

THE ORERE SOURCE

Abstracts for the Pastoral Care and Other Health Care Journals

I can still remember when I was very young that our family would gather around the radio at 6:30 p.m. each evening to listen to the BBC news, followed by Commentary. Because it was wartime, it was important that we knew quickly (and reliably) what was happening in the northern hemisphere. In New Zealand, we were so far away. This nightly ritual - though there were other reasons too - seemed to cement our ties to Great Britain, the "home country." It is a tie of which I am still conscious today. It made us conscious of a reality and a heritage that came from half a world away and more.

September 11th of last year had led to a reality and a heritage in a radically different way; one that is proving more bewildering, and frightening and demanding. The newly awakened threat of terrorism here in the U.S., a threat which has been painfully present in other countries for many years, has now taken root for us here in the U.S. We have been awakened to the world of Islam. In the religious community, we are having to re-examine what it means to be a dominantly Judeo-Christian culture which has in its midst a small but growing number of Muslims, Buddhists and other religious groups. It is an awakening that is not always easy.

As hospital chaplains, we have been struggling to define ourselves in an environment notable for the impact of spirituality. We have been trying to decide whether we provide religious or spiritual care - or both. And how these are related. Now there is another ingredient in the mix.

The issue for chaplains, who are mainly Protestant, Roman Catholic, and (fewer) Jewish is to figure out how to respond to the needs of persons of various faith groups heretofore not identified within the hospital setting. What does one do to minister to a Jain? How will a Muslim patient or family receive our offer of ministry?

There seem to be three broad types of responses developing within hospital chaplaincy in the U.S. The first type of response is from those chaplains who function as they always have toward strangers, to offer ministry within the tradition they know best - their own.

The second type of response is to hire a "minority" chaplain of some kind, in the well-meant belief that doing something is better than doing nothing. This is often an indication that a chaplaincy department is taking seriously the fact that there are faith groups in the community who need support during hospitalization, but that realistically there cannot be a religious person on staff to meet the spiritual and religious needs of persons who every faith group. It is often the sign of a good faith effort to meet new pastoral needs.

The third type of response is by pastoral care teams who understand that they cannot bring new chaplains into their hospital, usually for financial reasons, and who then train themselves to be proactive on behalf of persons whose beliefs they do not share. This is a challenging decision. It may necessitate some serious personal theological reflections in the area of soteriology, though by no means exclusively in that arena. Beyond that it will necessitate establishing working relations with appropriate persons from different faith groups in the community; seriously educating themselves about the practices, needs, and expectations of persons from those "new" (to us) groups; and educating medical and nursing staff so that they know that the chaplain's role includes being a contact person no matter the background of a patient or family with religious or spiritual needs, because the chaplain is the person who ensures that the religious needs of patients and families are met.

The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) is the body in the U.S. which sets general standards of care in hospitals. They have adopted standards which require hospitals to create policies and procedures which respect the cultural and spiritual needs of patients. This does not mean that every hospital has to employ a chaplain, simply that the administration of a hospital has to have in place a demonstrable plan to ensure that the cultural and spiritual needs of patients are met. There are teeth in the standards. At the 3- or 4-yearly review, the surveyors look for evidence that the Standards are reflected in a hospital's policies. They then check to see that the hospital is adhering to its own policies in actual practice, and not just writing nice-sounding policies. This all usually translates in to the chaplains' bailiwick. The growing visibility of "new" faiths is accompanied by a growing number of physicians inquiring about the religious practices of their patients, and then making referrals to chaplains. (See the Koenig abstract below.) It means that chaplains have an even greater opportunity to "visit the sick" than ever before, and are asked to do so.

The pastoral care literature now has a reasonably large number of papers which will help in this effort, especially when they are supplemented by papers from the nursing and medical literature. (Contact <oreresource@rocketmail.com> for a bibliography.) It is a time of challenge and opportunity.

