

THE ORERE SOURCE

Noel Brown

Abstracts from the Pastoral Care and other Healthcare Journals

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Nancy Berlinger

Promoting patient safety: implications for pastoral care

J of Pastoral Care & Counseling

Vol. 58 # 1-2 (Spring/Summer 2004) pp. 55-61

Berlinger writes about a subject which has been flying below the radar of most US chaplains. However, they are not the only health care professionals who have been unsure of their role concerning patient safety. A report by the national Institute of Medicine ([To Err is Human: Building a Safer Health System](#)) plus a national patient safety movement, has led to new JCAHO Standards for patient safety which have now been in place since July 2001.

Berlinger, who is on the staff of The Hastings Center (an important ethics think-tank in Garrison NY) has been a participant in a project started by the Center to look at the ethical implications of mistakes affecting hospital patients. She writes for chaplains, whom she believes have a potentially important role in efforts by hospitals to cut down the number of mistakes which are made in them each year. The Institute of Medicine report says that more patients die as a result of medical mistakes each year than from motor vehicle accidents, breast cancer or AIDS!

Two case studies are used to show patient safety initiatives in two health care systems, and to illustrate the relationship between institutional core values and the just treatment of injured patients. She also suggests opportunities for chaplains to contribute to patient safety. (27 refs)

Patricia Blair

Is family presence practical during emergency resuscitation?

Nursing Management

Vol. 35 # 6 (Jun 2004) pp. 20,23,53

Blair is a nurse-attorney, and here provides the strongest possible encouragement for the practice of allowing families to be present when a family member is being given resuscitation.

She notes some of the reasons commonly given for refusing family members the opportunity to be present: elevated stress on the team, adverse effect on patient care, friction in the trauma team, negative impact on the trauma team, emotional impact on the family, trauma team's exposure to lawsuit risk, compromised confidentiality, psychological trauma to family members, all of the above.

Blair notes that none of these objections is evidence based. Moreover, the Emergency Nurses Association has endorsed the concept (1999), and the American Heart Association guidelines for codes (2000) advocates and recommends family-witnessed resuscitation attempts.

Blair includes a strategic plan that could be followed in a hospital where staff wished to consider the creation of a written policy on family presence at resuscitations.

Gerard T. Broccolo, Larry VandeCreek

How are health care chaplains helpful to bereaved family members? Telephone survey results

J of Pastoral Care & Counseling

Vol. 58 # 1-2 (Spring/Summer 2004) pp. 31-39

This is a research report which describes how next-of-kin (n=130) whose loved ones had died in hospi-

tal, had been helped by a hospital chaplain - or not. The information was gathered by telephone interview at least a month after the deaths. The index question was: "What did the chaplain say or do that was particularly helpful?" and then, "How was that helpful?" The methodology and the analysis of the results is clear even for readers not very familiar with research methods.

The responses showed that chaplains helped the next-of-kin in 5 specific ways: by providing comfort and support; by helping with details before, during and after the death; by acting as surrogate family members until other family members arrived; by being available as a "safety net"; by functioning as a spiritual figure who provided a connection between heaven and earth.

One family member summarized the ministry they received like this: "I will never forget what the chaplain said or did. It helps your heavy heart."

Rod Burton

Spiritual pain: a brief overview and an initial response within the Christian tradition

J of Pastoral Care & Counseling

Vol. 57 # 4 (Winter 2004) pp. 437-446

Burton makes use of a literature survey as well as drawing on his own experience in order to provide an overview of the current work being done to understand more clearly the nature of spiritual pain. He acknowledges that while this kind of pain can be noticed, at the same time it is not easy to define. (Here he doesn't attempt a definition of his own.)

He describes some typologies of spiritual pain before addressing the problem of how to assess it. When we think of this kind of pain, he says, we are trying to understand something at the level of the spirit, and so "an assessment of spiritual pain will have to depend at least as much upon the spirituality of the caregiver, and upon their capacity for contemplation, for close listening to narrative, for intuition, and for discernment." (p.442) He also considers the practical issue of how we can attend to spiritual pain in the persons we minister to. (37 refs)

The Center for Spiritual and Health, University of Florida, Gainesville

Web site on Spirituality and Health

<http://www.spiritualityandhealth.ufl.edu>

(Downloaded 24 Jun 2004)

The University of Florida's Center for Spirituality and Health was established to explore the relevance of spirituality to the art and science of health main-

tenance and healthcare services. The intention of the center staff is to bring together teachers, counselors, healthcare practitioners, and researchers who value viewpoints from established as well as newly emerging disciplines and traditions.

