Gender-Based Perspectives on Professional Healthcare Chaplaincy Board Certification

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This article explores the ways in which gendered processes play out through the professionalization of chaplains in healthcare settings. It describes how gender manifests within organizations, how literature addresses the role of gender in professionalization, and considerations for professional chaplaincy. Fifty interviews with U.S. chaplains were analyzed to explore the relationship between the professionalization of chaplaincy and male and female positionality. Although gender theory moves beyond binary conceptualizations of gender, all participants in this study self-identified as male or female and our data were analyzed accordingly. The language and professionalization efforts used by male and female chaplains mirror the gendered cultural expectations associated with these groups. This article notes how the patriarchal structures of both religious and healthcare institutions are inextricably embedded in the chaplaincy profession; thus, female chaplains have found it necessary to challenge these systems from the beginning.

Keywords: chaplaincy, healthcare, certification, gender, professionalization.

INTRODUCTION

The achievement of leadership and authority within healthcare develops from the repeated prioritization of institutional values over time. Healthcare leaders such as physicians and healthcare administrators move into positions of power with greater ease when their social location (e.g., education, income, race, ethnicity, and gender) has yielded greater access to resources (Grusky and Weisshaar 2014). Gender plays a significant role, as it often influences one's authority, wages, and role within leadership hierarchies regardless of work sector (Acker 1990). The ways in which assumptions about gender merge with religious authority is evident through the professionalization of healthcare chaplains. Healthcare and religion have a longstanding relationship in the United States, even as healthcare has become more secular (Fayard, Stigliani, and Bechky 2016; Myers-Shink 2008). Chaplains embody the remnants of medicine's historical ties with religion

(Cadge 2019). Healthcare delivery systems hire chaplains to provide spiritual and religious care to patients and their families. Chaplains have masters' level education and clinical training. They often translate patients' needs, inclusive of religious identity and cultural priorities to the secular world of medical intervention (de Vries, Berlinger, and Cadge 2008). The number of clinicians identifying as chaplains has grown since the mid-20th century (Cadge 2012).

Chaplaincy has professionalized increasingly over time (Cadge 2019). Unlike other professions, national chaplaincy organizations have attempted to professionalize without competing for jurisdictional ground with other professionals (Cadge 2019). Rather, as a group often found "on the edge of healthcare organizations," chaplaincy has adapted professionalization efforts by adopting healthcare language, medical norms, and methods "…to articulate their value and professional mandate" (Cadge 2019:13). Adapting to the norms and standards of older, more institutionalized processes can reinforce gender division and stifle attempts to make organizational processes more inclusive.

How do gendered processes play out through the professionalization of chaplains within healthcare settings? To explore this difference as it relates to healthcare chaplains, this article begins by describing how gender manifests within organizations and how existing literature speaks to its role in professionalization efforts. This is followed by a discussion about related considerations within professional healthcare chaplaincy. Analyzing interviews with 50 U.S. chaplains, this study aims to describe the observed relationship between the professionalization of chaplaincy and male and female gender roles. Although current gender theory moves beyond binary thinking, we utilize the traditional constructions of gender, those of binary male and female, since all research participants identified as either male or female when asked their gender identity in an open-ended question. Both language and professionalization efforts used by members of gender groups seem to mirror gendered cultural expectations and roles of those groups. This article will note how the patriarchal infrastructures of both religious institutions and healthcare institutions are inextricably embedded in the profession of chaplaincy, and so female chaplains have needed to challenge these systems from the beginning.

Theoretical Framework

Gender and Work

The published literature contains extensive discussion about the social construction of gender. West and Zimmerman (1987) suggested that socially generated concepts include expectations of characteristics, behaviors, and activities that qualify as feminine or masculine. Gender then becomes "something that one does, and does recurrently, in interaction with others" (West and Zimmerman 1987:140) to the extent that individuals' interactions reinforce these socially defined assumptions. West and Fenstermaker (1995) focused on an intersectional approach furthering the argument of "doing" gender as described by West and Zimmerman (1987). In this, West and Fenstermaker (1995) argued that gender, race, and class are "accomplished" or shown through the creation of differences in each category, building a complex set of matrices. Further, they argued that gender "is a situated accomplishment of societal members, the local management of conduct in relation to normative conceptions of appropriate attitudes and activities for particular sex categories" (p. 21, as cited from West and Zimmerman 1987). The argument of "essential differences," such as those with gender and race, further sustains and supports the system of social relations that distributes individual personal and professional opportunities based on identities (West and Zimmerman 1987:29). As a result, these differences become reified within the social structures as normal and natural, further legitimizing the socially constructed organization of social life. This reification is evident through the persistent attribution of specific jobs and occupations to a certain gender (Bielby and Baron 1987).

After the end of the Second World War, the presence of women within medicine, law, and the clergy steadily increased (Chaves 1996). Despite more women entering the labor force, work organizations continued to reinforce gender divisions as consistently placing men "in the highest positions of organizational power" (Acker 1990:146). Gender divisions within organizations reflect socially imposed and unequal distributions of power and skill through symbols, such as educational degrees or credentials (Acker 1990). A "gender revolution" began in the 1970s in which progress was made desegregating gendered occupations and after which women began to earn more baccalaureate and doctoral degrees than men (England, Levine, and Mishel 2020). However, progress has stalled in recent years and gendered occupational segregation remains common. To address these issues, England, Levine, and Mishel (2020) suggest that significant changes must occur institutionally and culturally.

