

THE ORERE SOURCE

Abstracts from the Pastoral Care literature and other Helping Professions

A Wee Drap of Scotland in the U.S. Heartland.

Life really has changed in America. The fanatics who brought destruction to New York and Pennsylvania on 11th September 2001 have changed the way we go about our lives, as well as in ways that are as yet unclear. Security is an issue to an extent that was never true before. The financial cost of the war effort has not been fully grasped by the general population. There is an increasingly cynical tone to some of the discussions now taking place in the media and in religious forums about the activities of the Administration, as well as about the entrepreneurs who have appeared in order to take advantage of the personal tragedies in people's lives.

My own immediate encounter with change has been minor. I had to fly to the annual conference of the Association of Professional Chaplains in early March. This now requires arrival at the airport for check-in 2 hours prior to departure, so preparations for an early morning flight that used to start with a shower at 6 a.m. now start at 4:30 a.m. A forgotten Swiss-army pocket-knife in a carry-on bag, led to some moments of excitement at security as I was frisked, searched and my shoes checked for explosives. How could I have forgotten the pocket-knife? Oh, and the small pair of scissors too?

Cincinnati was the location of this year's conference. There had been talk of moving it to another city after rioting occurred there in April 2001. A black man had been shot and killed by a white policeman while fleeing to avoid arrest. The man had 14 outstanding arrest warrants against him. It was another splinter in the eye of a city where there has been on-going tension between the police and the African-American community. There was brief talk about moving the conference to another city, but it is virtually impossible to plan and mount a meeting for over 650 persons in under a year, so Cincinnati remained the venue. The city councillor who gave the city's official welcome was obviously relieved that a large clergy group had not packed their tents for another location.

Race and cultural diversity issues were prominent during the five-day conference. The four plenary speakers were asked to help us understand some of the dimensions of their respective traditions which are important in spiritual care and healing. Rabbi Rami Shapiro spoke from the rabbinic tradition. Leslie Blackhall MD spoke about the impact of Buddhist practices on patient care. The Rev. L.H. Mayfield, now nearly 90 years old spoke about some of the foundational figures in modern Christian pastoral care in the US. Cynthia Lindquist-Mala a.k.a. Hoton Ho Waste Win spoke about the wisdom for healing from the cultural traditions in her Dakotah Nation. Her name translates to mean: "Pretty, good talk woman." She is, and she did!

Of the 28 papers presented in workshop settings, nine were devoted to some aspect of religious or cultural issues. The titles give the flavour of the materials being presented. "Cross-cultural issues in the care of the dying patient;" "Ministering to multicultural groups;" "Maintaining personal faith while ministering in the midst of religious and cultural diversity;" "Religious tolerance at the most vulnerable time in our lives;" "A comparison of American, Jewish and Islamic medical ethics: illness, health and obligation;" "The cultural and religious diversity education series: chaplains providing leadership in valuing and understanding the diversity of our patients;" "Being with the dying: Exploring the world's religious teachings on death and dying;" "Dakotah spiritual care;" "The colour of fear: an exploration of racism and strategies for valuing openness, inclusiveness, and hospitality." The problems of evil and suffering were addressed in three other workshops. The rest of the workshops could be divided into three groups: practical ministry, administration and development of pastoral care departments, and new ministries.

The 278-page workshop syllabus can be obtained from the APC. Details can be requested from the A.P.C. at their website www.professionalchaplains.org or you may contact me direct at oreresource@rocketmail.com Please note that the printed papers published in the handbook range from abstracts to complete papers.

There is an abstract in the following section describing the presentation of Larry Wedel, his distant collaborator Marshall Scott, and other colleagues. Their work and that of Bill Iler and his colleagues (refer to that abstract also) show that it is possible for the person in a one-chaplain department to do some valuable research which will benefit chaplains elsewhere. There is one caveat however. In both of these projects, the work would not have been so valuable had each chaplain not collaborated with others who contributed in ways that made the project a robust one. Research does not have to be complex, though it can be. It does have to be rigorous and many of us in chaplaincy are not well prepared for that aspect of a research project.

