

ORERE SOURCE

Abstracts for the Pastoral Care and Other Health Care Journals

Some Thoughts About Speaking for Ourselves

The best known firm in the U.S. for working with hospitals to help them measure patient satisfaction, and plan for improvement of patient care services is Press Ganey. This past summer they published an article by Harold G. Koenig M.D. It can be accessed on their website. (www.pressganey.com and type the name "Koenig" in the search feature.)

Koenig is an associate professor of psychiatry and internal medicine at Duke University Medical Center, and has been one of the U.S.'s leading medical proponents of the idea that doctors should take account of the spiritual needs of their patients. To date he has published over 100 articles in peer-reviewed journals concerning different aspects of health, religion and spirituality. For Press Ganey's publication *Satisfaction Monitor* (July/August 2003) he wrote a review piece titled "*Meeting the spiritual needs of patients.*" In it he describes the spiritual needs of patients, looks at the data concerning the frequency of such needs, and how often they are addressed, describes the consequences of unmet spiritual needs (quoting his own work and that of Kenneth Pargament) and concludes with some suggestions about how to address patients' spiritual needs. He offers five questions that he suggests all health professionals should be trained to ask:

- Do your religious or spiritual beliefs provide comfort and support or do they cause stress?
- How would these beliefs influence your medical decisions if you became really sick?
- Do you have any beliefs that might interfere or conflict with your medical care?
- Are you a member of a religious or spiritual community and is it supportive?
- Do you have any spiritual needs that someone should address?

He concludes by stating that once spiritual needs have been discovered, the health professional "must orchestrate the meeting of those needs. This may involved referral to chaplain services, providing access to inspirational readings or directions to the hospital chapel; notifying the patient's clergy or friends at church; praying with or simply listening and trying to understand." The article also announced that at Press Ganey's National Conference in November 2003 Koenig would present a session titled: "Religion, spirituality and health: meeting the spiritual needs of patients."

In a few days, news of Koenig's article and of his conference session reached a large group of on-line chaplains, which, though based in the U.S. also has participants in the United Kingdom. (Any chaplain may join by going to www.yahoo.com, selecting Groups, and signing up for the "pastoralcare" group.) From the reactions in the correspondence that followed, it was clear that a lot of oxes had been gored. Surely it was not appropriate that a physician, rather than a spiritual care specialist such as a chaplain should be the one making such a presentation!! What gave him the legitimacy necessary to be presenting outside his field of expertise? Gored indeed!

So what does make him a legitimate presenter outside the field of his professional training? I was still pondering the question when the July-August issue of *Holistic Nursing Practice* arrived (Vol. 17 # 4). It contains three articles which focus on "spirituality in nursing interventions". The first article is "*Examining the ethics of praying with patients*" by Winslow and Winslow. In it, they establish an ethical basis for nurses upon which they can offer prayer as part of their respectful care for patients, and at the same time maintain their own integrity. They present and discuss five guidelines for doing so.

The second article is "*Prayer's clinical issues and implications*" by Elizabeth Johnston Taylor. Her key question is: How shall nurses incorporate prayer in nursing practice? It was this paper that made me weep, not because it is a bad paper. Quite the contrary, it is an excellent paper. I wept because it was a paper which should (and could) have been written by a chaplain. Taylor approaches the subject of prayer with patients with the greatest

possible care, and making use of all that has been discovered and described in the pastoral, nursing and psychological literature. She has done her homework, even locating one of the very early articles on prayer and the dying patient in a long-forgotten gem of a book from the mid-1970s. (Bane, Kutscher, Neale and Reeves (eds) Death and Ministry (1975) U.S. publisher - Seabury.)

Consider the matter of *how* to pray. She quotes several pieces of research (all done in the U.S.) which have indicated that most adults pray conversationally (as opposed to meditatively or ritually). She also quotes a small Australian study which showed that a person's style of prayer changes as their health status changes. Taylor's point is that a nurse's (and chaplain's ?) approach to making prayers needs to match the situation, personality as well as the current physical and spiritual status of the person.

She discusses the matter of assessing if and how one should pray with a patient. She suggests two questions that can be used. However, she also notes that assessment questions may not be necessary if the nurse has been listening carefully to the person's story. "Prayer can take the form of listening for what individuals would have said if they were in touch with their real feelings and needs."