Healthcare organizations offer one example of these socially generated divisions. Throughout U.S. history, the healthcare hierarchy has placed physicians—typically men—at the apex of power and authority, even within the specialty of maternal health (Carter 1994). In the 1920s, medical care and delivery shifted from providing charity care to the sick and poor into a national institution (Cadge 2012). Policy changes within medical education reallocated the power to supervise pregnancy and childbirth away from women, who had traditionally provided community care for prenatal, maternal, and infant health (Barker 1998). The Sheppard-Towner Act, passed in 1921, moved pregnancy care decisions from midwives to physicians by means of requiring specific medical education, traditionally achieved by physicians, for maternity care (Barker 1998). However, at that time women who wanted to become physicians were barred from access to medical education due to their gender (Barker 1998). These challenges forced women to develop strategies for inclusion within the educational hierarchy, to seek peer inclusion as physicians, and to reclaim expertise regarding maternal health.

Religious organizations offer another example of how gender and work interact within formal organizations as well as how socially determined indicators, such as education level, determine authority. Some U.S. religious organizations, such as the Roman Catholic Church and the Southern Baptist Convention, employ more gendered leadership processes than others and have historically utilized female members in pastoral and judicatory posts only in times of limited male leadership (Wessinger 1996). Even among more progressive religious communities, greater access to higher education propagates women's authority (Chaves 1996). When national policies increased educational access for women, mostly after the Second World War, leadership within religious organizations adapted to the changing social norms and increased women's leadership opportunities (Wessinger 1996). Although many debates around female leadership within religious organizations arise from ideological and theological arguments, researchers have proposed that a religious community's increasing acceptability of female leadership may be in response to changing social norms, concerns for community survivability rather than their ideological priorities (Ecklund et al. 2007), and changing external social pressure to become more inclusive (Chaves 1997; Lehman 1997). Women in religious organizations may then adopt strategies for inclusion within educational settings as well as for peer recognition within faith communities. In both healthcare and religious organizations, history demonstrates how women aiming for occupational recognition must adopt a wide array of strategies to achieve inclusion and authority.

Professionalization Strategies Within Gendered Work Organizations

The same patterns appear among occupational groups aiming for professional recognition (Appendix 1 in the Supporting Information). Occupational closure refers to the manner in which a trade becomes a "profession" by defining an area of expertise, drawing jurisdictional boundaries, and restricting entry to only those who are suitably qualified (Abbott 1988). Socially constructed conceptions of gender influence how groups stake jurisdictional claims. The extent to which a professional group claims expertise on a specific type of work occurs within a social,

political, and economic context (Abbott 1988). Professionalization also includes efforts to create occupational closure as a manner of claiming jurisdiction and dominance over specific tasks or knowledge(Abbott 1988; Crompton 1987; Parkin 1979).

The role gender plays as occupational groups stake claim to specific skills, competencies, services, or provision of services requires intentional examination (Atkinson and Delamont 1990; Witz 1990) and has been explored frequently with regard to physicians and nurses (Barker 1998; Lorber 1984; Melosh 1982; Moldow 1987). In general, researchers suggest that the gender of the majority within an occupational group determines the types of strategies used to accomplish occupational closure and stake jurisdictional claims. Witz (1990), who focused on the professionalization efforts of primarily female occupations, describes four strategy types: exclusionary, demarcating, inclusionary, or dual closure. As detailed in the proceeding paragraphs and illustrated in Appendix 1 in the Supporting Information, the professionalization strategies used depends on the position of the subordinate group and gender composition of the occupational group (Witz 1990). Since social institutions continue to reinforce male authority, male professionalization efforts rely on demarcating and exclusionary strategies while predominately female professions tend to employ inclusionary, dual closure (exclusionary and inclusionary simultaneously), and demarcating strategies (Witz 1990). Each of the four strategies refers to a way in which an occupational group attempts to gain professional status, power, and recognition.

Exclusionary and demarcating strategies are most prevalent in male-dominated professionalization projects where power is determined through hierarchy (Witz 1990). Exclusionary tactics focus on strategies for intra-occupational control over the entry into a professional group and internal priorities of the professional group, while demarcating tactics focus on inter-occupational control among occupational groups with regard to a body of knowledge (Witz 1990; Parkin 1979). Exclusionary efforts typically employ legalistic methods, such as licensure or certification. Power exerted by a dominant group aims to exclude those not qualified from a specific professional status. For example, the medical profession used exclusionary tactics such as the 1858 Medical Act, which required state-approved entities to provide the educational foundation for an individual to become registered (Witz 1990). Legalistic tactics, such as state licensure and registration, tend to hold central positions in professional closure by controlling access to education (MacDonald 1985).

Demarcating tactics, on the other hand, appear as two professions or occupations debate jurisdictional claims of knowledge and care provision (Witz 1990). As the nursing profession grew throughout the late 1800s and early 1900s, nurses, a vast majority of whom were women, campaigned for state recognition of professional status through credentialing and mirrored the medical profession (Carter 1994; Witz 1990). They attempted to harness the power of credentialing to challenge power dynamics and establish their own professional territory. The exertion of power occasionally utilizes state-level credentialing to draw jurisdictional boundaries.

Inclusionary strategies refer to a social group's efforts to seek upward mobility, power, recognition, or inclusion within an occupation's ranks (Witz 1990). These efforts focus on changing perceptions of equality and attempt to exert power toward more dominant groups. For example, when women campaigned for entry to the medical profession in England in the 1860s and 1870s, they began developing their own medical education and degrees (Witz 1990). Their efforts for inclusion in the medical arena culminated after parliament granted women access to medical education and registration in 1876. They aimed to be considered among the occupational ranks and faced varying levels of institutional power dynamics (Witz 1990). Inclusionary professionalization approaches reflect efforts to attain equal authority and rights within a specific occupation.

