THE ORERE SOURCE

On the Asking of Questions

In October 2004, I returned to New Zealand for a family visit that was planned to include a reunion with my classmates from the Presbyterian Theological College of New Zealand – Knox College. We graduated at the end of 1964, and had not met together as a group since November of that year, a forty year gap.

It had been planned that we would spend just a day and a half together, and the more I thought about that short length of time, the more certain I became that without at least a modicum of structure for our talking, the more we might not get beyond the listing of places we had been and offices we had held. I wanted to be able to talk more deeply about our lives and our ministries, the events that had stretched us, the joys and the sorrows we had experienced. I came to the conclusion that if, after a person had recounted their journey in ministry, they should be asked a couple of questions, the same two questions for each of us, that we would have a richer time of reconnecting and understanding our lives in ministry.

The issue that occupied my mind on the 12-hour flight across the Pacific was: what might those two questions be. My hope was that the answers would help us to go a little deeper, to talk about what had happened to us as a result of being ministers. I finally decided the two questions: First, "*What were the most important gifts for ministry that you received from Knox* (the theological college)?" It was a question I hoped would allow each of us to reconnect with the many important positive experiences and lessons we had been blessed with in our time together. Second, *"In what ways has your spirituality developed while you have been in ministry?"* I hoped this would be an invitation to talk about our inner growth as a result of being engaged in pastoral care, the blessings we had received as we had engaged in ministry in the many different places to which we had been called.

When we gathered in Dunedin (the Edinburgh of the South) there were just eleven of the original nineteen who had graduated. Death, ill-health and geography had taken its inevitable toll on our numbers. We met at Roslyn Presbyterian Church, where the minister is a Scot from Glasgow, a former student of John Swinton's. It is a small world indeed! As each man finished his story I would ask my two questions, though after the first two men had shared their stories, each person with no bidding from me would say: *"Now in answer to Noel's questions……."* The answers were themselves most interesting, but that may be for another time. What left me a little curious was the fact that the *"Now in answer to Noel's questions……"* sounded just a tad defensive. I decided not to ask whether I was right or not about that. There are limits to the questions I ask.

I had been back in the States about a month when I received a Christmas e-mail from perhaps my closest friend in the class. We are always forthright with one another, and I value his observations about life and ministry. Still I was somewhat taken aback when he wrote in the e-mail about my questions, my *"interrogating"* questions which he said he personally valued, but which seemed to have put some of our brothers on the spot. And of course, they had, as I had hoped. After all, I had flown halfway around the world, and many in the group had had to make some sacrifices to be present. I wanted to hear the stories they had to tell, and the experiences they had to share. Time was limited. I had assumed that having two questions would hasten the process, as indeed it had.

His word, though, gave me considerable pause. The questions had to me seemed appropriate and useful. They had given each speaker an open-ended opportunity to respond in whatever way they chose. The questions and their focus were such that each person had a great deal of freedom to take us wherever those wished. To me, they seemed easy and natural questions to ask. But was my assessment of

the questions wrong because of some cultural shift that has taken place within me? After all, I have spent almost all of my ministerial life in the U.S. and Americans have often been described as being too direct. Or was it more of a cultural shift that has taken place during my development as a minister? On a day to day basis I meet patients who are strangers, and it is my responsibility to be able to get alongside each person, to establish a relationship which will carry within it a sufficient level of trust that they will allow me to minister to them; to qualify myself as a chaplain, as a person who can be trusted – at least in an embryonic way – with their spiritual life. In part that involves asking questions, a practice I was taught was wrong when I entered my CPE training in the late 1960s. It is a rule which I now believe should be judiciously broken. In the 60's and 70's, pastoral care was being strongly influenced by the work of Carl Rogers, and being non-directive was the essence of being pastoral, hence the rule about no questions.

Questions should not be easily asked. We have been wisely warned that they have the effect of directing where the conversation of a patient (and our self) will be focused. Reading the verbatim of a pastoral visit which consists of a list of questions asked by the chaplain is a sure indication that there was a great deal taking place between the chaplain and the patient that the questions were not addressing. On the other hand, pastoral ministry with a sick patient is not the place to follow the non-directive rules which may be important and necessary in the pastoral counselling setting.