The Center has as its central hypothesis that enhancing spirituality could enable us to optimize our potential for scientific creativity and for more effective healthcare. Its active participants acknowledge that a relationship with a deeper and higher Reality is at the heart of spirituality, and that health involves physical, emotional, mental and spiritual dimensions of individuals, families, communities, societies, and ecosystems.

The site has annotated bibliographies on such topics as: general spirituality, religion and health, spirituality in health care practice, and the nature of healing. There are also links to related spirituality and health web-sites.

Angela Fagerlin, Carl E. Schneider

Enough - the failure of the living will

Hastings Center Report

Vol. 34 # 2 (Mar/Apr 2004) pp. 30-42

"Enough. The living will has failed, and it is time so say so." With these words, the authors set out to show how the living will does not do what it was intended to do, despite the hard work done by chaplains, and clinicians to make them work. They begin to make their case by asking "the obvious but unanswered question: What would it take for a regimen of living wills to function as their advocates hope? First, people must have living wills. Second, they must decide what treatment they want if incompetent. Third, they must accurately and lucidly state that preference. Fourth, their living wills must be palatable to people making decisions for a patient. Fifth, those people must grasp and heed the living will's instructions. These conditions are unmet and largely uneatable." (p. 32)

They consider each of these questions in turn, and conclude: "our survey of the evidence suggests that living wills fail not for want of effort, or education, or intelligence, or good will, but because of stubborn traits of human psychology and persistent features of social organization." (p. 38) (105 refs)

Karen Fleming-Michael

Chaplains to use medics' tool for spiritual care

dcilitary.com

Vol. - # - (18 March 2004) pp. 1-4

Medics in the U.S. army use personal digital assistants - PDAs - to track the care they give in the field to injured troops. Fleming-Michael writes that chaplains have begun to use the system which was designed by a special-forces medic. Known as the Battlefield Medical Information System - Tactical (BMIS-T) it is used to record the information they need in order to perform their ministries. She gives several examples of its use.

Arthur W. Frank

Emily's scars - surgical shapings, technolux and bioethics

Hastings Center Report

Vol. 34 # 2 (Mar/Apr 2004) pp. 18-29

Surgery has historically been a means to repair or restore wounded bodies. Increasingly, though, surgery is being used to remodel, revise and revamp as much as to heal and mend. Surgical shaping of feet, limb-lengthening of dwarf children, intersex surgery on children with anomalous genitalia, craniofacial surgery on children with major facial deformities - if the body does not fit, then reshape it. Breast augmentation as a present for high-school graduation. Why not?

Frank is troubled by such activities, the work of neo-liberal medicine he says, and he carefully constructs a case which argues that the choice for such surgeries has implications for all of us in society, and that the choices should be made slowly, and in ways that allow a wider discussion of the broader ethical issues linked to such activities. He calls for a "Socratic approach" to the ethical evaluation of such surgeries. He argues that "consumer protectionist bioethics", the term he uses for the bioethical offshoot of modern liberal thought which focuses on the issues of risk and benefits; adequate disclosure; and the sovereignty of the "consumer", that this ethical approach is flawed and inadequate. (52 refs)

Regina Fredrickson

Marian images: Madona and Hodigitria

J of Religion and Health

Vol. 43 # 2 (Summer 2004) pp. 151-163

This issue of the Journal is devoted to articles concerning in some fashion the issue of metamorphosis, specifically the transformation of consciousness as persons are engaged by archetypal images which lead to the world below the surface of reality, the inner world of the spirit.

Earlier in the issue Kathleen Ford wrote about the Virgin Mary in "Portrait of Our Lady." Frederick-

son's is a companion piece on the Hodigitria, the Mother of God - an Eastern liturgical icon. She discusses its theological and psychological influence on the course of treatment of a young woman. (16 refs)

Carl Goldberg

Curiosity as an agent of conscience

Pastoral Psychology

Vol. 52 # 4 (Mar 2004) pp. 329-338

How could Adolf Eichman have been found to be absolutely sane (by half-a-dozen Israeli psychiatrists) and even described by his minister as "a good man," and yet be responsible for the deaths of so many tens of thousands of people?