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Phil Barker

The tidal model: the healing potential of metaphor with a patient's narrative

Journal of Psychosocial Nursing

Vol. 40 # 7 (Jul 2002) pp. 43-50

Psychiatric nurses use a number of distinct approaches to understanding why they practice their nursing in the ways that they do. One approach, the Tidal Model was developed in the late 1980s, and Barker, a professor of psychiatric nursing practice describes the approach, its features and values.

According to him, it uses a pragmatic and respectful approach to helping patients identify problems of living. It emphasizes the centrality of the patient and their lived experiences. Methods of revealing and clarifying meaning and values which patients attach to or associate with problems of living are addressed. When appropriate, this exploration extends from the intra- personal through interpersonal conceptions of self and others to address the religious, mystical or spiritual dimensions of self-hood.

In emphasizing the fluid nature of human experience, the model recognizes that change, growth and development often occur through small, often barely noticeable changes, following patterns that can be unpredictable. The model holds few assumptions about the proper course of patient's lives, unlike other theories of psychiatric nursing. Instead, it fo-

cuses on the types of support patients believe they need to live good lives. The Tidal Model recognizes that life experiences associated with mental illness are invariably described in metaphorical terms. The model assumes that patients are their narratives.

As part of his conclusion, Barker states: "The exploration of meanings patients attribute to the experiences of their lives is one definition of spirituality. As such, it is possible that for some patients, the process of working with the narrative of their problems of living ultimately might be construed as a form of spiritual enquiry". (p.49)

Miriam C. Berkowitz

Moses meets Kubler-Ross: the five stages toward accepting death as seen in the Midrash

Journal of Pastoral Care

Vol. 55 # 3 (Fall 2001) pp. 303-308

In her paper Rabbi Berkowitz describes and discusses a midrash which begins with the Biblical verse in Deuteronomy(31:14) in which the Lord tells Moses that the time of his death is approaching. The midrash is a long one, and Berkowitz follows Moses' reactions to the news of his forthcoming death. She finds in the rabbinic interpretations, a process which parallels Kubler- Ross's stages of dying.

Having shown the parallels, she presents their implications for caregivers. Her focus is primarily on the pastoral care of Jewish patients by rabbis, but her insights about the grief process in persons anticipating their death will also be of value to other-than-Jewish chaplains.

Colin Douglas

The royal touch

British Medical Journal

Vol. 325 # 7355 (13 Jul 2002) pp. 111a

Funding for chaplaincy seems to be a world-wide issue. The matter has popped up in a short satirical piece published in the British Medical Journal by a Scottish doctor who is also a novelist.

In a piece lampooning certain excesses in the UK health delivery system, he mentions chaplains. Describing how a hospital may have to build and lease retail shopping space in order to make money for their health care operations, he writes: "Only one unit in our much admired retail mall was still to be let, and they (referring to a group of volunteers) were bidding against both our former chaplaincy - now the PFI's choral/spiritual entertainment cost centre - and Starbucks; and in the fair and open competition that characterizes the modern NHS, Starbucks won hands down. So, like the chaplain, the (volunteers) must now get real, think serious flag days and big coffee mornings, and try again in the next bidding round. We wish them well."

Ah, if only it were not so close to the truth!!

Bruce D. Feldstein

Toward meaning

Journal of the American Medical Association

Vol. 286 # 11 (19 Sept 2001) pp. 1291-1292

Feldstein describes his experience when, as a physician in his emergency department, he has to care for an 86-year old woman who is critically ill, and who asks him, point-blank, to tell her the results of her brain scan. He had hoped to pass her back to her oncologist, but she wanted to know, now.

He has to tell her that her cancer has spread to her brain. They continue to talk and seeing a crucifix around her neck, he asks her if she is a prayerful person. She says she is, and he awkwardly offers to pray with her. "Now what? We were from different worlds. She was Catholic, originally from Mexico. I am Jewish, originally from Detroit and, at 43, half her age. We had only just met. She prayed to Jesus. I do not pray to Jesus. What would I say? I certainly

had not been prepared in medical school for a situation like this."