Dual closure strategies, typically evident by their complexity, refer to how a social group aims to gain professional recognition through a combination of inclusionary and exclusionary strategies simultaneously (Witz 1990, 1992). A subordinate occupational group resists the attempts of dominant groups to exclude them and at the same time "seek to consolidate their own position within a division of labor by employing exclusionary strategies" (Witz 1990:679). For

example, women physicians, nurses, and midwives campaigned against U.S. legislative efforts in the 1920s that shifted maternal health responsibilities. Those women wanted to gain authority over maternal health and inclusion within the medical profession, and thus implemented a dual closure strategy. Legislation and male physicians claimed greater authority over the knowledge of maternal health by positioning it within the medical realm rather than as home care (Witz 1990). Due to the authority typically already bestowed upon male physicians, occupational groups that are predominantly male do not typically require dual closure strategies for professionalization.

Efforts by women to move into the medical field highlight the exclusionary tactics made manifest through extensive educational requirements. Women must navigate and overcome institutionalized oppression within the organization or profession they seek to enter. Witz (1990) argued that professionalization projects of female-dominated occupations utilize dual closure and inclusionary tactics. Conversely, professionalization projects dominated by men tend to use exclusionary and demarcating efforts. The fact that women face multiple layers of gendered dynamics in professionalization efforts, comes from the reinforced gendered norms historically present within the United States. Women tend to need a wider array of tactics for professional inclusion, both as an occupational group and as individuals, due to the reinforced patriarchal expectations and hierarchy.

Considerations for Professional Healthcare Chaplains

Chaplaincy in the United States has become more prominent in healthcare since the 1920s (Cadge 2019). Chaplains, sometimes referred to as spiritual care providers, began as community religious leaders who cared for the sick within hospitals. Prior to the 1920s, most chaplains in hospitals were local clergy, retired clergy, or volunteers (Cadge 2012). As healthcare grew as a formal sector, the provision of psychological and psychiatric care shifted away from religious leaders and toward physicians (Cadge 2012). Clergy attempted to respond to shifts in jurisdictional claims by emphasizing education and creating experiential educational chaplaincy programs (Cadge 2012). In 1921, administrators from Protestant hospitals broke off from the American Hospital Association to create their own association called the American Protestant Hospital Association (APHA; Thomas and LaRocca-Pitts 2006). The APHA, emphasizing the role of religious care in healthcare, provided chaplains with the ideal atmosphere to begin occupational closure efforts.

In the 1940s and 1950s, the chaplains who trained through the first experience-based educational programs formed the first formal chaplaincy organization, the Association of Protestant Hospital Chaplains (Cadge 2012). These chaplains were all White men. Clinical training programs continued to expand for chaplains following the passage of the Hill-Burton Act in 1946 that increased federal funding for hospital construction (Cadge 2012). The Joint Commission of Hospital Accreditation first included a standard for the provision of spiritual care in 1969 and thus provided further legitimization of professional spiritual care within hospitals. Aiming to achieve greater professional recognition and demarcate their expertise, the professional chaplaincy organizations began to formalize credentialing through board certification (Cadge 2012; Thomas and LaRocca-Pitts 2006).

Since the 1940s, national chaplaincy organizations have employed board certification for membership credentialing (Thomas and LaRocca-Pitts 2006). Sociologists suggest that professionalization for chaplains has begun "moving from the 'subjective' to the 'official' labor force" as chaplains more frequently discuss jurisdictional claims, competency standards, theological training, and credentialing (de Vries, Berlinger, and Cadge 2008:24). The most recent examination of chaplaincy within hospitals suggested that around 64 percent of hospitals reported having a chaplaincy department in 2003 (Cadge, Freese, and Christakis 2008) and potentially as high as 75 percent in 2019 (White 2019). In 2010, men accounted for about 60 percent of membership in the largest chaplaincy organization, the Association of Professional Chaplains (Cadge 2012:48).

However, in 2018, the proportion of men and women who belonged to the three largest professional chaplaincy organizations—the Association of Professional Chaplains, the National Association of Catholic Chaplains, and the Neshama-Association of Jewish Chaplains—was roughly equal (White et al. 2020:8).

Chaplaincy professionalization sits uniquely at the intersection between healthcare and religion, each with a history of patriarchy. Their professionalization efforts provide an opportunity to examine questions about the types of strategies that are used in an occupation that was once male dominated but is now composed of equal proportions of male and female professionals. Based on Witz's (1990, 1992) professionalization concepts, one would expect male and female chaplains to discuss occupational closure in different ways. The aim to become a professional in a healthcare setting and within religious communities requires female chaplains to face multiple areas of resistance and subtle exclusion.

Using qualitative interviews with healthcare chaplains, this study aimed to discover how chaplains describe the value of certification, a demarcating professional strategy, and what denotes a professional identity. Specifically, we sought to answer the following: what gendered processes are visible in chaplains' ideas about professionalization, competency, and certification within healthcare settings? The analysis does not intend to label one strategy superior to another, nor does it intend to demonstrate inadequacies. Rather, we argue that subtle differences in language between male and female chaplains speak to the complex manner in which gender differences may appear.

METHODS

Data Collection Procedures and Sample

The data analyzed in this study originated as part of a larger study on board certification initiated by the two largest chaplaincy organizations in the United States and the Center for Health Organization Transformation at [BLINDED FOR REVIEW]. Researchers recruited 50 chaplains from the organizations' membership via email between July and August 2019. Key informants qualified to participate based on their time since certification and current professional role. Researchers categorized willing respondents as either (1) a chaplain board certified in the past 2 years, (2) a chaplain failing to receive board certification in the past 2 years, (3) an experienced chaplain with 7 or more years of experience, (4) a board certified chaplain who interviewed certification candidates, or (5) a manager of certified chaplains.

