is stated on the form. There are questions for international applicants, questions about any prior CPE, and a place to attach your resume. None of it is difficult. Read each item, answer it fully, and move on.

The Interview

Most programs will ask to meet you after they read your application, in an admissions interview. This is not an interrogation, and it is not a test you can fail by saying the wrong thing. It is a conversation, usually with the educator who would

work with you, meant to sense whether you are ready for the intensity of a unit and whether the program is a good fit for you as much as the other way around. The best preparation is the same honesty the application asked for. Come as yourself, speak plainly about why you are drawn to this work and what you are unsure of, and let it be a real conversation. Some of the applicants I remember most warmly are the ones who admitted, in the interview, how nervous they were.

One Last Word Before You Send It

When you have filled in every section, read the whole thing once more, and ask yourself a single question. Can the person reading this see me? Not an idealized applicant, and not the chaplain you imagine you are supposed to be, but you, with your history and your hopes and your honest uncertainties. If they can, the application has done its work. Put yourself into it and let the reviewers see you. That willingness to be seen is the beginning of everything that follows in this book.

PART ONE

Understanding the Work

CHAPTER 2

What Chaplains Do, and How It's Different

Don't just do something. Stand there. Because there's connection and healing in that.

— A Still Small Voice

The Picture in Our Heads

Most of us come to chaplaincy carrying a picture in our heads, and the picture is usually a little off. Perhaps you imagine a figure in a dark suit or a clerical collar, appearing at the bedside in the final hour to say a prayer and offer last rites. Perhaps you picture someone deeply religious and a little remote, who shows up mainly to comfort the dying. These images come from somewhere. They come from films and television, from a funeral we attended years ago, from the one time a hospital sent someone to sit with our family in a waiting room. The images are not false. They are simply small. The work is larger and more human than the picture suggests.

That gap, between what people imagine chaplaincy to be and what it actually is, is worth noticing at the start. If you are about to begin Clinical Pastoral Education, or if you are simply curious about the profession, you are probably working from that inherited picture without realizing it. Part of what CPE does is replace the picture with something truer, and part of what I hope this book does is the same. Underneath almost every conversation I have with newcomers sits a single question, some version of, "Isn't this just therapy?" or "Isn't this just being a hospital pastor?"

Where the Word Comes From

The word chaplain has an origin worth knowing, because it says something about the work. The story usually told begins with Martin of Tours, a Roman soldier in the fourth century. Meeting a beggar shivering in the cold, Martin cut his military cloak in two and gave the man half. The cloak, the *cappa* in Latin, became a treasured relic. The clergy who cared for it were called *cappellani*, and the small sanctuary that housed it was the *cappella*, from which we get our word chapel. Over the centuries the *cappellanus*, the chaplain, came to mean a member of the clergy who served people outside the walls of a settled congregation, in armies and courts, on ships, and eventually in hospitals.

I find that history worth remembering, because the whole image turns on a cloak shared with a stranger in need. The chaplain is not the pastor of a gathered flock. The chaplain is the one who goes to whoever is cold, in whatever place they happen to be, and offers a share of what warmth there is. Hold that picture alongside the small one you inherited, and you are already closer to the truth of the work.

An Ordinary Visit

The stories people expect from chaplaincy are the dramatic ones, the deathbed reconciliations and the miraculous turns. Those moments do happen. But they are not the center of the work. The center is more ordinary than that, and it looks something like this.

Some years ago, I visited a man I will call Walter. He was recovering from surgery on a general medical floor. His chart told me almost nothing, only that no religious preference had been recorded, which in a hospital often means the admitting clerk was

busy and never asked. I knocked, introduced myself, and told him I was one of the chaplains. He looked at me over the top of his reading glasses with an expression I have come to know well, a mixture of politeness and wariness. “That’s kind of you,” he said, “but I’m not religious. You don’t need to waste your time on me.”

There was a version of this visit in which I thanked him and left. A man who is not religious, I might have reasoned, has no need of a chaplain. Early in my training I might have done exactly that, partly out of respect and partly, if I am honest, out of relief. Walter had given me an easy exit. Instead, I asked him whether the food had been any good. He laughed and told me it had not. We talked for a moment about hospital food, a subject on which nearly everyone has opinions. Then I noticed a photograph on his windowsill and asked him about it. It was a picture of a vegetable garden, rows of tomatoes and beans. Walter had grown that garden for forty years. This was the first summer he would miss it, and he was not sure, given his heart, that he would ever plant it again.

We did not solve anything. I did not pray, because he had not asked me to, and to pray anyway would have been an imposition. I listened while an old man talked about his tomatoes. Underneath the tomatoes he was talking about growing older. Underneath that he was talking about a life he could feel changing shape. When I stood to leave, he took my hand and held it a moment longer than a handshake. “I didn’t think I wanted to talk to anybody today,” he said. That was all. I have thought about Walter many times since, and I have come to believe that this ordinary visit is a truer example of chaplaincy than any dramatic scene I could offer you.

What Chaplains Actually Do

So, what did I do in that room? I paid attention. I followed the person rather than an agenda. I let the conversation go where it needed to go, including toward nothing in particular. And I trusted that being with someone is itself a form of care, even when nothing gets fixed and no god is mentioned. That is much of what chaplains do. We show up. We pay attention. We stay a little longer than people expect. It is not the whole of the work, but it is where the work begins.

People of Every Faith, and of None

Chaplains serve people of every faith and of no faith at all. This surprises many newcomers, and it surprises a fair number of patients too. A hospital chaplain is not there to convert anyone. Nor is the chaplain there to represent one tradition and hope the patient belongs to it. In a single afternoon you may sit with a devout Catholic, a Muslim family keeping vigil, and a Jewish patient who has not been to synagogue in thirty years. You may sit with an evangelical Christian who wants to pray aloud, and then with a thoroughgoing atheist like Walter, who has no use for religion, but who is, like all of us, facing something. The chaplain meets each of them as they are. Your own faith, whatever it is, becomes something you draw on rather than something you impose.

I will have much more to say about this later, because caring for someone whose beliefs differ sharply from your own is one of the more demanding parts of the work. For now, it is enough to know two things. The door is wide. And the person's beliefs, not yours, set the terms of the visit.

Where Chaplains Serve

Chaplaincy is also larger than the setting most of us picture. Healthcare chaplains work in hospitals, on medical and surgical floors, in intensive care units and emergency departments, in cancer centers and children's hospitals and psychiatric units. But chaplains also serve in hospice and home care, sitting with people in their final months in their own living rooms. They serve in nursing homes and assisted living. They serve in prisons and jails, in the military, in universities, in police and fire departments, in airports, and in workplaces of many kinds.

The common thread is not the building. The common thread is that human beings, wherever they are, meet moments of fear and loss and meaning and hope. It helps to have someone present in those moments, someone trained to accompany them without flinching and without needing to make the discomfort go away. This book focuses on healthcare settings, since that is where most CPE happens and where most readers are headed. But hold the wider picture in mind, because it tells you something about what chaplaincy fundamentally is.

How This Work Differs From Counseling, Social Work, and Ministry

If a chaplain mostly listens, and pays attention, and sits with people in hard moments, how is this different from what a therapist does? Or a social worker? Or a good and caring pastor? New students ask me some version of this all the time, and the questions are fair ones. The honest answer is that the roles overlap. We are all, in different ways, trying to help. But the differences are real and understanding them will help you find what I sometimes call your lane, the particular contribution that is yours to make on a team.

Different From a Counselor

Consider the counselor or psychotherapist first. The difference comes down to what each of us is working on. A counselor works to identify and treat a mental health condition. There is assessment, often a diagnosis, and a course of treatment aimed at easing a disorder of the mind. A chaplain works in a different domain. The chaplain assesses and attends to spiritual distress, the pain that arises when a person's sense of meaning, hope, or connection has been shaken, and does so largely through the ministry of presence.

This does not mean the chaplain drifts in without discipline. Both of us read the person carefully. We simply read for different things, with different lenses, toward different ends. The counselor looks through a clinical lens for a condition that can be named and treated. The chaplain does a spiritual assessment, reading for distress but also for the resources a person still has to draw on, their faith, their relationships, the meaning they are making of what is happening to them.

Presence is the chaplain's ground, but it is not the chaplain's only tool. From it flow the other things a chaplain may offer when the person wants them, a prayer, a ritual, a sacrament, the naming of a grief. Presence is not really what separates the two roles, since good counselors are present too, and the non-directive tradition in chaplaincy was borrowed from a psychologist, Carl Rogers. The difference is what each of us is present for. The counselor is present to heal a wound of the mind. The chaplain is present to accompany a person through a distress of the spirit.

None of this should suggest that a person is divided into a mental part and a spiritual part. We come as whole beings, and distress of the mind and distress of the spirit are usually tangled together in the same life. We draw these distinctions not because

the person is built from separate compartments, but because those of us who care for them need to be clear about what is ours to do and what belongs to a colleague.

Different From a Social Worker

The social worker offers a different comparison. Social workers in a hospital do essential work that chaplains are not trained to do. They arrange discharge plans. They connect families to community resources. They navigate insurance and finances, assess for safety, and coordinate the practical scaffolding a patient needs to leave the hospital and manage at home. When Walter goes home, it is a social worker, not a chaplain, who will make sure someone can check on him and that he can afford his medications. The chaplain and the social worker are often close allies. The best of them refers to one another constantly, because they see different dimensions of the same person. The social worker tends to the person's situation. The chaplain tends to the person's spirit, to the meaning they are making of what is happening, to their grief and their hope and the questions that surface at three in the morning. Neither role is more important than the other. They are different instruments in the same orchestra.

Different From a Pastor

The comparison to clergy trips people up the most. Many chaplains come from parish or congregational ministry, and the clerical collar looks the same in a sanctuary and a hospital corridor. But the work is different. A parish pastor, imam, or rabbi serves a defined community of people who share a common faith and have chosen to belong to it. The pastor preaches, teaches, leads worship, and shepherds people over years within a shared

tradition. The chaplain serves whoever is in bed, regardless of tradition, usually for a very short time, and cannot assume any shared belief at all. A pastor who visits the hospital comes as a representative of one faith to a member of the flock. A chaplain comes as a professional presence to anyone at all. The chaplain sets aside the impulse to represent a single tradition, so that the patient's own tradition, or lack of one, can have the room. If you are coming to CPE from congregational ministry, and many readers are, know that this shift is real and takes time. Your ministry experience is not worthless. Far from it. But it has to be translated and learning that translation is much of what the first unit of CPE is about.

I want to be careful not to draw these lines too sharply, because in practice they blur, and a good team relies on the blur. Sometimes a chaplain does something that looks like counseling. Sometimes a social worker offers profound spiritual comfort. Sometimes a chaplain prays with a patient in a way that would be at home in any congregation. The distinctions are not walls. They are more like the colors on a painter's palette, each with its own character, and often mixed. But knowing the colors, knowing what is distinctly yours to offer, keeps you from two common mistakes. It keeps you from overstepping into work that belongs to a colleague. And it keeps you from shrinking back and offering less than you could because you are unsure what your role permits.

Presence, and the Question of Whether It Helps

At the center of the work is presence. Nearly every other helper on the team is oriented, and rightly so, toward doing something. The physician diagnoses and treats. The nurse monitors and administers. The social worker arranges and connects. The

therapist assesses and intervenes. The chaplain is the one professional whose first move is not to act on the patient but to be with them.

The philosopher Martin Buber offered a way of describing this that I have found useful for many years. Buber said we can meet another person in one of two ways. We can relate to them as an It, an object, a case, a problem to be managed. Or we can meet them as a You, a full human presence, a whole person who is an end in themselves. Much of chaplaincy is the discipline of meeting people as a You when the machinery of a hospital, for understandable reasons, is often built to treat them as an It. One of my teachers, borrowing a phrase from the rabbi and family therapist Edwin Friedman, called this bringing a non-anxious presence into rooms that are thick with anxiety. It sounds easy. It is not. Staying present with someone's suffering, when every instinct in you wants to reassure them or advise them or change the subject or leave, is one of the hardest disciplines I know.

This is a place, though, where chaplaincy is arguing with itself, and you will walk into the middle of that argument. For much of the last century, chaplains were formed in a particular tradition, shaped by the psychologist Carl Rogers, that prized being non-directive. The chaplain was to follow the patient, to carry no agenda, to resist the urge to steer or to fix, and to trust that presence itself was enough. There is real wisdom in that tradition, and you have felt its truth if you have ever been helped simply by someone's willingness to stay. Taken too far, though, it can leave a chaplain adrift, unable to say what good a visit was meant to do or whether it did any.

So, a second emphasis has grown up alongside the first. A growing number of chaplains, and I count myself among them,

have become convinced that presence, while essential, is not the whole of the work. They ask what outcomes our care is meant to serve. Did the frightened patient feel less alone? Was the family better able to make the decision in front of them? Did the person in spiritual distress find some measure of peace? These chaplains want to be clear about the good they hope to do, and honest about whether they are doing it. This emphasis is sometimes called outcome-oriented or evidence-based chaplaincy, and it is part of the profession's effort to take its place, credibly, among the other healthcare disciplines.

These two emphases, presence for its own sake and care aimed at outcomes, sit in real tension, and thoughtful chaplains disagree about how to balance them. You do not need to resolve that tension now. I raise it here only so that you are not caught off guard when it surfaces in your training, as it will. My own conviction is that these are not truly opposites. A chaplain can hold both at once: a deep, unhurried presence that makes no demands on the patient, and a clear sense of the good that such presence is uniquely able to bring about. Learning to hold both together is a good deal of what it means to mature in this work.

If You Feel Unready

Some of you, reading this, may feel a worry taking shape. You may be thinking that you do not know how to do this. You may be wondering what you could possibly say to a frightened patient, how you will keep from making things worse, whether you are qualified to sit at the bedside of someone in real anguish when you cannot fix a single thing that is wrong. If that is what you are thinking, consider that the worry itself is a good sign. It means you already understand that this work is serious, and that presence is

not nothing. The students who worry me are not the ones who feel unready. They are the ones who arrive certain they have it all figured out. You do not need to have the answers. One of the first things CPE will do is relieve you of the burden of needing them. What you need is a willingness to show up, to pay attention, and to learn. If you have picked up this book, you very likely have all three.

An Invitation to Carry With You

Before we turn to what CPE actually is, the subject of the next chapter, I want to offer you a small invitation. It is not an assignment, and you need not write anything down unless you want to. It is simply a question worth carrying with you.

Think back to a time when you were struggling with something, and someone was present with you. Not someone who fixed your problem or gave you good advice, but someone who stayed, who listened, who let you be where you were without rushing you toward feeling better. Perhaps it was a friend, a grandparent, a teacher, a stranger. Bring that person and that moment to mind and consider what their presence did for you. What was it like to be accompanied rather than corrected? What did it make possible?

I ask because that experience, whatever it was, is closer to the heart of chaplaincy than anything I could teach you in a chapter. You already know, from the inside, what it is to be cared for this way. The work ahead, in large part, is learning to offer to others what someone once offered to you.

CHAPTER 3

What CPE Is, and Why It Exists

What the Three Words Mean

Perhaps you have just been accepted into a unit of CPE, or perhaps you are still deciding whether to apply, or simply curious what the training involves. Wherever you stand, there is a good chance you are not entirely sure what CPE actually is. That is normal. The letters stand for Clinical Pastoral Education, three words that sound more forbidding than the thing they name. It helps to take them one at a time.

The word clinical can sound cold, as though you were about to be trained in a laboratory. Its origin is warmer than that. It comes from the Greek word *kline*, which means a bed, or more precisely, at the bedside. Medical students earn the word clinical when they leave the lecture hall and begin learning from actual patients, at the actual bedside. CPE borrows the word for the same reason. You will learn the care of persons not by reading about it, but by doing it, with real people, in real rooms, and then reflecting on what happened.

Pastoral is an old word for the care of persons, drawn from the image of a shepherd tending a flock. In CPE it is used broadly. You will care for people of every faith and of none, so pastoral here means something closer to the care of the human spirit than the ministry of any single tradition.

Education is the word I would ask you to hold onto most tightly, because it is the one students forget first. CPE is not a job, and it is not an internship where you prove you already know what

you are doing. It is a form of learning. You are there to be formed, not to perform. A good deal of the anxiety students carry into the first day comes from confusing the two.

Put the words together and you get, in one official definition, "interfaith professional education for ministry." That is accurate, if a little dry. The three words on their own tell you more.

Learning by Doing, and Then Reflecting

If CPE is a form of learning, it is an unusual one, and it helps to understand why it is built the way it is. Most of us were educated in classrooms, where someone who knew a great deal talked, and we took notes, and later we were tested on what we had retained. That method has its place. But it is a poor way to learn how to sit with a dying man, or how to be present to a family that has just received unbearable news. You cannot lecture someone into that kind of capacity. It has to be practiced, and reflected upon, and practiced again.

CPE calls this the clinical method of learning, though among ourselves we describe it more plainly as a cycle of three movements: action, reflection, and new or revised action. First comes the action, the actual practice of ministry, a visit with a patient. Then comes the reflection, when you step back and examine what happened. And then comes new or revised action, when you return to the work changed by what you noticed and try again. The cycle looks like this.

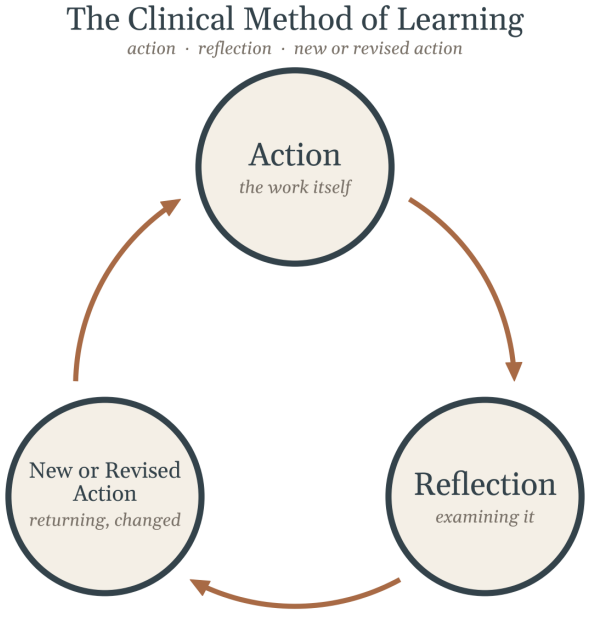


Figure 2.1. The clinical method of learning: action, reflection, and new or revised action, turning over and over until it becomes a way of being.

A visit with a patient becomes something to think about rather than something merely to get through. What did you do, and why? What were you feeling? What did the patient need, and did you meet it, or miss it? The next visit is shaped by the last one. Over a summer, or a year, this cycle turns many times, and a person slowly becomes a chaplain.

This is not a new idea. The educator John Dewey argued a century ago that we learn most deeply not from information poured into us, but from experience we have taken the trouble to reflect on. CPE was one of several movements in the early twentieth century that took him at his word, and it has held to that conviction ever since.

There is a spirit to that reflection that is easy to miss. In a documentary that followed a year of my program, I once put it to a resident in four words: explore rather than explain. The instinct, when we look back at a hard visit, is to explain ourselves, to justify what we did and move on. Reflection asks for the opposite. It asks us to stay curious about the experience a little longer than is comfortable, to explore it rather than explain it away, because the exploring is where the learning hides.

Why They Keep Asking How You Felt

There is one feature of this method that catches nearly every new student off guard. In CPE, people will ask you, again and again, how you felt. How did you feel when the patient started to cry? What came up in you when the family turned angry? Students who arrive expecting to be taught techniques often find this maddening at first. They came to learn what to say, and instead they are being asked what they felt.

There is a reason for it, and it sits close to the heart of why CPE exists. In this work, you are the instrument. A physician has a stethoscope and a surgeon a scalpel, but the chaplain only has the self, the whole person who walks into the room. Instruments have to be known and tuned. If a patient's tears remind me, without my realizing it, of my own mother's death, that memory will shape how I respond whether I notice it or not. The point of all those questions about feeling is not to turn CPE into therapy. It is to help you see yourself clearly enough that you are not unconsciously getting in your own way. We will return to this at length in a later chapter. For now, it is enough to know that when they ask how you felt, they are not prying. They are teaching.

Where CPE Came From

CPE has a history worth knowing, partly because it is a good story and partly because it explains why the training feels the way it does. It begins in the 1920s, with two very different men.

The first was Anton Boisen, a Congregationalist minister who suffered a severe psychological breakdown and spent time as a patient in a mental hospital. Most people would have wanted to forget such an experience. Boisen did the opposite. He became convinced that his crisis had been, at least in part, a spiritual one, and that the hospital wards held religious meaning the seminaries had overlooked. In 1925 he began bringing theological students into the hospital where he had once been a patient, not to study textbooks, but to study people. He called them living human documents. His conviction was plain and radical at once: that a human being in crisis is a text worth reading as carefully as any book, and that ministers should learn to read them.

The second man was Richard Cabot, a Harvard physician who had helped invent medical social work. Cabot came at the same problem from the side of medicine. He had watched medical education transformed by sending students out of the lecture hall and onto the wards, and he believed theological education needed the same medicine. In a widely read essay of 1925, "A Plea for a Clinical Year in the Course of Theological Study," he called for what he named a clinical year for ministers, a stretch of real experience with the sick, the troubled, and the imprisoned. He wanted future ministers to practice their theology, as he put it, where it was most needed, in personal contact with individuals in trouble.

Boisen and Cabot did not always agree, and the movement they helped begin has argued with itself ever since. But between

them they planted the conviction that still animates CPE. Ministry is learned at the bedside, from living human documents, through experience examined with care. Everything else in your training grows from that root.

My Own First Unit

I know something about how this training can change a person, because it changed me, and not in the way I had planned.

I took my first unit of CPE in 1998, in the middle of a Master of Divinity degree at a Pentecostal seminary in Tennessee. I was in my mid-twenties. Years as a Pentecostal lay behind me, a college and a seminary, youth groups led and revivals preached. What I had not admitted to many people, including myself, was that I was no longer sure I believed what I had been taught. I did not choose CPE as a way to face that. If I am honest, I chose it hoping for a good summer. A unit could be done almost anywhere, so I applied to programs in places that sounded like an adventure, Colorado among them. Every one of them turned me down, and I ended up, a little deflated, at the hospital down the road.