Feldstein describes what then took place, the marvellous unfolding of faith, for both of them. He then reflects on the ethical aspects of what he had done.

He is now a full-time hospital chaplain.

P. Gallagher, K. Clark

The ethics of surgery in the elderly demented patient with bowel obstruction

Journal of Medical Ethics

Vol. 28 # 2 (Apr 2002) pp. 105-108

What would you want your surgeon to do if you were: in your late 70s, suffering from a dementia, incontinent and you could not recognize your family? Then a surgeon discovers that you have a bowel obstruction.

Such a situation is typically a medical emergency. Conservative treatment with intravenous fluids and enemas are tried but unsuccessfully. Would you want to undergo surgery for what is probably going to be a carcinoma or diverticulitis?

The authors contacted 37 surgeons in Great Britain and Ireland who specialize in colon surgery to find out how they would evaluate a situation like this, and decide what to do.

There was a remarkable diversity of responses: 26% said they would do nothing, while 35% would operate. Some would operate against their own judgment, if the family wanted the surgery. Some would not do so.

The article will provide chaplains of elderly patients useful insights into the issues to be considered before a family makes a decision about an elderly family member, as well as shedding light on the diverse practices of surgeons concerning the same medical problem.

John Harris, Charles Erin

An ethically defensible market in organs - editorial

British Medical Journal

Vol. 325 # 7356 (20 Jul 2002) pp. 114

Now that the A.M.A. has voted to encourage studies to determine whether financial incentives would increase the pool of donated organs from cadavers, the debate about whether such a practice is ethical is beginning to come alive.

The authors here re-present a proposal they made in 1994. It would allow an ethical market in donated organs from living but unrelated donors. They assert that if legitimate ethical and regulatory concerns

could be met, then an ethical case can be made for such activity. They propose a "monopsony", a situation where only one buyer exists for the products of several sellers. That purchaser would obtain and then would have the responsibility for ensuring that there is fair distribution for all the organs and tissues purchased. In other words, the monopsonist runs the scheme of collecting and allocating.

Several other ethical and practical issues are presented on an issue demanding the widest possible debate. Such a change would necessitate a major shift in ethical thinking and social acceptance.

Harold G. Koenig

An 83-year-old woman with chronic illness and strong religious beliefs

Journal of the American Medical Association

Vol. 288 # 4 (24/31 Jul 2002) pp. 487-493

Some chaplains, for a variety of different reasons, have become alarmed at the thought of doctors starting to discuss religious beliefs and practices with their patients. In this article, Harold Koenig, who has published widely in this area, provides a very clear example, using a case history, of what he believes are the appropriate boundaries and behaviours for doctors who do so.

His remarks are made in the context of a grand-rounds where an 83-year old woman is presented. She has multiple medical problems yet manages to cope with her illness, which produce chronic progressive pain and weakness. She is able to cope remarkably well, aided in large part by her religious faith.

We are given the patient's medical history, the views of the patient herself about her life and suffering and the place of her faith. Koenig then answers questions put to him by other physicians. In this section, he addresses such matters as: do religious beliefs make a difference in terms of health and coping? (unequivocally, yes), how religion facilitates coping with chronic pain, disability and serious illness, and the major current questions being asked by physicians about; taking a spiritual history, religious beliefs influencing medical decisions; religious beliefs that conflict with medical care; the role of a supportive community; the patient have additional religious needs.

His concluding comment is about "professional boundaries" in which he points out that while more than half of the US medical schools now have courses on religion and medicine "a couple of lectures or even a more intensive course throughout a

semester or 2 is no match for the training a chaplain receives. Whenever anything but the most simple and uncomplicated spiritual issues come up, chaplains or pastoral counsellors should be consulted." (p. 490) There are 74 references and a box with five questions for taking a spiritual history are appended. His questions are different from those suggested by Christine Pulchalski.