Three members of the research team conducted semistructured interviews by phone. The research team utilized the phone for interviews because participants came from across the U.S. Interview questions covered the value of certification, educational preparation, participant definitions of professional/competent (relative to chaplaincy), preparation of one's board certification application, and board certification interview experiences. The interviewers also requested participant recommendations for improvements to the certification process. Interviewers asked an open-ended question of the participant's gender to allow self-identification. Interviews ranged from 20 to 75 minutes and were audio recorded and transcribed verbatim by a third party.

Analysis

The research team conducted an inductive qualitative analysis (Merriam 2009). The team managed the data in the qualitative analysis software Dedoose, version 8.0.36. Initially, a third of transcripts were read closely and open coded by members of the research team. Each data segment in the transcripts was assigned a code or codes summarizing the content in a word or phrase. The research team members were trained in the constructivist grounded theory techniques employed

in the analysis (Charmaz 2014). Then, using a process of peer debriefing and consensus building (Erlandson et al. 1993), the team determined which codes occurred most frequently or were the most significant to the research question. The team then defined these codes to further elucidate understanding of their meaning and assist with code application. These codes formed the codebook. Then, the research team tested interrater reliability to assess internal coding consistency with excerpts from the subset of interviews; the Cohen's Kappa score (.82) was calculated within Dedoose and indicated strong agreement. The remaining transcripts were then coded using the codebook. The coded excerpts were exported and analyzed, and the team reached consensus on the qualitative themes.

This article focuses on a subanalysis of all excerpts originally coded as "defining professional and competent" and "the value of certification." The first author sorted excerpts according to participant gender and then re-coded in each gender category inductively and separately. After the final inductive analysis, the professionalization strategies discussed in literature were discussed in relation to the subthemes and patterns identified. The [BLINDED FOR REVIEW] Institutional Review Board approved this study in June 2019. Participants received preamble unsigned consents to review and verbally consented prior to the interview.

<h2 style="text-align:center">RESULTS</h2>

Email invitations were sent to 3,143 eligible members from the two largest professional chaplaincy organizations in the United States. Recruitment yielded 786 responses, a 25 percent response rate. Researchers scheduled interviews on a first-come, first-served basis according to respondent category (newly certified, experienced chaplain, chaplain manager, etc.). Forty-eight percent of chaplains identified as female and a majority identified as White (92 percent). The average age was 55.3 years old ($SD = 13.4$) and in terms of religious affiliation, most chaplains interviewed were either Catholic (38 percent) or Mainline Protestant (32 percent). Most chaplains worked within a hospital (56 percent). Table 1 summarizes sample demographics. As compared to the broader body of professional chaplaincy, the sample for the present study was similar in age, gender composition, employing organization, and region (White et al. 2020). The present sample had more White respondents and more Catholic respondents then the larger body of chaplaincy (White et al. 2020).

Thematic Analysis

Figure 1 illustrates the subthemes developed from the primary analysis' themes. Excerpts were separated according to participant gender and then further examined according to identified subtheme. The theme entitled "defining professional and competent" contained the following subthemes: (1) competence requires interprofessional capacity, (2) competence requires knowledge and skill, and (3) competence requires credentials. The theme "value of certification," as mentioned by participants, elicited two subthemes about (4) the value of certification for the chaplaincy community and (5) the implications of certification for interdisciplinary respect. Within these subthemes, male and female chaplains utilized different language to describe each and at times appeared subtle, while in other cases female chaplains added descriptors not used by male chaplains. Table 2 provides a simplified overview of participant language as related to exclusionary, demarcating, inclusionary, and dual closure strategies.

Competence Requires Interpersonal Skill

All chaplains interviewed, regardless of gender, noted the central importance of interpersonal skills and self-awareness. However, subtle differences in their priority were found. Male chaplains most frequently named interpersonal skills or described skills related to engaging with

Table 1: Descriptive statistics of chaplains interviewed, $N = 50$

	Recent Candidates (Certified) N (Percentage)	Recent Candidates (Not Certified) N (Percentage)	Certification Committee Members N (Percentage)	Experienced Chaplains N (Percentage)	Managers/ Directors N (Percentage)	Full Sample N (Percentage)
N	10 (20)	10 (20)	10 (20)	10 (20)	10 (20)	50 (100)
Age						
Mean (*SD*)	41.4 (14.5)	53.6 (11.2)	63.4 (12.7)	63.2 (7.2)	54.8 (8.5)	55.3 (13.4)
18–44	6 (60)	2 (20)	1 (10)	–	2 (20)	11 (22)
45–64	4 (40)	7 (70)	3 (30)	7 (70)	8 (80)	29 (58)
65+	–	1 (10)	6 (60)	3 (30)	–	10 (20)
Gender						
Female	5 (50)	2 (20)	5 (50)	6 (60)	6 (60)	24 (48)
Race/ethnicity						
Black or African American	–	1 (10)	–	–	–	1 (2)
White, Non-Hispanic	9 (90)	9 (90)	9 (90)	10 (100)	9 (90)	46 (92)
White, Hispanic	1 (10)	–	–	–	1 (10)	2 (4)
Hispanic or Latino	–	–	–	–	–	–
Other	–	–	1 (10)	–	–	1 (2)
Employing organization						
Hospice	2 (20)	4 (40)	1 (10)	1 (10)	–	8 (16)
Hospital	6 (60)	4 (40)	3 (30)	6 (60)	10 (100)	29 (58)
Other HC	2 (20)	2 (20)	3 (30)	1 (10)	–	8 (16)
Other	–	–	3 (30)	2 (20)	–	5 (10)