All the benefits of a conference can never be planned in advance. Meeting old friends and making new ones, that is what is hoped for, as well as exposure to new ideas about our ministry. Cincinnati was no exception in this regard for me. But there were several unexpected bonuses. A colleague introduced me to his friend, Daniel Davis, who had come to the conference to conduct a workshop. We got to talking about Chicago, and I learned that it had been he (and another seminarian, Glenn Davidson) who had approached the psychiatrist Elizabeth Kubler-Ross for help in finding some dying patients to talk to as part of a term paper for the Divinity School. This had then led to the death and dying seminar at the University of Chicago Hospitals and the work and writings of Kubler-Ross which have played such a large part in the way we talk with dying people today. I mention their names here because they were always unnamed when Kubler-Ross spoke about how her work got started. Unfortunately, Davis could shed no light on the relationship between Kubler-Ross and the Rev. Carl Nighswonger. Nighswonger was the head chaplain at the University of Chicago Hospitals and collaborated with her in the death and dying seminars as they became known. Kubler-Ross became the more public figure and her model in On Death and Dying is quite different to that of Nighswonger. His model has languished, mostly forgotten, despite the fact that it is not open to many of the criticisms which have subsequently been levelled at Kubler-Ross' work. His "dramas of dying" include consideration of affect, as well as cognition and has a much richer potential for informing pastoral care. ("Ministry to the dying as a learning encounter" by Carl A Nighswonger in the Journal of Pastoral Care Vol. 26 # 2 (June 1972) Pp.77-85.) Tragically, his death was announced in the same issue in which this article appeared.

Unfortunately, just before leaving for the conference, I learned of the untimely death on March 5th of David B. Larson MD. He too was 51. An epidemiologist and psychiatrist, he was a tireless researcher in the field of religion and health. He co-authored the Handbook of Religion and Health with Harold Koenig and Michael McCullough. (2001. Oxford University Press) He founded the National Institute for Healthcare Research which has been generously funded by Sir John Templeton. An active Episcopalian layman, he leaves behind a wife, Susan and two teenage children. He also leaves a rich legacy of information and insights that will benefit those of us who address issues of religion and health and who seek to minister with clearer understandings of these two realms.

There was one other surprise in Cincinnati which is worthy of mention. One evening a colleague and I had to get away to finalise the details of a project for the year ahead. It was Sunday evening, and few of the eating places in the centre of the city were open. However, we at last stumbled into Nicholson's Pub, and there in the centre of Cincinnati we had found a delightful Scottish tavern. The waitresses wore tartan, over the fire was a magnificent print of Carnoustie and the menu brought a variety of excellent dishes. I had not anticipated good shepherds pie and sticky pudding in the heartland of the US. Where else could we have found a wine and spirits list that boasted 80 different Scottish malt liquors? And they were only the singles. We had an excellent evening!

Until next time, best wishes to my colleagues across the waters.

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J. Timothy Allen
God-talk as apocalyptic
J of Pastoral Care
Volume 54 No. 4 (Winter 2000)
Page(s) 387-401

Apocalyptic God-talk - talk about God by patients that seems to come right out of the apocalyptic literature, that is the focus of Allen's article. He argues that when patients use such language they can be better understood when the caregiver is aware of the dynamics of, the psychology surrounding, and the spiritual need for such imagery. Allen provides sufficient rich detail so that the reader obtains an understanding that will allow us to reach inside the words to better understand the inner world of the speaker. He also has warnings about the biases in one's training that may make this task difficult.

D. Baldaccino, Peter Draper
Spiritual coping strategies: a review of the nursing research literature
J of Advanced Nursing
Volume 34 No. 6 (Jun 2001)
Page(s) 833-841

This paper examines some of the limited nursing research-based literature which has looked at the use of spiritual coping strategies in illness. The authors want to identify coping strategies used by believers and non-believers, and then discuss the implications of their findings for holistic care by nurses. Their insights may be of value also to chaplains.

