

THE ORERE SOURCE

Abstracts from the Pastoral Care literature and other Helping Professions

Introduction

A Scottish Presbyterian layman is in no small way responsible for changes that are taking place in health care in the US. They are changes which may in time reach other parts of the world, including changes affecting the provision of pastoral care outside of the US. Sir John Templeton was an enormously successful international financier. He retired in 1987 and established The John Templeton Foundation, the purpose of which is "to encourage a fresh appreciation of the critical importance... of the moral and spiritual dimensions of life." The Foundation is currently funding more than 150 projects, studies, award programs and publications.

Over the past 4 years, one field receiving funding has been that of spirituality and health. Templeton's aim in doing so is "to promote a deeper understanding of the influence spirituality, beliefs, and values have on human health." US Medical Schools can apply for up to \$10,000 to assist them to develop and offer courses that examine the role of faith and spirituality in patient care. Support has also been given for an annual conference intended to bring together medical school educators, deans of schools of medicine, and others interested in this field, so that there can be exchanges of ideas and cross-fertilisation as a result of different experiences around the US.

I have just returned from this year's conference which was held in Dallas Texas in September, 2000. The conference brought together just over 100 persons from around the US to focus on the theme "Spirituality in Health Care: Issues of Culture and the End of Life in Medical Education." Over two and a half days, we heard three lectures and could attend our choice of 22 workshops and a poster-session with 21 participants. People in attendance included medical educators, physicians from a variety of specialisations, nurses, several others in health work and - chaplains.

The conference opened with a lecture by Ira Byock MD. He is the director of a palliative care service, and the president of the Missoula Demonstration Project. This project is an attempt to do nothing less than change the way an entire community thinks about dying and death. The second plenary was by Dr Arthur Frank, a professor of sociology at the University of Calgary. An articulate speaker and wonderful story-teller. He addressed the question: Must dying be a spiritual quest? His thoughtful answer was a both yes and no one, as he led us through his understanding of the nature of the dying process, from within the person.

The final plenary was by Christina Puchalski MD. She is an Asst Prof. of Internal Medicine at The George Washington University Medical Centre, and Director of Education of The National Institute for Healthcare Research. She has become well-known in the US for her introduction of the simple FICA spiritual assessment tool which she teaches to medical students. Puchalski described the development of their curriculum in spirituality and health at GW. It is a very comprehensive one, with elements included in all four years of the medical school's course work. Her presentation was supported by several of the workshops and posters which also dealt with curriculum development. What should be included in medical school education concerning spirituality, values, ethics is still in flux, as are the ideas as to how best to teach them. Poetry, films, role-plays, debates, lectures - all of these are being used in different ways.

There has been a significant increase in the number of medical schools offering courses in spirituality and medicine. From three or four about five years ago, the number is now over 70. One third of the conference workshops involved presenters who were either chaplains or people who have been theologically trained. Several workshops drew heavily on the expertise and experience of chaplains both as workshop facilitators for groups of medical students, and as mentors who are shadowed by medical students. This latter practice is an increasingly

common one and was one of the striking aspects of the entire conference. Using one of several possible approaches, a medical student observes a chaplain as they make their rounds, later discussing what they have seen and heard. One of the conference organisers offered: "We need to learn from chaplains but not become chaplains."

Overall Impressions

It is difficult to assess what effect this will all have on the work of chaplains. It was clear that none of the speakers or presenters were advocating that doctors begin to function as chaplains, only that the existence of spirituality of their patients should be acknowledged by doctors in their practice. It is possible that the already busy chaplain is going to become even busier if spiritual issues are identified by physicians, these being then turned into consultation requests for chaplains, something that has already begun to happen in my hospital.

Models are being created by doctors and psychologists which would appear to have some interest for chaplains who, under the constraints of an already busy schedule need to find ways to more quickly (and pastorally) engage with their patients. The former Rogerian paradigm within which many of today's chaplains were trained, and which largely leaves to the patient the initiative for raising religious and spiritual issues is being questioned. Some work is being done outside as well as inside chaplaincy which offers ways of more effectively attending to the religious and spiritual needs of patients- those who are churchd and those who are not.