Taylor looks at the research experience which has considered how illness affects patient's prayers, and addresses the spiritual conflicts that patients may be experiencing. She also lifts up the difficult matter of how to help a person address questions or doubts about prayer. "I can't concentrate, so how can I pray?" "How do I pray when I am too sick?" "Am I praying the right way?" "Why is God silent? Is God there?"

There are additional matters which Taylor addresses e.g. supporting a person without praying with or for them ("I am hearing your doubts about whether God is answering your prayers. I know that must be disturbing. I sense that it would be helpful for you to have someone more experienced than I to talk with you. May I call the chaplain or someone you prefer?")

Then there is the patient for whom prayer is harmful. Taylor helpfully describes a short process for engaging the patient who believes, for example that prayer will be more efficacious than treatment and refuses the latter. Throughout her paper, she is making use of the reported wisdom of many care-providers, and presenting it in a manner which will undoubtedly educate nurses, and may hold insights even for experienced chaplains.

So what makes Taylor (and Koenig) legitimate presenters? They have done their homework and have spent the time and effort it takes to gather the insights of others - and their own - into an accessible and useful vehicle for helping others to learn. And that is how it will continue until we chaplains tackle the challenging task of representing our ministry, and different aspects of that ministry to those colleagues outside our field of training, and also to our own junior colleagues.

Right after the brouhaha following Koenig's temerity to be a spokesperson for spiritual care, a woman chaplain who has been challenging her colleagues to do research and to write about spirituality did so again, calling on someone to contribute to Press Ganey's readers from within the profession. As I write these words, no one from among the 350+ chaplains in the pastoralcare group has offered to do so.

(A copy of Taylor's article may be obtained by contacting oreresource@rocketmail.com)

Rev. W. Noel Brown, Chaplain and ACPE Supervisor, North-western Memorial Hospital, Chicago, and editor of the ORERE SOURCE, a bi-monthly compendium of his abstracts from the pastoral care and healthcare literature. Contact: oreresource@rocketmail.com

Homer U. Ashby

Being forgiven: toward a thicker description of forgiveness

J of Pastoral Care & Counseling

Vol. 57 # 2 (Summer 2003) pp. 143-152

The last decade has seen a significant increase in interest in the general topic of forgiveness, leading to the appearance of several major books on different aspects of the subject. (McCullough, Pargament, & Thoresen (eds) Forgiveness: Theory, Research, Practice (2000) Guilford Press. Worthington (ed) Dimensions of Forgiveness: Psychological Research and Theological Perspectives. (1998) Templeton Foundation Press.)

Ashby has noted that a less commonly studied aspect of this subject is seeking forgiveness from others. He describes both the process of seeking forgiveness, and then being-forgiven process, before giving examples. He concludes by examining the specific steps of being forgiven, which he presents as a four-step process. (8 refs)

Lyndsay S. Baines, John T. Joseph, Rahul M. Jindal

Emotional issues after kidney transplantation: a prospective psychotherapeutic study

Clinical Transplantation

Vol. 16 # 6 (Dec 2002) pp. 455-460

When a kidney transplant proceeds uneventfully, as they now routinely do, the patient's hospital course may not (from an emotional perspective) reflect how the person will cope in the months following.

This study, done in Scotland and still on-going, is being conducted to examine the relative benefits of psychotherapy (individual versus group versus none) for persons who have received their first cadaver transplant.

Of interest to the chaplain will be their findings concerning the emotional states of such patients. Negative emotional states appear to be the single most influential factor in determining the quality of life after a medically successful kidney transplant. The primary emotional concern for these patients appears to be their wish to "return to normal," with "normal" often being defined with reference to their former life perspectives, before the onset of their renal disease. Consequently, much of the help needed by these patients is to assist them in redefining normality, to be understood in terms of daily (social, relational, vocational, recreational) lifestyle. The person who is unable to do this experiences

ongoing frustration, a sense of failure, and low mood.

The paper has a rather rich description of what the inner world of these persons can be like.

**The CHA Theology and Ethics Department
Genetics and confidentiality**

Health Progress

Vol. 84 # 1 (Jan/Feb 2003) pp. 24-25

The first of six ethics cases which will appear in this journal.

This case involves genetic testing and issues of confidentiality. The case involves a man in his late 20s who tests positive for early-onset Alzheimers Disease, and who is subsequently denied employment on the basis of this information.

Following the case, there are discussion questions for sponsors and board members of a hospital, for executive teams, and for ethics committees. There are also brief highlights of guiding ethical principles drawn from Roman Catholic moral tradition. A side-bar lists several resource articles.