While they found 187 articles about spirituality in the nursing literature from 1975 onwards, there were only 5 research studies which examined spiritual coping strategies. Four were done in the US and one in the UK.

The authors suggest that the onset of an illness can make a person, whether a believer or not, realise the lack of control they have over their life. The use of spiritual coping strategies may increase self-empowerment, leading to the findings of meaning and purpose in illness.

Charles Christie
Gwinnett Health System takes chaplaincy into the community
Chaplaincy Today
Volume 17 No. 2 (Winter 2001)
Page(s) 5-9

Christie presents a case in which, following the unexpected death of an office-worker (of 15 years) in front of many staff at her place of work, he is asked

by the human resources department of the firm to go to their workplace to provide pastoral care.

Trained in providing critical incident stress debriefing (CISD), Christie shows how a combination of this approach, group work and ritual were used to help the staff of this business come to terms with what had happened, to mourn their loss, and to ritually mark the death of their colleague.

"This case is just one example of how chaplains can make themselves available to the community in which their institution is located." "..... we sell ourselves short if we limit our vision to those within our hospital walls." "This particular business would never have been able to have its own institutional chaplain, but we were able to provide that service....." (p.8-9).

Timothy P. Daaleman, Ann K. Cobb, Bruce B. Frey
Spirituality and well-being: an exploratory study of the patient perspective
Social Science & Medicine
Volume 53 No. 11 (Dec 2001)
Page(s) 1503-1511

Many articles have now been written attempting to describe the nature of spirituality. Daaleman and his colleagues are among the latest to do so, but their method, while not unique is far more substantial and appears to have produced the beginnings of a model that is trustworthy.

Focus group meetings were held with two groups of women ages 35-75 years. A total of 35 were involved and each group had 3 meetings lasting 2 hours each. Each group was similar in composition to the other in every way demographically, except that the women in one group all had type 2 diabetes mellitus. The women did not know each other beforehand. All the group sessions were taped and later analysed for content.

Upon analysis, it was found that the stories the women told about their lives could be clustered into 8 general groups. The themes of the clusters were: 1. change in functional status; 2. core beliefs; 3. medical/disease state information gathering and processing; 4. interpretation and understanding; 5. life scheme; 6. positive intentionality; 7. agency; and, 8. subjective well-being.

Each of the 8 categories is discussed, with verbatim quotes to illustrate the meaning and typical content of each category. The categories are then brought together in one conceptual framework of health-related spirituality.

Central to the framework are the concepts of life-schema (a framework through which a person views all of their life events) and positive intentionality (best reflected in the saying "mind over matter").

The long-term value of the model for the authors is their hope that they can refine their research and design an instrument that will assess spirituality in a more specific manner. The immediate value for chaplains is the recognition of the dynamic inter-relationships between the different aspects of a person's spirituality. Firstly, it forces us as chaplains to recognise that a person's spirituality is changing all the time. Second, it re-iterates the central importance of meaning-making in response to changes in life, and that it is "found" meaning not implicit meaning that is central. Third, it highlights positive intentionality, describes the practices of affirmative thinking and self-talk. Here the chaplain's task is to encourage the person in these activities, in order to strengthen their spirituality.

Len Doyal

When doctors kill their patients

British Medical J

Volume 318 No. 7196 (29 May 2001)

Page(s) 1432-1433

Early in 2001, an English doctor was acquitted of murder after he had given a dying patient a lethal dose of an opioid. At his trial, he had used the double effect argument for his defence. Doyal here comments on implications of this decision for future ethical debates. He is concerned that the effect of the decision is to raise the question of the moral character of a clinician above the question of the best interests of the patient.

He argues that the double effect argument offers less protection for end of life decisions than might at first appear, and describes several situations where it might offer no protection at all. "It is time we stopped avoiding real debate on the possible legalisation of active euthanasia by pretending that the double effect argument will resolve it for us. It will not." Doyal is a professor of medical ethics.