Finally, are we as chaplains ready to respond if doctors learn one of their patients has a specific issue or problem in the area of spirituality or religious faith, and to then respond to their referral in a problem-focussed way? Physicians are trained to identify their patient's problems and to then make a specific response, which they can justify later on if required. Rightly or wrongly, that is what they may expect of chaplains if they start to make problem-based referrals to us. Are we as chaplains both ready to provide interventions, and to be able to make the necessary written descriptions of the ministry we in turn provide, plus a description of the outcome? Some chaplains may question whether it is appropriate for us as a profession to even function in this way. We may need to have serious discussions about this issue within the overall guild of chaplains, in that it has serious theological and practical implications.

In the US, I see the likelihood of chaplains being called upon to increasingly act as resource-persons because we are perceived as knowledgeable about cultural and religious diversity. I also believe we will be expected to be knowledgeable about the relationship between spirituality and health, a burgeoning field which is still needing greater conceptual clarity, but a field which we cannot ignore.

Finally, it is possible that chaplains will be called upon more to help doctors to listen. They do not get much training in medical school as to how to do this, a fact that is being addressed by some medical schools through the hiring of Ph.D.s in communication. The well-trained chaplain has much to offer, given the time to do so, and is probably cheaper to hire!

In the rationale for the conference, the organisers wrote in part: "Many physicians and medical educators see (the inclusion of spirituality in patient care) as a way to re-emphasise the service aspect of our profession." It was impressive to see the significant contributions that chaplains are making to these profound changes in patient care.

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John A. Astin, Elaine Harkness, Edzard Ernst
The efficacy of "distant healing": a systematic review of randomised trials

Annals of Internal Medicine

Volume 132 # 11 (6 Jun 2000) Page 903-910

The debate continues concerning the relationship between the performance of such "non-medical" acts in anticipation that there will be a physical response of some kind, and what, specifically, if anything, happens. Such acts would include prayer, mental healing, Therapeutic Touch, and spiritual healing. Astin and colleagues have very carefully located all of the research – there is not a lot when the search criteria are stringent - to learn whether is any efficacy to be found from such interventions. They found a total of 23 research projects which had looked at these four activities, re-analysed the results, and conclude: "The methodologic limitations... make it difficult to draw definitive conclusions about the efficacy of distant healing. However, given that approximately 57% of trials showed a positive treatment effect, the evidence thus far merits further study." A carefully nuanced examination of a complex set of issues.

William Beers

When the community cares

Health Progress Volume 81 # 1 (Jan/Feb 2000)

Page 43-45

A description of what has happened in the two years to January 2000 since 30 members of a largely rural community in Wisconsin in the US banded together to "provide (their) community with the highest possible quality of end-of-life care." The article is very complete in detailing what they have done and how. Beers states that a top priority for the coalition was agreeing on a common language they would use when talking about dying and death. Included in the article is the coalition's four ways of measuring the effectiveness of their work. They use (1) a continuous quality improvement (CQI) process; (2) a formal review process to monitor all of their activities; (3) an organisational assessment tool which has allowed them to obtain the opinions of patients, family members, healthcare professionals and others about end-of-life care; (4) a public assessment survey. One of the hospitals they work with has instituted a comfort care pathway within which they can track patient satisfaction with pain control management.

Mark Burleigh

Careview

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(Aug 2000) Page 1-14

Burleigh is a hospital chaplain in England who has developed a database program which he calls Care-View. It can be used to track the daily activities of a chaplain or team of chaplains, and then produce a variety of reports when requested. The program runs in Microsoft Access 97 and produces a variety of lists describing a hospital chaplain's activities, which can then be given to administrators. It is password protected. The program has several special features. e.g. it will flag people needing to be intensively visited, also patients who have birthdays while they are hospitalised. Rather than sell the program, he has been installing it on an expenses only basis, and then Burleigh charges a maintenance fee which provides support for the working of the program by e-mail and by phone. A request to the above e-mail address, and Burleigh will e-mail you a copy of a brief introductory manual for the program which nicely illustrates the potential of the program.