This is the question that focuses Goldberg's struggle to understand the general question concerning the disconnect in some people between their moral principles on the one hand, and their public behavior on the other. How can a person behave as an upright and moral member of the community while at the same time leading a corporation to manipulate accounting practices in order to pocket millions of dollars, eventually depriving employees of their pension benefits?

Goldberg suggests that the answer lies not in an undeveloped conscience, but in an undeveloped sense of curiosity which leads to an insufficient development of conscience. (22 refs)

Janet E. Gregory, Robert J. Gregory

The spirit feather: an ecologically based celebration of life

J of Palliative Medicine

Vol. 7 # 2 (Apr 2004) pp. 297-300

The final moments of life can be special and important. Sadly, such moments are often not like that at all for many people. It takes sensitive arranging of the total situation for there to be harmony and a memorable transition event.

This paper describes such a death in a case study which powerfully illustrates the concepts referred to in the discussion that follows.

"When the death was not too far away, a younger sister arrived where her older sister was dying. "Hello, older sister, I have come a long way to be with you," the younger sister announced. "I am so happy you are here, younger sister," and the elder sister smiled a welcome that warmed the heart of the younger sister and the attending nurses.

The younger sister then, with pain in her heart and a lump in her throat, spoke: "Older sister, one of my friends knew I was coming to see you," and here she

whispered, "for the last time. This special friend gave me a gift to share with you. This gift, a feather, is to provide a safe journey to the spirit world." She embraced her older sister's hands with her own and gently placed the feather in her sister's hand, so she could feel and hold it. The younger sister added: "I give you this feather now, so when the time comes, you will be able to fly beyond, to where your spirit seeks to go."

Later that night, the dying woman indicated that she wanted to hold the feather. "It's time," she said. When she was given it, she looked at her sister and whispered, "Thank you for the feather. I am ready to fly now." Holding the feather tightly, she managed one last smile, a smile that filled the younger sister with hope and the knowledge that her older sister had been and would always be a part of who she was." (13 refs)

Daniel E. Hall, Harold G. Koenig, Keith G. Meador

Conceptualizing "religion" - how language shapes and constrains knowledge in the study of religion and health

Perspectives in Biology and Medicine

Vol. 47 # 3 (Summer 2004) pp. 386-401

Until now, Koenig, Meador and the others at Duke Medical Center in North Carolina who have been examining the relationships between religion/spirituality and health have done so within the traditional Enlightenment model of "objectivity," the notion that it is possible to build a body of universal knowledge available to all people, knowledge that can be gained by empirical observation and the application of reason.

In this article, they are joined by Daniel Hall from the Duke Divinity School and together they describe the increasingly challenged assumptions being levelled against the Enlightenment model. With Wolterstorff, they come to the conclusion that foundationalism - their word for Enlightenment assumptions about knowledge - "is dying because trust (nor proof) plays a much larger role in our systems of knowledge than we often like to admit. This critique of foundationalism does not mean that reliable knowledge is impossible to attain. We do have substantial knowledge, but the nature of its reliability is different than once thought." (p. 389)

They present a summary of the linguistic-cultural critique of the dominant paradigm for understanding religion which they conceive as "a frosting added to

the generic cake of secular human experience." (p. 398)

They then ask, if this critique holds up, what are its implications for religion and health. They make several crucial points which they suggest will need to be kept in mind while having future discussions in this field: 1. secularism is not objective. 2. that it will be necessary to measure "fluency", not content. 3. the assertion that spirituality is not a universal language. 4. the claim that religion may be relevant to health care even if it does not "work." 5. ("the most dangerous and threatening") the question whether there are any measurable implications for the way in which people interpret the world. Hidden inside the discussion of this final question, they suggest could be another, and even more troubling question: "What would happen if a clinical trial demonstrated that secularism was killing us?"