That local program became one of the most important experiences of my life. It was my first time inside an ecumenical group, learning alongside peers and an educator whose Christianity looked nothing like mine. My peers spoke with excitement about a Buddhist teacher who had come to lecture at a Christian school. A woman in my own peer group, someone I was already wary of, said out loud that she did not believe Jesus was God. I had understood that belief to be the center of everything, and I could not fathom how a fellow Christian could stand where she stood.

So, I did what an earnest and frightened young man does. I marched into my educator's office, a Baptist minister, sat down, looked him in the eye with all the intensity I could gather, and said, "You believe Jesus is God, don't you?" He held my gaze. There was a long pause. And, wisely, he did not answer. He would not hand me back the reassurance I was demanding. Instead, he gave me room to ask the question, to look at why it mattered so much to me, and to search out my own answer. He stayed with me through what became a scary and painful stretch of months.

At the time it felt like a betrayal. It took me years to understand it as a gift. The faith I had carried into CPE was a borrowed one, inherited and largely unexamined, and what my educator refused to do was hand it back to me unexamined. What he did instead, mostly through his presence, was show me how to hold a hard question without running from it. Along the way, by making eye contact and holding silence and paying attention, he taught me something I had not yet learned. He showed me what human connection looks like, and I would learn in time that this connection sits close to the center of how chaplains do their work.

Through that long disorientation and a slow reorientation, I came out understanding two things I had not known going in. I wanted to be a hospital chaplain. And the faith I thought I was losing was not disappearing but changing, becoming, for the first time, my own. In the years that followed I found my spiritual home in the Episcopal Church, and in time I became an Episcopal priest, a board-certified chaplain, and a certified educator who now sits on the other side of that office door. I offer this not as a map for your journey, which will be nothing like mine. I offer it because CPE is capable of this kind of transformation. You may arrive to

learn a set of skills and discover, as I did, that the person learning them is being changed in the process.

Why the Discomfort Is Part of It

In CPE, discomfort is not a sign that something has gone wrong. It is often a sign that something is about to go right.

We do not usually grow while we are comfortable. We grow when we are stretched past what we already know how to do, and being stretched is, by its nature, uncomfortable. The question that so unsettled me was not a problem for someone to solve. It was the occasion of my growth. The patient who leaves you feeling clumsy and inadequate is, very often, your best teacher that week. This is worth remembering in the early days, when the discomfort can be considerable and it is tempting to read it as evidence that you are not cut out for this work. Usually, it is evidence of the opposite. It means you have been placed at the edge of your ability, which is the one place real learning happens.

None of this means CPE is meant to break you down, and a good program will not. There is a difference between being stretched and being harmed, and part of what your educator is doing is keeping you close to the first and away from the second. But you should expect to be stretched. If you arrive expecting comfort, the first weeks will confuse you. If you arrive expecting to be stretched, you will be able to meet the discomfort as what it usually is, the feeling of growth beginning.

A Small Experiment

Before we picture an actual day in CPE, the subject of the next chapter, here is a small experiment you might try, in the spirit of the method itself.

Think back over the last day or two and find one small conversation, nothing dramatic, an exchange with a colleague, a stranger, someone you love. Walk it slowly through the cycle CPE will teach you. First the action. What actually happened, described as plainly as you can, who said what and who did what. Then the reflection. What were you feeling as it unfolded, and can you tell why? What did the other person seem to need? Did you give it, or miss it, or something in between? And finally, the turn toward new action. Knowing what you now see, is there anything you would do differently if the moment came again?

That small movement, from action to reflection to changed action, is the engine of everything ahead of you. You have just done in miniature the thing you will spend your whole first unit learning to do. It is not as mysterious as it sounds. It is attention, turned on your own practice, again and again, until it becomes a habit and finally a way of being.

PART TWO

How CPE Works

CHAPTER 4

Inside a CPE Unit: The Day, the Verbatim, and the Group

"Feet on the floor. Gather your energy and bring it into this room. Are you here?"
"I'm here."
— A Still Small Voice

The Shape of a CPE Unit

By now you have a sense of what chaplains do and why CPE teaches it the way it does. What you may still be missing is the plainest thing of all, a picture of what you will actually do with your days. Students often tell me that the not knowing is worse than any single part of the reality. So let us walk through it.

A CPE unit is a defined block of supervised experience. A full CPE unit comes to four hundred hours, and the way those hours are divided tells you something about the training's priorities. Around two hundred and fifty of them are clinical, spent in patient care on the floors. Another hundred are educational, spent in seminars, in the peer group, in individual meetings with your educator, and in reading and writing. The remaining fifty are administrative, the record-keeping and logistics that any structured program involves. The standards leave some room to move within those numbers, but the shape is deliberate. The bulk of your time is in the rooms, because that is where the learning

happens, and the rest is time set aside to make sense of what the rooms are teaching you.

CPE units come in two common shapes. The intensive version is done full-time over roughly ten to twelve weeks, usually in a summer, which is why summer programs fill with seminarians on break. The extended version spreads the same hours across a longer stretch, often an academic year, one or two days a week, which suits people who are working or studying at the same time. The content is the same. Only the pace differs. If you are about to begin, you already know which shape yours takes, and it is worth picturing your particular week rather than a generic one.

Whatever the shape, the same handful of elements make up the experience. You will visit patients. You will write up some of those visits and present them to your peers and your educator. You will sit in a seminar where a topic is taught or a case is discussed. You will meet one to one with your educator. You will chart your visits in the medical record. And, threaded through all of it, you will be part of a small group of fellow students who become, over the CPE unit, both your colleagues and a kind of mirror. Each of these deserves a closer look, because each one carries some of the worry students bring to the first day.

A Day on the Floor

Picture an ordinary day, the kind you will have many of.

You arrive in the morning and check in with your team, however your program handles it. Some programs begin with a short gathering of the group. You are assigned an area of the hospital, perhaps a few floors, perhaps a single hospital unit such as oncology or the intensive care unit. You look over the census, the list of patients on your floors, and you begin to make rounds.

That word, rounds, you will hear constantly. It simply means going from room to room, seeing the people in your care.

Most of the day is visits. You knock, you introduce yourself, you see who is there and what the moment asks of you. Some visits last two minutes because the patient is asleep, or in pain, or wants nothing to do with a chaplain that day. Some last half an hour because a frightened woman has been waiting all morning for someone who was not going to check her vital signs or ask about her insurance. Between visits you write. You make short entries in the medical record, so the rest of the team knows a chaplain has been present and, in general terms, what you found. You will learn what belongs in a chart and what does not, and there is a later chapter on exactly that, so set the worry about charting aside for now.

Some part of the week is set aside for education, time to step back from the clinical work and reflect on it. How that time is arranged varies so much from one program to the next that it is not worth predicting. The principle is what holds. You spend the larger share of your hours in the rooms and a smaller, protected share making sense of what happens there. This is the action and reflection cycle from the last chapter, built into the very structure of your week. You act, out on the floors. Then you gather to reflect. Then you go back out changed a little by what you noticed, and act again.

By the end of the day, you will be tired in a way that surprises people who have not done this work. It is not physical tiredness, or not only that. Being present to one person after another, staying open to whatever each of them brings, asks something of you that a desk job does not. Learning to notice that tiredness, and to care for yourself through it, is part of the training too, and it has a

chapter of its own. For now, it is enough to say that the tiredness is normal and does not mean you are doing it wrong.

The Verbatim

Of everything in CPE, the piece that gathers the most dread before students have tried it is the verbatim. The word sounds technical. It is not. It comes straight from Latin and means, simply, word for word. A verbatim is a written account of a single pastoral visit, reconstructed from memory as closely to word for word as you can manage, and then examined.

You will not audio record your visits. Chaplains do not carry recorders into patient rooms, and you will write your verbatim afterward, from memory, which is itself part of the exercise. What you remember, and what you forget, turns out to be information. A typical verbatim lays the conversation out almost like a script. It marks who spoke and what they said, your words and the patient's, in the order they came. Around that dialogue you add other things. You describe the setting and the person. You note what you observed that was not spoken, the way the patient would not meet your eyes, the untouched food, the relative sitting rigid in the corner. And then, and this is the part that matters most, you write down what was happening inside you. What you felt as the visit unfolded. Where you got anxious, or lost, or wanted to flee. What you think you did well and where you think you faltered. Many programs also ask you to reflect on the meaning you make of the encounter, theological or otherwise, and to offer an assessment of where the patient was and what they might need.

A short stretch of a verbatim looks something like this.

Chaplain 1: I'm one of the chaplains here. I wanted to stop by and see how you're doing today. (I stayed near the door. My hands were sweating.)

Patient 1: How I'm doing. (She laughed, but not really.) You want the truth or the version I give the doctors?

Chaplain 2: The truth, if you want to tell it.

Patient 2: The truth is I don't know why God is doing this to me. (She looked right at me.)

Chaplain 3: (I froze. I said something about how God doesn't give us more than we can handle. The second it left my mouth I wanted it back.)

You can feel, even in five lines, why the verbatim is such a powerful teacher. It slows a visit down until it can be looked at. In the moment, that exchange took perhaps twenty seconds and went by in a blur. On the page it holds still, and every choice inside it becomes visible, including the ones the student regrets. That is the point. The verbatim is not there to celebrate a smooth visit. It is there to give you and your group something honest to think about together, which almost always means a visit that was uneven, because real visits are.

Students dread the verbatim because it feels like exposure. You are handing your peers a transcript of a moment you did not handle perfectly and inviting them to look at it. I will not pretend that is comfortable. But it helps to know what the verbatim is for. It is not evidence gathered against you. It is the raw material of your learning, and the willingness to bring your real work rather than a polished version of it is itself one of the things CPE is trying to grow in you.

The Group

The verbatim does not stand alone. You present it to your peer group, and the group is the second thing students fear, often more than the verbatim itself. So, it is worth being clear about what the group is and, as much, what it is not.

Your peer group is a small circle of fellow students, usually a handful of you, who move through the CPE unit together under the guidance of your educator. You will spend a good deal of your educational time with them. Sometimes the group functions as a seminar, working through a topic or a reading. Sometimes it gathers to hear a verbatim and reflect on it together. And sometimes, in what many programs call interpersonal relations (IPR), the group turns its attention to itself, to what is happening among you in the room, right then, as you work and react and rub against one another. That last kind of group is the one that unsettles people most, and we will take up the deeper reasons for it in the next chapter, which is about the inner work. Here I want to address the fear directly, because it is usually built on a misunderstanding.

Students imagine the group as a tribunal. They picture presenting a verbatim and being taken apart, their mistakes catalogued, their competence judged, their fitness for the work put on trial. I understand where the picture comes from. We have all been in rooms where feedback was really just criticism wearing a kinder name. But that is not what a healthy CPE group is for, and it is not, in my experience, what usually happens. The group is a learning instrument, not a court. Its purpose is to help each of you see what you could not see alone.

There is a reason a group can do this that no amount of private study can. The sociologist Charles Horton Cooley described what he called the looking-glass self, the way we come to know

ourselves partly through the reflections we catch in how others respond to us. We are, all of us, partly hidden from our own view. I cannot easily see the expression on my own face when a patient starts to cry or hear the edge that comes into my voice when someone challenges me. My peers can. When they tell me what they noticed, kindly and honestly, they hand me a piece of myself I could not have reached on my own. That is what the group is for. Not judgment, but reflection, in the plainest sense of the word.

Consider a student I will call Malik, who had recently finished seminary and arrived sure that his years of preaching had prepared him well. His first verbatim was the visit those five lines above are drawn from. He had walked into the room of a woman with a frightening diagnosis, she had asked him, looking right at him, why God was doing this to her, and he had answered with a line he had heard a hundred times, that God does not give us more than we can handle. He knew the moment he said it that it was hollow. He finished the visit somehow, went out into the hallway, and spent the rest of the day certain he had failed, certain the woman was worse for having met him, half hoping no one would ever ask him to present it.

When he brought that verbatim to the group, he braced for the verdict. It did not come. His peers did notice the platitude, and they were honest about it, because honesty is the group's kindness. But they noticed other things he had walked right past. They noticed that after he said the hollow thing, he did not leave. He stayed. And that the woman, given a chaplain who had just stumbled, kept talking to him anyway, which told them something about what she needed that had little to do with getting the words right. Then his educator faced a choice about where to take the conversation. One direction leads toward craft, toward what else

Malik might have said when the woman asked her question, and with some students, on some days, that is just where a good educator goes. With Malik, his educator went the other way, and asked him the question from the last chapter, the one that catches everyone off guard. Not what should you have said, but what were you feeling when she looked at you and asked why. Malik sat with it and finally admitted that he had been afraid, because he did not know the answer to her question either, and a preacher is not supposed to be caught without the answer. That was the learning his educator judged he most needed. It was less about a better line than about what happens in him when he is asked a question he cannot answer, and how that fear had pulled him toward a phrase that served his anxiety rather than her need. Both directions have their place, and part of an educator's art is reading which one will serve the student presenting and the group around him in a given hour. He left that session with more to work on than he came in with, and less afraid of the group than he had been in his life. The thing he had dreaded turned out to be the thing that helped him.

That is the group at its best. It will not always run so cleanly, and there will be sessions that feel hard or tangled or unfair in the moment. But the underlying purpose holds. Your peers are not there to grade you. They are there to see what you cannot, and to let you do the same for them.

Time With Your Educator

Alongside the group, you will meet one to one with your CPE educator, the person responsible for your training. In the older language they were called supervisors, and you will still hear that word, though many of us now prefer educator because the work is teaching more than oversight. These individual meetings are a

quieter, more private space than the group. Here you can bring what you are not ready to say in front of your peers. Here your educator helps you set the learning goals you will work toward and, later, helps you take honest stock of how the work is going.

It is worth being clear about what your educator is and is not. Your educator is a teacher and a guide, someone who has been trained at length to help people learn this particular work. Your educator is not your therapist, even when the conversation turns personal, and not your judge waiting to catch you out. The relationship can become one of the more meaningful of your professional life. Mine did. The Baptist minister who would not answer my question, whom you met in the last chapter, was doing the work of a CPE educator, holding a hard space open for me and trusting me to find my own way through it. You may find, as I did, that the person who declines to hand you easy answers is offering you something better.

How You'll Be Evaluated, and Whether You Can Fail

Which brings us to the question underneath all the others, the one students are often too anxious to ask out loud. Am I being judged, and can I fail?

Yes, there is evaluation in CPE. It would be strange if there were not, since it is a form of professional education. But the evaluation is not what most people fear, because it is mostly what educators call formative rather than summative. A summative evaluation is the kind you know from school, a final grade stamped on you at the end. A formative evaluation is ongoing and aimed at growth. Its question is not how did you score, but what are you learning and where do you need to go next? Almost all the

feedback you receive in CPE, from your peers, from your educator, from your own reflection, is formative. It exists to move you forward, not to rank you.

You will do a striking amount of that evaluating yourself. Near the start you will write learning goals, naming what you hope to grow in during the CPE unit. Along the way, and especially at the end, you will write a self-evaluation, an honest account of how you did against those goals and what you have come to see about yourself. Your educator will write an evaluation of you as well, and the two are meant to be in conversation. This surprises people. They expect to be assessed from above, and instead they are asked to take part in assessing themselves, because learning to evaluate your own practice honestly is one of the competencies the whole enterprise is trying to build. A chaplain who cannot see their own work clearly cannot improve it.

The evaluation is also tied to outcomes, to a defined set of learning outcomes that describe what a student should be able to do and understand by the end of a CPE unit. These are not invented by your educator on a given morning. The body that accredits CPE programs names five broad areas that every program must address, and your program sets its own outcomes within those areas, in advance and in writing. Together they give the whole process a shape and a fairness. You are not being measured against your educator's private preferences or against the most gifted person in your group. You are being helped to grow toward a set of stated aims. Knowing that the aims are established beforehand, and written down, steadies a lot of students who assume the standard is whatever will be held against them.

And can you fail? CPE is not graded like a course, so there is no F to be handed. What happens at the end of a CPE unit is that you

either receive credit for it or you do not, and not receiving credit is uncommon. When it does happen, it is not a surprise sprung at the end. It comes after much conversation, after your educator has named a concern early and worked with you on it over weeks. Sometimes a student and educator decide together that a CPE unit should be repeated, not as a punishment but because the learning is not finished, and there is no shame in that. On rare occasions a program concludes that this work, at this time, is not the right fit for someone, and even that is arrived at with care. What almost never happens is the thing students picture, a competent and willing person blindsided by failure. The system is built to form you, not to weed you out. Your educator's success is measured by your growth, which means they are, in the deepest sense, on your side.

An Invitation to Carry With You

Before we turn to the inner work that all this rests on, the subject of the next chapter, here is something to sit with.

Think of a time someone gave you feedback that was hard to hear and turned out to be a gift. Not flattery, and not an attack, but an honest observation from someone who wanted good things for you, something you could not see about yourself until they named it. Bring that moment to mind. Recall who offered it, and how, and what made it possible for you to receive it rather than defend against it. Consider what changed in you afterward.

I ask because that experience is close to what the verbatim and the group are built to offer, repeatedly, over a whole CPE unit. The parts of CPE that students dread most, being seen, being reflected back to themselves, being told the truth by people who are for them, are not the ordeal they appear to be from the outside. They

are the very machinery of the growth you came for. You already know, from that one good memory, that being seen clearly by someone who wishes you well is not a threat. It is one of the ways we become who we are meant to be.

CHAPTER 5

The Inner Work: Self-Awareness and Formation

The Question Underneath the Others

In the last chapter I left a question standing without answering it. When your peer group turns its attention to what is happening among you in the room, or when your educator asks not what you should have said but what you were feeling when the patient looked at you, many students have the same reaction. They wonder why the training keeps turning back on them. They came to learn how to care for people who are sick and frightened, and instead they find themselves being asked, repeatedly, about their own history, their own feelings, their own reactions. It can feel intrusive. It can feel like the wrong subject. A student once said to me, half joking and half not, "I signed up to study the patients, not myself."

I understand that reaction, because I had it too. This chapter is about why CPE cares so much about the person you are, and not only the skills you are acquiring. It is the part of the training that surprises people most, and, in my experience, the part that changes them most. If you can understand now, before you begin, why the work is so personal, you will be able to meet that part of it as an opportunity rather than an intrusion.

The Self Is the Instrument

I said earlier that a physician has a stethoscope and a surgeon a scalpel, but the chaplain only has the self. Every helping profession works through some instrument. The surgeon's skill is real, but it reaches the patient through the scalpel. The instrument can be sharpened, cleaned, calibrated, and when it fails, replaced. The chaplain has no such tool standing between the self and the person in the bed. What you bring into the room is you: your attention, your capacity to stay present when someone is suffering, your tolerance for silence, your reactions to anger and to tears, the whole history you carry of how you have loved and lost and been afraid. There is no scalpel to hold up between you and the encounter. You are the scalpel.

This is why self-awareness is not a soft or optional part of the training. It is a professional competence, as much as knowing how to introduce yourself or when to stay quiet. An instrument that is not understood cannot be used well. If I do not know that a certain kind of patient makes me anxious, or that anger sends me toward the door, or that I reach for reassurance whenever a silence lasts too long, then those things will operate in me without my consent, and they will shape my care whether I notice them or not. The point of self-awareness is not to become preoccupied with yourself. It is close to the opposite. The better you know your own instrument, the freer you are to attend to the person in front of you rather than to your own untended reactions.

The psychologist Daniel Goleman helped popularize the term emotional intelligence, and he placed self-awareness at its foundation. His argument, put plainly, is that we cannot manage what we cannot see. A person who does not notice their own irritation is governed by it. A person who can notice it, name it, and hold it has a measure of freedom the first person lacks.

Chaplaincy asks a good deal of this kind of intelligence, more than most work does, because the material we handle is the very material most likely to stir us: fear, grief, mortality, the questions that have no answers. Learning to notice what those things do inside you is not self-indulgence. It is the training of your only instrument.

There is a phrase some of us use for this, the person of the practitioner. It names the truth that in this work you cannot separate what you do from who you are. The two arrive together in the room. CPE takes the person of the practitioner as a serious subject of study, which is why the training will ask you to look at yourself with the same care Anton Boisen asked his students to bring to patients. You will remember that Boisen called the suffering person a living human document, a text worth reading closely. In CPE you learn that you are a living human document too, and that reading yourself well is part of learning to read anyone else.

Why Your History Comes With You

Students sometimes hope they can leave their personal history at the hospital door and simply be professional inside. It is an understandable hope, and it does not work, because the history comes in with you whether you invite it or not.

Consider a student I will call Diane. She had spent fifteen years as a nurse before coming to CPE, and she was competent and calm in a way that impressed all of us in her first weeks. Then she was assigned to visit an older man dying of the same cancer that had taken her father three years before. She did not think much of it beforehand. She was a professional, she told herself, and this was simply another patient. But in the room something happened

that she had not expected. The man's daughter was sitting beside the bed, holding his hand the way Diane had held her own father's, and when the daughter looked up and asked Diane whether her father was going to die, Diane heard herself say, with an edge that startled her, "You should be talking to his doctor about that." She left the room quickly. She was shaken, and she did not fully understand why.

When she brought that visit to her group, the picture came clear. Diane had walked into her own grief without recognizing it. The daughter's question was not really the problem. The problem was that the whole scene had reopened her father's death, and her sharp answer had been a way of protecting herself from a pain she had not finished feeling. Her history had been in the room the entire time, shaping her care, and because she had not seen it, she could not do anything about it. Once she could see it, she had her freedom back. The next time she sat with a dying patient, her own loss was still present, but it was present in a way she could hold, and it made her more able to be with that family rather than less.

This is what the older language calls countertransference, a word from psychotherapy that names the reactions a helper has to the people they are helping, reactions that come from the helper's own life rather than from the person in front of them. You do not need the technical term to grasp the reality. We all carry our histories, and those histories are stirred by the people we care for. The mother whose son reminds you of your brother, the angry man who sounds like your father, the frightened young woman who could be you at a harder time in your life: these resonances are constant in this work. They are not a flaw to be eliminated. They are a fact to be known. A chaplain who knows her own tender

places can keep them from silently taking over a visit. A chaplain who does not know them is at their mercy.