B. Casey, A. Long

Meanings of madness: a literature review

J of Psychiatric and Mental Health Nursing

Vol. 10 # 1 (Jan 2003) pp. 89-99

How people make meaning for themselves when they are sick is of great importance for chaplains. When a person is mentally ill, in addition to the normal complexity of the process which is grounded in our human nature, there is another layer of complexity associated with the illness itself for the chaplain to work with.

This paper examines how people make sense of the experience of mental illness. They are influenced by the contexts of their environments, available cultural explanations, and the nature of their mental states.

The authors suggest that when a person experiences a psychological trauma, they attempt to regain a sense of order by imposing a narrative structure on the trauma they are experiencing. And when such personal stories are shared, the meanings they began with are shaped and refined through talking and over the passage of time.

Richard Chartres

Healthy living: healthy dying

<http://www.Kingsfund.org.uk/>

Vol. Downloaded 07/25/2003 pp. 1-6

The Kings Fund is an English independent charitable trust whose purpose is to improve health, espe-

cially in London, England. This paper is the annual lecture for 2003 by the Fund's President, the Reverend and Right Honorable Richard Chartres, Bishop (Anglican) of London. He describes how Western society today seems to be unable to see life and death holistically. Because of our strong Western medical model, no integrated view can develop of the person who is sick. Nor can a vision be created of the culture from which sick persons come.

However, he does not limit his criticism to the medical profession. "The Western Churches have a confession to make here. They have played a part in casting into shadow the social and relational aspects of healthy living and healthy dying by sometimes narrowing their discussion of what constitutes salvation to focus on mental assents and dispositions. The word used in the New Testament for "salvation" and the verb "to save" both include the idea of restoration of physical well-being and healing and do not simply point to some supposed spiritual part of ourselves. "Salvation in the Christian tradition was originally a holistic notion which was bound up with building a health giving community." (p. 3)

He also speaks out against thinking of health as a commodity, that there be a "truce" in reorganizing health care organizations; and that the culture of blame in health care be more and more discouraged.

Linda Ganzini, Elizabeth R. Goy, Lois L. Miller, Theresa A. Harvath, Ann Jackson,
Nurses' experiences with hospice patients who refuse food and fluids to hasten death
New England J of Medicine
Vol. 349 # 4 (24 Jul 2003) pp. 359-365

There are well-known barriers preventing patients from being assisted in ending their life (euthanasia, physician-assisted suicide). However, the choice to stop eating and drinking is legal throughout the US, is an option for competent patients, and does not necessarily require the participation of a physician. The authors of this paper, who are from Oregon where physician-assisted suicide is an option available to residents, decided to find out whether persons do in fact choose to end their lives by ceasing to eat and drink. They asked nurses in hospice programs whether they knew of persons who had done so, and also about persons who had asked for physician-assisted suicide, so that they could compare and contrast the two groups. One hundred and two nurses (33%) reported that they had cared for at least one patient who had hastened their death by stopping all food and liquid intake.

The nurses reported that persons had done so because they were ready to die, saw their continuing existence as pointless, and considered their quality of life poor. The nurses reported that 85% of the patients died within 15 days of having stopped the food and fluids, and on a 0 - 10 (very bad - very good) scale, the median rating for the quality of these deaths was 8.

While there are ethical issues that need to be considered, the authors suggest that there should be further discussions about the choice to hasten death by refusing food/fluids, and about standards for evaluating and caring for patients who make this choice. (24 refs)

Fiona Haas
Bereavement care: seeing the body
Nursing Standard
Vol. 17 # 28 (26 Mar 2003) pp. 33-37

What evidence is there to support the commonly accepted belief that it is helpful to the subsequent grieving process for family members to view the body at the time of death?

Haas looks at reports from a variety of different settings, mainly disasters, and concludes that, generally speaking, it is beneficial for people to see the body of the deceased, even if the body has been damaged. There are strong emotional reactions at first, but the grieving process appears to resolve itself more beneficially when the deceased has been seen.

However, Haas has also found some reports which suggest that seeing the deceased can be traumatic, and make it difficult for the person. She describes these findings.

In summary: it is natural to want to view the body and relatives should be encouraged to do so; if they wish, children can view the body, they may need support; children benefit from being treated with honesty and are helped by being involved and not isolated; if the body has been damaged, the family should be prepared, but not prevented from viewing if that is their wish; relatives may need time and privacy to be with the deceased; more research is needed concerning mother's reactions to stillbirths; the wishes of those who do not wish to view the body should be respected.