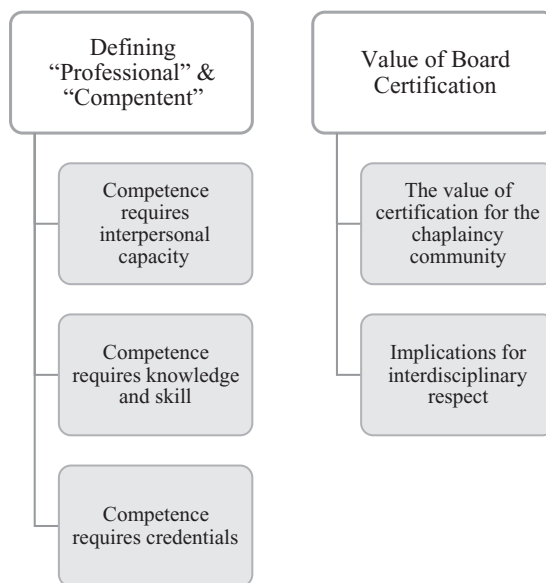(*Continued*)

Table 1: (Continued)

	Recent Candidates (Certified) N (Percentage)	Recent Candidates (Not Certified) N (Percentage)	Certification Committee Members N (Percentage)	Experienced Chaplains N (Percentage)	Managers/ Directors N (Percentage)	Full Sample N (Percentage)
Religious affiliation						
Catholic	4 (40)	2 (20)	5 (50)	4 (40)	4 (40)	19 (38)
Evangelical Protestant	4 (40)	3 (30)	1 (10)	1 (10)	–	9 (18)
Mainline Protestant	2 (20)	3 (30)	3 (30)	5 (50)	3 (30)	16 (32)
Other	–	2 (20)	1 (10)	–	3 (30)	6 (12)
Region						
Midwest	–	2 (20)	5 (50)	3 (30)	1 (10)	14 (28)
Northeast	3 (30)	1 (10)	1 (10)	3 (30)	5 (50)	10 (20)
South	4 (40)	5 (50)	2 (20)	1 (10)	2 (20)	14 (28)
West	2 (20)	2 (20)	2 (20)	3 (30)	2 (20)	11 (22)
Other	1 (10)	–	–	–	–	1 (2)

Table 2: Summary of themes and type of professionalization language

	Theme	Professionalization Language			
		Exclusionary	Demarcating	Inclusionary	Dual Closure
Female language	1. Interpersonal capacity	Interpersonal skills ad self-awareness required[a]		Demonstrates leadership	
	2. Knowledge and skill	Knowledge and skills come from theory and education[a]		Communication skills	Multifaith comfort/ knowledge
	3. Credentials			Achieved and maintained	
	4. Value for the chaplaincy community			System of accountability	System of accountability
	5. Interdisciplinary respect			Peer with other healthcare professionals	
Male language	1. Interpersonal capacity	Interpersonal skills and self-awareness required[a]			
	2. Knowledge and skill	Knowledge and skills come from theory and education[a]			
	3. Credentials		Achieved		
	4. Value for the chaplaincy community	Quality assurance			
	5. Interdisciplinary respect	Subject matter expert			

[a] A description used by both female and male chaplains.

Figure 1

Subthemes developed from primary codes in initial analysis

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┌─────────────────┐        ┌─────────────────┐
│   Defining      │        │ Value of Board  │
│ "Professional" &│        │ Certification   │
│  "Compentent"   │        │                 │
└─────────────────┘        └─────────────────┘
        │                          │
   ┌─────────────┐            ┌─────────────┐
   │ Competence  │            │ The value of│
   │ requires    │            │certification│
   │interpersonal│            │for the      │
   │ capacity    │            │chaplaincy   │
   └─────────────┘            │ community   │
        │                     └─────────────┘
   ┌─────────────┐                  │
   │ Competence  │            ┌─────────────┐
   │requires     │            │Implications │
   │knowledge    │            │for          │
   │and skill    │            │interdisciplinary│
   └─────────────┘            │respect      │
        │                     └─────────────┘
   ┌─────────────┐
   │ Competence  │
   │requires     │
   │credentials  │
   └─────────────┘
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other people before focusing on self-awareness. For example, one male chaplain explained that interpersonal engagement necessitated intrapersonal awareness:

> […] how effective can a person be walking into a particular patient's room and be able to engage in conversation in a way that is useful to the patient without the chaplain and the chaplain's own ego, and self, getting in the way? I mean, we can't avoid that, but to the extent that someone is aware of themselves and their inner workings, I think they are much more likely to be good chaplains and good spiritual care providers.

Generally, female chaplains first discussed self-awareness, then interpersonal skills. This typically included emotional attunement and awareness of strengths and weaknesses. One chaplain explained that she understood demonstrating competence to mean:

> … to know who I am, and what is my role as a person of faith. For me, it's meeting people where they are at, and it's just knowing the background that I bring, and the skills that I bring…

Before discussing the manner in which chaplains engaged with others, female chaplains typically focused on identifying their own strengths and abilities.

Additionally, female chaplains added that leadership in social settings is necessary to demonstrate competence, specifically in the form of interdisciplinary engagement. For example, one manager shared that she hoped a chaplain's competence would include the ability to enter a room with some authority:

> I think there is also a level of leadership that I would expect to find with a competent chaplain. That they would be able to go into a room and give a presentation. Being able to speak up at a meeting. My chaplains work on many, many different committees and I would see it as a waste of time if they were not contributing.