The earlier work of Koenig and the others at Duke has challenged the medical profession and chaplaincy. If they themselves take the implications of their article seriously, both professions can anticipate a greater complexity and nuance in future Duke work concerning religion/spirituality and health. (59 refs)

Edmund G. Howe

Death-defying empathy

J of Clinical Ethics

Vol. 14 # 4 (Winter 2003) pp. 233-245

In his article, Howe introduces the central topic of this issue of the J of Clinical Ethics: the role of empathy in clinical ethics. Much of what he writes is based in the recent book From Detached Concern to Empathy: Humanizing Medical Education by Jodi Halpern.

In his editorial, Howe has in mind a woman Halpern describes in her book: Ms G, a woman in her mid-50s who died after refusing treatment. (Halpern believes she could have been helped to change her mind, Howe tends to disagree.) Hence Howe's title "Death-defying empathy." Most of what Howe writes is drawn from the work of Lester Havens whose abilities as an empathic medical doctor are widely regarded. Howe's essay is a valuable summary of the nature of empathy, and of the power of empathy. "The right words can mobilize the will to live" (So Norman Cousins). Some readers might respond, however, "But these kinds of caregivers are rare." Haven's approaches can be used by all care-providers. They also be effective when used in brief

interventions. And even brief interventions can produce long-lasting and permanent change." (p. 234)

We are introduced to Haven's theory concerning empathy, and then the potential applications are described, including examples of interventions.

While this material alone will be of value to chaplains at the bedside, Howe then applies his ideas to formal ethics consultations, describing at length how insights about empathy can be employed by an ethics committee to strengthen their work. (83 refs)

Logan C. Jones

What language shall I borrow? The poetry of Rainer Maria Rilke and the care of souls
J of Pastoral Care & Counseling

Vol. 58 # 1-2 (Spring/Summer 2004) pp. 11-21

"Words shape and form our worlds" writes Jones. And for those of us who provide pastoral care, he suggests that rather than allowing our thinking to be shaped by the words/metaphors of current health care management, that we turn to the words of a poet in order to construct the world of seeing and being and doing in ministry.

He chooses Rainer Maria Rilke, the 19th century Czech poet, provides a brief biography, and then from his poetry lifts up images of - the interior life, grief and death, and images of God.

He then turns to the practice of the care of souls, suggesting that Rilke's poetry "invites us into a new world, a world where the depths of the interior life are honored and not just measured, a world where defeat leads to transformation, not humiliation, a world where there is a deep longing to live our un-lived lives." "The construction of Rilke's world is found in new images, like Grief being as a Sister, or God as a dark net threading through us, and of being held softly in the hands of the One who holds us in our falling." (p. 21) (55 refs)

Elisabeth Koenig

Discernment

Spirituality & Health

Vol. 6 # 2 (May/Jun 2003) pp. 42-45

Discernment is a phrase which is commonly used in faith communities. It is defined in the dictionary as "the act or process of exhibiting keen insight and good judgment." Koenig, who teaches Christian spirituality at an Episcopal (Anglican) seminary describes how her practice of discernment began 20 years ago when she unwittingly went away "on a weekend from hell." She had to spend the weekend in the company of two women; one, the friend who

had invited her; the other a stranger, who did not know Koenig had been invited. The anger in this latter woman was palpable, the friend immediately took to bed in order to avoid the situation.

Koenig describes how she dealt with the givens - the withdrawal of her friend, the anger of the stranger. What she did has led her to an understanding of the nature of spiritual discernment. She describes discernment as "a process of learning to make choices that are life-giving rather than destructive. It is a way of focusing our lives on the most valuable dimension of our experience: call it God, ultimate reality or ultimate concern. Practicing discernment, one learns to progress toward a spiritually integrated state by meditating and praying on a steady stream of questions: Who am I? What am I doing here? Whom do I love? What rational method will I use to decide this issue? What are my most cherished values? How do I intend to consult God in my upcoming choices?"

Philip LeMasters

The practice of medicine as theosis

Theology Today

Vol. 61 # 2 (Jul 2004) pp. 173-186

The pastoral care literature suffers from a serious lack of papers written from an Eastern Orthodox perspective. So for the chaplain who is not Orthodox, or has had little contact with persons of this tradition, LeMaster's article should prove to be very rewarding reading.