At first glance, this article may appear to be a rather nit-picking matter. I suggest that time will prove Doyal is correct in making this early warning. The US attorney-general's recent move against the State of Colorado strongly pushes physician's back into double-effect territory, as palliative care physicians are already confirming. If Doyal is correct, it is territory that may prove hard to defend.

A.R. Gatrads, A. Sheikh

Medical ethics and Islam: principles and practice

Archives of Diseases in Childhood

Volume 84 No. 1 (Jan 2001)

Page(s) 72-75

Two doctors from a hospital in Wales suggest that a minimum level of cultural awareness is a necessary prerequisite for the delivery of care that is culturally sensitive. They have simplified and highlighted certain key teachings in Islamic medical ethics and explore their implications.

H. Helm, J.C. Hays, E. Flint, H.G. Koenig, D.G. Blazer

Effects of private religious activity on mortality of elderly disabled and nondisabled adults

J of Gerontological Sciences

Volume 55A No. - (2000)

Page(s) M400-M405

The authors were curious about the effect, if any, of private religious activities such as prayer and Bible-reading on physical survival of the elderly. They followed 3,851 adults ages 64-101 years for six years.

During that period, 1177 died. Even after factoring out such variables as social support and health behaviours, they found that a lack of private religious activity predicted a 47% greater risk of dying.

William L. Her, Don Obenshain, Mary Camac

The impact of daily visits from chaplains on patients with chronic obstructive pulmonary disease (COPD): a pilot study

Chaplaincy Today

Volume 17 No. 1 (Summer 2001)

Page(s) 5-11

This is a groundbreaking article for several reasons. First, it reports a research project conducted by a sole-chaplain in a medium-sized community hospital. Second, the results show that consistent pastoral care affects hospitalisation patterns in ways that can be measured. Third, patient-satisfaction survey scores are again shown to be impacted by pastoral care.

The study focussed on patients with COPD, a group not previously visited on a regular basis by the chaplain. Patients admitted with this diagnosis were randomly divided into two groups - one group contained patients who were visited daily, the other group was not visited at all. (The latter were seen at the start and end of their hospitalisation to obtain some data.)

Several variables were measured: anxiety level at time of discharge; length of stay; overall satisfaction with their stay; willingness to recommend the hospital to others. The results from both groups are then compared and discussed.

The results: anxiety at discharge - significantly lower in visited group. Length of stay - significantly less in visited group; Satisfaction with hospital - significantly higher in visited group. Recommended hospital - slightly more positive in visited group, but not quite statistically positive.

Miller and his colleagues discuss their findings and the limitations of their study.

Michael King, Peter Speck, Angela Thomas
The Royal Free interview for spiritual and religious beliefs: development and validation of a self-report version

Psychological Medicine

Volume 31 No. 6 (Aug 2001)

Page(s) 1015-1023

These English authors have previously published several papers describing their work to develop a way of measuring religious and spiritual beliefs. They have published the details of an interview approach for doing so, for example.

In this paper, they report the development of a self-report instrument which they based on their interview approach. They have found it to be just as reliable as the interview approach. They found, for example, that it could reliably differentiate between persons with high and low spiritual beliefs. Their questions will be of interest to chaplains.

Leonard Leibovici
Effects of remote, retroactive intercessory prayer on outcomes in patients with bloodstream infection: randomised controlled trial

British Medical J

Volume 323 No. 7327 (22-29 Dec 2001)

Page(s) 1450-1451

Each year there is something of a "silly season" in *The Lancet*, a prestigious British medical journal. The Christmas issue usually contains a number of articles in which doctors take a lighter look at their profession, or some matter related to it. This past Christmas, the practice has spread to another important journal, the *British Medical Journal*.

With (presumably) a straight face, the editor has published this article describing research whose objective was: "to determine whether remote, retroactive intercessory prayer, said for a group of patients

with a bloodstream infection, has an effect on outcomes." The patients had been in a hospital between 1990-6, and they were (reportedly) prayed for in July 2000. Leibovici reports that mortality was lowered in the prayed-for group! Also that length of hospital stay and duration of fever were shortened. He concludes that "Remote, retroactive intercessory prayer..... should be considered for use in clinical practice."