Arthur L. Caplan, Glenn McGee, David Magnus

What is immoral about eugenics?

British Medical Journal

Volume 319 # 7220 (13 Nov 1999)

Page 1284-1285

Eugenics, the practice of genetic engineering has a very bad name as the authors readily acknowledge. "...no sensible person can be in favour... so much horror, misery, and mayhem have been carried out in (its) name..." But these authors urge that a distinction be made between what has happened in the past, and what might happen in the future. Rather than closing the door in a global fashion, they want to leave the door open in order to focus on helping individuals, rather than a group of population. They consider the question of coercion, the subjectivity of perfection, and equality to argue that "No moral principle seems to provide sufficient reason to condemn individual eugenic goals."

Alan J. Carson, Steven Best, Charles Warlow, Michael Sharpe

Suicidal ideation among outpatients at general neurology clinics: prospective study

British Medical Journal

Volume 320 # 7245 (13 May 2000)

Page 1311-1312

Suicide is one of the ten most common causes of death in adults in Great Britain. When a person is believed to have a psychiatric problem, they are routinely asked about suicidal thoughts or acts. This is seldom done in medical assessments. This study (of 312 consecutive new patients in a general neurology outpatient clinic in Edinburgh) revealed that, in the previous two weeks, almost 10% had considered suicide. Almost all had a major depression. And half were not sick with debilitating symptoms. Rather they had either unexplained or non-progressive symptoms. The bottom line seems to be that suicide can lurk in unexpected places, so watch for depression.

Ian Carter

Health care spirituality and change: creating a 21st century NHS

IRISC website (31 May 2000) Page 1-8

Writing on May 31st 2000, the day the UK Secretary of State for Health designated as "Census Day" for the National Health Service, Carter makes some critical observations about the changes facing health care in Great Britain. He describes the changes that have occurred, and those trends which seem to be on-going. He makes no predictions about how the changes will affect chaplains, but urges that they take part in the conversations which he hopes will take place as the NHS is re-shaped for the 21st century.

P-J. Charters

The religious and spiritual needs of mental health clients

Nursing Standard

Volume 13 # 26 (17/23 Mar 1999) Page 34-36

A research study which shows the necessity for both mental health nurses as well as allied clinical staff to be aware of the religious and spiritual needs of their clients. Charters argues that a comprehensive assessment of these needs should be routinely done, that multidisciplinary liaison should always occur, and that the resources of chaplains should be used. As in other recent studies, there was a marked discrepancy between what health care professionals stated they themselves should do in making use of chaplains, and their actual usage of chaplaincy services.

Howard Clinebell, David W. Randle

Whole earth and whole person ministry

Chaplaincy Today

Volume 15 # 2 (- 1999) Page 39-45

For the past two years, the authors have been teaching a course "Whole earth and whole person ministry for the Twenty-first century." In this article they present the biblical foundations of their course and refer to three dimensions of the work as it is specifically related to the role of the chaplain. The three areas are: the Medicine Wheel as a metaphor for wholeness; creature PLEASURE as a way of life; and, Ecotherapy. Not only are the three areas described, the authors elaborate on their usefulness for chaplains.