That is why CPE cares about your history. Not to excavate you for its own sake, and not because your educator is curious about your childhood, but because your history is part of the instrument, and an instrument you cannot see is an instrument you cannot tune.

Is This Therapy?

At about this point many students grow uneasy and ask a fair question. If CPE is going to look at my feelings and my history and my tender places, is this therapy? Am I becoming the patient?

CPE is not therapy, though it borders on it and sometimes brushes against it. The difference lies in the aim. Therapy exists for your healing. Its purpose is your own wellbeing, and the material of your life is examined so that you might suffer less and live more freely. CPE examines some of that same material, but for a different purpose: your competence as a caregiver. When your educator asks what you felt when the patient's question frightened you, the goal is not to treat your fear. The goal is to help you see how that fear moved you, so it does not move you unawares the next time. The self is being studied as an instrument of care, not as a patient in need of treatment.

A good educator keeps this line in view even when the conversation turns personal. Your educator is a teacher, not your therapist, and the group is a learning community, not a therapy group. You are not there to be fixed. You are there to learn, and part of what you learn is how your own inner life shapes your work.

That said, the border does get crossed. CPE has a way of stirring things up. The work puts you close to suffering and loss, and closeness like that can awaken old wounds that have been waiting for years. A student begins a CPE unit to become a chaplain and finds, several weeks in, that a grief they thought they had settled is not settled at all, or that a strained relationship with a parent is pressing on them in ways they cannot ignore. When that happens, a wise educator does not try to become your therapist. The wiser thing, and the more common one, is for your educator to notice what is surfacing, to name it with care, and to help you find real support for it outside the program, from a counselor or a spiritual director or a trusted person in your life. Knowing the limits of the CPE relationship is itself part of what protects you. The training will take your inner life seriously, but it will not pretend to be the place where every deep thing gets healed. It points you toward those places rather than replacing them.

Becoming More Yourself, Not Less

There is a fear that sits beneath the others, one students rarely voice. If CPE is going to change me, will I still be me when it is done? Will I lose the faith, or the personality, or the convictions I walked in with?

I understand the fear from the inside, because I lived it. When my educator would not answer my question about whether Jesus was God, I felt the ground I had stood on my whole life begin to move. For a while I was sure I was losing something essential, that the training was taking my faith apart and would leave me with nothing. What I could not see at the time was that I was not being emptied. I was being changed. The faith I had carried into CPE was borrowed, inherited from the people who raised me and never

really examined. What that first unit did was not to take my faith away but to make it, for the first time, my own.

The educator John Westerhoff described faith as moving through four styles. The first, which he called experienced faith, is the faith of early childhood, absorbed through the people, stories, and practices around us before we have words for any of it. Two of the styles that follow have stayed with me because they name my own experience so exactly. He spoke of an affiliative faith, the faith we hold because it belongs to our people, the faith of our family and community that we have received rather than chosen. And he spoke of a searching faith, the often painful stretch when we begin to question what we were given and to look for what we can truly own. Beyond the searching lies what he called an owned faith, a faith that is finally ours because we have wrestled it into our own hands. I went into CPE with an affiliative faith and did not know it. The disorientation I felt was searching faith arriving, and it was frightening because it is meant to be. On the far side of it I found a faith I could call my own, and I found my way, in time, into a tradition I chose rather than inherited.

I tell you this not because your journey will look like mine. It will not. Some of you will find your existing faith deepened rather than disturbed. Some of you hold convictions that will only grow more solid. Still, CPE tends to move a person through what I think of as three movements: orientation, when you arrive settled in what you know; disorientation, when the work unsettles it; and reorientation, when you come out the other side standing on ground you have tested for yourself. I prefer the word transformation to formation for what this training did to me, because formation can sound like being shaped by someone else's

hands, and what happened felt more like becoming who I already was underneath the borrowed parts.

If there is reassurance here, and I believe there is, it is this. The students I have watched go through CPE do not come out as less themselves. They come out as more themselves, more honest about who they are, more at home in their own convictions because they have looked at them squarely, more able to be present to another person because they are less afraid of what that person might stir up. You will not be dismantled. You may well be deepened.

Curiosity as the Master Disposition

If I had to name the single disposition that makes all of this bearable, and more than bearable, I would name curiosity. It is the stance that turns the inner work from an ordeal into an adventure, and it is worth cultivating now, before you begin.

The word curious comes from the Latin *cura*, which means care. The same root gives us curator, one who cares for a collection, and it sits inside our word cure. To be curious, in the oldest sense, is to attend to something with care. That etymology carries a truth I have found again and again in this work. When I meet my own reactions with curiosity rather than judgment, I am, in the deepest sense of the word, caring for myself, and I become more able to care for others.

Consider the difference between two ways a student might respond to the discovery that they froze when a patient wept. The first response is judgment. I froze. I am not good at this. A real chaplain would have known what to do. This response is exhausting, and it teaches nothing, because it is too busy condemning the self to examine it. The second response is

curiosity. I froze. That is interesting. What happened in me just then? What was I afraid of? What did the patient's tears touch? This response is generative. It treats the reaction as information rather than as a verdict, and information is something you can learn from.

The students who flourish in CPE are almost always the curious ones, not the ones who arrive most competent. Competence can be acquired. What is harder to teach is the willingness to look at oneself with interest instead of dread, to treat one's own mistakes and reactions as fascinating rather than shameful. If you can bring that stance to the training, or even the intention of it, you will find the hard parts more survivable and the whole experience more alive. Curiosity is the master disposition because it makes everything else possible. It is difficult to grow while you are busy defending yourself, and curiosity is what lets you set the defense down.

Feedback as a Gift Rather Than a Verdict

I ended the last chapter by asking you to recall a time someone gave you feedback that was hard to hear and turned out to be a gift. I asked because feedback is where the inner work becomes most concrete, and most uncomfortable.

In CPE you will receive a good deal of feedback, from your peers, from your educator, sometimes from patients and staff. Much of it will be about your work, and some of it will feel as though it is about you, because in this profession the two are hard to separate. When a colleague tells a surgeon that a suture was crooked, the surgeon can hear it as a comment on the work. When a peer tells you that you seemed to pull back the moment the patient got emotional, it is a comment on your work too, but it

lands closer to home, because the pulling back came from somewhere in you. This is why feedback in CPE can sting in a way that feedback in other settings does not. You are being told something about your instrument, and your instrument is yourself.

The reflex, when feedback lands close, is to defend. We explain why we did what we did. We describe the circumstances that made it reasonable. We point out that the peer giving the feedback was not in the room and does not understand. All of this is human, and all of it, in the moment, closes the very door the feedback was trying to open. The work is to notice the defensive reflex, to feel it rise, and to set it down long enough to ask whether there is something true in what you are being told. You do not have to accept every piece of feedback as accurate. Some of it will miss. But you will learn nothing from any of it if your first move is always to protect yourself.

I know the sting of this from both sides of the chair. A documentary once followed our CPE residents through a year, and in one scene I found myself telling a colleague about my own training, years earlier. My first supervisor could be threatening in ways I still remember. I once watched an educator tear a student's verbatim in two and toss it back across the table. And when I gave my own first presentation, guarded and nervous, my supervisor said he did not know whether to tear down my guard or let me take it down. I decided to take it down myself, and I did, but I have never forgotten that the feedback arrived as a threat. One of my own goals, even now, is to sit more easily in the role of authority, to carry it without the edge my own teachers sometimes had. Part of why I teach the way I do, and part of what I hope your educators offer you, is feedback that is honest without being a weapon. The

honesty is the kindness. The threat is not necessary, and where you meet it, you are allowed to notice that it says more about the person giving it than about you.

It helps to remember what feedback in this setting is for. It is data about the instrument, offered by people who can see what you cannot. Recall the looking-glass self from the last chapter, the way we come to know ourselves through the reflections others give back to us. Feedback is that reflection made deliberate. When a peer tells me, kindly and honestly, that my voice changed when the patient challenged me, they are handing me a piece of myself I could not have reached alone. That is not an attack. It is a gift, though it does not always feel like one in the moment. The chaplains who grow the most are the ones who can receive it as a gift even while it stings, who can hold the discomfort and the usefulness at the same time.

None of this means you must receive feedback with a smile, or that it will stop being hard. It will be hard, at least at first, and the hardness is not a sign that you are doing it wrong. The aim is not to stop feeling the sting. The aim is to keep the door open despite it, to let curiosity outlast the defensiveness, so that the honest observation of a colleague who is for you can become one more way you come to see yourself clearly. That is the whole purpose of the inner work, and feedback is one of its sharpest and most reliable tools.

A Private Invitation

Everything in this chapter points toward a single practice you can begin now, before your first day, and it is a private one. No one need ever see it.

Somewhere in your life there is probably a loss, or a wound, or a hard passage that still carries some charge for you. A death you have not fully grieved. An illness, yours or someone you love. A relationship that ended badly, a fear you do not speak of, a season when your faith or your hope gave way. You know the ones I mean, because you can feel them stir a little even as you read this. These are the places most likely to be touched when you begin sitting with people who are suffering, because suffering has a way of finding the tender spots in the one who comes to help.

Consider naming one of them to yourself now. Not solving it, and not deciding what it means, only naming it, the way Diane came to name her father's death. You might write a sentence or two about it in a private place or simply hold it in mind for a moment with the curiosity I have been describing rather than the judgment that usually guards it. The purpose is not to reopen an old pain for its own sake. The purpose is to know your own instrument a little better before you begin to play it in front of others.

Students often assume that a wound is simply a liability to be hidden. Henri Nouwen argued for something closer to the reverse, giving one of pastoral theology's most enduring modern formulations of the "wounded healer." In his small and much-loved book *The Wounded Healer*, Nouwen reached back to an old rabbinic story from the Talmud in which the Messiah sits among the poor and afflicted at the gates of the city, unbinding and rebinding his own wounds one at a time so that he will always be ready when needed. The minister, Nouwen suggested, serves in much the same way. Our own hurts, acknowledged and carefully tended rather than denied or displayed raw, can deepen our recognition of the hurts of others and our capacity to remain with

them. A wound does not necessarily disqualify the one who cares. Properly tended, it can become part of what makes compassionate care possible.

This is not to say that suffering is a credential, or that you must have been wounded to be of use. It is to say that the wounds you carry are not disqualifications to be smuggled past the admissions committee. Anton Boisen founded a movement out of his own breakdown. Many of the finest chaplains I know were drawn to this work by something that broke in their own lives and taught them, from the inside, what suffering feels like and what presence can mean within it. Your history is not something to hide from CPE. It is part of what you bring. The one real danger is a wound you refuse to look at, because that is the one that will run a visit without your knowing. To notice it now, before you begin, is not a weakness. It is the first act of the self-awareness this whole profession rests upon, and you have already begun.

CHAPTER 6

What You'll Feel, and How to Care for Yourself

The Tiredness That Surprises People

By the end of a day on the floor, you will be tired in a way that surprises people who have not done this work. The tiredness is not mainly physical. Being present to one suffering person after another, and staying open to whatever each of them brings, draws on reserves that ordinary work leaves untouched. This chapter is about that tiredness, and about the wider emotional weather that comes with it: the grief that surfaces without warning, the self-doubt, the moments that catch you off guard. Learning to care for yourself through all of it belongs to the training as much as anything you will learn about visiting a patient.

You may arrive expecting to learn skills, and you will, but you will also feel things in the first weeks that you did not sign up for and cannot always explain. Students are so often unprepared for this. Knowing in advance that the feelings are coming, and that they do not mean something has gone wrong, is one of the more useful things I can offer you before you begin.

A Few Voices From the Second Week

Here are a few students. They are composites, blended from many people I have accompanied over the years, but the feelings are exact.

There is a woman I will call Priya, a thoughtful seminarian who had wanted to do this for a long time. In her second week she came out of an unremarkable visit, nothing dramatic, an older man who mostly wanted to talk about his garden, and she found herself weeping in the parking garage before she could get to her car. She could not have told you why. The tears frightened her more than the visit had. She wondered whether she was too fragile for this work.

There is a man I will call Marcus, a former hospice volunteer who thought he knew what he was getting into. He was present for a difficult death at the end of his second week, a young patient, a room full of stunned family. He did what was asked of him and did it well. Then he drove home and felt nothing at all. No sorrow, no relief, only a flat, distant numbness that stayed with him for two days. He was more troubled by the numbness than he would have been by grief. He began to wonder whether something in him was broken or cold.

There is a student I will call Hannah, who sat in her group convinced that everyone else belonged there and she did not. When her peers spoke, they sounded wise to her. When she spoke, she heard herself fumbling. She was sure the educator could see it too, and that any day now someone would take her aside and suggest, kindly, that she had made a mistake in coming.

I could add more. The student who felt an unexpected exhilaration after a hard shift and then felt guilty for it, as though being moved by this work were somehow improper. The one who found himself short with his family at home and could not understand where the irritation was coming from. The one who could not stop thinking about a particular patient, whose face followed him into sleep. If any of these sound like they could be

you, I want you to hear one thing first, before we examine any of it. You would be in good company. None of these students was failing. Every one of them was responding, as a whole human being, to work that asks the whole human being to show up.

Why the First Weeks Hit So Hard

It helps to understand why the early days of CPE carry such an emotional charge.

The first is simple exposure. Most of us, in ordinary life, are protected from concentrated suffering. We encounter serious illness and death a few times across many years, and we have time to recover between them. In a hospital you meet more of it in a week than most people meet in a decade. You are not built to be unaffected by that, and you should not want to be. The tiredness you feel at the end of a day on the floor is the natural cost of staying open to one suffering person after another. It is the ache of a capacity being used, not the sign of a defect.

The second reason is the one I described in the last chapter. This work reaches into your own history. The patient's fear finds your fear. The grieving daughter touches your own losses. You are using yourself as the instrument, and an instrument that resonates with the room is going to vibrate. Some of what you feel in the first weeks is not about the patients at all. It is your own material, stirred up by proximity to theirs, arriving for your attention.

The third reason is disorientation, which we also met earlier. You are learning a new language, a new setting, a new role, and often a new way of understanding yourself, all at once. You are being asked to give up the answers you used to reach for and to sit in uncertainty instead. That is destabilizing by design, and

destabilization has a feeling to it. Much of the anxiety of the first weeks is the ordinary vertigo of standing on ground that has not yet settled.

When you put these three together, the emotional weather of the early days stops looking like a personal weakness and starts looking like exactly what you would expect. A sensitive person, exposed to real suffering, using their own inner life as their tool, while everything familiar is being rearranged, is going to feel a good deal. The feelings are not the problem. They are the evidence that you are in the work.

The Difference Between Stretching and Straining

I have been telling you that hard feelings are normal. That is true, but it is not the whole truth. Not all distress is the good ache of a muscle being worked. Some of it is the sharper signal of a muscle being torn. Part of caring for yourself is learning to tell the two apart, and I would rather you begin thinking about the difference now than discover it the hard way.

Most of what you feel in the first weeks belongs to healthy stretching. You are tired at the end of the day but restored by a night's sleep and a good conversation. You are moved to tears sometimes, and the tears pass and leave you a little more open than before. You doubt yourself, and the doubt sits alongside a growing sense that you are learning. You carry a patient home in your thoughts for an evening, and by morning you have set them down. The common thread is that the feeling moves. It comes, it is felt, it is reflected on, and it passes, and you are enlarged rather than diminished by it.

Straining feels different, and it tends to persist. The tiredness that sleep no longer touches. A dread that settles over you on the

way in, morning after morning, rather than the ordinary nervousness that eases once you are working. Images that intrude when you do not want them, or that follow you into sleep and will not leave. A numbness that does not lift after a few days but hardens into a flat inability to feel much of anything. A reaching for alcohol or other things to blunt the edges of the day. A pulling away from the people who care about you. A hopelessness that colors more than the hard moments. When feelings like these take up residence and stop moving, they are telling you something that deserves attention, not willpower.

There is a name for part of what I am describing, or at least a widely used one. In healthcare we speak of compassion fatigue, a term the traumatologist Charles Figley helped bring into common use, along with the closely related idea of secondary traumatic stress. The plain meaning is that caring for people who are suffering carries a cost, that the cost can accumulate, and that being worn down by the weight of others' pain is a known occupational reality rather than a private failing. That much is well documented among nurses, physicians, social workers, and chaplains, and I find the recognition useful. A student who has never heard of it can mistake the symptoms for personal inadequacy, when they are closer to the marks of having cared without enough flowing back in.

I have become increasingly convinced, though, that the term itself is something of a misnomer, and here I am following researchers such as Shane Sinclair and teachers such as Joan Halifax. Their argument, in plain terms, is that true compassion does not fatigue us. It tends to sustain us and can even energize us. What wears us down is not compassion but something nearer its edge, what is sometimes called empathic distress: the experience

of absorbing another person's suffering into ourselves with nowhere steady to stand, feeling their pain without the grounded, caring presence that compassion actually involves. Compassion, in this understanding, is not what drains us. It is nearer to what carries us. I hold the two accounts together without much strain. Figley named something real that healthcare needs to take seriously, and Sinclair and Halifax help me see that the answer to it is not to care less, which would only leave the work colder and more depleting, but to learn to stay present to suffering without being pulled under by it. Learning that difference is much of what a first unit begins to teach.

I do not want to alarm you. The great majority of what you will feel in your first unit is the healthy kind, and it passes with rest and reflection. But you do not have to diagnose yourself, and you should not try to. The wisdom here is simple. When a hard feeling will not move, when it deepens or hardens or begins to interfere with your sleep, your relationships, or your sense of hope, that is the moment to say something to someone. Tell your educator. Talk to a counselor. Reach out to your own physician or to whatever employee assistance resource your program offers. The line between stretching and straining is not always sharp, and you are not expected to locate it alone. When in doubt, the move is always the same: bring it to another person rather than carry it in silence.

Self-Care Is Not a Luxury

Somewhere along the way, the phrase self-care picked up a faint air of indulgence, as though it meant bubble baths and days off, something you earn once the real work is done. I want to dislodge that association before it costs you anything, because in this

profession self-care is not a reward for the work. It is part of the work.

Consider the word compassion. It comes from the Latin *com*, meaning with, and *pati*, meaning to suffer. To be compassionate, in the root sense, is to suffer with another person. That is the very thing chaplaincy asks of you, and it tells you why the work costs what it costs. You are not observing suffering from a safe distance. You are drawing near enough to feel some of it yourself. A person who does that day after day, without anything flowing back in, will eventually have nothing left to bring, not because the chaplain has grown callous, but because no well gives water forever without rain.

This is why I put self-care under the heading of professional competence, alongside self-awareness and listening. It is not separate from your capacity to do the work. It is what protects that capacity over time. The chaplain who has learned to rest, to process what they carry, and to replenish what the work draws down is not a chaplain who cares less. They are a chaplain who will still be able to care in a year, and in ten. The instrument, to return to that image, must be maintained. A tool used constantly and never cleaned or oiled does not stay sharp because its owner is dedicated. It wears out faster.

There is a version of dedication that is actually a failure of self-awareness, and CPE will help you see it. The student who skips lunch, stays late, takes every hard case, and regards their own exhaustion as proof of their devotion is not more spiritual than their peers. They are heading toward the edge of what they can sustain, and often they are avoiding something in themselves by staying perpetually busy. Learning to care for yourself is partly learning to notice that pattern and to question the belief

underneath it, the belief that your worth depends on giving until there is nothing left.

A documentary that followed our CPE program for a year caught a version of this that I have not forgotten. A resident of mine was worn thin, and she kept answering the on-call crisis phone on her days off, certain that if she did not, someone might come to harm. I pressed her on it, and these are not easy conversations, because her reasoning was so sympathetic. She cared. But I could see what the depletion was costing her. That assumes you are the only person, I said, and you are not. What I was reaching for, and did not always reach gracefully, was a set of structural boundaries that would let her keep caring across a whole career rather than burning through herself in a single year. Setting a boundary is not the opposite of devotion. It is what allows devotion to last.

Some Practices Worth Beginning

I am wary of handing you a checklist, because self-care is not one-size-fits-all, and the thing that restores one person leaves another cold. What follows is not an assignment. It is a set of possibilities, offered so you can find the few that fit you.

Begin with rhythm. One of the most protective habits I know is some reliable way of setting the day down before you carry it home. For some people this is a few minutes of writing at the end of a shift, naming what happened and what it stirred. For others it is a conversation with a peer on the walk to the parking garage, or a ritual as small as washing your hands with attention and saying to yourself that the work is finished for now. The content matters less than the fact of it. You are teaching yourself that the stories

have a place to be put down, so they do not follow you into every dinner and every sleepless hour.

Tend the body, because the body carries this work whether you attend to it or not. Sleep is not a negotiable extra when you are doing emotionally demanding work; it is part of how you metabolize the day. Movement, food, time outdoors, all the ordinary things, matter more when you are under strain, not less. Chaplains sometimes speak as though we are only souls attending to other souls, but you will do your caring inside a tired or rested body, and the difference reaches the patient.

Keep the relationships that remind you who you are outside this work. The friends who knew you before, the family that does not need you to be a chaplain, the communities where you are simply yourself. It is possible to become so immersed in the world of the hospital that you begin to lose the parts of your life that have nothing to do with it, and those parts are not a distraction from your vocation. They are part of what keeps you whole enough to sustain it.

Find your own sources of replenishment, whatever they are, and treat them as necessary rather than optional. For many people drawn to this work, some of that replenishment is spiritual: prayer, worship, meditation, time in silence, the practices of whatever tradition holds them. You spend your days tending the spiritual lives of others. Your own needs tending too, and no one will do it for you. If your tradition gives you ways to lay burdens down and be met by something larger than yourself, this is the season to lean on them.

And accept support as a strength rather than a confession of weakness. This may be the hardest one for people who are drawn to caregiving, because we are often much better at giving help than

receiving it. Your educator and peer group can be places of real support if you let them. Your educator will point you toward resources when you need them, as I described in the last chapter, and taking them up is not an admission that you have failed. Many chaplains keep a counselor or a spiritual director throughout their careers, not because they are unwell, but because a person who works this close to suffering deserves a place of their own to be heard. Learning now that it is not weakness to be cared for is one of the more valuable things your first unit can teach you.

An Invitation Before You Begin

You do not have to wait for CPE to start thinking about any of this. There is a small piece of preparation you can do now that will serve you later.