Keith Hawton, Sue Simkin
Helping people bereaved by suicide
British Medical J

Vol. 327 # 7408 (26 Jul 2003) pp. 177-178

Does bereavement by suicide differ from bereavement resulting from some other form of sudden death? Not necessarily, according to this paper. However, certain themes or features in the grieving process may be more prominent. These are: stigmatization, shame and guilt, and a sense of rejection. The authors also point out some of the social and environmental factors which affect the course of the grief process.

The article includes contact details for 5 organizations in the U.K. They also name two useful books: A Special Scar by A. Wertheimer (2001) Brunner-Routledge; and, The Bereavement Information Pack for those bereaved by suicide or other sudden death, from the Royal College of Psychiatrists in London.

Christine Kennedy, Sharon E. Cheston
Spiritual distress at life's end: finding meaning in the maelstrom

J of Pastoral Care & Counseling

Vol. 57 # 2 (Summer 2003) pp. 131-141

What is a spiritual emergency? How would you define spiritual distress? Hospice chaplains are very familiar with patients who are distressed, but who, when they are provided with standard psychotropic medications fail to respond and continue in their distressed state. Kennedy and Cheston suggest that acute distress that has no organic etiology (and is therefore unresponsive to pharmacologic intervention) is most likely a manifestation of spiritual distress.

In their paper, they suggest there is an urgent need for continuing dialogue across all disciplines in hospice care in order to more certainly identify spiritual distress so that spiritual distress can be appropriately responded to. They report anecdotal evidence from four hospice professionals of differing backgrounds who each describe their work in identifying and responding to this kind of distress. (25 refs)

Daniel E. Lee
Physician-assisted suicide: a conservative critique of intervention

Hastings Center Report

Vol. 33 # 1 (Jan/Feb 2003) pp. 17-19

Lee is unambiguously opposed to physician-assisted suicide. He agrees with Karl Barth: "it is for God and God alone to make an end of human life."

(Church Dogmatics Vol III: The Doctrine of Creation, Part 4 (1961) 404, 425.) He has been active in his opposition.

However, he says he has begun to struggle with the question whether "those of us with deep moral reservations about the morality of physician-assisted suicide have any business using the coercive power of government to try to prevent those who disagree with us from doing what they believe is right?" He has come to the position, based on ideas spelled out in On Liberty by John Stuart Mill, and Joel Feinberg's more recent commentary (Social Philosophy (1973) 49-51) that it is more important to truly discover what a person's choice is concerning his present and future medical situation.

He adds that Oregon's Death with Dignity Act has not created a slippery-slope situation as he and many of his like-minded colleagues had feared.

"Those of us opposed to physician-assisted suicide would do well to focus our efforts on helping others discover the meaning and hope that are possible in life, even in the midst of suffering. We can accomplish far more by reaching out in a loving, caring manner to those experiencing great suffering, instead of sitting around moralizing about what they should or should not do and threatening physicians with legal penalties if they act in ways at odds with the values we hold dear." (7 refs)

Julia Neuberger
A healthy view of dying
British Medical J

Vol. 327 # 7408 (26 Jul 2003) pp. 207-208

Neuberger, a rabbi in London, urges society to adopt a new approach to dying, one that will allow persons to have a good and healthy death. She believes that insufficient attention is often given to the overall world of the person in the care that is provided for them as they are dying; that psychosocial and spiritual care is essential for a good death; that the curative model of care does not fit for chronic conditions that may lead to death; and that hospices have the right approach to good death, but largely for patients with cancer, AIDS, or motor neurone disease, a fact that leaves many terminally ill people untouched by good care as they die.

Michele Le D. Sakurai
The challenge and heart of chaplaincy
Health Progress
Vol. 84 # 1 (Jan/Feb 2003) pp. 26-28, 56

Sakurai describes the many recent changes in health care in the U.S. which have, in turn, brought changes to the roles of hospital chaplains. They are now expected to have expertise in areas such as risk assessment, crisis intervention, advocacy, cultural and religious diversity, ethics, the ability to integrate the patient's story into a larger faith perspective, create and enact ritual support, be able to discuss end-of-life issues, and bereavement and grief. It is an excellent resource article which will help chaplains interpret chaplaincy to community clergy and the institutional religious community.

Yolande Saunders, J.R. Ross, J. Riley
Planning for a good death: responding to unexpected events
British Medical J
Vol. 327 # 7408 (26 Jul 2003) pp. 204-206

When a terminally ill patient develops an acute problem, risky emergency treatment may seem futile to the medical staff. But sometimes patients are not ready to die. What is a good death in such circumstances, and how can the health care team achieve it?