Sinead Donnelly

Traditions associated with dying in the west of Scotland

Journal of Palliative Care

Volume 15 # 4 (Winter 1999) Page 64-69

Donnelly works in an oncology centre in Glasgow Scotland and thought it would be helpful if more was known about how people had, several generations ago, been supported during their dying, and supported one another when a family/community member was dying, and afterwards. He believes that this information can inform modern palliative care, because professionals will understand something of the customs of the persons they are working with. To this end he went to the Scottish offshore islands of Barra and Skye. The islands share some linguistic and cultural similarities (Gaelic is the first language on both) but Barra is predominantly Roman Catholic and Skye is heavily Free Presbyterian. He conducted twenty unstructured interviews. The stories he has captured will help the modern chaplain to understand what these people did (and still do) to care for their own and themselves at times of dying and death. You attend funerals by invitation. "A formal invitation was as important as an invitation to a wedding." Prayer, salt, nails, hold water - all have their place.

Laura M. Festa, Inez Tuck

A review of forgiveness literature with implications for nursing practice

Holistic Nursing Practice

Volume 14 # 4 (Jul 2000) Page 77-86

Clinical investigators historically tended to shy away from the subject of forgiveness. However, in the past five years or so, this has changed with a

number of clinical psychologists conducting research on various aspects of this subject. In this article Festa and Tuck examine forgiveness where it is a central patient/family issue. They describe the consequences of both forgiveness withheld and the transformative power of forgiveness extended. They define how they understand forgiveness and then look at it in primary, secondary and tertiary intervention terms. To extend the practical value of forgiveness interventions, they describe some of the instruments that have been developed to measure the intrapsychic and interpersonal dimensions of forgiveness. They freely acknowledge that there is much to yet be learned about the processes in forgiveness and conclude by looking at some of the as yet unanswered questions. Their work which will be of value to both pastoral counsellors and chaplains.

David Field, Gina Copp
Communication and awareness about dying in the 1990s

Palliative Medicine

Volume 13 # 6 (Nov 1999) Page 459-468

During the past quarter century, health care professionals in the western world have slowly changed accepted the idea that improved communication with the terminally ill is fundamental to good care. Field and Copp also point out that there is increasing evidence that doctors have changed their policy of "withholding" to a policy of "revealing" to patients their terminal prognosis. Despite this trend, there are recent studies which show that in actual practice, doctors and nurses use "conditional" rather than "full open disclosure." They retain control over information and its disclosure, despite their stated commitment to the ideology of "open awareness." The authors examine this situation looking at some of the recent ideas which have been suggested concerning modes of communication with the dying, and the overall matter of patient awareness of their state. Readers are introduced to Glaser and Strauss' four types of awareness: (closed awareness, suspicion awareness, mutual pretence, open awareness) and Seale's added type: full open awareness.

Richard B. Haines, Bobbye T. Cohen
When the caregiver needs care: a review of the interdisciplinary team response to stressful events in a tertiary care setting

Journal of Pastoral Care

Volume 54 # 2 (Summer 2000) Page 167-172

A Critical Incident Stress Management team (CISM) is a small group of persons, or just one person designated to respond to acute situations of stress in staff by conducting a debriefing session or sessions at regular or certain defined moments in the life of a group in an organisation. They are also expected to articulate the chronic stress which is being experienced by people in a unit, because it is easy for people to become so accustomed to high levels of stress that they have trouble discerning when stress is becoming unmanageable. The authors of this article, a chaplain and a nursing service unit manager describe the development of their CISM team at the Univ. of Virginia Medical Centre, key to which is the integration of chaplains as the "frontline diffusers." They describe an actual debriefing meeting, as well as the processes used in their work. They also offer an evaluation of the strengths and weaknesses of their program.

Zosia Kmietowicz

Guide to caring for Muslim patients published British Medical Journal

Volume 321 # 7255 (22 Jul 2000) Page 198

Report of a newly published book "Caring for Muslim Patients" from Radcliffe Medical Press for 17.95 pounds Sterling (Tel 01235 528820). Material is presented in a patient-centred way and the book covers Muslim customs such as pilgrimage, fasting, and grieving, and the relevance of these to health and the delivery of health care.