Think about what already restores you. Not what you believe should restore you, or what a wellness article recommends, but what actually returns you to yourself when you have been depleted. It may be walking, or music, or a particular friend, or the ordinary quiet of a morning before anyone else is awake. You know what yours are, even if you have not named them in a while, and you may notice that in busy seasons they are the first things to fall away. Consider choosing one of them and deciding, before your first day, that it is not going to be the thing you sacrifice when the work gets full. Protect one small practice in advance, and you will have somewhere to stand when the weeks get heavy.

The inner weather of the first weeks deserves to be met as something expected rather than as a private emergency. The tears in the parking garage, the numbness on the drive home, the certainty that everyone else belongs and you do not, these are not signs that you have chosen wrongly. They are the ordinary

experience of a whole person entering this work with their heart still open, which is the only way worth entering it. What remains is to walk you into the hospital itself, the setting where all of this happens, and that is where we turn next.

PART THREE

Stepping Into the Hospital

CHAPTER 7

The Hospital World and Who's On the Team

A Strange Country

The first time you walk onto a hospital floor as a chaplain, the building itself can be the hardest part. You have been in hospitals before, as a visitor or a patient, but you came then as a guest and left when you were done. Now you are meant to belong here, and belonging asks something different. There is a language you do not yet speak, a rhythm you cannot yet feel, and a great many people in scrubs moving with a purpose you cannot read. Many students tell me that this, more than any single patient, is what unsettles them in the first days. They are afraid of looking lost, of standing in the wrong place, of interrupting something important, of being the one person on the floor who does not know how things work.

That fear rests on a misunderstanding worth clearing up. You are not being asked to learn medicine. You will not be quizzed on anatomy or expected to read a monitor. What you are learning in these first weeks is something closer to what a traveler learns in a new country, the customs and the courtesies and the general shape of the place, enough to find your way and to be a considerate presence in it. That kind of learning comes faster than you think, and no one expects you to arrive already fluent. Every chaplain now moving so easily down these halls once stood where you are standing, unsure which way to turn.

It helps to know where the word hospital comes from, because its history says something about the place you are entering. It descends from the Latin *hospes*, a word that meant both host and

guest, the two sides of a single relationship. From that one root we also get hospitality, hospice, and hostel. The medieval hospital was a house of hospitality, a place where travelers, the poor, and the sick were taken in and cared for by people who understood welcome as a duty. The modern hospital has grown into something vast and technical, and much of the old meaning is buried under machinery and paperwork. But it is still there, underneath. At bottom this is a house built to take people in. You are joining the household whose oldest task is to make room for the stranger, which, when you think about it, is not far from the work you already came to do.

The Geography of the Place

A hospital is organized, and once you see the logic, the map stops looking like a maze. Broadly, patients are grouped in two ways, by how sick they are and by what kind of care they need, and the different areas of the building reflect that.

The word unit needs a note before we go on. In a hospital, a ward or floor is itself often called a unit, as in intensive care unit or oncology unit. This book keeps two phrases distinct, so nothing gets confused. Your block of CPE training is a CPE unit. A ward in the hospital is a hospital unit. In this chapter we mean the hospital kind almost every time.

Some hospital units are defined by acuity, a word you will hear often that simply means how sick a patient is and how much monitoring they need. The intensive care unit, or ICU, holds the most critically ill, one nurse for every patient or two, machines tracking every breath and heartbeat. A step-down unit cares for people who are past the worst but not yet ready for an ordinary floor. The general medical and surgical floors, often shortened to

med-surg, hold the largest number of patients, those who are ill or recovering but stable. The emergency department, the ED, is the front door for the unplanned, where people arrive in crisis and are sorted, treated, and sent home or admitted.

Other hospital units are defined by the kind of care they give. Oncology cares for people with cancer. Cardiac units care for the heart. Labor and delivery, and the postpartum floor beside it, are where babies are born, one of the few places in the hospital devoted to joy, though not without its own losses. The neonatal intensive care unit, the NICU, cares for the smallest and most fragile newborns. Pediatrics cares for children. Behavioral health, sometimes still called the psychiatric unit, cares for people in mental and emotional crisis. Rehabilitation helps people relearn what illness or injury has taken from them. Palliative care and hospice attend to those with serious illness, tending comfort and meaning when cure is no longer the aim.

You do not need to memorize any of this, and you will not learn it from a page in any case. You will learn it the way you learn a neighborhood, by walking it. Within a week or two the names will stop being strange, and you will know that a call from the ICU carries a different weight than a call from med-surg, not because someone taught you in a seminar but because you have been to both. If you want the fuller catalogue, with the abbreviations spelled out, there is a directory in the back of this book you can visit when you are curious and ignore the rest of the time. It is there to serve you, not to be studied in advance.

The Rhythm of the Day

A hospital never closes, and that fact shapes everything about how it feels. Care goes on through the night, which means the building

runs in shifts, and the shift is the basic unit of its day. Nurses commonly work in blocks, often twelve hours, and at the change of each shift they gather to hand off their patients to the ones coming on, passing along what happened and what to watch for. If you arrive on a floor during shift change, you have walked in at a busy moment, and it is worth knowing that, so you can wait or come back rather than adding yourself to the crowd.

Mornings have their own event, which is rounds. The medical team moves from room to room, reviewing each patient, examining them, and deciding the plan for the day. In a teaching hospital this can be a small procession, an attending physician trailed by residents and students, pausing outside each door to discuss the case. Rounds are important, and they are not a moment to begin a pastoral visit. Part of learning the rhythm is learning to read these signs, the closed door, the cluster of white coats, the nurse hurrying past with a purpose, and to time your presence to the life of the floor rather than against it.

Between these fixed points the day has a tempo of its own, and it is not the tempo of an office. Admissions arrive and discharges depart. A patient who was stable in the morning can turn by afternoon. Tests are ordered and results come back and plans change. Much of the work happens in a kind of controlled urgency that can feel foreign if you are used to a calmer pace, and it is easy, early on, to read that pace as coldness. It is usually not. The people around you are moving quickly because they are carrying a good deal, and the briskness is how they carry it. In time you will find your own way of moving through that current, neither rushing to match it nor standing so still that you are in the way. You will learn, as one of my students put it, to walk at the speed of the floor.

There is a small practical wisdom that will serve you from the first day, and it is this. Before you visit a patient you do not know, check in with their nurse. The nurse can tell you whether now is a good time, whether the patient has just had hard news, whether a procedure is about to happen, whether the family is in the room. It takes ten seconds and it will save you from walking into moments you would rather not have interrupted. It also does something else, which we will come to. It begins to make you known to the people you will be working beside.

Who's on the Team

Consider a single patient. I will call him Leon, a man in his sixties who has had a stroke. Picture the number of people who touch his care in a day. The neurologist and the medical team decide what is happening in his brain and how to treat it. Nurses are with him around the clock, giving his medications, watching for changes, turning him, answering the call bell, and knowing him, often, better than anyone. A physical therapist works to get him moving again, an occupational therapist helps him relearn to dress and feed himself, and a speech therapist helps with the words that have become hard to find and with the swallowing that a stroke can disrupt. A social worker and a case manager begin planning where he will go when he leaves and how his care will be paid for. A dietitian adjusts what he eats. A pharmacist checks his medications against one another. And somewhere in all of this a chaplain comes to sit with him and with the wife who has not left his side, because a stroke is not only a medical event. It is a door slammed shut on the life a man thought he was going to keep having, and someone should attend to that too.

That is the team. It is larger than most newcomers expect, and no one holds all of it in their hands. Each person contributes one dimension of the care, and the patient is well served only when the dimensions fit together. These are the ones you will work beside most, described not by their credentials but by what each brings to someone like Leon.

The physicians diagnose and direct the medical treatment. In a teaching hospital you will meet them at several stages of training, and the words can be confusing at first. An attending is the senior physician who carries final responsibility. Fellows, residents, and interns are physicians in stages of advanced training, and medical students are still in school. In some teaching hospitals the length of the white coat is itself a clue to rank, with students in short coats and senior physicians in long ones, though the custom is not universal and is not worth relying on. You do not need to keep the hierarchy straight at first. What matters is that you treat each of them with respect and learn, over time, who is who on your floors.

The nurses will be your closest colleagues on the unit. The word nurse comes from the Latin *nutrire*, to nourish, and the root still fits, because the nurse is the one who sustains the patient hour by hour. Nurses are present in a way no one else on the team can match, and they usually know the patient, and the family, and the mood of the room, better than the physicians who visit briefly on rounds. A charge nurse oversees the floor for a single shift, keeping the work moving hour by hour. A nurse manager stands over the hospital unit, responsible for its staffing, its standards, and its daily operation across the long run, more its administrative leader than a presence at the bedside. If you learn to work well with nurses, to check in with them, to respect how busy they are, to

let them know what you noticed in a room, your work will go better, and your patients will be better served. Some of the most useful referrals you receive will come from a nurse who tells you, in passing, that the woman in the far bed has been crying all morning and might want to see you.

Advanced practice providers are part of the picture too, and you will hear them referred to by their initials, NP and PA. Nurse practitioners and physician assistants are clinicians with advanced training who examine patients, diagnose, and prescribe, often carrying much of the day-to-day medical care. For your purposes you can relate to them much as you would to physicians. They are colleagues managing the patient's medical course.

You already met the social worker in an earlier chapter, tending to the patient's situation while you tend to their spirit, and I will not repeat all of that here. Alongside the social worker you will often find a case manager, whose work overlaps and who concentrates on coordinating the path out of the hospital, the discharge plan, the insurance, the arrangements for care at home or in a facility. When Leon is ready to leave, these are the people making sure he has somewhere safe to go.

The therapists restore function, each in their own domain. Physical therapy works on strength and movement, occupational therapy on the ordinary tasks of daily life, speech therapy on language and swallowing, respiratory therapy on breathing. You do not need to know the boundaries between them in any detail. It is enough to recognize that when you see them working with a patient, they are doing the patient care of getting a life back, one function at a time, and that their work and yours are related.

Mental health has its place on the team as well. Psychologists and psychiatrists attend to the mind, to depression and anxiety

and the psychiatric conditions that illness can stir up or reveal. Their work is distinct from yours in the way we drew out earlier, and the two are often allies. A good chaplain knows when what a patient is carrying has moved past spiritual distress into something that needs a mental health professional and refers without hesitation.

One team deserves a particular mention, because chaplains work so closely with it and are often part of it. Palliative care is an interdisciplinary team, usually including physicians, nurses, social workers, and frequently a chaplain, that cares for people with serious illness by tending to comfort, to symptoms, and to the larger questions of what the patient most wants as their illness runs its course. If you find yourself drawn to this work, you are in good company, since chaplaincy and palliative care grew up as natural partners.

I have left out many people deliberately, because a full roster would overwhelm you and there is a directory in the back for that purpose. But two things should be said before we move on. The first is that the list does not stop at the people with clinical titles. The unit clerk who knows where everything is, the patient care technician who takes the vital signs, the person from environmental services cleaning the room, the transporter wheeling a patient to radiology, these are members of the household too, and often they carry more of the human texture of a floor than anyone. Treat them as colleagues, because they are, and because a chaplain who is kind only to physicians has misunderstood the work. The second is that all these people, from the attending to the transporter, are among the ones you are here to care for. We will return to this but hold it for now. Your patients are not only in the beds.

Finding Your Place

New chaplains tend to make one of two mistakes about the team, and they pull in opposite directions. The first is to shrink. Intimidated by the medicine and the expertise all around them, they become apologetic, hovering at the edge of the floor, reluctant to speak in rounds or to add their observation to the record, as though they were guests who had wandered in and might be asked to leave. The second is to overstep, to wade into territory that belongs to a colleague, to offer the sort of advice or intervention that is not theirs to give. Both mistakes come from the same root, which is not yet knowing what your place on the team is. The remedy for both is to learn your lane and to occupy it fully.

You are a member of this team. Not a visitor, not an add-on, but one of the disciplines caring for the patient, responsible for a dimension of their wellbeing that no one else on the floor is trained to attend. That is worth saying because so many students do not feel it at first. You bring the spiritual and emotional dimension of care, the meaning a person is making of what is happening to them, the fear and the grief and the hope that the medical chart has no column for. When you contribute that in rounds or note it in the record so the team can see it, you are not decorating their work. You are completing a picture that would otherwise be missing a part.

Earning your place is mostly a matter of showing up reliably and behaving like a colleague. Introduce yourself to the staff, not only the patients. Learn the names of the nurses on your floors. Ask when you do not understand something, which will be often, and let people teach you, since most are glad to. Contribute what you see, and do it in language the team can use, which you will pick up faster than you expect. Document your visits so that a

chaplain's presence becomes visible in the record, a subject we will take up in its own chapter. None of this requires you to pretend to a competence you do not have. It requires only that you be present, respectful, and willing to learn, which are the same dispositions the work asks of you at the bedside.

There is one more thing, and it is the note I asked you to hold a moment ago. The people you work beside are carrying hard things too. Nurses lose patients they have cared for through long nights. Physicians deliver news that costs them something to deliver. A resident who seems brusque may be running on three hours of sleep and the memory of a code that did not go well. Part of your ministry, more of it than you may expect, will be to the staff, sometimes in a word in the hallway, sometimes in a longer conversation with someone who needed a person to whom they did not have to be strong. You do not need to seek this out in your first weeks, and you should not force it. But keep your eyes open to it, because the same presence you bring to the bed is needed, and less often offered, among the people who work these floors.

An Invitation to Carry With You

Before we turn to the patient's room itself, the subject of the next chapter, spend a few minutes with this.

Picture yourself walking onto a hospital floor for the first time, in whatever hospital your CPE will take place. You come through the doors and the sounds reach you first, the soft chime of a monitor, an overhead page calling someone to somewhere, a cart rolling past, a television murmuring behind a curtain. There is a smell, part antiseptic and part something harder to name. There are signs everywhere, and badges, and people in scrubs of different colors moving past you, each of them knowing exactly

where they are going. There are doors, some open, some closed, and behind each one a person and, often, a family, living through one of the harder days of their lives. Stand in that hallway in your imagination and notice how it feels to be new there, to belong to none of it yet.

I ask you to sit with that feeling rather than rush past it, because it will not last, and it is worth remembering. Within weeks the hallway that feels foreign now will feel ordinary, and you will walk it without a thought, checking a census, greeting a nurse by name, timing your visit to the rhythm of the floor. When that day comes, and it will come sooner than you believe, I hope you will remember standing at the door as a stranger. It will make you kind to the next newcomer, and it will keep you close to something your patients feel every time they are wheeled through those same doors, frightened and out of place in a country whose language they do not speak. You are entering a house whose oldest name means welcome. Before long you will be one of the people whose task is to offer it.

CHAPTER 8

Entering the Room and Learning to Listen

At the Door

You will spend much of your first weeks standing outside doors, gathering yourself before you go in. This is the moment students often dread, more than the conversation that follows it. The hallway is public, and you can look busy in it, checking a name, glancing at a list. The room is private, and once you cross into it you are committed. A student I will call Grace, a schoolteacher who came to chaplaincy in her fifties, told me she stood outside her first patient's door for a full minute, rehearsing an opening sentence, sure that everyone passing could see she did not belong. When she finally went in, the patient was asleep. She stood there another moment, then backed out, and counted the whole thing a failure. It was not. She had done the hard part, which was to walk up to the door at all.

The doorway rewards a little attention, and not only because of nerves. The threshold is an old idea with a long history. Our word liminal comes from the Latin *limen*, the doorsill, the line between one space and another, and people have long felt that thresholds are charged places, neither wholly out nor wholly in. When you stand at a patient's door you are standing on exactly such a line. Behind you is the corridor, with its traffic and its errands. In front of you is a room where someone is living through an experience you know little about yet. Much of entering well is a matter of respecting that line rather than stepping over it as though it were not there.

Before you reach the door at all, there is a small preparation worth making a habit. Look at the chart, so that you know something of the person you are about to meet and are not walking in blind. Speak with the nurse, who can tell you whether now is a good time and what the last few hours have held. And wash your hands, which you will do at every room for the sake of hygiene, but which can serve a second purpose if you let it. The few seconds at the sink or the sanitizer dispenser are a kind of threshold too, a chance to set down whatever you were carrying out of the last room and to arrive empty and attentive for this one. Many chaplains come to treat the washing as a small ritual of centering, and I commend the practice to you.

So, before you knock, pause and take in what the door already tells you. A closed door, a posted sign asking you to see the nurse before entering, a meal tray just delivered, a burst of laughter or the sound of weeping, the curtain drawn around the bed, these are all information, and they are free. When something signals that this is not the moment, honor it. Then knock, even when the door stands open, and say who you are before you are all the way in. Something as plain as "Hello, may I come in?" gives the person the one thing a hospital takes from them constantly, which is the power to decide who enters their space.

Once you are invited in, come only as far as feels welcome, and let the patient set the distance. Many new chaplaincy students make the mistake of advancing straight to the bedside and standing over the patient, which puts the sick person flat on their back looking up at a stranger who towers above them. If there is a chair, ask whether you may sit. Sitting does something a whole speech about compassion cannot. It says you are not in a hurry, that you have come to be here rather than to pass through. There is

even research behind the instinct. When a clinician sits rather than stands, patients tend to remember the visit as having lasted longer than it did and to experience it as more positive, though the actual time at the bedside barely changes. Sitting also brings your eyes level with theirs, which turns an inspection into a meeting and helps to level two very unequal roles. If there is no chair and standing is your only option, step back half a pace and lower yourself a little rather than looming. The body speaks before you do, and what you want it to say is that there is time, and that the person in the bed is the reason you came.

Saying Who You Are

Then you have to introduce yourself, and the word you carry is a complicated one. Many patients do not know what a chaplain is. Some hear the word and reach a frightening conclusion, that things must be worse than they were told, because why else would the chaplain be here. I have had patients look at me with real fear and ask whether I had come because they were dying. It is worth expecting that reaction so it does not unsteady you, and answering it plainly and warmly when it comes. Usually a simple truth settles it, that you visit everyone on the floor, not only the gravely ill, and that no one sent you with bad news.

A good introduction is short, clear, and easy to decline. Without making a speech of it, it answers the handful of questions any patient is entitled to have answered when a stranger appears in their doorway. Who are you? Why are you here? For whom is this, and for how long? Are you part of the team treating me? A single sentence can carry all of it: “Hello, my name is Sam. I’m one of the student chaplains, and I work with your doctors and nurses to offer spiritual and emotional support to patients and their

families while you're in the hospital." That tells the person who you are, what you have come to offer, to whom, and that you belong to the team caring for them, which is a good deal to settle in one friendly breath. Patients have a right to know who has walked into their room and why, and a clear introduction gives them that as a matter of respect.

Then, before you go any further, ask two small questions that matter more than they look. "Is this a good time to visit?" and, if it is, "May I have a seat?" Both are requests for permission, and permission is the point. A hospital strips people of control almost from the moment they arrive, over their schedule, their body, their privacy, even their clothing. Researchers who study what preserves a patient's sense of dignity find that much of it comes down to whether they feel comfortable, in control, and valued, and to how much the people around them protect those feelings or erode them. To ask whether now is a good time, and to mean it, and to accept a no, hands a little of that lost control back. The patient may be in pain, or waiting for news, or wary of anyone who represents religion, and any of those is reason enough to decline. Honoring the refusal is not a failed visit. It is the first act of care.

Notice what the introduction does not do. It does not announce a religious agenda or presume anything about what the patient believes, because you do not yet know who is in the bed. The person may hold a faith very different from yours, or none at all, and the chaplain serves them all. We will spend a whole chapter on caring across that kind of difference, so set the deeper question aside for now and keep only this in view, that your opening should open a door rather than narrow it.

You will develop your own version of these lines, and you should. Borrowed words feel borrowed, and patients can hear the

difference between a sentence you mean and one you are reciting. Before your first day, it is worth deciding roughly how you want to introduce yourself, in language that sits comfortably in your own mouth, so that the words are ready when your nerves are not.

Reading the Room

While you are saying who you are, you are also learning where you have landed, because the room has been telling its story since before you knocked. A good deal of what you need in the first minute comes not from what the patient says but from what you notice. Look at the person. Are they turned toward you or away, alert or exhausted, eager for company or braced against one more interruption. A patient who keeps their eyes on the television and answers in single words may be asking you, without saying so, to keep it brief or to come back later, and honoring that is its own form of care.

Notice who else is present. A spouse who has not slept, an adult child sitting rigid in the corner, a room full of relatives who go silent when you enter, each of these changes the visit, and sometimes the person most in need of you is not the one in the bed. Notice the objects, too, since people surround themselves with what matters to them. A worn Bible on the tray table, a rosary looped around the bed rail, a prayer rug, a stack of family photographs, a phone playing music low in the background, all of these are small invitations, offered by the patient before you have asked a single question. You do not have to act on any of it in the first visit. You are simply learning to walk into a room with your eyes open, gathering the small signs that tell you who this person is and what kind of presence they might welcome.

The Work Is Listening

Once you are in the room and have said who you are, the temptation is to feel that you must now do something, produce comfort, say the wise thing, leave the person better than you found them. Set that burden down. The work you have come to do is mostly listening, and listening is harder and more valuable than it sounds.

I have come to think that the essence of this work is communicating to another person, mostly without words and through careful listening, that they are seen, heard, and loved. It is worth setting that beside its near neighbor, being seen, heard, and judged, because the difference between the two, though it can be hard to name, decides whether a visit heals or wounds. A patient can be observed closely and listened to attentively and still feel weighed and found wanting, and most people carry finely tuned instruments for detecting judgment even when no one says a word. The listening that heals is emptied of that. It does not grade the person's choices, or their theology, or the way they are carrying their illness. It receives them as they are. When someone in a hospital bed, frightened and diminished and half convinced they have become a burden, feels themselves received that way by another human being, something eases that no advice could have reached.

Our ordinary listening is thin. We listen while planning what we will say next, or while deciding whether we agree, or while waiting for the pause that lets us tell our own version of the story. Real listening asks us to stop doing all of that and to give the other person the whole of our attention. The word attend comes from the Latin *attendere*, to stretch toward, and that is the physical truth of it. To attend to someone is to lean your whole self in their

direction and hold it there. The philosopher Simone Weil thought of attention as a kind of generosity, close to the heart of loving a neighbor. She believed that to give another person your full attention, emptying yourself enough to receive them as they actually are rather than as you expect them to be, is rare and difficult work, and that most of what passes for attention is something shallower. A dying man or a frightened woman can tell at once whether they have your attention or only your presence in the doorway, and the difference is much of what you have to offer.