Giles Legood

Chaplains and the parochial ministry

Contact

Vol. 138 (2002) pp. 3-9

Giles sketches the long and varied history of clergy in the U.K. who became chaplains when they were sent to work outside the usual parochial structures, starting from as far back as the 14th century. It is because chaplains have ministered outside the established structures of the church for such a long time, Legood suggests, that they have much to contribute today to discussions about the roles the Church in the community in this new century.

In light of the fact that most people do not live settled lives, in one location, which was the norm when the traditional parochial system was first devised (by Theodore in the 7th century) the church is having to rethink its strategy for ministering within communities which are both larger and more transient, where multicultural issues are the norm, and where working relationships between persons of other faiths have to be developed.

He offers talking 8 points for discussion by the churches, all of which are based on particular insights arising out of chaplaincy ministry.

Jacqueline Lowden

Children's rights: a decade of dispute

Journal of Advanced Nursing

Vol. 37 # 1 (Jan 2002) pp. 100-107

What does it mean to be a child when the child becomes sick? What are the rules governing the child's right to make, or to participate in decisions about their treatment? When must a child's decision not to undergo treatment be accepted? These are some of the questions relating to Lowden's review of the ethical principles governing the health care for children in the U.K. in light of the passage of the Human Rights Act (Dept of Health 1998) which became law in the UK in Oct 2000.

Despite the debates of the 90's, with all the recommendations which have been made, a child's rights,

especially the ability to consent to health care, remain complex and inconsistent.

Lowden suggests that the way forward must involve the development, in adults, of a more pragmatic approach. (NB: In his mind, the pragmatic approach includes a balance of protectionists and liberationist ideas.) which will require a better understanding of children and their experiences of health care. What is in the "best interests" of a child can only be discovered by exploring the nature of a child's experience.

Thomas St. Journal. O'Connor, Fred Koning, Elizabeth Meakes, Kelly McLarnon-Sinclair, Quantity and rigor of qualitative research in four pastoral counselling journals

**Journal of Pastoral Care
Vol. 55 # 3 (Fall 2001) pp. 271-280**

Presents the results of their study on the quantity (found to be limited) and rigor (overall fairly weak) of the qualitative research published from 1993-1997 in the Journal of Pastoral Care, Pastoral Sciences, the Journal of Religion and health, and Pastoral Psychology. There are just 26 studies.

Aside from the importance of the findings themselves, this article is of value for any chaplain who wishes to do some research about their ministry, because the methodology used to evaluate the articles is spelled out in a clear and detailed manner. In effect, their criteria are a potential road-map for doing good research

But even before the methodology, they describe the overall field of qualitative research, providing an introduction to the various approaches that are now in use, how they differ from one another, and the respective values of each. They cite examples from each field.

The article is a gold-mine for any chaplain considering doing some research.

**Tom Sensky
Withdrawal of life sustaining treatment
British Medical Journal**

Vol. 325 # 7357 (27 Jul 2002) pp. 175-6

The case of Ms B, a 43 year-old woman who in 1999 suffered a haemorrhage in her upper spinal cord, almost completely recovered, only to re-bleed again in early 2001, is discussed from an ethical perspective. The second event left her a quadriplegic and needing permanent ventilator support. It was this latter fact that was most troubling for Ms B, and after seeking much information took to court the

NHS Trust treating her because they would not agree to have her ventilation discontinued.

Dame Elizabeth Butler-Sloss who wrote the judgment is favour of Ms B stated in part that "the right of the competent patient to request cessation of treatment must prevail over the natural desire of the medical and nursing professions to try and keep her alive."

Sensky reviews the arguments that had been presented by the patient's doctors, and also describes what a doctor must do if they feel they cannot remove a person's life-support under such circumstances.