Ryan LaMothe

Challenges of faith: transitional objects, faith, and postmodernity

Journal of Pastoral Care

Volume 53 # 3 (Fall 1999) Page 255-267

This essay is LaMothe's examination of the sources of and challenges to faith provided by post-modern society and the ways it thinks. He argues that "post-modernity" challenges the transitional objects important to religious groups for articulating and enacting their faith. These objects include adult religious objects, rituals and narratives. The challenges by postmodernity to such objects and believer's use of them create anxiety in the individuals in religious groups. LaMothe hopes that by understanding such challenges, pastoral care-givers can both respond empathetically, and also develop ministries which will include careful consideration as to how best to respond to such anxiety, given the prevailing pressures of postmodernity on all sides.

George Masterton
Psychosocial factors in selection for liver transplantation

British Medical Journal

Volume 320 # 7230 (29 Jan 2000) Page 263-264

In this editorial, a psychiatrist considers the problems associated with the selection of recipients of (scarce) livers for transplantation. The demand for such organs far outstrips their current availability, a situation which is seen as unlikely to change anywhere in the UK in the near future. There is prejudiced thinking about this issue among the general public, and, to a lesser extent, within the medical profession. (Masterton refers to a paper published in the same Journal in 1998 which revealed a noticeable level of prejudice among physicians in this regard. A surprising number held judgmental moralistic views.) Confidence in the medical system is compromised when the public's value judgements differ from those of physicians, hence the need for greater understanding of the scarcity of organs, for a more clearly defined assessment program which leads to a transparent selection process, and better care of persons with drinking histories. Also, more sensitive assessment of persons with psychiatric illness or disability.

Rajesh Nadkarni, Don Grubin
Stalking: why do people do it?

British Medical Journal

Volume 320 # 7248 (3 Jun 2000) Page 1486

Stalking is a complex behaviour which is as yet little understood. The authors provide helpful information about this kind of behaviour, describing what is known, as well as the limitations in current knowledge. One of their emphasis points is the great psychological damage which can be done to the targeted person. They mention the Suzy Lamplugh Trust as an important source of helpful information.

Harold R. Nelson

The near death experience: observations and reflections from a retired chaplain

Journal of Pastoral Care

Volume 54 # 2 (Summer 2000) Page 159-166

Nelson became interested in near death experiences (NDEs) about 20 years ago when an elderly woman complained to him about the fact that the medical team had resuscitated her. "Why didn't they let me stay? I was in such a beautiful place." Nelson states that he has always maintained a Christian perspective on afterlife, but that NDEs have filled in some

of his blind spots and "greatly illuminated my own viewpoint" about life after death. He describes the elements of NDE that Raymond Moody first presented in *Life After Life* (1975). He then turns to their implications for spiritual care and biblical spirituality. In effect, he presents a list of matters (Nelson calls them guidelines) which he believes chaplains need to be conscious of as they minister to the dying. He suggests that chaplains must be able to help people to: approach death consciously; finish relational business; do their grief work; practice stillness (in meditation-to learn to surrender). He also discusses the importance of pre-death visions, premonitions and dreams.

James A. O'Donohoe

End-of-life care and Catholic ethics

Health Progress

Volume 81 # 1 (Jan/Feb 2000) Page 46-48

Following the recent controversies that arose after the activities of Jack Kevorkian, also known by some as Dr Death, the Roman Catholic church's teachings regarding the provision of pain relief for the dying has been sometimes misrepresented. In this interview, the priest ethicist for the Covenant Health Systems in Lexington MA, Fr O'Brien is asked to clarify his church's teachings on the subject. He does so with brevity and clarity. He answers questions about end of life care and pain control, whether suffering is considered to be good, whether sedation at the end of life is not a treatment option, and family disagreements about end-of-life care. He quotes from the Ethical and Religious Directives for Catholic Health Care Services, the Vatican's Declaration on Euthanasia, Pius XII, among others.