Some of what CPE will teach you about listening comes from Carl Rogers, whom you met earlier. Rogers noticed that people feel understood when their listener reflects back what they have heard, not by parroting the words but by catching the feeling underneath them and offering it back to be corrected or confirmed. A patient says, "I just don't know how my wife is going to manage all this," and instead of reassuring him that his wife is strong, you might say, "It sounds like you're worried about her, maybe more than about yourself." If you have heard him rightly, he will feel it, and he will go further. If you have heard him wrongly, he will correct you, and that too is a gift, because now you both know something truer than you did a moment ago.

Above all, listen for what is beneath the words, because people rarely lead with the thing that weighs most. Consider a man I will call Ray, in his fifties, a few days out from a heart attack that had come without warning. When the student chaplain arrived, Ray wanted to talk about his truck, and about the crew at work who were covering his shifts, and about how soon he could get back. The student, wanting to be useful, began reassuring him, that his job would surely wait, that his coworkers sounded dependable. Ray nodded and kept circling back to the same worries. Then the

student stopped solving and asked a small open question, something like what it had been like for him, lying here these last few days. Ray was quiet, and then he said he had never been the one in the bed before. He was the one who fixed things, who took care of everybody. He did not know how to be the person who needed taking care of, and it frightened him more than the heart attack had. None of that was about the truck. The truck was how a proud man talked about his fear until someone made it safe to say the rest.

The Gift of Silence

When Ray fell silent before he told the truth, the student did the wise thing, which was to let the silence sit. This is among the hardest disciplines for beginners, because silence in a sickroom feels to the newcomer like a failure they are responsible for repairing. The urge to fill it is strong. You say something, anything, to end the discomfort, and in doing so you often step on the very moment the patient was gathering themselves to speak.

Not every silence needs rescuing. A good deal happens in the quiet that words would only interrupt. A patient is finding their courage, or feeling something they have not let themselves feel, or simply resting in the fact that another human being is willing to stay in the room without demanding anything. Buber's distinction, which we met in an earlier chapter, is useful here. When you stop treating the encounter as a problem to be managed and simply meet the person as a You, the silence stops being empty. It becomes a form of company.

It helps to know that the silence almost always feels longer to you than to the patient. Five seconds can feel like a minute when you are new and anxious. You can steady yourself by breathing, by

keeping your attention on the person rather than on your own discomfort, and by reminding yourself that you are not there to perform. If the quiet truly needs a word, let it be a small one that keeps the door open, “Take your time,” or “I’m here,” rather than a rush of talk that closes it. Much of what patients remember later is not anything a chaplain said. It is that someone sat with them and did not flinch and did not leave.

Beginning to Listen for Meaning

At some point in your training you will hear the phrase spiritual assessment, and it can sound clinical and daunting, as though you were expected to measure something invisible with an instrument you do not own. At the beginning it is much simpler than that. To assess, in its plain sense, is to pay careful attention and to notice what you find. A spiritual assessment, at the level you need for your first day, is nothing more than listening for what this illness means to this particular person, and for what they have to draw on as they face it.

As you listen, a few questions can help organize what you hear, not questions to fire at the patient but questions to hold in your own mind. What is this person most afraid of? What are they hoping for? What or who sustains them, gives them strength or comfort or a sense of who they are? Is there something they are wrestling with, a sense that their suffering is unfair, or a fear that it is deserved, or a faith that is holding or slipping? Where, if anywhere, do they find meaning in what is happening to them? You will not get answers to all of these in one visit, and you should not try. You are simply learning to hear the spiritual and emotional dimension of a person’s experience, the layer the

medical chart has no column for, which is the dimension you are on the team to attend.

There are more structured tools for this, and CPE will introduce you to them in time. They travel under names and acronyms, and a good deal of careful thought has gone into how to do spiritual assessment well, and even into how to study whether it helps. You do not need any of that yet, and reaching for a formal model too early tends to turn a human conversation into a questionnaire. For now, let the tools wait. Learn first to listen for what matters to the person in front of you. The frameworks will make more sense later, once you have sat at enough bedsides to have something real to organize.

Where Beginners Stumble

Almost every new chaplain makes the same handful of mistakes, and naming them here may spare you a little of the sting of discovering them in a verbatim seminar. None of them makes you unfit for this work. They are the ordinary missteps of caring people who have not yet learned to trust that presence is enough.

The most common is the reflex to fix. Someone tells you something painful and you feel the pressure to make it better, so you offer a solution, or a bright side, or a reason it might all work out. The trouble is that most of what patients carry cannot be fixed by anyone, least of all by a visitor they met five minutes ago, and the attempt, however kindly meant, tells them that their pain made you uncomfortable enough to want it to stop. Close to this is premature reassurance, the “I’m sure everything will be fine” that we reach for when we cannot bear a person’s fear. You do not know that everything will be fine. What the frightened person needs is

not a promise you cannot keep but a companion who will not leave, which is the one thing you can actually give.

Beginners also tend to talk too much, and often to talk about themselves. A patient mentions a diagnosis and you remember that your aunt had the same one, and before you know it you are telling her story instead of hearing his. Your own experiences can occasionally build a bridge, but in the early weeks the safer rule is to keep the visit about the patient and to notice the pull to make it about you. Watch, too, the impulse to bring in religion when the patient has not, or to assume that because you are a chaplain the person wants prayer or scripture. Some do, deeply. Others will feel intruded upon, and a chaplain who imports their own faith into a room uninvited has stopped serving the patient and started serving themselves.

Two smaller mistakes are worth flagging because they are so easy to avoid. The first is staying too long. A visit that has done its work should end; more time is not more care, and an exhausted patient will not always tell you they are tired. The second is coming between yourself and the patient with a clipboard or a screen. Whatever you need to remember, remember it, and write it down in the hallway afterward. Notes belong outside the room. Inside it, the person deserves your face and not the top of your head.

Leaving Well

Endings deserve as much care as beginnings, and beginners often neglect them, slipping out with a mumbled word because the visit has grown intense and they do not know how to close it. A clean ending is a kindness. Signal that you are coming to a close, thank the person for letting you in, and, when it fits, offer to come back. “I’m glad I got to meet you. I’ll be on the floor this week, and I’d be

happy to stop in again if you'd like." That simple offer tells the patient the visit was not an obligation you were discharging but a relationship you are willing to continue, and it leaves the door open for the deeper conversation that sometimes comes only on the second or third visit.

This is also where the question of prayer usually lands, because so many beginners are unsure what to do about it. Prayer is an intervention, not a routine. Like any intervention, it belongs in a visit only when what you have heard suggests it might actually help this person now. Do not pray in every visit, and do not even offer to pray in every visit. Many good visits contain no prayer at all, and reaching for it out of habit, or to bring a conversation to a tidy close, or to relieve your own discomfort, turns something that should serve the patient into something that serves you. With time and practice you will develop a feel for when an offer of prayer fits and when it does not, and that discernment is part of what your assessment is for. When prayer does fit, offer it in words that make it easy to decline, something like, "Would it be helpful if I said a prayer with you, or would you rather I didn't?" Then follow the patient. Pray for what they have told you they are carrying, in language that belongs to their tradition rather than yours where you can manage it, and keep it short and honest. And hold onto this: the listening was the ministry. Prayer, when it belongs, only gathers up what the listening has already gathered. CPE will give you much more practice with all of this, so you do not need to have it settled before you begin.

Then you cross the threshold again, back into the corridor, carrying something of what you heard. Take a moment there before you rush to the next thing. Write down what you need to remember. Notice what the visit stirred in you, because that, as an

earlier chapter suggested, is part of your instrument and worth attending to. And let the person go for now. You gave them your attention while you were with them, which was the gift. You are not required to carry them out of the room, only to have been fully present while you were in it.

An Invitation to Carry With You

Before we go on to the harder question of caring for people whose beliefs and lives differ sharply from your own, spend a little time with this.

Write your own opening line. Imagine you have just knocked on the door of a patient you have never met, and they have invited you in. In your own words, in language that feels like yours and not like a script, how will you tell them who you are and why you have come. Write it down, say it aloud, and listen to whether it sounds like you. Then write a second version, a little warmer or a little plainer than the first, for the patient who seems frightened, or guarded, or unsure what a chaplain even is. You will revise these a hundred times once you begin, and you should. What matters now is that you arrive on your first day with words that are ready, so that when you are standing at the door like Grace, gathering your courage, at least the first sentence is already yours.

And when you do walk in, remember what the whole chapter has been circling. You are not going in to fix anything, or to have the right answer, or to fill the silence. You are going in to attend, to stretch your whole self toward another person and stay there, and to listen for what matters most to them beneath whatever they happen to say first. That is a skill you will spend the rest of your working life refining, and you already have everything you need to begin practicing it on your first day.

CHAPTER 9

Caring Across Difference

Serving People Unlike Yourself

Sooner than you expect, often on your very first day, you will walk into a room and find someone whose life bears little resemblance to your own. They may pray to a God you do not recognize, or to no God at all. They may come from a country you have never visited, speak a language you do not share, or hold convictions you find puzzling, or wrong, or hard to sit beside. The hospital gathers everyone. It does not sort patients by belief, and it will not hand you an assignment sheet of people who happen to think as you do. Whatever your own tradition, most of the people you care for will not belong to it.

For many new students this is the part of the work that unsettles them most, though they do not always say so out loud. It is one thing to imagine offering comfort to someone who shares your faith and your words for things. It is another to sit down beside a person whose whole framework for suffering, for God, for what happens after death, differs from yours, and to wonder what on earth you have to offer them. A student once asked me, with real distress, how she was supposed to give spiritual care to a man whose religion she considered false. She was not being unkind. She was being honest about a difficulty that every one of us meets, and that the pretense of easy tolerance does not resolve.

Consider a student I will call Caleb, who had grown up in a small town where nearly everyone shared his church and his assumptions. In his first weeks he was assigned to Mrs. Aziz, a

Muslim woman recovering from a serious illness, whose family kept a close and prayerful vigil at her bedside. Caleb told me afterward that he had stood outside her door at a loss, aware that he knew almost nothing about Islam beyond a few headlines, and afraid that whatever he said would be either ignorant or offensive. He very nearly did not go in. What happened when he finally knocked taught him one of the more important lessons of his first unit, and I will return to it. First, though, it helps to name the disposition that made it possible.

A Humility Before Difference

The word that has come to matter most to me here is humility, and it deserves closer attention. It comes from the Latin *humus*, the ground, the soil under our feet. To be humble, in the root sense, is to be low to the earth, close to the ground, not above others but among them. That image is worth holding onto, because it describes something truer than the false modesty we sometimes perform. Humility before another person is not thinking little of yourself. It is standing on the same ground they stand on, at the same level, without the elevation that expertise can tempt us to claim.

In healthcare there has been a useful conversation about this over the last few decades, and it gave us a phrase worth knowing. For a long time hospitals spoke of cultural competence, as though a clinician could study up on a culture the way one studies anatomy and eventually achieve mastery of it. Two physicians, Melanie Tervalon and Jann Murray-García, questioned whether competence was even the right goal. They proposed that the better aim is not competence but what they called cultural humility, a lifelong posture of self-examination and openness rather than a

body of knowledge to be completed. Their insight was that you can never become expert in another human being. Cultures are not uniform, individuals vary within them, and the moment you believe you have someone figured out because you know their category, you have stopped seeing the person. Humility keeps you learning. Competence, wrongly understood, can close the door.

What this means at the bedside is more freeing than it first sounds. You are not required to be an authority on every faith and culture you will meet. No one could be, and the attempt would only make you more anxious than you already are. What you are asked to do is far simpler and far more human, which is to approach each person as the authority on their own life and to let them teach you. The patient in the bed knows what their tradition means to them, how they practice it, what would comfort them and what would intrude. You do not have to supply that knowledge. You just have to be curious enough, and humble enough, to receive it.

This is where Caleb's story turns. When he finally went in and introduced himself as one of the chaplains, careful, as we discussed earlier, not to assume anything about what Mrs. Aziz believed, her son answered for the family, wary at first. Caleb did the one thing that served him best. He admitted what he did not know. He said something close to, "I'll be honest, I don't know very much about your faith, and I don't want to get anything wrong. Would you help me understand what would be most supportive for your mother right now?" The wariness in the room eased. The son told him about the prayers his mother said at fixed times through the day, and how the family wished to face her bed a certain direction, and that their imam would be coming, and that having a chaplain who respected all of this and helped protect the

space for it meant a good deal to them. Caleb did not lead a single prayer. He learned when to time his visits so as not to interrupt theirs, he let the nursing staff know what the family needed, and he sat with the son in the corridor on a hard afternoon and listened. He gave real spiritual care, and he gave it by not pretending to possess a knowledge he lacked.

Difference Is More Than Belief

It would be a mistake to think of difference as belonging only to religion. Much of what you will meet at the bedside is cultural, and it runs deeper than most of us notice, because our own culture is the one we cannot see, the set of assumptions so familiar that they feel like plain reality rather than choices. Whether a person meets your eyes or lowers them, whether they welcome a hand on the shoulder or find it an intrusion, whether the patient speaks for herself or defers every question to a son or a husband, whether bad news is to be spoken plainly or softened and held within the family, all of this varies from one culture to the next, and none of it is written on the chart. A gesture that means comfort in the world you grew up in may mean something else across the bed from you.

Language is its own kind of difference. When a patient does not share your language, resist the easy shortcut of leaning on a family member to translate, however willing they seem. Hospitals provide trained medical interpreters for good reasons, and those reasons hold for spiritual conversations as much as for medical ones. A frightened daughter pressed into interpreting her mother's fears about dying is carrying a burden no one should ask of her, and she may soften or edit what her mother says to protect you both. Learn early how your hospital summons an interpreter, whether by phone, by video cart, or in person, and use that help

without embarrassment. Speaking through an interpreter feels slow and awkward at first. It is still far better than a conversation in which neither of you is sure what the other means.

None of this asks you to memorize the customs of every culture you will meet, which would be impossible and would miss the point. It asks you to hold your own habits loosely, to assume less, and to ask more. When you are unsure, a simple and humble question serves better than a confident guess. "Is it all right if I sit here?" "Who in your family should I be speaking with about this?" "Is there anything I should know so that I don't unintentionally do something disrespectful?" Most people, asked with real care, are glad to tell you. They would far rather teach a willing stranger than be handled by someone who assumed.

Respect Is Not Agreement

Somewhere in your first weeks a worry may surface that many thoughtful students carry, which is that caring for people of other faiths requires you to believe that all faiths are equally true, or to set your own convictions aside as though they were an embarrassment. I do not think that is so, and I would not ask it of you.

There is a difference between respect and agreement, and holding the two apart is much of the skill of this chapter. To respect a person's belief is to honor its reality and its weight in their life, to treat it as worthy of your care and your protection, and to refuse to argue them out of it at the bedside. It is not to declare that you share it. You can be a committed Christian, or Jew, or Muslim, or Hindu, or Buddhist, or a thoughtful person of no particular tradition, and still offer full-hearted care to someone whose convictions differ from yours entirely. You are not

endorsing their theology. You are honoring their humanity, and honoring the fact that in a hospital bed, frightened and stripped of the ordinary supports, a person's faith is often the deepest thing they have. Your job is not to correct it. Your job is to help them draw on it.

Picture how this looks in practice. A woman recovering from surgery tells you she is certain her illness was sent by God to punish her for a decision she made years ago. You may find that theology painful, even harmful, and everything in you may want to talk her out of it. Notice the want and set it aside. This is not the moment for a seminar on the nature of God. What she has handed you is not a proposition to debate but a window into her fear and her guilt, and the care she needs is for you to stay with her there, to ask what that decision was and how long she has carried it, to let her say aloud what she has perhaps told no one. Respecting her belief does not mean agreeing that God punishes people with illness. It means honoring that this is how she is making sense of her suffering right now. What she needs from you is to feel seen, heard, and loved rather than seen, heard, and judged, and a person who is received that way is far more able to move, in her own time, toward something gentler than a person who feels corrected. You do not have to endorse the map to walk with someone through the country.

Sometimes respect asks for more than restraint. During the hardest weeks of the pandemic, a former student of mine was called to the labor and delivery floor, where a mother laboring alone under the visiting restrictions was about to deliver a baby who was not expected to survive. The mother, a Catholic, wanted her child baptized. There was no time to bring a priest to the bedside, and my former student, who is a Jewish humanist and

does not hold the theology of baptism as her own, did not pause over that. She found the words, practiced them, and talked a nurse through performing the baptism in the small hours of the morning, then reached the on-call priest afterward to bless and record it. Her reasoning, when she later explained it, was simple. If this was a family's deepest expression of love, and it would bring them some spiritual relief, then she would help it happen. She was not pretending to believe what the mother believed. She was honoring it, and spending everything she had to serve it. That is respect doing its fullest work, a chaplain of one tradition giving herself to make possible the rite of another.

The mistake in the other direction is just as real. Some students, anxious not to impose, decide that the only safe course is to have no convictions at all, to become a kind of blank, endlessly agreeable surface that reflects back whatever the patient offers. That is not humility either. Patients can feel the difference between a person who is present with them and a person who has gone hollow out of fear of giving offense. You do not have to erase yourself to honor someone else. You bring your whole self into the room, your faith and your history and your care, and you hold all of it in service of the person before you rather than in competition with them.

The Harder Difference Is Often Your Own

I have been describing difference as though it lived entirely in the patient, but the first difference you will have to reckon with is usually your own reaction. This is where the inner work we spoke of earlier returns.

I know this from the inside. In my own first unit, years ago now, the disorientation that shook me most did not come from a

patient at all. It came from within my own group of peers, when a woman I was already wary of said aloud that she did not believe what I had been taught to believe about Jesus. I have told that story earlier, so I will not tell it again. What matters here is what it taught me. My difficulty in that moment was not really about her. It was about me, about the ground shifting under my own certainties, and about how threatened I felt when someone near me held the world differently than I did. Much of what looks like difficulty with another person's beliefs is actually difficulty with our own reaction to them.

You will feel this at the bedside. A patient will say something that strikes you as foolish, or offensive, or theologically wrong, and you will notice a tightening in yourself, an urge to correct, or to argue, or to withdraw. Sometimes the patient's certainty will grate against you because it resembles a certainty you have left behind, or one you secretly wish you still had. Sometimes a person's views on matters far from religion, on politics, on family, on the choices that landed them in that bed, will trouble you in ways you did not anticipate. This is the countertransference we named in an earlier chapter, the reactions that rise from your own life rather than from the patient's need. The work is not to have no reaction. The work is to notice it, to set it down for the length of the visit, and to keep your attention on the person rather than on your own discomfort. What surfaces in you is information about you, and it belongs in your reflection afterward, in your journal or your verbatim or a conversation with your educator, not in the patient's room.

I will not pretend every case is easy. You will meet patients whose beliefs are not merely different but hard for you to sit beside, and now and then someone whose words or history you

find repugnant. Caring for such a person does not require you to approve of them, and it does not require you to pretend. It requires you to find the human being underneath the position, the frightened or grieving or dying person who is more than the worst thing they believe or have done. That is demanding work, and no one does it perfectly. When you find you cannot do it at all, that too is worth knowing, and worth bringing to your educator, who has been there and will not be shocked.

Neither Imposing Nor Disappearing

One image holds much of this chapter together. The chaplain caring across difference walks a line between two failures, both common in beginners.

The first failure is imposing. This is the chaplain who brings their own faith into the room uninvited, who reaches for their own scripture and their own prayers and their own certainties as though every patient were a member of their congregation. We touched on this among the beginner mistakes in the last chapter, and it deserves repeating here because it does its harm without looking like harm. A chaplain who imposes has stopped serving the patient and started serving themselves, using the encounter to reassure their own faith rather than to tend the patient's. It can come from the best of motives. It is still an intrusion, and the patient, already powerless in a hundred ways, rarely feels free to refuse it.

The second failure is disappearing. This is the chaplain who, so afraid of imposing, offers nothing at all, who becomes so cautious and so neutral that no real person is present in the room. The patient reaches for something to lean on and finds only politeness. A chaplain who vanishes this way has confused

restraint with erasure. The care you bring travels through a real and grounded self, offered in service of another rather than withdrawn to keep yourself safe.

Military chaplaincy has a useful way of naming the work that lives between those two failures. The Navy Chaplain Corps describes the chaplain's role with four verbs: provide, facilitate, care, and advise. To provide is to offer, out of your own tradition and training, the prayers and rites you are formed to give, for those who share them. To facilitate is to make possible what you cannot provide yourself, by finding the priest for the Catholic who wants anointing, the rabbi, the imam, or a family's own community, the way my former student facilitated a baptism she could not have believed her way into. To care is to offer pastoral presence and support to anyone, of any faith or none, and it is the ground the other three stand on. To advise, in a hospital, is to help the team around a patient understand the spiritual, religious, and moral dimensions of what that patient is facing, the layer that shapes how a person receives everything else that is done for them. Provide, facilitate, care, advise. The vocabulary is military, but it maps the terrain of caring across difference as well as anything I know, because it holds together the two things beginners tend to split apart, a real self with something to offer and an honest deference to the person in the bed.

Holding those four together is more art than formula, and you will spend your whole career learning to do it well. You offer, you do not impose. Prayer, as we said last chapter, is an intervention offered only when it seems to fit the person in front of you, not a routine you carry into every room, and when it does fit, you follow the patient's lead into their tradition rather than importing your own. When the care a patient needs lies beyond what you can

provide, the humility to hand it to someone who can is not a failure but one of the truest forms of the work itself. You are not the whole of a person's spiritual support. You are, often, the one who makes sure the rest of it can reach them.

There is real freedom in this once it settles into you. You can walk into any room, of any faith or none, and know that you are not being asked to be an expert, or to have the answers, or to represent a tradition you do not hold. You are being asked to be humble, curious, respectful, and present, and to help each person draw on whatever sustains them. That you can do on your first day, long before you know anything about the tradition in the bed.