The word "theosis" refers to the Eastern Orthodox understanding of "salvation." LeMasters describes an understanding of the process of healing from within that tradition. It becomes apparent that all pastoral care, from an Orthodox perspective, is bound up with this concept.

In this article, he describes the relationship between illness and the Fall; the approach to ethical thinking about health issues from this perspective; the place of Orthodox bioethics in the public arena; and the understanding of personhood in health care.

Suzanne Mayer

The Communion of Saints as a paradigm for pastoral counseling: a revised look at an ancient symbol

J of Pastoral Care & Counseling

Vol. 58 # 1-2 (Spring/Summer 2004) pp. 23-30

Drawing upon theologian Elizabeth Johnson's revisioning of saints as "friends and prophets", Mayer

offers a new paradigm for understanding the nature of the pastoral counselor.

She describes: the sanctity of the ordinary, attention to the present moment, the gift of connectedness, and the vision of transcendent hope. These are the characteristics she credits as the potential sources of richness for growth in the counseling relationship.

Holcomb B. Noble

Elisabeth Kubler-Ross, psychiatrist who revolutionized care of the terminally ill, dies at 78 - obituary

The New York Times

(26 Aug 2004) p. A22

A fairly balanced description of the life of the Swiss woman who did so much to drag the health-care community into caring for the dying in more humane ways. Her relationship with Karl Nighswonger, the chaplain at University of Chicago hospitals who worked with her (and from whom, some have claimed, she appropriated the concept of "stages"; he called them dramas) is touched on, as is her later work concerning life after death. She died as the result of a series of infections.

Carolyn E. Schwartz, Kathleen Mazor, Jane Rogers, Yunsheng, George Reed

Validation of a new measure of the concept of a good death

J of Palliative Medicine

Vol. 6 # 4 (Aug 2003) pp. 575-584

The concept of "the good death" has been an increasingly important focus in the field of palliative care in the last 10 years, as hospice staff have sought to provide the best possible care for the dying. However, there have been no satisfactory ways of measuring "the good death", other than intuiting what it might be. This paper describes the development and testing of a set of items (statements) intended to measure the importance of several parts of care that experienced care-givers have come to believe are critical to the concept of the good death. Four groups of people (undergraduate medical students, master's degree nursing students, graduate students in the life sciences, practicing hospice nurses, total n= 596) were each given a self-report questionnaire to complete and return. This was repeated 2-3 weeks later to check consistency.

Analysis of the results gave the authors confidence that their test is reliable and has a useful level of discrimination. They describe it as measuring three distinct factors which people consider to be impor-

tant to a Good Death: 1. Closure, which reflects the spiritual or psychosocial aspects of good death, and is associated with belief in an afterlife experience, having meaningful social support, spiritual beliefs and practice, and being older and female. 2. Personal control, which focuses more on the physical aspects of the dying experience. 3. Clinical, which is related to the biomedical aspects of a good death, and is associated with a perspective that death is a relief from the negative aspects of life on earth, and being older.

The references provide a comprehensive list of articles concerning "good death."

(31 refs)

Randy Shook, Laurie Fojut

Measuring what chaplains do

Health Progress

Vol. 85 # 2 (Mar/Apr 2004) pp. 37-40

"The role of the chaplain..... won't be widely understood until chaplains learn to report the full scope of their activities." This comment by a pastoral education supervisor in a Roman Catholic health care system in Colorado establishes the focus of this article. Shook and Fojut argues that identifying what chaplains should count as they engage in their ministry is fundamental to helping other health care professionals, and especially administrators understand what chaplains can contribute to the mission of an organization or system.

Shook and Fojut describe the process which was followed by Catholic Health Care Initiatives during an 18-month study of chaplaincy performance and productivity. The first step was to ask chaplains about their daily work, in order to gain the fullest possible picture of the activities of chaplains. The second step was to survey family members of someone who had died recently, in order to gain an additional perspective on what chaplains do, as they experienced them in their pastoral role. The results of these two steps, including four specific recommendations, were then shared with directors of pastoral/spiritual care departments in a telephone conference call. Each agreed to develop an action plan in response to at least one of the recommendations which each directed selected. Within six months, 30 facilities had begun work based on an action plan, the majority working on the first recommendation, which read: "Engage staff chaplains in a reflective process of role clarification, to identify and prioritize the most common key activities

and competencies expected of them." The authors also describe other fruits of the project.