Ah, were it that simple! A useful teaching paper which can be used to encourage common sense. Or perhaps we should pray for the author.

Kay Miller

Making the rounds with the pastoral care dog
Chaplaincy Today

Volume 17 No. 2 (Winter 2001)

Page(s) 23-28

There has been some research done in other fields to identify the health- benefits of the involvement of animals with persons who are either physically or emotionally sick, but this is the first paper, to our knowledge, describing the ministry of a dog and a chaplain. Author Miller is both a chaplain and a licensed therapy-dog handler. In her article she describes her pastoral ministry using her dog "Scruffy."

Her article is a report of a research project she undertook to discover whether a trained therapy dog can serve as a "bridge" to restore normal human communication between patient and staff when that has been broken for some reason.

She presented her project to the social workers, case managers and other chaplains in her hospital, suggesting they refer to her patients who were unable to discuss their feelings on a subject; where there was limited communication; where a person was depressed; where a person was fearful or anxiety, especially concerning their physical condition, or the hospital environment; where the patient was angry toward staff or family; and finally, where the patient was in a coma.

She describes the standard precautions (infection control procedures) she observed when she visited patients and then presents six cases - 2 are longer and 4 shorter.

The project was evaluated and determined to be a success and the pastoral care dog will be utilised in Miller's hospital on a permanent basis.

She concludes by describing the criteria for a successful program, as well as the procedure followed by the Delta Society, a US group that conducts for-

mal "team evaluations" to ensure that a chaplain/handler and the dog have the necessary skills to undertake the training necessary for this work. At the end, the Delta Society is also responsible for the final evaluation and credentialing of the team.

A National Bereavement Consortium

Standards of bereavement care in the UK

www.bereavement.org.uk/standards/index.asp

Volume Downloaded 03/02/02

Page(s) 1-9

The web site of the London Bereavement Network has a document which reflects the work of several groups who have a common concern - bereavement care. The Bereavement Care Standards: UK Project was set up in 1998 by the National Bereavement Consortium. It consists of representatives from: Cruse Bereavement Care, the London Bereavement Network, the National Association of Bereavement Services, and the National Council for Hospices and Specialist Palliative Care Services. The project has been funded by the National Lottery Charities Board. The document downloaded contains the results of their collaboration to date - a statement of introduction, the policy context and the basic principles. The core standards section (Section 3.2) are currently being updated. The intention of the project is "to provide a tool to ensure that those who deliver support to bereaved people in the UK can do so safely, ethically, and appropriately."

As it stands, the document reflects the work of the group as at October 2001. It is a complex and detailed document needing to be carefully studied.

Kenneth Pargament, Harold G. Koenig, Nalini Tarakeshwar, June Hahn

Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study

Archives of Internal Medicine

Volume 161 No. 15 (13-27 Aug 2001)

Page(s) 1881-1885

There have been many studies published showing that frequent church attendance is associated with increased life span (though many of these same studies have been dismissed for their lack of sophistication). In some ways, this study reports the obverse effect. Pargament and his colleagues show in this report that religious struggle as the result of an illness increases the risk of dying. This is the first empirical study to identify religious variables that increase, rather than decrease the risk of dying.

They studied 596 patients over a 2-year period and examined their mortality rate. Mortality during the study period was higher in those persons who said they were feeling abandoned or punished by God; those who questioned God's love for them; those who felt abandoned by their church; those who believed that the devil was at work in their illness; and those who questioned the power of God. The mortality risk increased by 6% for every point scored higher on a 0 to 21 point negative religious coping scale.

The revelation of the significant impact of these negative beliefs suggests an important area of ministry which chaplains will need to address in a more systematic way. It is an area of study being undertaken by Chaplain George Fitchett at Rush-Presbyterian Hospital in Chicago IL.