An Invitation to Carry With You

Before we turn, in the next chapter, to the more practical guardrails of this work, the notes you keep, what you may and may not share, and the boundaries that protect both you and your patients, spend a little time with this.

Recall a time when you were cared for by someone quite different from you. Perhaps a nurse or a teacher, a stranger on a hard day, a friend from another faith or another country, someone whose life looked nothing like yours and who nonetheless met you with kindness at a moment when you needed it. Bring the scene back as fully as you can. What did they do, or not do, that let their care reach you across the distance between you. Did they need to share your beliefs to comfort you, or did something else pass between you that had little to do with agreement.

Sit with that memory, because you already know, from the inside, the thing this chapter has been trying to say. You have been on the receiving end of care that crossed a difference, and it worked, and it did not require the two of you to become the same.

That is the care you are learning to give. When you stand at the next unfamiliar door, wary as Caleb was, remember that you are not being asked to close the distance between you and the person in the bed. You are being asked to cross it, humbly and with your eyes open, and to trust that presence and attention can travel further than sameness ever could.

CHAPTER 10

Notes, Confidentiality, and Boundaries

The Guardrails of the Work

You will have a visit that matters. A man will tell you something he has told no one, and you will leave his room carrying it, moved and a little unsteady, aware that something real passed between you. Then you will sit down at a computer on the hospital unit, and a blank note will be waiting, and you will face a set of questions no one quite prepared you for. What do you write about what just happened? How much of it belongs to the record, and how much belongs only to him? Who will read what you type, and what are you permitted to tell them? And where, in all of this, is the line between caring for a person and getting tangled up in a way that helps no one?

These are the less glamorous parts of the work, and beginning students sometimes treat them as afterthoughts, the paperwork and the fine print around the real business of presence. I would ask you to see them differently. The note you write, the confidences you keep, and the boundaries you hold are not the packaging around good care. They are part of it. They are how the care you give in one room reaches the rest of a patient's life, how the trust a stranger placed in you is honored, and how you keep yourself whole enough to do this work for years rather than months. None of it is complicated once you understand what it is for.

Why We Write It Down

Chaplains chart. That surprises some new students, who imagined the spiritual visit as the one encounter in the hospital that would leave no paper trail, a private thing between two people and no one else's business. The visit is private in the ways that matter, and we will come to that. But the fact of it, and something about what you found there, belongs in the record, and for reasons worth understanding rather than merely obeying.

Consider a student I will call Nadia, who came to CPE from a tradition where spiritual conversation was sacred and unrecorded, and who bristled at the idea of typing anything about her visits into a hospital computer. It felt to her like a betrayal of the intimacy. What changed her mind was watching what happened when she did not write. A patient she had spent an hour with, a woman frightened before surgery, was seen the next day by the overnight chaplain, who knew nothing of the first visit and had to begin again from the beginning, asking the tired woman to explain herself once more. Research on continuity of care shows that patients find this repetition burdensome and may interpret it as evidence that their caregivers are not communicating, weakening their trust in the team. Nadia realized that her silence had not protected the patient. It had isolated her. A brief note would have let the next chaplain walk in already knowing that this was a woman carrying fear about the operation and drawing strength from her sister and her church, so that the care could continue rather than restart.

There is an old saying in healthcare, repeated so often it has become a kind of proverb: if it is not documented, it did not happen. It can sound cynical, as though the record mattered more than the reality of the visit. What it means in practice is gentler and truer than that. Your note is what allows the care you gave in

one room to exist for anyone beyond the two of you. It shows the team, and the chaplains who follow you, something they could not otherwise know: that this patient is in spiritual distress, or at peace; that she has support at home, or none; that she asked not to be left alone tonight; that a visit happened and how it went. Medicine has long charted the body. When chaplains chart the spiritual and emotional life of a patient, we are saying that this dimension of a person is real enough to belong in the record beside the blood pressure and the medication list, real enough to be part of the plan. That is not bureaucracy. It is a claim about what counts as care, and it is one the profession has worked hard to earn.

There is a practical dimension too. A chaplaincy department that can show what it does, and that its visits reach the patients who most need them, is a department that survives the next round of budget decisions. I do not say this to make you a clerk. I say it because your notes, taken together with everyone else's, are part of how this work stays credible and funded in a healthcare system that increasingly asks every discipline to account for itself. You can hold that truth alongside the sacredness of the visit. In this profession we are learning to be both spiritually present and honest about our effects, and the note is one small place where those two commitments meet.

What Belongs in the Note, and What Does Not

Here is where Nadia's worry and the record's needs are reconciled, and it is the most useful thing this chapter can give you. You chart what the team needs in order to care for the patient. You protect what the patient handed you in trust. Most of the time these do not conflict, because the two are different in kind.

A basic chaplain's note holds a few plain things, and it helps to think of them as a chain rather than a checklist, each link connected to the next. There is the reason for the visit, whether you came at a nurse's referral, on your rounds, or for a crisis. There is your spiritual assessment, which is not only a list of the patient's religious facts but also your read on where the distress lies and what the person is drawing on to cope. There is what you actually did, the intervention, named in plain professional language, whether that was listening, helping a person explore what a loss meant, or facilitating a prayer they asked for. There is the patient's response, what shifted or did not because of the visit, given in their own words or in what you observed rather than in your assumptions about their insides. And there is the plan, which may be as simple as a note that you will return tomorrow, or that the patient asked for her own priest, or that the team should know she is anxious about being discharged alone. There is no single agreed-upon format for a chaplain's note, and hospitals differ, but nearly every good one moves along that chain, connecting a need you found to what you offered and what followed from it. What matters more than the exact form is the discipline of writing at the right altitude.

By altitude I mean this. You can record that a patient is working through longstanding guilt about a family estrangement without setting down the specifics of what she did or to whom. You can note that a man is frightened about his prognosis and finding comfort in his faith without transcribing the prayer he wept through. The team needs to know the shape of a patient's spiritual condition and what would help. It does not need, and should not receive, the intimate content that person trusted to you in a moment of vulnerability. A good note is specific about the care and

discreet about the confidence. When Nadia learned to write this way, the conflict she had felt dissolved. She could serve the team and still be a safe person to talk to, because what she wrote was true, useful, and stripped of the private particulars that were never the team's to read.

A word of caution that will save you grief. Assume the patient will read what you write, because increasingly they can. A federal law often referred to as the Open Notes rule now gives patients fast electronic access to their own records, including narrative notes, so the note you once thought of as a message to the team is now, just as much, a message to the patient. Write nothing you would be ashamed to have them read over your shoulder. Anything in the record can also be seen by the family with access and by every clinician on the case, and it can be produced in a lawsuit years later. Avoid speculation about diagnoses that are not yours to make and avoid recording another person's private business that happened to come up. When you are unsure whether something belongs, the safe instinct is to leave the content out and keep the assessment general. You will rarely regret discretion.

Some of the most useful counsel here comes from chaplains who studied their own notes after their hospital moved to open notes. At Mount Sinai in New York, a team of chaplains examined the language used in spiritual care documentation and found habits that carry judgment without meaning to. Quotation marks around a single word, writing that a patient was "anxious" or "worried," can read to that patient as doubt that they were really so. Phrases like patient states or patient reports can imply that you did not quite believe them. Even a warm-sounding description can turn out to be a subtle judgment, as when good spirits or a difficult family tells the reader more about the chaplain's comfort than

about the patient. Their recommendation, and it is a good one to take early, is to describe what you saw and heard in respectful, strengths-based language, to use the person's own words where you can, and to write with the same dignity you would want if the note were about you.

Confidentiality: Trust and Its Limits

The word confidential carries its meaning inside it. It comes from the Latin *con*, meaning with or fully, and *fidere*, to trust. To confide in someone is to trust them fully, to hand over something that could be used against you and to believe it will not be. When a patient confides in you, that is what is happening, often with a stranger they met twenty minutes ago, which tells you something about how starved people are for a safe place to speak. Guarding what they give you is not a rule imposed from outside. It is the substance of the relationship.

Confidentiality is not the same as secrecy, and the difference matters at the bedside. Secrecy says a thing will go no further under any circumstance. Confidentiality says a thing will be shared only with those who need it in order to help, and only as much as they need. Around every hospital patient there is what is sometimes called a circle of care, the team of people who are treating them, and within that circle information moves so the care can be coordinated. You are part of that circle. When you tell the nurse that a patient is terrified of being alone tonight or let the physician know that a family is nowhere near ready to hear the word hospice, you are not breaking a confidence. You are doing your job inside the circle. What you do not do is carry the patient's private life outside that circle, into the cafeteria conversation or the story told to your spouse over dinner.

This means you should be careful about the promises you make. A frightened person may ask, before they say the hard thing, whether you will keep it to yourself, and it is tempting to say yes without qualification because you want them to feel safe. Resist the unqualified yes. You can say something truthful and still warm, along the lines of, "What you tell me stays between us, and I only share with the rest of your team what would help them care for you, and only if it would." That is honest, and honesty here is itself a form of respect. It also protects you from the corner you would be painted into if a patient told you something you could not, in conscience or in law, keep to yourself.

You may have heard of clergy-penitent privilege, sometimes called priest-penitent or clergy-communicant privilege, the legal protection that can shield what a person tells a member of the clergy in confidence from being demanded in a courtroom. It is a real protection, but it is not a blanket one, and a beginner should be careful about leaning on it. It is a matter of state law, and it differs a good deal from one state to the next in who counts as clergy, in what conversations are covered, and even in who holds the protection. An older idea that it reaches only formal sacramental confession no longer describes most states, which now extend it more broadly to confidential conversations with a spiritual adviser, though not everywhere, and not always to a hospital chaplain who is not the patient's own minister. It is also a different thing from HIPAA and from your institution's confidentiality policy, and it is worth remembering that once you write something into the medical record, it enters a shared and discoverable file, which can weaken any later claim that it was private. The practical wisdom that follows is the wisdom of this whole chapter. Do not promise a patient a legal secrecy you cannot

guarantee, learn your own state and your institution's policy as you go, and when a situation feels legally fraught, bring it to your educator rather than deciding it alone.

Because there are limits, and you must know them before you need them. If a patient tells you they intend to harm themselves, or to harm someone else, that is not a confidence you keep. If you learn that a child or a vulnerable adult is being abused, most of us are legally required to report it, and your program will teach you exactly how. These are the moments when protecting the person means telling someone, and a beginner who has promised total secrecy will feel trapped between the promise and the person's safety. You will not face these situations often, but you will face them, and the time to understand the limits of confidentiality is now, calmly, and not in the middle of the crisis itself. When one of these moments comes, you do not carry it alone. You bring it to your educator and your team, who have been there before.

Picture how the ordinary and the exceptional differ. A man recovering from a heart attack tells you, with great shame, about an affair years ago that he has never confessed to his wife and asks you not to tell her. You can hold that. It is his to disclose or not, it threatens no one's safety, and it has no place in his chart beyond, if anything, a general note that he is working through longstanding guilt. You keep his trust. Now change one fact. The same man tells you he has decided that his family would be better off without him and that he has been thinking about how to make that happen. That is no longer a secret to be kept. That is a life to be protected, and the same care that made you a safe person to confide in now requires you to tell the team so they can keep him safe. The trust is not betrayed by acting. It is honored by it.

HIPAA in Plain Terms

You will hear the word HIPAA constantly, usually pronounced as though it were a large gray animal, and it is worth demystifying because the fear of it often exceeds the understanding of it. HIPAA is a federal law, the Health Insurance Portability and Accountability Act, passed in 1996, and the part you will live inside is its rule protecting the privacy of health information. In plain terms, it says that a patient's health information belongs to the patient, and that those of us entrusted with it may use it to care for them but not for anything else, and must guard it from everyone who has no business seeing it.

In your day this comes down to a few habits. You do not discuss patients where others can overhear, which means not in the elevator, the cafeteria line, or the parking garage, however careful you think you are being. You do not look into the record of a patient you are not caring for, not out of curiosity about a neighbor who was admitted, not to check on a friend, not ever, because access without a care reason is exactly what the law forbids and hospitals do audit it. You keep the screen turned from passing eyes and you do not leave a chart open and unattended. As a member of the care team you are allowed to see and to write what you need to do your work, no more, a principle the law calls using the minimum necessary. That phrase is a good one to carry. See what you need to see, share what helps the patient, and leave the rest alone.

None of this should frighten you into paralysis, which is the more common beginner error than any actual violation. HIPAA does not forbid you from charting your visits, from telling the team what they need, from praying with a patient who asks, or from discussing your care with your CPE educator and peers for

supervision and learning. It asks you to treat what you learn about a person's life and health as theirs, held by you in trust and shared only for legitimate purposes of care, coordination, supervision, and learning, within approved settings. The finer points you will pick up during your first unit, inside your own hospital's system and policies. For now, the habits above will carry you through without trouble.

Boundaries, Introduced Kindly

We come to the last of the guardrails, and the one that troubles thoughtful students most, because it can sound cold set against everything else this book has asked of you. You have been urged to be present, to bring your real self, to let care cross the distance between you and a stranger. Now comes the word boundaries, and it can feel like a door closing on all of that. It is not. Boundaries are what make the closeness safe, for the patient and for you. A relationship without them does not become warmer. It becomes distorted, and usually in ways that harm the very person you meant to help.

Recall the image from early in this book, that the chaplain's instrument is the self. A physician has a stethoscope and a surgeon a scalpel, and the chaplain has only the self to offer. That is why boundaries are subtle in this work. A surgeon does not wonder how much of himself to bring to the operating table. You will wonder, in every room, how much of yourself to offer, and the answer is not none and not everything. The guiding question, when you are unsure whether to share something of your own or to do some kindness beyond the ordinary, is whose need it serves. If telling a patient about your own loss will help her feel less alone in hers, it may be care. If you are telling it because you need to be

understood, or admired, or relieved of your own feeling, it has stopped being about her. The self is offered in the patient's service, not in your own, and holding that line is much of what professional maturity in this work turns out to mean.

Two ways of going wrong will tempt you, and they pull in opposite directions. The first is over-involvement, the failure of getting too close. This is the student who gives a lonely patient her personal phone number, who comes in on her day off to sit with him, who starts bringing him things from home, who lies awake carrying a family that is not hers to carry, who begins to feel that she alone truly understands this patient and that the rest of the team does not appreciate him. It always comes from tenderness, which is why it is so hard to see in yourself. But it creates a dependence that will not survive your rotation ending, it distorts your judgment about the patient's care, and it burns through the reserves you need for everyone else on the hospital unit. The care that lasts is the care that keeps its shape.

The second failure is the opposite, the retreat behind a wall. Frightened of getting it wrong, some students become so guarded and so correct that no real person is present in the room, only a professional performing distance. We named this in the last chapter as the chaplain who disappears. The patient reaches for warmth and finds procedure. This too is a boundary problem, an over-correction, and it fails the patient as surely as over-involvement does, only less visibly. The boundary you are looking for is neither the merger nor the wall. It is a warm steadiness, close enough that the patient feels met and stable enough that they can lean without the ground giving way.

The concrete lines are easier to name than the inner discipline behind them, and your program will have its own. As a rule you do

not give patients your personal contact information, you do not continue relationships with them after discharge as though you were friends, you do not accept gifts or money, you do not enter into anything romantic with a patient or a family member, and you keep physical touch simple, brief, and welcomed rather than assumed. If you notice you are treating one patient very differently from the rest, coming in more often, thinking about them at home, feeling something you cannot quite name, that noticing is not a sign that you are unfit for this work. It is the work. Bring it to your educator and your peer group, which is exactly what that group is for. The pulls you feel toward and away from patients are among the richest material your CPE unit will give you, and the students who grow most are the ones willing to say them out loud rather than hide them.

An Exercise to Carry With You

Before we turn, in the next chapter, to the hardest encounters of all, the ones with death and grief and the families who gather around them, spend a little while inside a single ordinary note.

Imagine you have just left the room of a woman recovering from surgery. Over half an hour, she told you that she is frightened the cancer will return. She has not told her grown children how scared she is because she does not want to burden them. She finds herself praying again after years away from it and is surprised by the comfort. Near the end, she told you that she once had an abortion she has never told anyone about and wonders in the dark whether her illness is a punishment for it. She asked you to keep that last part to yourself. She thanked you for staying.

Now sit with the questions this chapter has raised. What belongs in the note you will write for the team, and what does not?

How would you record that she is in spiritual distress and drawing on a returning faith, in a way that helps the next chaplain and the nurse without exposing what she trusted to you alone? What did you promise her, and can you keep it? Is there anything here that crosses from a confidence you hold into a concern you must share, and how would you tell the difference? And what in this visit belongs not in the chart at all but in your own reflection, in your verbatim or your journal or your next conversation with your educator, because it stirred something in you worth understanding?

You will not have tidy answers, and you are not meant to. The point of sitting with it now is that when the real version arrives, and it will, you will already have begun to think like a chaplain about the notes you keep, the trust you guard, and the lines that let you stay close without losing yourself. That thinking is not separate from presence. It is what allows presence to be safe, and lasting, and worthy of the confidence a frightened stranger places in you when they decide, for reasons they could not explain, that you are someone they can tell.

PART FOUR

Hard Realities and Getting Ready

CHAPTER 11

Death, Grief, and Being Present in Hard Moments

The Fear Beneath the Others

When students tell me what worries them about beginning, they rarely name the charting or the medical vocabulary or the evaluation. Those concerns are real, but they sit near the surface. Underneath them is the one most people are slower to say aloud, and it usually comes out as a question. What will I do when I am standing beside someone who is dying, and I have nothing to say?

You are right that there are no words that make dying all right. No sentence you memorize now will fix the moment you are dreading, and the family gathered around that bed is not waiting for you to produce one. That absence is not the problem you take it to be. It is where the work actually begins. The thing you are afraid you lack, the perfect thing to say, was never the thing that helps.

Death and grief will not be the whole of your first unit. Most of your visits will be with people who are frightened but recovering, lonely but in no danger, sorting through a diagnosis they will live with for years. But you will meet death, and you will meet it sooner than you expect, and the encounters will stay with you longer than the others. It is worth preparing for them now, calmly, while nothing is at stake, so that the first time is not also the first time you have thought about any of it.

Dying in the Modern Hospital

The death most of us carry in our imagination is a quiet one. A person lies in a bed at home, surrounded by family, says something meaningful, and slips away. That death still happens, and it is a mercy when it does. But it is not the death you will most often meet in a hospital, and it helps to know that before you walk in.

Dying in a modern hospital is frequently slow, technological, and uncertain. It happens in intensive care units attached to monitors and ventilators, or on ordinary hospital units over days that stretch longer than anyone expected. Very often it arrives not as a single moment but as a series of decisions, each one harder than the last, about whether to keep pushing against an illness that will not be pushed back. A family that imagined they would know the end when they saw it finds instead that they are being asked to choose it, to say when enough treatment has become too much, and to live afterward with having chosen. This is one of the deepest sources of suffering you will encounter, and it is not medical suffering. It is moral and spiritual, and it is often exactly where a chaplain belongs.

What this means for your work is that most of your time with the dying will not be spent at the last breath. It will be spent in the long uncertain stretch before it, with people who are exhausted, frightened, and grieving someone who is still alive. You will sit with a wife who has not left her husband's room in four days. You will stand at the edge of a family meeting where the physician is explaining, as kindly as she can, that there is nothing left that will help. You will meet death that comes without warning, in a trauma bay or a code called overhead, and death that everyone has seen coming for weeks. The settings and the pace vary, but the human center of it does not. Someone is losing someone, and you have

been given the strange privilege of being near them while it happens.

Being Present Without a Script

One realization frees most students, once they let it in. There is no script. If there were a set of correct words for the dying and the grieving, someone would have written them down long ago and handed them to you on your first day, and this chapter would be one page. The reason no one has is that the words are not what carry the care. What people remember, years later, is almost never a sentence the chaplain said. It is that someone stayed.

This runs against a strong instinct, especially in a beginner. When we are near great pain and feel helpless, we reach for words to fill the space, because the silence feels unbearable and saying something feels like doing something. Much of what we reach for, though, is not for the grieving person at all. It is for our own discomfort. The phrases that come most easily are the ones to be most careful of. He is in a better place. Everything happens for a reason. God needed another angel. She lived a good long life. At least she is not suffering anymore. I know exactly how you feel. Each of these is an attempt to make a loss smaller or more bearable or more explained. And each one, however kindly meant, tends to leave the grieving person more alone, because underneath it asks them to feel better than they do. Grief does not want to be solved. It wants to be witnessed.

There are two ways this goes wrong, and they pull in opposite directions. The first is talking too much, flooding the room with comfort and explanation because you cannot tolerate the silence. The second is fleeing, keeping the visit short and busy, hiding behind a task or a form, coming back later when things have

settled, because being near this much sorrow is frightening and part of you wants out. Most beginners lean toward one or the other, and it is worth knowing which is yours. What the moment actually asks is neither. It asks you to stay, and to be quiet enough that the other person can hear themselves, and to let them know by your attention rather than your words that they are, in this worst hour, seen and heard and loved rather than judged or managed or fixed.

I think of a student I will call Thomas, in his first weeks, sent to sit with the family of an elderly woman named Eleanor who was dying and no longer conscious. He was terrified. He kept waiting for the moment when he would be expected to say the right thing, and he had no idea what it would be. So, he did the only thing he could think of, which was to pull a chair into the corner of the room and stay. He stayed for most of the night. He fetched water. He found an extra blanket for a daughter who was cold. Once, when the woman's breathing changed and the room went tight with fear, he moved closer and put his hand near the family's, and someone took it. He said almost nothing the entire night. When Eleanor died near morning, her son embraced him and thanked him as though he had given the family a great gift. Thomas came to our group the next day confused, because as far as he could tell he had done nothing at all. What he had done was stay. He had let a family not be alone with the hardest hours of their lives. In this work that is not nothing. It is most of what you have to offer.

What If I Cry?

Students ask me this often, and under the question is a worry about professionalism. They imagine that a chaplain is supposed to be a steady presence, and they are afraid that if they are moved

to tears at a bedside they will have failed, made it about themselves, added their own need to a room that had no room for it.

That fear is real, but I want to reassure that being affected by another person's suffering is not a failure of professionalism. It is often a sign that the suffering reached you, that you were present enough to be touched by it. Families almost never experience a chaplain's tears as weakness. More often they experience them as company. To see that someone else finds this sad too can be a relief to a person who has been holding the whole weight alone. I have wept at bedsides, and I stopped apologizing for it a long time ago.