The title of the study is: Measures of Chaplain Performance and Productivity. It was published in June 2002. A copy can be requested from Catholic Health Initiatives @ 303-383-2696.

Puneet Singh, Kearsley Stewart, Scott Moses
Pastoral care following pregnancy loss: the role of ritual

J of Pastoral Care & Counseling
Vol. 58 # 1-2 (Spring/Summer 2004) pp. 41-53

The authors, two medical doctors and an anthropologist wanted to find the answer to one central question: How do clergy today ritualize pregnancy loss? It is not really clear why they decided to look at this question, but because of their backgrounds - Moses is an obstetrician - they sent surveys to 500 clergy in Chicago, followed by a reminder postcard. They received 23 responses!

Bearing in mind the implications of the very low number of responses, their paper is nevertheless an important examination of a pastoral care issue which has been little addressed. Their findings allowed them to divide their clergy responders into three groups: first, those who do not ritualize pregnancy loss at all; second, those who adapt existing rituals; and third, those who create new rituals.

They quote their respondents rather liberally and so we get a fairly clear overview of the factors which together make this issue an important one for the religious community. The data suggested that while the religious affiliation of a clergyperson influences which of the three approaches they take, individual preferences and theologies are the key factors driving what a clergyperson does to provide pastoral care. They conclude: "As leaders in their communities, clergy are in a particularly well-suited position to create an environment in which the silence surrounding pregnancy loss is no longer acceptable." (p. 53) Note: Special mention is made of two books which the authors highlight as reflecting the most disciplined reflection on the issues discussed in this paper. For a Jewish perspective - Rabbi Nina Cardin's Tears of Sorrow, Seeds of Hope (Jewish Lights Publishing. 1999). For a Christian perspective - Astrid Andersson Wretmark's Perinatal Death as a Pastoral Problem (Stockholm, Sweden. Almqvist & Wiskell International 1993). It should also be noted that Chaplain Richard B. Gilbert has produced a major (15 page) bibliography on the subject of

"*Pregnancy and Early Infant Loss*". Go to < www.twpcc.org > (19 refs)

Eric Stoddart
Hell in Scotland: a survey of where the nation's clergy think some might be heading
Contact

Vol. 143 (2004) pp. 14-27

This is the report of a survey of Scottish ministers (n=346) to find out what they believed about what lies beyond the grave for those who are "outside of salvation." Taking the figures, it is clear that a majority of Scotland's clergy believe there will be a Judgment Day when persons will be separated into one of two groups - the "saved" or the "lost." He is also able to report other finer details about this group's beliefs about judgment and punishment.

Stoddart then looks at the official positions of the major Christian denominations in Scotland, before concluding with an examination of what the current pastoral care literature is saying concerning the implications of believing in hell and/or its torments. The denominations included in the study were: Church of Scotland, Free Church of Scotland, Scottish Episcopal Church, Baptist, Congregational, Assembly of God, Roman Catholic, and the Apostolic Church.

Stoddart could find nothing in the current academic literature to help clergy or chaplains address the problem of death of a "non-Christian" loved one. He examines the pastoral approaches by several British evangelical writers: Dowsett (God, That's Not Fair), Fernando (Crucial Questions about Hell), Blauchard (Whatever Happened to Hell?), and Hosier (taped message, "Eternal Punishment.")

So what can be said to persons who have experienced the death of someone who was emotionally important to them, but who was also not known to have a committed religious life? And how do persons resolve their inner conflicts about such a dilemma? Stoddart describes the internal meaning-making maneuvers that some person's use. (25 refs)

Susan Strang, Peter Strang
Questions posed to hospital chaplains by palliative care patients

J of Palliative Medicine
Vol. 5 # 6 (Dec 2002) pp. 857-864

Much of what has been written about religious or spiritual care of the dying has come from research in the U.S. with its society which is generally highly religiously-oriented.

Would care of the dying be markedly different in a society in which only a small proportion of the population gather regularly to worship? The Strangs set out to find the answer to this question in Sweden where only 6% of the population attend worship at least once a month.