Additional themes that arose for female chaplains indicated a need for multidirectional uses of power. For them, professionalization requires the interpersonal relationship with professional colleagues and the ability to demonstrate authority and expertise. Authority and expertise ultimately provide the avenue for inclusion as a female member of the healthcare team.

Competence Requires Knowledge and Skill

Chaplains stated that a competent chaplain possessed certain knowledge and skills. Differences between male and female chaplains appeared stark with the additional role of communication identified by female chaplains. Male chaplains repeatedly prioritized the ability to "practice clinical skills grounded in theory." For example, one chaplain shared that:

> Competency generally is like, yes, I have a theology of care and I have a theory of practice.

In other words, any clinical care provided by a chaplain comes from a set of principles or formally learned concepts. The ways of thinking and practicing are learned, obtained, and applied. Chaplains' clinical skills arise from repeated study and practice. One manager explained:

> We want chaplains that the service that they provide is informed and is directed by the theory and the research that's out there, and I think board certification is an indicator of that. That this chaplain is integrating into their practice the best that's out there.

In other words, not only is a competent chaplain certified, but they also integrate specific knowledge into their practices. However, the data lack further specificity about the theory or skills that needed mastering.

Female chaplains repeated these themes but added points about communication skills and the ability to demonstrate plans of care with colleagues. When discussing the skills required of a competent chaplain, the topic of communication typically followed. One newly certified chaplain shared the skillsets she considered vital:

> Things like active attentive listening, compassionate engagement in conversation, being able to help families and patients navigate ethical decision making, conflict, the challenges that come with illness and injury and things that we encounter in the hospital, being able to communicate clearly with chaplain colleagues and with members of the interdisciplinary [team]…

The priority of self-awareness prior to social engagement as well as the importance of communication also arose in her interview. She continued:

> So, just the interdisciplinary and within our own discipline, communication in both of those areas. I think having at least part of one's demeanor that is compassionate and empathetic, and able to connect well with people …

Communication with colleagues, both within chaplaincy and with other disciplines, was considered vital to professional competency for female chaplains.

Additionally, female chaplains identified the importance of being able to provide spiritual care within an interfaith setting. Educational standards as well as certification competencies require chaplains to care for individuals who carry different beliefs and practices without evangelizing. Although chaplains receive endorsement from a particular religious or spiritual group, certification requires that one demonstrates the ability to provide appropriate care to individuals regardless of faith.

One chaplain manager shared that she routinely assessed applicants' knowledge and awareness of other faith traditions, explaining:

> Do [potential hires] have a basic understanding of not only their own faith tradition, but other faith traditions as well? Do they have an understanding of the concept of being present in another's tradition rather than in their own, […] to be able to say that I can minister in any faith tradition…

She considered this skill a central identifier of competence. Another interviewee explained that certification credentials identify a chaplain's comfort with, and ability to, provide care in interfaith settings. An experienced chaplain noted her assumption that certified chaplains can:

> …work in an interfaith, multi-faith capacity and meet people where they are and also that they value their ongoing professional development and relationships.

Female chaplains discussed that certification indicated a peer's ability to function in this manner and navigate relationships with individuals who do not share beliefs.

Competence Requires Credentials

Both female and male chaplains considered a competent professional credentialed. In other words, the act of receiving credentialing makes one a competent professional. One experienced male chaplain, when discussing why he sought certification many years prior, shared that board certification established his position as a chaplain in a more formal way:

> At the time I wanted the credential to kind of improve my qualifications as a professional chaplain.

Frequently, male chaplains signified that the credentials marked an endpoint for training and education. One male chaplain shared:

> So, it is just a culmination of proof that you finished this thing and there's a board out there that's verifying that you are fully trained and competent according to our standards.

Credentialing signaled that a chaplain met a set of standards and the certification can operate as a status signal to others. Although male chaplains commented on certification as a valued resource, language that minimized the value of certification arose frequently. With only one exception, this was not present in interviews with women. One experienced chaplain said that certification credentials simply communicates to other chaplains about his skill level and, beyond reassuring others of his competence, he felt it added no value:

> Practically, [certification] is seen as a measure in our hospital systems […] as a confirmation of my skill or competency. Amongst my peers it has some value. Personally, not so much in that I felt equally skilled and competent before I was board certified.

In another case, a male chaplain shared that most of his local colleagues did not have chaplaincy credentials, thus put little value on them. Most male chaplains found value in certification credentials; however, a smaller number seemed to minimize or dismiss their value.

Beyond acknowledging the importance of credentials to indicate competence, female chaplains prioritized continued education when discussing credentialing. Certification did not offer an end point or final demarcation for these chaplains. One female chaplain noted that board certification requires chaplains to continue learning skills and approaches to caring for others. Without continued learning, she worried her care would lose some level of impact:

> I think that's a fear for chaplains, that it becomes rote. […] And so how do I challenge myself to understand what are more things that I can put in the toolbox to use?

When discussing what becoming competent meant to her, she explained that credentials were achieved and maintained; a competent professional requires one to continue learning. Prioritizing continued education also communicates a dedication to chaplaincy and "…shows a level of commitment and seriousness about the profession." Female chaplains discussed the credentials

to demonstrate meeting minimum standards alongside communicating a larger professional and educational dedication. One chaplain shared that she wondered why a colleague would not seek certification:

> Is it because they don't value that, is it because they don't want to work or have the ability to work within a diverse group? Or are they just not concerned about their own professional development?