In this case, authors describe the medical choice points that they reached. The patient was a 19-year-old man with cancer of the prostate, lung metastases and bone marrow disease. He was in a hospice unit. He began to bleed at a catastrophic rate. The question became: what to do? He was "fully alert and fully oriented."

The paper describes how the doctors proceeded from that point. It is an excellent, albeit tragic ethics discussion case. (14 refs)

Nancy Scheper-Hughes
Keeping an eye on the global traffic in human organs
The Lancet
Vol. 361 # 9369 (10 May 2003) pp. 1645-1648

"The ideal conditions of economic globalization have put into circulation mortally sick bodies traveling in one direction and healthy organs (encased in their human packages) in another, creating a bizarre kula ring of international trade in bodies. The emergence of the organs markets, excess capital, renegade surgeons, and local kidney hunters with links to organized crime, have stimulated the growth of a spectacularly lucrative international tourism, much of it illegal and clandestine. In all, these new transplant transactions are a blend of altruism and com-

merce; of consent and coercion; of gifts and theft; of care and invisible sacrifice." (p. 1645)

In 1999, Scheper-Hughes and Lawrence Cohen, another medical anthropologist founded Organ-sWatch. This essay is essentially the fieldwork done around the world by Scheper-Hughes, supplemented by the reporting of her research assistants in different countries. The medical problems of donors are numerous, not to mention their subsequent social and psychological problems. In today's market, an Indian or African kidney will fetch as little as \$1000, a Phillipino kidney can get \$1300, a Romanian or a Moldavian kidney yields \$2700, but a Turkish or an urban Peruvian kidney can command \$10,000 or more. Sellers in the U.S. can receive up to \$30,000.

A truly frightening article.

Robert W. Stuford
The spiritual journey of an organ transplant patient
J of Pastoral Care & Counseling
Vol. 57 # 2 (Summer 2003) pp. 191-196

This article is a hospital chaplain's detailed description of the psychological, emotional and spiritual dynamics of an organ transplant patient, the recipient of a liver transplant. A man in his early 60s, a former fireman, he had been at death's door a number of times before he received his transplanted organ. We are told how his life, and that of his two daughters has been affected by his illness and how it continues to be even today because of the post-surgery routines.

Donald Thurn
What "big picture" should inform professional chaplaincy? - editorial
J of Pastoral Care & Counseling
Vol. 56 # 2 (Summer 2002) pp. 105-108

According to Thurn, chaplaincy faces the question: "How much can I assimilate into the culture before I lose my identity?" His ideas have been inspired by the thoughts of Huston Smith in his book *Why Religion Matters: The Fate of the Human Spirit in the Age of Disbelief* (San-Francisco CA: Harper San Francisco, 2001) where Smith argues that "scientism" has developed a cosmology which has people believing that science is the only way to understand all of existence. But where, he asks, does that leave "art, religion, love and the bulk of life we directly live?"

Thurn is concerned that chaplains need a centre for their professional identity that is not reliant on the recent research which has been linking religion/spirituality and health care. "As chaplains we need to understand the contradiction in which we live and work." (p. 107) He offers several suggestions as to how we might function within that contradiction.

Rachel Y. Zisk

Our youngest patients' pain - from disbelief to belief?

Pain Management Nursing

Vol. 4 # 1 (Mar 2003) pp. 40-51

Effective relief for the pain of surgery has been available only since the mid- nineteenth century, and for much of the period since that time, children have been denied pain relief, partly because it was believed that the very young could not experience pain, but mostly because they could not articulate the fact they were hurting.

This article reviews the development of knowledge and attitudes regarding pain in young persons, and

suggests why and how changes have occurred. According to Zisk, modern pain prevention began in Chicago in Oct 1846 when William Thomas Green Morton, a dentist extracted a tooth with the patient having been given ether. (This appears to be factually wrong, most records show that Morton provided ether to a man at Massachusetts General Hospital on 30 September 1846.)

Zisk describes how in the 1990s there has been a great change in the treatment of pain in young patients, though she maintains that there is more progress needing to be made.

The paper chronicles some of the fascinating beliefs held in the medical profession which slowed the acceptance of pain control. It was believed that the rich and educated, for example, felt more pain than those who were not. There are also horror stories from the modern era. A relatively recent one involves the belief that boys did not need any pain relief as they were circumcised.