David P. Phillips, George C. Liu, Kennon Kwok, Jason R. Jarvenin, Wei Zhang, Ian S.

The "Hound of the Baskervilles" effect: natural experiment on the influence of psychological stress on timing of death

British Medical J

Volume 323 No. 7327 (22-29 Dec 2001)

Page(s) 1443-1446

Phillips in several earlier research projects has shown that people do not die at random, that people wait to celebrate the holy days of their faith, for example, before dying. In this report he looks at the effect, if any, of the number 4 for Chinese and Japanese people. Unlike white persons, Chinese and Japanese associate the number 4 with death.

By examining the death certificates of approximately 47.5 million, they found that there is "excess cardiac mortality on "unlucky" days." In fact, cardiac mortality for Chinese and Japanese Americans peaks on the 4th day of the month.

Oh, and the title - recall that Charles Baskerville died from a heart attack induced by stress. Phillips and his team suggest that this is the same effect at work in real life as it was in the story by Sir Arthur Conan Doyle.

G.H. Rassool

The crescent and Islam: healing, nursing and the spiritual dimension. Some considerations toward an understanding of the Islamic perspectives on caring

Advances in Nursing

Volume 32 No. 6 (Dec 2000)

Page(s) 1476-1484

The author, writing in England, claims that there is widespread misunderstanding of the concepts and practices of Islam within the context of healthcare and nursing practice.

The focus of his paper is the provision of an awareness of Islamic health practices, health behaviours, code of ethics and a framework of Islamic perspectives on caring and spirituality.

A brief overview of the Muslim world, the historical development of caring and development, and the pillars of the Islamic faith are the context for the paper.

Peter A. Singer

Medical ethics - recent advances

British Medical J

Volume 321 No. 7256 (29 Jul 2001)

Page(s) 282-285

For Singer, the goal of ethics is "to improve the quality of patient care by identifying, analysing and attempting to resolve the ethical problems that arise in the practice of clinical medicine."

With this understanding, he identifies advances he thinks that have been made, and finds them mainly in five areas: end-of-life care, ("the emerging focus on the quality of life and how to improve it") medical errors ("development of the Tavistock Principles, which serve as an ethical foundation for those working to improve medical error"), setting priorities, ("development of an ethics framework - accountability for reasonableness - for legitimate, and fair decisions on setting priorities") biotechnology ("emerging consensus on the acceptability of stem cell research"), medical ethics ("emerging ethical issues include Health, and global bioethics"), education ("the General medical Council's requirement that medical ethics be a core subject in the medical curriculum and the development of a medical ethics curriculum").

Loane Skene, Richard Smallwood

Informed consent: lessons from Australia

British Medical J

Volume 324 No. 7328 (5 Jan 2002)

Page(s) 39-41

According to the authors, courts in both Australia and England have started to apply different standards concerning the information that doctors give their patients. It used to be that giving information in order to obtain an informed consent was considered to have been satisfied when a doctor gave information in the accepted medical way. (What is called the

"Bolam test", which says that doctors are not considered negligent if they do what is accepted by reasonable medical opinion.)

The test appears to be moving from "reasonable doctors" to "reasonable patients" and what they might expect. They cite some recent English case law to suggest that doctors better be aware of this shift, or become liable for not informing their patients adequately. To drive home their point, they include a chart showing the rapidly rising costs of litigation for the NHS in England between 1995 and 2000.

K. Street, J. Henderson

The distinction between withdrawing life sustaining treatment under the influence of paralysing agents and euthanasia

British Medical J

Volume 323 No. 7309 (18 Aug 2001)

Page(s) 388-391

It is both ethical and lawful to withdraw life sustaining medical treatment when continuing that treatment would not be in a person's best interests.

However, there is a potential ethical dilemma located at the point where treatment is withdrawn, as the case study presented in this ethical debate makes clear.