Rebekah Schiff, Chakravarthi Rajkumar, Christopher Bulpitt

Views of elderly people on living wills: interview study

British Medical Journal

Volume 320 # 7250 (17 Jun 2000) Page 1640-1641

Report of a study conducted in two hospitals in London with 74 person aged 65+ (range 66-97 years). Noting that while there has been considerable research in the US concerning various aspects of living wills, especially their use, the same is not true in the UK. The authors of this study found that despite little previous knowledge, many of the persons they interviewed were interested in the concept of an advance directive. 92% indicated they were at a point in their lives when they would no longer

want their lives to be prolonged by medical intervention. Almost 1/3 thought such a document would be helpful because it would mean that a potential burden would be lifted from their family. There are additional findings. The single most feared condition (78%) was advanced dementia.

Annalisa J. Sestini, Kenneth I. Pakenham
Cancer of the prostate: a biopsychosocial review
Journal of Psychosocial Oncology
Volume 18 # 1 (- 2000) Page 17-38

Almost nothing has been written to date about pastoral care to men who have had prostate cancer. Yet it is one of the most common and significant threats to the health and wellbeing of ageing men. The authors provide us with a biopsychosocial overview of this problem, looking at the illness as a complex system of stressors which affects a number of important aspects of a man's life. They give a brief but comprehensive review of the nature of the illness, how it is monitored and diagnosed, the treatment for it, both if it is still localised or if it has metastasised (stage D). However, the majority of the article looks at quality of life after diagnosis and treatment. They describe the impact of surgery and radiation, the effects on the spouse, and sexual impact. In their summary, they suggest that health professionals have important roles in assisting men with decision-making, coping and adjustment. Their words could well apply to chaplains, and this article will provide a helpful starting place.

Liz Smith
So who's teaching whom?
British Medical Journal
Volume 320 # 7230 (29 Jan 2000) Page 323

"Treat people as you would like to be treated." Sounds reasonable, but there is a problem, we are not all the same, as Smith points out using some of her personal and professional experiences. She spent two years as a nurse tutor in Zambia before returning to the UK when the debate about cultural awareness in hospitals was starting in earnest. With colleagues, she has developed a learning pack to help medical and para-medical staff reflect on multicultural issues and to test their self-awareness in this area. The pack *Bedside Manners* may be obtained

from the author at VSO London (Volunteer Service Abroad) at Tel: 0 181 780 7312. The cost is 5 Pounds Sterling. The editor of these abstracts has an examination copy.

Rick L. Williamson
Soul care: spiritual CPR
Journal of Pastoral Care
Volume 54 # 2 (Summer 2000) Page 207-8

A personal reflection in which the author parallels the work of the medical team at a "code" (when a person gets cardio-pulmonary resuscitation) and the work of the chaplain. In our ministry of soul care, he writes, we participate with God in resurrections. The creator God, the resurrected and resurrecting Lord, the breathe of God's Spirit, are present as the pastoral caregiver enters into the "respirations" of struggling souls in his or her care."

R. Wayne Willis
To what shall we liken the hospital chaplain? -
guest editorial
Journal of Pastoral Care
Volume 53 # 4 (Winter 1999) Page 391-394

Willis has some new metaphors that are suggestive of the role the chaplain - sitter, scatologist, seed-picker, stargazer, sistership, storymeister, spy. Chaplains have long used the metaphors of Nouwen, Hiltner, Campbell to capture something of their roles. These are a new and intriguing selection, worthy of reflection. For example, of the role as "spy" Willis writes, beginning with a quote from King Lear: "'And take upon us the mystery of things, As if we were God's spies' (Lear v,iii) When others observe us winding our way through the corridors of the hospital towards a patient's room in the middle of the night, they must sometimes wonder why. What can the chaplain possibly offer the patient in that room in the middle of the night that justifies a call-in from home? What we know, and what they don't know, is that there is more to us and what we do than meets the eye. We are, as the Blues brothers put it, on a mission from God. This clandestine activity is what distinguishes us on the health care team; we have taken upon ourselves the mystery of things. As if we were God's spies." (p.394)