What matters is not whether you feel, but where that feeling goes. There is a difference between being moved and coming apart. If your grief takes over the room, if the family finds themselves comforting you, then the visit has turned toward your needs and away from theirs. That is the line to watch. You can be affected without collapsing. You can let your eyes fill and your voice catch and still keep your attention on the person in the bed and the people around it. What you are offering is a real human being who is touched by what is happening, not a professional performing composure and not a mourner competing for the family's care. Somewhere between those two is the presence that helps.

There is an old idea in pastoral care, one you may hear named in your program, that our own wounds can become part of what lets us care for others. It is true, but it comes with a condition worth remembering. A wound helps only when it has been acknowledged and tended, not when it is displayed raw. Your own losses will make you more able to sit with the losses of others, but only if you have done some work with them, which is part of why

CPE asks you to look inward. What you absorb at these bedsides has to go somewhere, and if it has nowhere to go it will find a way out that serves no one. This is what the reflection and the self-care we spoke of earlier are for. They are not extras. They are how you stay able to keep walking into these rooms.

Grief Does Not Move in a Straight Line

Nearly everyone has heard of the five stages of grief, usually given as denial, anger, bargaining, depression, and acceptance. The idea has become so common that grieving people sometimes measure themselves against it, wondering why they are stuck in anger, or whether they have reached acceptance yet, as though grief were a staircase and health meant climbing to the top. It is worth knowing where the idea came from, because it has been widely misunderstood. The psychiatrist Elisabeth Kübler-Ross first described the stages from her work with dying patients, as an account of what those patients themselves seemed to move through as they faced their own deaths. They were later borrowed and applied to the bereaved, and Kübler-Ross herself came to regret how they were turned into a rigid sequence that everyone was supposed to pass through in order. They were never meant as a ladder.

The word grief descends from a Latin root, *gravis*, meaning heavy, and weight turns out to be a better guide to it than stages are. Grief, in the people you will actually meet, does not move in a straight line. It comes in waves, recedes, and returns without warning, sometimes years later, triggered by a song or a smell or an empty chair at a table. One person rages and another goes numb and another keeps busy and another cannot get out of bed, and none of them is doing it wrong. Grief is shaped by the

particular relationship that was lost, by culture, by faith, by whether the death was sudden or long foreseen, by everything that came before it. Some of the grief you encounter will not even be about a death yet. Families grieve while their person is still alive, mourning in advance a loss they can see coming, and this anticipatory grief is real grief and deserves the same care. Some grief goes unrecognized by everyone around it, the sorrow over a pregnancy that did not continue, over a long estrangement, over the self a patient has lost to illness. Part of your work is to recognize the grief that others have not thought to honor.

For you as a beginner, the practical wisdom is simple to state and harder to practice. Do not arrive with a map of where a grieving person ought to be. Do not try to move them along it. Meet the person in front of you where they are today, which may not be where they were yesterday or where they will be tomorrow, and let that be all right. Your steadiness matters more than your theory. The most useful thing you can offer a person in grief is not an explanation of their grief but a willingness to stay near it without needing it to hurry.

The Family Gathered

Some of the most demanding hours of your work will not be alone with a patient but in a room full of family, and often in what the hospital calls a family meeting. A family meeting is a conversation, usually called when decisions have become hard, in which the medical team and the family sit down together to talk about what is happening and what should happen next. The physician may be there, and a nurse, and a social worker, sometimes a palliative care team, and often a chaplain. The subject is usually some version of the hardest question a family ever faces, whether to keep treating

aggressively or to shift the goal toward comfort, whether their person would have wanted this, whether it is time to let go.

Your role in that room is easy to misunderstand, so let me be clear about what it is not. You are not there to explain the medicine, which is not yours to explain. You are not there to make the decision, which is not yours to make and never will be. You are there to attend to everything happening in the room that is not medical, the fear, the love, the old wounds and the guilt that surfaces when a family is asked to face a death together. Families in these moments are rarely of one mind. One child wants everything done and another wants the suffering to stop, and underneath the argument about ventilators and feeding tubes is usually something older and more tender, a lifetime of relationships arriving all at once at the worst possible time. You are the person in the room paying attention to that.

Practically, this often means watching for the person no one else is watching. The daughter who has gone silent. The son who flew in last night, was not there for any of it, and is angry in a way that is really grief. The spouse who keeps agreeing with the doctor while their eyes say something else. Sometimes your contribution is to name, in a few plain words, the feeling running under the conflict. Something like, it sounds as though everyone here loves him and is frightened of getting this wrong. A sentence like that can loosen a room, because it tells a divided family that their disagreement is not a failure of love but an excess of it. Sometimes your contribution is to ask for a pause, or to suggest a moment of prayer if this is a family that prays, offered because it fits these people and not as a routine you bring to every room. And sometimes, often, your contribution is simply to be a steady presence who is not on anyone's side except the family's as a

whole, so that the room feels a little less like a negotiation and a little more like people trying to love someone well. You will not resolve the medical question. That is not your job. But you may help a family stop fighting long enough to grieve together, and that is a worthy contribution.

After

The work does not end when the patient dies. Some of your most important moments will come in the minutes and hours after a death, when the monitors have been switched off and the room has gone still and the family does not know what to do with their hands. There is much a chaplain can offer here, most of it small. Being present with the body and the family, unhurried, in a culture that will want to move quickly. Honoring whatever ritual matters to these people, a prayer, a reading, a washing, a silence, and asking rather than assuming what that is. Offering a blessing if they want one. Finding a chair for the person whose legs have gone weak, or a cup of water, or a quiet room, or the phone number they cannot remember. You are, in that hour, one of the few people whose entire job is simply to help them bear it.

And then you will walk out of that room and back into a hospital that is still running, and you will carry something out with you. You are meant to. The idea that a chaplain should be able to move from a death to the next room untouched is neither true nor healthy. What you carry has to be set down somewhere, in your reflection, your journal, your verbatim, your conversation with your educator, the practices of self-care that keep this work sustainable. Tending what these encounters stir in you is not self-indulgence. It is part of how you remain able to offer the next family the same presence you offered this one.

Before We Turn to the First Day

You will not feel ready for any of this, and I would be wary of you if you did, because no one is ready the first time and the ones who think they are usually have the least idea of what they are walking into. The good news, and it is real news, is that being ready was never the requirement. The requirement is a willingness to stay, to be quiet, to be moved, and to keep your attention on the person in front of you rather than on your own need to help. Those you already have, or you would not be reading a book like this one.

If you want something to sit with before your first unit begins, try this. Recall a time when you were in real pain, and someone stayed with you. Not someone who fixed it, because it probably could not be fixed, but someone who was simply there. Remember what they did and what they did not do, how their presence felt different from the absence of everyone who did not know what to say and so stayed away. That memory is closer to your future competence as a chaplain than anything you could study. You already know, from the inside, what it is you will be offering. You have received it.

We turn now from the day you are most afraid of to the day you are most curious about, the first one, and to what will actually happen when you finally walk in.

CHAPTER 12

Your First Day

The Day You Have Been Waiting For

For weeks now the first day of CPE has been a fixed point somewhere ahead of you, and now it has a date on the calendar, and the date is close. You have probably run through it in your mind more than once, part eager and part afraid, the way we all rehearse the things that matter to us. You have pictured yourself walking in and not knowing where to go. You have imagined being asked a question you cannot answer, or standing in a room of strangers who all seem better prepared than you are. This chapter walks through that day roughly as it tends to go, so that the version you have been rehearsing can give way to something closer to the truth. The truth is almost always less frightening than the rehearsal.

I remember my own first day, and it did not begin the way I had hoped. I was in my mid-twenties, a middler in an MDiv program at a Pentecostal seminary in Tennessee, and I had applied to a summer of CPE unit partly because I wanted to spend it somewhere interesting. I applied to programs in places I had never lived, including one in Colorado, imagining mountains and a change of scenery. Every one of them turned me down. I ended up in an extended CPE unit at the local hospital, a short drive from where I already lived. On the morning of the first day I felt that the adventure I had pictured had shrunk to something ordinary and a little disappointing. I had no way of knowing that this ordinary local hospital was where my life would change. I walked in

nervous, underprepared in my own estimation, and stepped into my first ecumenical group without any idea of what was about to happen to me. Most of what I feared that morning never came to pass, and most of what mattered, I could not have anticipated.

Getting There

Some of what weighs on you the night before is not spiritual at all. It is logistical, and logistics have a way of looming large in the dark and shrinking to nothing by nine in the morning.

Dress the way you would to meet a patient's family for the first time, which for most of us means a step more formal than we expect and shoes we can walk in for hours, because you will walk. The back of this book has a short list of practical questions students always ask, including what to wear and what to bring, so you do not have to carry those worries into this chapter. Arrive earlier than you think you need to. Expect to get a little lost, because hospitals are built like small cities and you have not learned this one yet. There will be a security desk, a badge with a photograph you will not love, a parking situation you will curse for the first week and forget about by the second. Someone will be expecting you. Part of an educator's job on the first morning is to watch for the new students who are standing in a lobby looking uncertain. If you are that person in the lobby, you are exactly where you are supposed to be.

You may not sleep well the night before, and if you lie awake running through everything that could go wrong, you are in good company. Nearly all of us did. Try not to treat the poor sleep as a bad omen or as proof that you are not ready. It is what a person's body does before something that matters, and it will not follow you through the day the way you fear it might. Adrenaline and the

sheer novelty of the morning tend to carry you further than a good night's rest would have. Get what sleep you can, forgive yourself for the rest, and trust that you will be more awake than you expect once you are actually there.

Orientation, and What the Word Means

In many programs the first day, and sometimes the first several days, are given over to orientation. That word is worth pausing on. To orient yourself, in its oldest sense, is to find east, to turn toward the sunrise and get your bearings from it. That is the task of the first day. You are not there yet to do the work. You are there to learn where you are.

So, the first day is often less dramatic than you have imagined. There is paperwork, and there are badges and computer logins and the passwords you will forget. There is training on fire safety and hand hygiene and how the medical record system works, none of which feels like ministry and all of which you will be glad to know. There is a tour of a building you will still get lost in for a week afterward regardless of how carefully you follow along. In most programs you will not visit a patient on the first day, and if that disappoints the part of you that came ready to begin, let it also relieve the larger part of you that was afraid. The plunge is coming, but not in the first hour. Programs do vary, and a few will send you onto a hospital unit sooner than this, even to walk alongside a chaplain on the first afternoon, so hold my description loosely and let your own program teach you its rhythm.

The Group

At some point on that first day you will meet the people who will matter most to your learning, which is not the patients and not even, at first, your educator. It is the small group of students who are starting alongside you.

They will be a mix. CPE groups tend to gather people from across traditions, generations, and paths into this work. Part of what unsettles a new student is how little the person in the next chair resembles them. Someone will be fresh out of seminary, and someone will be starting a second career at fifty. Someone will carry a faith very sure of itself, and someone will be holding theirs together with both hands. You will look around the circle and do the thing we all do, which is to measure your insides against everyone else's outsides and conclude that you are the least prepared person present. Nearly everyone in that room is making the same calculation and reaching the same conclusion. The impostor feeling we talked about earlier arrives right on schedule on the first day, and its arrival is not evidence about you. It is evidence that you understand the seriousness of what you have begun.

Early on, often on that first day, the group will talk about how it intends to be together. You may write or agree to a covenant, a set of promises about confidentiality, honesty, and respect that will govern your time as a group. Take it seriously, because this group is not an audience for your learning. It is an instrument of it. The strangers in that circle will become, over the weeks ahead, some of the few people who know exactly what your days are like, and the willingness to be honest with them is much of what CPE will ask of you. You do not have to feel close to them on the first day. You only have to be willing to begin.

You will also meet your educator, the person who will guide you through your time here. New students often arrive braced for someone who will test them, waiting to catch the wrong answer. I understand where the fear comes from, because we have all sat in classrooms run that way. That is not what a CPE educator is for. The educator's work is to make and hold a space safe enough that you can look honestly at your own practice without needing to defend yourself, which is difficult work and not the same as being easy on you. You may not take the measure of your educator on the first day, and you are not meant to. Trust of that kind is built slowly, out of many hours, and it is enough on the first day to notice that you have been welcomed rather than examined.

Your Assignment, and the Shape of the Weeks

Somewhere in the first day or two you will be given your assignment, the part of the hospital that will become yours. It might be a medical or surgical hospital unit, a floor with a particular kind of patient, a service you will follow. Hearing which one is yours can bring a small jolt of fear, because now the abstract idea of visiting patients has an address. That fear is ordinary. You are not expected to know what to do with the assignment yet. You are only being shown where you will learn.

You will also see, probably for the first time, the actual shape of your weeks. There are the clinical hours you spend on the hospital units, the reason you came. There are the seminars, including the verbatim seminar where you and your peers will look together at written accounts of your visits. There are didactic sessions where you will be taught. There is individual time with your educator. Seeing it laid out can feel like much at once, and it is more than you can absorb on the first day, so do not try. The

schedule will become second nature faster than you expect, and within a week or two you will move through it without thinking, the way you eventually stop reading street signs in a neighborhood you have come to know.

You may also learn what your first piece of written work will be, and it often surprises people. New students tend to expect an assignment about theology, the hospital, or some skill they are meant to master. Instead, many programs ask you first to write something about yourself, a set of learning goals, a short account of your own story and what brought you here, a reflection on who you are as you begin. If that seems like a strange place to start, remember what we said early in this book about the chaplain's instrument being the self. Your program is not being self-absorbed by asking you to look inward first. It is beginning with the tool you will use in every room, which is you, and asking you to get acquainted with it.

Many programs also include being on call, which for a new student is often the item on the page that raises the most fear, the picture of being alone in a large hospital at night when something terrible happens. Notice how the fear runs ahead of the facts. You will not be sent to your first overnight cold and unprepared on day one. Programs orient you first, and there is backup, a person you can reach, an educator or a more experienced chaplain, so that you are never truly carrying it alone. The first call comes later, after you have found your feet, and we will not borrow that particular worry today.

If your program does send you onto a hospital unit on that first day, even to shadow, remember that you are not being asked to perform everything this book has described all at once. The knock at the door, the introduction that answers who you are and

why you have come, the choosing of a chair, the listening that is most of the work: these are waiting for you, and you will grow into them one visit at a time. On the first day it is enough to watch, to follow someone who has done it before, and to notice what you notice.

Driving Home

You will go home from the first day, a day in which you may not have visited a single patient, a day of paperwork and introductions and tours, and you will be exhausted, and almost no one will have warned you. It will not make sense to you. You did nothing, you will think, and yet you feel as though you ran a race.

There is a reason for it and knowing it will keep you from mistaking the tiredness for failure. You spent the whole day taking in more newness than a person can comfortably hold. New faces, a new building, a new vocabulary, a new set of expectations, and underneath all of it the low, steady strain of a self that is beginning to be rearranged. That work is real even when nothing visible has happened. Some students go home elated, some numb, some closer to tears than the day seemed to warrant, and more than a few feel all three within the same hour. Whatever you feel, it belongs. The tiredness is not a sign that you were not up to the day. It is a sign that you were present for it.

Be kind to yourself that first evening. Eat something. Tell someone who loves you that you started, even if you cannot yet explain what you started. Do not sit down and try to make meaning of it all before you sleep. The meaning comes later, in the reflection that this training is built to give you. It does not have to be forced out of a single tired day.

A Word for Your First Day

What you bring on the first day is smaller than you wish and more than enough. You bring your willingness to be a beginner, your curiosity about the people you are about to meet, and your honesty about what you do not yet know. You do not need more than that to walk in. Everything else is what the CPE unit is for.

So, when the morning comes, go. Let yourself be nervous and go anyway. Let the day be ordinary, disappointing, and holy, sometimes in the same hour, the way mine was. Learn where east is. Meet the strangers who will become your group. Find the floor that will become yours. And go home tired, and let that tiredness be the first small proof that you have begun something that will change you, in its own time.

A Word for the Road

We began this book with you at the threshold, a little frightened and a little eager, waiting for a first day that had not yet come. This last word comes from the far side of that journey, from the end of a CPE unit rather than its beginning.

In *A Still Small Voice*, the documentary that followed a year of our CPE residency, there is a scene at the residents' graduation. I am speaking to them, and I tell them it is a bittersweet week, bitter because I grieve a little to see them go, and sweet because they have done something so hard. Then I say the thing I most want to leave with you. It takes a lot to stay open-hearted in this work, to keep going back into the rooms again and again, and to build, slowly, the muscles and the capacity to do it. That capacity is not something you arrive with. It is something the work grows in you, one visit, one reflection, and one honest conversation at a time.

You are at the beginning of that, not the end. You do not need to have the capacity yet. You only need to be willing to begin building it, and to be kind to yourself while it grows. The tears and the laughter both belong. The tiredness belongs. The doubt belongs. All of it is the ordinary experience of a person becoming a chaplain.

So, go. Knock on the first door. Introduce yourself. Stay a little longer than you think you should. And trust that the capacity you do not yet have is already, in the willingness that brought you here, beginning to form.

Questions New Students Ask

Certain questions come up repeatedly, usually the practical ones the chapters did not stop to answer. Here are short answers to the questions students bring me most. Where the fuller answer lives in a chapter, I point you there.

Before the First Day

What should I wear?

Dress professionally and comfortably, and check whether your program has a dress code. You will be on your feet and walking long hallways, so wear shoes you can stand in for hours. Beyond that, aim for neat and unremarkable. You want the patient thinking about the visit, not your clothes. If you wear religious dress, ask your program how it prefers you to handle it, since practices vary.

What should I bring?

Less than you think. A small notebook, a pen, comfortable shoes, water, and something to eat. Your program will give you what you need for the logistics. The most important thing you bring is not an object. It is a willingness to show up and pay attention.

Do I need to study medical terminology before I start?

No, and I would steer you away from cramming it. You will absorb the words you need by being on the floors, and the directory in the back names the units, roles, and abbreviations you will hear about most, if you are curious. Your work is presence, not medicine. Arriving worn out from memorizing abbreviations would cost you more than the abbreviations are worth.

Should I read a lot to prepare?

This book is meant to be enough. If you want more, the resource list in the back offers a few good places to begin, but do not feel you must arrive well-read. Rest may serve you better than reading. You will learn far more in your first week of visits than in any book, this one included.

Do I have to be ordained, or religious, to do CPE?

Requirements vary by program, so confirm yours, but in general you do not need to be ordained to take a unit of CPE, and you do not need to belong to any particular faith. CPE is interfaith, and people of many traditions and of none do it well. What it asks of you is not a credential but a willingness to learn.

How long is a unit, and can I do it part-time?

A full unit is four hundred hours. The intensive version runs full-time over about ten to twelve weeks, often in a summer. The extended version spreads the same hours across a longer stretch, often a semester or an academic year, a day or two a week, which suits people who are working or studying. Chapter 4 describes both.

Is CPE paid?

It depends on the program and the level. A first unit is often unpaid, and some programs charge tuition. Yearlong residencies usually offer a salary and benefits. Ask your program directly, since this varies widely.

On the Units

How should I address the doctors and other staff?

Follow the culture of your unit, which you will pick up quickly. In many hospitals colleagues use first names, but not all, so watch and match. When in doubt, introduce yourself simply as one of the chaplain students and ask people how they would like to be addressed. Most will tell you.

What do I call myself to patients?

Be honest that you are learning. Chaplain is fine, and so is student chaplain or chaplain intern, depending on your program's language. You do not need to hide that you are a student. Chapter 8 walks through how to introduce yourself at the door.

How many patients will I see in a day?

It varies widely, and the number is not the point. Some days you will have many short visits, some days a few long ones. A single unhurried visit that mattered is worth more than a dozen you rushed through to raise your count.

Can I use my phone? What about patients and social media?

Keep your phone put away during visits, both out of respect and because presence and a screen do not mix. And never post about patients or write anything online that could identify them. What you learn in a hospital room is confidential. Chapter 10 covers this in full.

The Human Moments

What if a patient asks me something I cannot answer?

Then you say you do not know, which is both true and often exactly what the moment needs. You are not there to have the answers. You are there to be with the person while they sit with a question

that may have no answer. Chapters 2 and 5 return to this more than once, because it is the fear underneath so many others.

What if I cry in front of a patient, or in my group?

You may, and it is usually fine. Tears are not a failure of professionalism. They are often a sign that you were moved, that you were really present. Chapter 6 takes up the whole emotional weather of the early weeks, including this.

Do I need to memorize prayers or scripture?

No. When prayer fits a visit, and it does not fit every visit, you can pray in your own words, or ask the person what they would like, or simply be quiet with them. Prayer is something you offer when it seems to help the person in front of you, not a routine you perform in every room. Chapters 8 and 9 say more.

What if a patient dies while I am there, or I am called to a death?

You will not be sent into that unprepared, and you do not have to know exactly what to do. Being present, even without words, is most of the work. Chapter 11 is given over to death, grief, and how to be with people in those hours.

What if something in my own life surfaces during the unit?

It happens often, because this work sits close to grief and fear and can stir up our own. Tell your educator and seek support outside the program if you need it, from a counselor or a trusted person. That is not a sign you are failing. Chapters 5 and 6 explain why it is so common and what to do with it.

Learning and Evaluation

Can I fail?

CPE is not graded like a course. You receive credit or you do not, and not receiving credit is uncommon and never a surprise sprung at the end. Chapter 4 explains how evaluation actually works, and why it is meant to grow you rather than rank you.

What do educators want from me? How do I make a good impression?

Curiosity, honesty, and a willingness to be seen, far more than polish. The students who worry me are the ones who arrive certain they have it all figured out. You do not need to be good yet. You need to be willing to learn, and to let your educator and peers see your real work rather than a tidied version of it.

What if I do not get along with someone in my group?

That is ordinary, and it is not something to hide. The friction that comes up among people working this closely is part of the material you will learn from together. Chapters 4 and 5 describe why the group works the way it does.

A Glossary of CPE and Chaplaincy Terms

The words below are the ones this book and CPE itself use most. You do not need to memorize them. Skim the list now if you like and return to it whenever a term in the book or on the floors is unfamiliar. The definitions are kept plain and brief, in the sense the words carry in chaplaincy, which is not always their sense elsewhere.