They sent a questionnaire to Swedish hospital chaplains (n=172), both general and hospice. It had 12 open-ended questions dealing with various aspects of support to palliative care patients. The key question they asked was: list three of the most frequent questions posed to you by patients with life-threatening terminal illnesses.

The most frequently asked questions fell into 5 categories: meaning (34%); death and dying (21%); pain and illness (13%); relationships (15%); and religious issues ((8%). They were struck by this last figure, and also note that this was based on answers that were often 3rd choices.

The Strangs conclude that the role or focus of hospital chaplaincy has changed with the focus, in Sweden at least, being on existential rather than more explicitly religious questions.

Gretchen Thompson

Personality disorders and the dying experience: reflections on pastoral care

Chaplaincy Today

Vol. 20 # 1 (Spring/Summer 2004) pp. 8-15

Thompson addresses the issue of how to evoke hope and trust in dying patients, and especially in patients who have particular issues in being able to do so, because they are persons with personality disorders. These are the patients who often cause great management problems for nursing staff, who will often (in the US at least), in desperation, call for the chaplain's help.

She gives an excellent introduction as she considers the question: what is a personality disorder? It is based largely, though not exclusively, on the work of Gregory Lester. She wisely cautions the reader about the dangers of labeling persons, and especially persons with personality disorders. She highlights issues around inflexibility, and also difficulties with relationships.

She then presents suggestions about how to provide pastoral care to these "special patients, their loved ones and their care-giving staff." She lifts up two key issues: how to establishing trust, and, how to evoking hope. She also discusses the utilization of the life review, and the special significance of tradi-

tion, ritual and prayer with this particular group of people. (6 refs)

Author Unknown

Genetic testing in assisted reproduction - case study

Hastings Center Report

Vol. 33 # 6 (Nov/Dec 2003) pp. 11-12

A 20 year-old student replies to an advertisement offering money to young women willing to donate ova to infertile couples. The young woman, Z, needs money to pay for her college tuition, and she likes the idea of helping someone have a family. In drawing up an agreement about costs and the parameters concerning Z's relationship with the couple, Z's attorney learns that the couple is insisting that she undergo genetic testing for certain abnormalities and disorders: cystic fibrosis, fragile X, thalassemia. Z is readily willing to sign such an agreement. The lawyer says, "Whoa, have you thought about the implications of what you are signing? Have you thought about what you might find out, how it might affect your health insurance, how it might affect the rest of your family?"

Cynthia E. Fruchtman and Caroline Lieber have comments. Fruchtman's contribution is the most thorough, producing a list of implications that is daunting and might scare Z off altogether. However they are important ethical issues that any donor would best be helped to think about.

The question is: what are the obligations of the professionals working with the infertile couple and with any young woman donor in this case? What are the ethical obligations of a chaplain to adequately understand the implications of the treatments being offered in this field, especially as these become more commonplace.

Donald F. Walker, Richard L. Gorsuch

Dimensions underlying sixteen models of forgiveness and reconciliation

J of Psychology and Theology

Vol. 32 # 1 (Spring 2004) pp. 12-25

Our understanding of the processes in forgiveness and reconciliation are still very far from complete. Walker and Gorsuch's paper is an interesting contribution which helps clarify some of the ideas in 16 specific models of forgiveness and reconciliation by exploring the underlying dimensions of each.

He analyzes items representing the steps in each of the models. (There are other models in the literature,

as Walker explains. However, he describes his criteria for including some and excluding other models. The strength of this paper is Walker and Gorsuch's interest in being able to more clearly assess the validity of the different models. (45 refs)

Shelley A. Wiechman, David R. Patterson
Psychosocial aspects of burn injuries
British Medical J
Vol. 329 # 7462 (14 Aug 2004) pp. 391-393

The emotional (and spiritual) needs of persons who have been burned differ at each stage of their treatment and recovery. This review article describes the

emotional challenges that patients with large burns face. The recovery has been divided into three stages - the critical or resuscitative, the acute, and long-term rehabilitation. The psychological challenges and the treatments of each stage are presented.

Chaplains who minister in a burn unit will find in this paper the latest information about the psychosocial care needed at each stage and be better equipped to provide effective ministry. The book Changing Faces, available in both the US and in the UK, is described as an excellent resource of information and support for burn survivors.