**Hans-Christoph Steinhausen
The outcome of anorexia nervosa in the 20th century**

**American Journal of Psychiatry
Vol. 159 # 8 (Aug 2002) pp. 1284-1293**

Has the outcome of treatment for anorexia nervosa improved in the last 50 years? Having looked at 119 studies of 5, 590 patients, Steinhausen answers, no, he can find no convincing evidence that it has. The mortality rate is still 5%. In surviving patients, just under half (47%) fully recover, 33% improve, and 21% go on with the problem as a chronic one.

**Jackie Stephen-Haynes
The concept of hope - a phenomenological study
Journal of Community Nursing
Vol. 16 # 3 (Mar 2002) pp. 1-9**

In the UK, 2.7 million people receive care annually from district nurses. They are stereotyped as nurses who "drink tea in an unhurried, low tech, backwater service..." and while they are being pushed to undertake increasingly technical tasks, Stephen-Haynes argues that there is an urgent need for these nurses to also have a greater understanding of the psychological and spiritual elements of the care they provide.

In order to ensure that these elements are included in the nursing practices of the future, she argues that there must be a clearer understanding of some of the intangibles which nurses promote in their work, with hope being central. Her paper is a report of her research study which investigated what district nurse understood hope to mean.

She found that for district nurses, the essence of hope was comprised of: patient centered holism, care, partnership and personal worth, future orientation grounded in the past and linked to the future, and, spirituality.

The article has an extended and comprehensive bibliography from within the nursing literature.

Howard Stone, Andrew Lester

Hope and possibility: envisioning the future in pastoral conversation

Journal of Pastoral Care

Vol. 55 # 3 (Fall 2001) pp. 259-269

The cornerstone of pastoral conversation is hope, according to Stone and Lester, who describe how they have arrived at this conclusion, and who then present a number of specific ways in which care-givers can encourage or evoke hope in the persons they minister to.

Their understanding of the nature of hope begins in Kierkegaard's understanding of persons. He describes individual's as possessing actuality (which refers to the past), freedom (what we have in the present), and possibility (which addresses the future). Stone and Lester assert that clergy "need to foster a kind of hope that recognizes actuality, but also steps directly into the future by exercising freedom in the present - by taking action." (p.260)

"Hope represents a future filled with possibilities, and it offers a blessing. Used theologically, the word hope is a recognition of possibilities that lie ahead, a trusting anticipation of a time when troubles lessen or end, an investment in a tomorrow that holds promise. It is based upon a trustworthy God who calls us into an open-ended future, who promises deliverance, liberation, salvation." (p.262)

They present a number of different ways, eight in all, which chaplains and pastoral counsellors can use to help persons focus on the future, and thus engender hope. They discuss in turn: reframing, storytel-

ling, tracking and expanding future stories, envisioning the future without the problem, establishing future goals, imagining a miracle, guided imagery, and, "as if" conversations, giving examples of each.

John Swinton

Editorial

Contact

Vol. 138 (2002) pp. 1-2

Introduction to an issue on the changing roles of chaplains, and the meaning of chaplaincy in a changing social and professional context. Swinton suggests that "chaplaincy may be emerging as a discipline charged with the responsibility of caring for the spiritual needs of patients, but which has no necessary connection with religious communities." Swinton writes from a United Kingdom perspective.

Godfrey P. Oakley

Delaying folic acid fortification in flour

British Medical Journal

Vol. 324 # 7350 (8 Jun 2002) pp. 1348

Oakley accuses European governments, including the government of the United Kingdom of "public health malpractice" by their refusal to mandate that flour be fortified with folic acid.

He thinks it is especially ironic that the UK has not done so, because it was in England in 1991 that it was discovered that folic acid dramatically prevents some common and serious birth defects, namely spina bifida and anencephaly. He cites the marked decrease in these birth defects in the US since the addition was made there in 1997.