ACPE (Association for Clinical Pastoral Education). The organization that accredits most CPE programs in the United States and certifies the educators who lead them. When a program is described as ACPE-accredited, it meets that body's standards. Other accrediting bodies exist, but ACPE is the largest.

Action and reflection. The rhythm at the heart of the clinical method of learning. You do the work of ministry (action), step back and examine it (reflection), and return to the work changed by what you noticed (new or revised action). See Chapter 3.

Affiliative faith, searching faith, owned faith. Terms from the educator John Westerhoff for three of the four styles of faith he describes, following the experienced faith of early childhood: the inherited faith of one's family and community (affiliative), the often unsettling period of questioning it (searching), and the faith one finally claims as one's own (owned). Used in Chapters 3 and 5.

Board certified chaplain (BCC). A chaplain who has met the professional standards of a certifying body, usually including graduate theological education, several units of CPE, and a

formal review. Board certification is a later milestone, not something required to begin CPE.

Census. The list of patients on a given floor or unit. Checking the census is how you see who is in your care on a given day.

Chaplain. A professional who provides spiritual care to people of any faith or none, usually outside a single congregation, in settings such as hospitals, hospices, prisons, the military, and workplaces. See Chapter 2, including where the word comes from.

Clinical method of learning. CPE's core approach to education: learning the care of persons by doing it with real people and reflecting on the experience, rather than by studying it in a classroom. Often described as action and reflection. See Chapter 3.

Clinical Pastoral Education (CPE). Supervised, experiential training in spiritual care, in which students provide care to real people and reflect on it with an educator and a peer group. The subject of this whole book.

Countertransference. A term borrowed from psychotherapy for the reactions a caregiver has that come from their own history rather than from the person in front of them. Knowing your own is part of self-awareness. See Chapter 5.

Cultural humility. A posture of lifelong self-examination and openness toward people whose culture or beliefs differ from your own, as distinct from claiming competence or mastery over another's culture. See Chapter 9.

Didactic. A teaching session or seminar on a particular topic, such as grief, spiritual assessment, or family systems. One of the educational components of a CPE unit.

Educator (CPE educator). The person who leads a CPE program and guides students' learning. In older and still common usage this person is called a supervisor. This book prefers educator, because the work is teaching more than oversight. See Chapter 4.

Embedded theology and deliberative theology. Embedded theology is the set of beliefs we absorb before we examine them, the faith we grew up inside. Deliberative theology is what we arrive at after reflecting on those beliefs. CPE tends to move a person from the first toward the second.

Formative and summative evaluation. A summative evaluation is a final judgment, like a grade. A formative evaluation is ongoing and aimed at growth, asking what you are learning and where to go next. Almost all evaluation in CPE is formative. See Chapter 4.

Interfaith (or multifaith). Involving people of many religious traditions, and of none. CPE peer groups and the patients you serve are typically interfaith.

Interpersonal relations (IPR). A kind of group session in which the peer group turns its attention to what is happening among its members in the room, in the moment, as a way of learning about oneself in relationship. See Chapters 4 and 5.

Learning goals. The aims a student names near the start of a unit, describing what they hope to grow in. Your own goals,

written by you, become part of how your learning is guided and evaluated. See Chapter 4.

Living human document. Anton Boisen's phrase for a suffering person understood as a text worth reading as carefully as any book. It captures CPE's conviction that we learn ministry by attending closely to people. See Chapter 3.

Non-anxious presence. The capacity to remain steady and present with someone in distress without being pulled into their anxiety or rushing to fix it. The phrase comes from the family-systems writing of Edwin Friedman. See Chapter 2.

Pastoral care and spiritual care. Care directed at a person's spirit, their meaning, hope, grief, and relationship to what they hold sacred. Increasingly the field prefers spiritual care as the more inclusive term. See Chapter 2.

Peer group. The small circle of fellow students who move through a unit together under an educator, functioning as seminar, case-reflection group, and mirror. See Chapter 4.

Person of the practitioner. A phrase naming the truth that in this work you cannot separate what you do from who you are. CPE studies the person of the practitioner as seriously as it studies skills. See Chapter 5.

Presence (the ministry of presence). The chaplain's core offering: being fully with a person rather than acting upon them. Not passive, and not the whole of the work, but where the work begins. See Chapters 2 and 8.

Residency. A yearlong, usually paid CPE program, often several units, typically undertaken after a first unit. See Chapter 3.

Rounds. Going from room to room to see the patients in your care. You will also hear medical teams speak of rounding, making their own circuit of patients.

Self-evaluation. An honest written account, which you compose, of how your learning has gone against your goals and the program's learning objectives, and what you have come to see about yourself. It is meant to be in conversation with your educator's evaluation. See Chapter 4.

Spiritual assessment. The chaplain's disciplined attention to what a person's situation means to them, what they draw on, and where they are in spiritual distress, held lightly through a few questions rather than a fixed script. See Chapter 8.

Spiritual distress. The pain that arises when a person's sense of meaning, hope, or connection to what they hold sacred is shaken. Attending to it is much of the chaplain's work. See Chapters 2 and 8.

Unit (of CPE). One complete block of the training, four hundred hours, done either intensively (full-time over about ten to twelve weeks) or extended (part-time over a longer stretch). See Chapters 3 and 4.

Verbatim. A written, reconstructed account of a single spiritual care visit, laid out almost like a script and examined with your peers and educator. From the Latin for word for word. See Chapter 4.

A Directory of Hospital Units and Roles

A hospital has its own geography and its own cast of characters, and both can feel bewildering at first. What follows is a map to consult when you are curious, not something to memorize. You will learn most of it simply by being there. Chapter 7 walks through this world in prose; this directory is for looking things up. One caution: abbreviations and unit names vary from one hospital to the next, so treat these as the common versions rather than universal law, and when a set of initials baffles you, it is always helpful to ask.

Common Hospital Units

Emergency Department (ED), or Emergency Room (ER). Where patients arrive in crisis, acutely ill or injured. Fast-paced and unpredictable, and often a place of sudden loss and shock.

Intensive Care Unit (ICU). For the most critically ill patients, who need close monitoring and often life support. You will see several kinds: the medical ICU (MICU), surgical ICU (SICU), cardiac or coronary care unit (CCU), neurological ICU (Neuro ICU), and, for the youngest, the neonatal ICU (NICU) and pediatric ICU (PICU).

Step-down unit (also intermediate care or telemetry). A level of care between the ICU and a general floor, for patients who still need close monitoring but not full intensive care.

Medical-surgical unit (med-surg). The general inpatient floors, for patients who are ill or recovering from surgery but not critically so. Much of a chaplain's daily rounding happens here.

Oncology. Cancer care, on inpatient floors and in outpatient infusion centers.

Cardiac care (cardiology). Care of the heart, which may include a coronary care unit and a cardiac step-down floor.

Labor and Delivery (L&D) and Postpartum. Where babies are born and families recover afterward. Usually a place of joy, and sometimes, hard as it is, a place of loss.

Neonatal Intensive Care Unit (NICU). For critically ill or premature newborns. Long stays and high stakes make chaplains frequent visitors.

Pediatrics (peds). The care of children, with its own particular weight for everyone who works there.

Behavioral health (psychiatry). Inpatient mental health care. Programs differ in how chaplains work on these units, so follow your program's guidance.

Rehabilitation (rehab). Where people rebuild function after a stroke, an injury, or a major surgery. Progress is slow and the emotional work is real.

Operating Room (OR) and Post-Anesthesia Care Unit (PACU). Surgery itself and the immediate recovery afterward, where patients wake and families wait.

Palliative care and hospice. Palliative care attends to comfort, meaning, and quality of life alongside other treatment,

at any stage of a serious illness. Hospice care is for people understood to be near the end of life. Chaplains are commonly part of both teams. See Chapter 11.

Who's Who: The People on the Team

Attending physician. The senior doctor with ultimate responsibility for a patient's care. In a teaching hospital, the attending oversees a team of doctors in training.

Fellow, resident, and intern. Physicians in training, in descending order of experience. A fellow is pursuing further specialty training after residency; a resident is a doctor still in supervised training; an intern is in the first year of residency. In teaching hospitals these clinicians do much of the daily care under the attending.

Hospitalist. A physician who specializes in caring for patients while they are in the hospital, rather than in an office practice.

Nurse (RN, registered nurse). The professional most constantly at the bedside, administering treatments, watching for changes, and coordinating much of a patient's daily care. The charge nurse leads the nurses on a unit for a shift. The nurse manager oversees the unit's nursing staff and operations across shifts. Nurses are often a chaplain's closest partners in noticing who needs a visit.

Nurse practitioner (NP) and Physician assistant (PA). Clinicians who assess, diagnose, treat, and usually prescribe, working alongside physicians and, in many settings, carrying much of the direct care.

Certified nursing assistant (CNA) or patient care technician (PCT). Provides hands-on daily care, such as bathing, moving, and taking vital signs, under the direction of nurses.

Social worker. Arranges discharge plans, connects families to community resources, and navigates finances and safety. A chaplain's frequent ally, tending the patient's situation while the chaplain tends the spirit. See Chapter 2.

Case manager. Coordinates a patient's overall care and their transition out of the hospital, work that often overlaps with social work.

Psychiatrist and psychologist. A psychiatrist is a physician who can prescribe medication for mental health conditions; a psychologist provides assessment and therapy. Both differ from the chaplain, who tends spiritual rather than psychological distress. See Chapter 2.

Physical therapist (PT), occupational therapist (OT), speech-language pathologist (SLP), and respiratory therapist (RT). The therapies that help restore, in turn, movement and strength, the ability to manage daily tasks, speech and swallowing, and breathing.

Dietitian and pharmacist. The dietitian manages a patient's nutrition; the pharmacist manages medications and their safe use. Both are consulted more often than a newcomer expects.

Palliative care team. An interdisciplinary team, frequently including a physician, nurse, social worker, and chaplain,

focused on comfort and on clarifying goals of care in serious illness.

Chaplain (spiritual care). You, and your colleagues. The member of the team whose work is the patient's spirit, meaning, and hope, and who belongs in the interdisciplinary conversation alongside everyone above.

Unit clerk or health unit coordinator. Runs the desk on a unit, managing orders, records, and communication. A good relationship here makes your days easier.

Interpreter. A trained medical interpreter who bridges language between patient and team. Use trained interpreters rather than family members, for accuracy and for the patient's privacy. See Chapter 9.

Environmental services, transport, and security. The people who clean the rooms, move patients through the building, and keep everyone safe. They are part of the community of a hospital, they often know the patients in ways clinicians do not, and they deserve a chaplain's respect as much as anyone on this list.

Notes

I have kept footnote numbers out of the chapters on purpose, so the reading stays unbroken. These notes gather, chapter by chapter, the thinkers I have leaned on and the sources behind particular claims. They are not a formal bibliography. They are closer to the answers I would give if you stopped me after a chapter and asked, where did that come from? When I think something is worth reading in full for its own sake, you will usually find it in the resource list instead, which does a different job.

Two words before the chapter notes. The people in the stories throughout the book are composites, as the opening pages explain, so they carry no citations. They are drawn from many years of practice and disguised to protect real people. And the small word origins scattered through the book, such as chaplain, clinical, verbatim and the rest, draw on the Oxford English Dictionary. Where a story has grown up around a word, as with the cloak of Martin of Tours behind the word chaplain, I have told it as the traditional account rather than as settled history.

The opening chapter, on the application. The description of the application follows the common application used by ACPE-accredited programs. Check the current version, since it is revised from time to time. The chapter is adapted from an essay of mine called, “What You Need to Know When Filling Out a CPE Application,” and found at www.DavidFleenor.org.

Chapter 2, What Chaplains Do. The distinction between meeting another person as an “It” and as a “You” comes from Martin Buber’s *I and Thou*, first published in German in 1923; I

have used the "You" of Walter Kaufmann's translation rather than the older "Thou." The chaplain's non-directive stance, and its roots in a particular psychology, traces to Carl Rogers, whose *Client-Centered Therapy* and *On Becoming a Person* shaped how a generation of chaplains was formed. The phrase "non-anxious presence," which I first heard from a teacher, comes from the family-systems writing of the rabbi and family therapist Edwin H. Friedman, especially *Generation to Generation: Family Process in Church and Synagogue* (New York: Guilford Press, 1985). The line I use as the epigraph is my own, spoken in Luke Lorentzen's 2023 documentary *A Still Small Voice*.

Chapter 3, What CPE Is. The history here rests on two figures. Anton Boisen, who coined the phrase "living human document" and began bringing theological students into a mental hospital in the 1920s, told his own story in *The Exploration of the Inner World* (1936). Richard Cabot, the physician who called for a "clinical year" in the training of ministers, made that case in "A Plea for a Clinical Year in the Course of Theological Study," published in *Survey Graphic* in September 1925 and reprinted in his *Adventures on the Borderlands of Ethics* (New York: Harper & Brothers, 1926). The conviction that we learn most deeply from experience we have reflected upon runs back to John Dewey. The definition of CPE as "interfaith professional education for ministry" is the ACPE's own. "Explore rather than explain" comes from the work of Yvonne Agazarian's Theory of Living Human Systems, and is a phrase I use with residents, caught here in *A Still Small Voice*.

Chapter 4, Inside a Unit. The "looking-glass self," the idea that we come to know ourselves partly through others' reflections

of us, comes from the sociologist Charles Horton Cooley, in *Human Nature and the Social Order* (New York: Charles Scribner's Sons, 1902). The figures for a unit's hours, and the areas a program's outcomes must address, follow the ACPE standards; confirm the current numbers, since the standards are revised. The centering exchange in the epigraph is from *A Still Small Voice*.

Chapter 5, The Inner Work. The placing of self-awareness at the foundation of emotional intelligence follows Daniel Goleman's *Emotional Intelligence: Why It Can Matter More Than IQ* (New York: Bantam Books, 1995). The movement of faith from an inherited, affiliative form, through a searching one, toward a faith a person can own, comes from John Westerhoff's *Will Our Children Have Faith?* (New York: Seabury Press, 1976). Westerhoff names four styles of faith; the chapter dwells on the second, third, and fourth, and mentions the first, experienced faith, only briefly. The image of the "wounded healer" is Henri Nouwen's, from his short book of that name, *The Wounded Healer: Ministry in Contemporary Society* (Garden City, NY: Doubleday, 1972), where he draws on a story from the Talmud (Sanhedrin 98a) of the Messiah sitting among the afflicted at the city gates, binding his wounds one at a time. Nouwen gave the idea an enduring modern form but did not invent it; it is older than he is, and he offered it partly against the professional model of a strong helper and a weak patient. His reading of the Talmudic story is a Christian one, shaped as well by Jungian psychology and by the pastoral theology of Anton Boisen. It matters, too, that a wound helps only when it has been tended, not when it is displayed raw. The reflection on my own training is from *A Still Small Voice*.

Chapter 6, What You'll Feel. The idea of compassion fatigue, and the related notion of secondary traumatic stress, was brought into common use by Charles Figley, especially through the collection he edited, *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (New York: Brunner/Mazel, 1995). The argument that "compassion fatigue" is something of a misnomer, that compassion tends to sustain us and what wears us down is closer to empathic distress, follows two sources. The first is a review by Shane Sinclair and colleagues, "Compassion Fatigue: A Meta-Narrative Review of the Healthcare Literature," *International Journal of Nursing Studies* 69 (2017): 9–24, which found no evidence that compassion itself causes fatigue and argued that the construct deserves critical reexamination. The second is Joan Halifax's *Standing at the Edge: Finding Freedom Where Fear and Courage Meet* (New York: Flatiron Books, 2018), which distinguishes compassion from empathic distress. The boundary conversation is from *A Still Small Voice*.

Chapter 7, The Hospital World. The descriptions of hospital units and roles are general orientation rather than claims from any single source. The fuller catalogue lives in the directory at the back of the book.

Chapter 8, Entering the Room. The introduction, and the preparation around it, draw on my own teaching materials. Two pieces of research stand behind particular claims: work on what preserves a patient's sense of dignity, by Lesley Baillie (*International Journal of Nursing Studies* 46, no. 1, 2009), and a small study finding that patients perceive a clinician who sits as having stayed longer than one who stands, by Swayden and

colleagues (*Patient Education and Counseling* 86, no. 2, 2012), which was a pilot study, so I have not leaned on it too hard. The understanding of attention as a kind of generosity owes something to Simone Weil, especially her essay "Reflections on the Right Use of School Studies with a View to the Love of God," collected in *Waiting for God* (published in French in 1950 and in English in 1951), which I have paraphrased rather than quoted. The often-repeated line that "attention is the rarest and purest form of generosity" comes not from that book but from a letter Weil wrote to the poet Joë Bousquet in April 1942. The phrase I use for the heart of it, that people long to be seen, heard, and loved rather than seen, heard, and judged, is credited to my wife, the Rev. Amy Strano, BCC.

Chapter 9, Caring Across Difference. The distinction between cultural humility and cultural competence comes from two physicians, Melanie Tervalon and Jann Murray-García, in a 1998 essay I name in the chapter (*Journal of Health Care for the Poor and Underserved* 9, no. 2). The account of the chaplain who helped a family arrange an emergency baptism is drawn from a published report by Lucy Soucek in *America* magazine. The four verbs I borrow for the chaplain's role, provide, facilitate, care, and advise, come from the doctrine of the Navy Chaplain Corps, set out in Chief of Chaplains Instruction 5351.1 CH-1, *Professional Naval Chaplaincy* (22 March 2022).

Chapter 10, Notes, Confidentiality, and Boundaries. The saying that "if it is not documented, it did not happen" is an old one in healthcare. The claim that patients find it burdensome to repeat their story to clinician after clinician, and that it can weaken their trust in the team, draws on J. L. Haggerty and

colleagues, “Experienced Continuity of Care When Patients See Multiple Clinicians: A Qualitative Metasummary,” *Annals of Family Medicine* 11, no. 3 (2013): 262–271, and on T. A. Adekunle and colleagues, “A Qualitative Analysis of Trust and Distrust within Patient-Clinician Interactions,” *PEC Innovation* 3 (2023), article 100187. The fact that patients can now read their own notes quickly and electronically follows from the information-blocking provisions of the 21st Century Cures Act, which took effect in 2021 and are often described as the “open notes” rule. The counsel on writing notes in respectful, strengths-based language draws on work by chaplains at Mount Sinai, Jo Hirschmann, Karen Terry, Rachel Van Thyn, and Amy Strano, who studied their own charting after the move to open notes: “Chaplains’ Charting in the USA in the Era of ‘Open Notes’: Recommendations from a Quality Improvement Project,” *Journal of Religion and Health* (published online August 23, 2025). HIPAA is the Health Insurance Portability and Accountability Act of 1996, and the “minimum necessary” principle comes from its Privacy Rule, which asks those who handle protected health information to use, share, or request only as much of it as the task requires. Clergy-penitent privilege is a matter of state law and varies widely, which is why I urge you to learn your own state’s version rather than rely on a general rule.

Chapter 11, Death, Grief, and Being Present. The “five stages of grief” come from Elisabeth Kübler-Ross, who first described them in *On Death and Dying* (New York: Macmillan, 1969) from her work with dying patients and later regretted how they were turned into a fixed sequence the bereaved were expected to climb. The reminder that our own wounds can serve

our care, but only when tended rather than displayed raw, echoes the Nouwen material of Chapter 5.

Chapter 12, Your First Day. The first-day story is my own. The rest of the chapter describes common CPE practice rather than drawing on particular sources.

Where to Go From Here: A Few Resources

What follows is not a bibliography. It is a short, personal list of places you might go if you want to understand this work more deeply, chosen for someone who is beginning rather than for a scholar. You do not need to read any of it before your first day. Keep it for the season when you find yourself wanting more.

To Read

Gordon J. Hilsman, *How to Get the Most Out of Clinical Pastoral Education: A CPE Primer* (London: Jessica Kingsley Publishers, 2018). If you want a companion to this book written by another CPE educator, this is the one I would put in your hands. It is a practical, experienced guide to making the most of a unit once you are in it, and it goes further into the day-to-day mechanics of the training than I have tried to here.

Steve Nolan, *Spiritual Care at the End of Life: The Chaplain as a "Hopeful Presence"* (London: Jessica Kingsley Publishers, 2012). A thoughtful study of what chaplains actually do at the bedside of the dying, and of the chaplain as a hopeful presence rather than a fixer. If you want to understand what presence looks like in practice, at the hardest edge of the work, this is a good place to turn.

Stephen B. Roberts, editor, *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain's*

***Handbook* (Woodstock, VT: SkyLight Paths, 2012).** A broad, practical, multifaith handbook, with chapters by many hands on the concrete skills and settings of spiritual care. It is more a reference to dip into than a book to read straight through, and a useful one to keep on the shelf as you begin.

Keith W. Wakefield, *Stay with Me, I Want to Be Alone: A Chaplain's Search for Meaning* (2025). A chaplain educator's memoir of grief, loss, and the search for meaning in this work. The paradoxical title catches something true about the people we sit with, and about the vocation itself. A warm companion for the reader who wants to feel their way into what chaplaincy asks and what it gives.

Danielle Tumminio Hansen, *Trauma-Informed Spiritual Care: Interventions for Safety, Meaning, Reconnection, and Justice* (Minneapolis: Fortress Press, 2024). A short, current guide to caring for people who have lived through trauma, which is to say a great many of the people you will meet. It brings what the wider world has learned about trauma into the practice of spiritual care, and it is a steadying companion for a beginner who wants to do no harm and some good.

To Watch

***A Still Small Voice* (2023).** A documentary that follows a year inside a hospital CPE residency, from a resident's first uncertain visits through the growth and exhaustion of a full year. I appear in it as one of the educators. If you would like to see what this work actually looks like before you begin, it is the closest thing I know to sitting in on a unit.

To Follow

Christine Vaughan Davies, *Journeying Alongside* (journeyingalongside.substack.com). A hospital chaplain and spiritual director who writes, in her own words, about "everyday sacred moments from the bedside to the chicken coop." Her short reflections braid the work of spiritual care with the ordinary rhythms of rural life, and they make an unhurried, companionable read for anyone drawn to this vocation.

* * *

This list will grow. There are books, articles, and podcasts worth adding, and a few of the works named in the chapters ahead reward reading in full. We will build it out together.