Another newly certified chaplain talked about the importance of credentialing as a manner to ensure clinical inclusion:

> […] as a profession, to be seen as equal members of the medical team, we need to have a level of professionalism and level of education and certification is perfect, as part of it. Because every other discipline has to be licensed or certified and has to do continuing education.

A woman who did not receive certification initially shared that certification keeps a chaplain attuned their care and skills:

> So just having to continue that training and that education and that formation is important. When you just go out there and do the work, and you get into a rut, and you write the same thing in every chart about every patient, and all you're doing is walking by, basically blessing them, and going on your way, you're not really providing spiritual care.

Although male chaplains valued certification as a way to demarcate professionalism, they did not discuss the necessity of continued education. The language used by female chaplains suggested that professional status must be repeatedly demonstrated or proven.

The Value of Certification for the Chaplaincy Community

Both male and female chaplains identified that board certification held value within the chaplaincy community, however, they described that value differently. Men frequently used "quality assurance" language, while women discussed peer accountability. For example, one newly certified chaplain explained in depth about how he identifies competent chaplains:

> As a whole, I believe the institution of being board certified gives everybody a baseline, a minimum requirement to meet. And it allows me to better […] trust and understand the [other chaplains] that I'm working with, whether it's with handoff or calling other facilities when patients are getting transferred.

He explained that he wanted reassurance that colleagues at other facilities functions with the same understanding of spiritual care, emotional processing, and support. He considered certification credentials as an indicator that the care provided by other chaplains remained consistent. One male manager shared his concern in identifying competent chaplains:

> […] I think our chaplains, by either going through or having finished the board certification process, are providing spiritual care that's attuned to the medical and treatment needs of the patient, is coordinated with the treatment team, and so there's a quality assurance that we're not going to come in and provide spiritual care that's going to be contradictory to their wellbeing, contradictory to what the medical team is suggesting or recommending. […] I do think board certification is a very helpful screening process.

Although the language in his discussion indicated that certification provided quality assurance to the medical team, his use of the term "screening process" suggested he was concerned about quality variation among chaplains. Certification demarcates chaplains from other types of religious/spiritual care and appears to reassure chaplains that their peers will not provide care that harms the treatment team's efforts.

Female chaplains used different language, emphasizing certification's value to the larger chaplaincy community. The term "accountability" arose frequently. For example, after sharing that she did not receive certification on her first attempt, one chaplain stated that she considered this system of accountability to be multitiered.

> I'm accountable to my department on a day-to-day basis at work. But then I'm accountable also to the endorsement process. And then above that to [the professional organization] in general, […] multiple peoples' eyes are on us to make sure we're giving the best care we can to the patient in the end. And not abusing our profession or people or power or authority.

Although both excerpts seem to indicate a concern for misuse of the role as a religious/spiritual leader, the manner in which men and women discussed the internal professional value of the credentials varied. For female chaplains, the focus suggested the desire for inclusion with peers while the language used by male chaplains suggested the desire to trust the other unknown peers.

Implications for Interdisciplinary Respect

Both male and female chaplains discussed the value certification provided across disciplines. Although more frequently discussed by female chaplains, all shared how credentials indicate expertise and authority within healthcare settings. One newly certified chaplain shared that she considered certification important because of the interdisciplinary inclusion it provided:

> Especially in working in the healthcare field, having a demonstrated ability to do this work, and having that recognized by an overarching organization, I think carries a lot of weight. Especially when I'm wanting to be a peer at the table with doctors, and nurses, and people who've gone through their own board certification process.

She continued to reflect about how the certified title on her badge impacts relationships with clinician colleagues rather than perceptions of patients or families:

> I mean, my badge says certified chaplain, but I'm not sure that a patient or a loved one who I encounter knows what that means,[…] or that it looks any different than if I just walked in with my former badge that said 'chaplain' versus 'certified chaplain.'

Her reflection suggests that the challenge was less about being recognized as being certified by patients and families and more about recognition by chaplains' clinical peers.

Additionally, chaplains shared that certification allowed other professionals to see them as subject-matter experts. One male manager shared that he thought that, for patients, certification spoke to a level of knowledge or skill:

> [Certification is] to recognize that the individuals in the room have expertise and training in their specific environment, not the pastor who is trying to help them as in a church context, but we actually have the expertise to deal with them in a medical context.

Chaplains explained the need to reinforce to colleagues that their work complimented medical treatment. Chaplains commented that they build trust and reassurance with colleagues by utilizing a credentialing process that mirrors the language and practices of the larger medical community. Both female and male chaplains utilized inclusionary language to discuss the value of certification to professionals in other disciplines.

Discussion

Over time, increasing proportions of female professionals have joined the healthcare and religious workforces. The history of these organizations shows that men have traditionally held

positions of authority and knowledge. Although women are now more widely accepted as professionals, the institutionalized gender inequity remains present in subtle ways that are evident as growing professions establish themselves. Healthcare chaplains began utilizing professionalization tactics, specifically board certification, in the 1920s to cement legitimacy within healthcare. The most recent efforts to continue professionalization occur within a context where female membership has continued to grow. This study, guided by gender and professionalization theories, highlighted differences in professionalization language between male and female chaplains. Even as occupational groups such as chaplains professionalize and increasingly include women in their professional ranks, this study highlighted the recurring gender stratification processes within workforce expansion efforts. Female chaplains utilized multiple layers of language, signaling both inclusionary and exclusionary efforts, to discuss obtaining professional recognition and indicative of the patriarchal history within healthcare. Male chaplains most frequently used language indicative of exclusionary and demarcating professionalization strategies. The variations in gender perspectives highlight the layers and nuances of continued stratification.