The background is this: Prior to the act of withdrawing life support, if a person has been on a ventilator, they will have been receiving paralysing agents, probably continuously, so that the ventilator can breathe for them. The paralysing agent ensure that the patient and the machine do not fight for breath. These agents take time to clear from a person's system when their administration is stopped. Practically then, a person is paralysed for some time after the infusion is terminated.

The ethical question is this: " Should a doctor wait to turn off the ventilator so that the paralysing agent can clear out of the person's system first? If the vent is withdrawn while the infusion continues, it might be argued that the paralysing agents cause the death of the patient.

A case involving this kind of situation with a 2-year-old girl is presented, with three responses by doctors, and a parent.

David Trembley, Lo-Ann Trembley
God in the oven: about the demonstration of faith and gifts of persons who have developmental disabilities

*****J of Religion, Disability and Health**

Volume 5 No. 1 (- 2001)

Page(s) 75-82

What can persons with disabilities teach us about God? asks the Trembleys. Quite a lot, it seems. They examine the possible gifts and demonstrations of faith in persons who have mental disabilities, and argue that persons with disabilities can contribute gifts to the Church if we are not constantly "correcting" how they believe and what they say.

The Trembley's tell the story of a congregation in which, one Sunday morning, as they bowed for prayer, the voice of a woman, Karen, was clearly heard across the sanctuary: She prayed distinctly: "Our Father in the oven...." They suggest that if you were a member of the congregation you might have later heard responses of judgement: "Karen is not praying properly, we must correct her." Or amusement: "Isn't that cute." The Trembley's suggest that the only theologically appropriate response is humility. "We cannot know what God is doing in Karen's (or anyone else's) spirit."

They take up issues of pistis and gnosis, and what it means to be human,

Authors Various

Buddhist articles on death and dying

http://www.buddhanet.net/r_booksd.htm

Volume - No. - (Aug 2001)

Page(s) 1

This site has many resources concerning Buddhist beliefs and practices, including a page titled "Reflections on death, Buddhist hospices, and HIV/AIDS, which lists 14 articles by a number of authors. "The spiritual needs of the dying," "Ministering to the sick and the terminally ill," and "Death: a Buddhist perspective" are three.

Earle H. Waugh

Muslim "Chicken Soup for the Soul"

The Park Ridge Centre Bulletin

Volume 25 No. - (Jan/Feb 2002)

Page(s) 3-5

There has been a rapid polarisation in US society of majority and minority groups (especially Muslims) following the terror of 11 September 2001. Waugh believes it is timely to be aware that Islamic medicine developed an aspect of health care that is relevant to the current situation, concerning mental health. He refers to what he calls a Muslim version of "chicken soup for the soul." The work was begun in the writings of the physician al-Kindi (801-873), developed further by Muhammad al-Razi (865-924) as Tibb al-Ruhani, literally "medicine of the spirit." The philosopher Ibn Miskawayh (923-1030) carried on this perspective by identifying Tibb al-Rufus (soul medicine) as an important part of Islamic knowledge.

Waugh summarises some of the more important principles of Ibn Miskawayh's description of maintaining health. Two of these may be of interest.

"Take care not to invest completely in physical pleasures and bodily activities, and don't let yourself be bogged down in coveting "things."

"Your mind can do you in; keep it busy with the pursuit of knowledge, and make it work hard. That way it can't be used in counterproductive ways. Remember you are the master of your mind."

Melissa G. West

**Building a playground for your spirit
Spirituality & Health**

Volume 4 No. 3 (Fall 2001)

Page(s) 54-55

Labyrinths, ancient devices found in medieval cathedrals and remote hilltops around Europe can now be found in many modern places, including hospitals. West describes how wooden finger labyrinths can be used by hospital patients. Finger labyrinths, also known as "Troy Stones" were used in Cornwall, England at least 500 years ago. Etched in slate, they were considered sacred, and handed on to following generations - or destroyed upon the owner's death.

West describes their use by hospital patients, where they can be purchased, and there is also a template for anyone wishing to make their own.

This issue of Spirituality and Health also contains photos and comment on over a dozen full-sized labyrinths, in addition to those with West's article.