Much of the exclusionary language occurred among male chaplains. Exclusionary professionalization language or language that focused on intra-occupational composition appeared when chaplains discussed the interpersonal capacity of chaplains, the basis of the knowledge and skills required for chaplaincy, the value of certification for the larger chaplaincy community, and board certification's implications for interdisciplinary respect. Although female chaplains identified the same themes as male chaplains, women often added layers to the discussion, signaling the need to exert power in additional directions. Demarcating tactics, such as the formalization of credentials for chaplains, historically functioned as an institutionalized way to exclude and create closure for a profession (Murphy 1988; Witz 1992:65). Medicine, as a field, utilized state licensure, formal corporations, and associations to organize power and authority in the 1700s and 1800s (Witz 1992). Those requirements included formal education from university settings originally inaccessible to women. Demarcating and identifying the bounds of professional chaplaincy practice, as noted by interviewed chaplains, requires credentials; however, female chaplains also highlighted the importance of continued education.

Although Witz's (1990, 1992) framework coincides with the present study's findings, it traditionally approaches professionalization as if professions are wholly male or female. The framework may be limited for professional healthcare chaplaincy that reports an equal number of female and male chaplains (White et al. 2020), The consideration of gender within professionalization theories and frameworks must also consider the political environment in which such changes occur as well as variations in communication strategies about one's profession.

Inclusionary strategies, or the assertion of authority and power to a larger group, appears most frequently in the language of female chaplains. Language revealing inclusionary strategies arose through the identification of the need for leadership as a chaplain and accountability. The need to establish chaplains as peers among other healthcare professionals stood out most prominently for its inclusionary tone. The challenges for women in leadership within religious organizations may be intertwined with those experienced by female chaplains. For instance, women clergy often face barriers to achieve equal salary, support, or advancement as compared to male clergy (Zikmund, Limmis, and Chang 1999; Meyer 1999). The difference appears through the tangible social and cultural hurdles (Zikmund, Lummis, and Chang 1999; Meyer 1999).

Dual closure tactics emphasize the need to exert power in multiple directions for professional closure as well as equal professional recognition (Witz 1990, 1992). Although the chaplaincy workforce is not comprised simply of women, language of dual closure tactics appears in discussions about knowledge and skill as well as accountability. Women seeking entry into healthcare historically argued for "nongendered individualistic criteria of inclusion" (Witz 1992:195). Similarly, female chaplains may continue to emphasize the value of board certification as a means of recognition and inclusion within a profession that is at the intersection of two traditionally male-oriented occupations.

Women noted professional certification as a tool for accountability among peers while men discussed it as a manner to ensure quality assurance of peers' skills. Women's language hints at the need for inclusion while their male counterparts focused on exclusion. The theory of comparable worth suggests that gender norms influence the construction and reconstruction of skill used to assess performance in employment settings (Steinberg 1990). Sociologists suggest that when women began to gain entry into professional occupations, efforts aimed to devalue feminizing occupations increased (Mandel 2018; Steinberg 1990). Typically, "women's work is treated as invisible in the definition of job factors" (Steinberg 1990:463), thus requiring women to advocate differently for their professional efforts. The differences arising in chaplains' language may require certifying bodies to establish standardized language so that the professionalization efforts within specific locations undertaken by chaplains, regardless of gender identity, advocate for the whole body of chaplaincy rather than disseminate conflicting messages.

Further, professionalization efforts that aim to usurp existing power occur within dual closure strategies. The female chaplains' discussion of interfaith competence—a theme that did not arise for male chaplains—could suggest efforts to usurp the extensive traditional male authority from formal religious organizations. Another possibility is that by emphasizing equality among minority groups, a social group can challenge inequality regimes that reinforce organizational hierarchies (Acker 2006:455). Although discussions did not equate to formal efforts to minimize inequality, the suggestion of interfaith and inclusionary priorities may set the stage for addressing inequalities more broadly (Acker 2006). Advocacy at an organizational level, such as the professional chaplaincy organizations engaging with the leadership of professional nursing or physician organizations, may further advance interprofessional understandings of the role and scope of chaplaincy. This advocacy, alongside standardized language for what competence and certification mean, will help address inequities that manifest in chaplains' language.

Limitations

Qualitative research aims to examine a topic in-depth, and the results are not intended to be generalizable. Thus, these results should be considered exploratory rather than representative. The research team's choice to separate excerpts by self-identified gender during quote extraction and then to code inductively may have introduced some bias. The team attempted to mitigate this by analyzing one group at a time during initial coding. Finally, this research would have benefited from more gender diversity in the sample. Future research should explore the viewpoints of chaplains who identify beyond the gender binary.

Conclusion

Professional chaplains work at an intersection of healthcare and religious organizations. Both institutions are evolving from a gender perspective. Through board certification, the professional chaplaincy organizations aim to strengthen their membership and refine their jurisdictional claims. Although many of the same themes arose between male and female healthcare chaplains, the language used to describe current professionalization efforts differed. Female chaplains appear to utilize the language and tactics of female professionalization projects (Witz 1990, 1992) while male chaplains' language focused on drawing boundaries and denoting expertise. Future research should explore how these differences impact communication with other clinical providers as well as other clinical providers' expectations of chaplains. Further, this topic warrants a more intentional study to identify the extent of such professionalization differences and their impact. A future quantitative study could add to the results by highlighting the extent of the differences identified herein. The challenges inherent to female professionalization appear present for female chaplains despite the professional body's contemporary gender balance.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

APPENDIX 1. Occupational closure strategies adapted from Witz (1990).