Because I have been a chaplain now for many years, it is easy to forget how difficult it can be to ask strangers "good" pastoral questions. My friend's comment about *"interrogatory questions"* was a salutary reminder, as were some comments from my new Chaplain-Interns at the start of this year. These men and women were coming from a variety of ministries in the community to learn how to provide pastoral care in a hospital. At times, they would report that they did not know how to proceed: the patient had said something ambiguous; or, the patient had stopped their "social-level" talk and was waiting; or, the next step in the conversation was unclear. The Chaplain-Intern would report that they did not know what to say next. *"Did you think to ask a question?"* I would offer. *"Oh I couldn't do that. That would be prying into their private life".* And of course, they were right, it would be.

It is a sensitive, pastoral skill that we, as chaplains, must exercise on a daily basis. It is a skill that separates us as professional carers from well-meaning strangers who have not been given (and given themselves) permission to ask the question that may be direct and provocative, but which will encourage the hearer to share matters of their heart and soul. It also requires that we understand that the most powerful questions are not those which seek information, but which invite people to re-examine some aspect of their life or faith. Certain kinds of questions are helpful in enabling a person to re-sort their memories or beliefs so that different meanings can emerge and different stories can be told. And then there are the embedded questions……

But that is for another time. Why not start?

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Lars Albinsson, Peter Strang
Existential concerns of families of late-stage dementia patients: questions of freedom, choices, isolation, death and meaning
J of Palliative Medicine
Vol. 6 # 2 (Apr 2003) pp. 225-235
Dementia has a great impact on the family of the person with this diagnosis. In this Swedish study, the authors wanted to better understand the existential issues which arise for family members in such situations. While the palliative aspects of the caregiver's burden have been described, there are only a few studies which have focused on the existential issues which have implications for the providers of pastoral care. The authors taped their interviews with family members (n=20) and then analyzed the comments using a hermeneutic approach, following the concepts of Heidegger and Gadamer. They state the seven assumptions behind their research methodology.
They found that (a) taking responsibility, (b) in order to be faithful, or (c) to re-pay the person was generally experienced as motivating and rewarding, though in some cases it was more a matter of duty accompanied by elements of guilt and obligation. Existential isolation became real as communication with the demented person declined and ended and/or a role reversal occurred with a daughter or son having to parent a parent.
Anticipatory grief was common. Thoughts about the inevitable death were common. Some of those interviewed spoke of an increased awareness of the shortness of life, which had the effect of making them live their own life more intensely in the present. The illness itself was most often discussed in terms of meaninglessness. However, many of the respondents could identify meaning in the past (memories), present (daily routines, positive aspects of responsibility), and future (to pass on the patient's lifework).
The article is liberally illustrated with actual quotations. (41 refs)

Lucy Bregman
Defining spirituality: multiple uses and murky meanings of an incredibly popular term - guest editorial
J of Pastoral Care & Counseling
Vol. 58 # 3 (Fall 2004) pp. 157-167
The word "spirituality" is everywhere - which is both a blessing and a bane. Bergman considers the meaning of the word in its many current uses, not as a warning, but to alert us to some of the "factors and histories" that lie behind its present currency. She does want to discourage any moves toward a once-for-all definition of the word though, believing such a development would be counter-productive. (14 refs)

Cullene Bryant
The modern mystic: a spirituality for health care workers
J of Pastoral Care & Counselling
Vol. 58 # 4 (Winter 2004) pp. 319-324
Bryant suggests that in order to remain fulfilled and not burnt out in the health care profession, one has to deepen one's spirituality. She illustrates this belief by following a young chaplain through his CPE experience.
She concludes her essay in part with these words: "I am suggesting .... that in all of us there is a longing for God and that health care workers live and work in a context that makes them particularly open to an experience of the Divine. Equally true, however, is that the changing face of health care creates an environment in which spiritual nourishment is much needed for the soul's well-being." (p. 324) (9 refs)

Lucille Cardella, Myrna L. Friedlander
The relationship between religious coping and psychological distress in parents of children with cancer
J of Psychosocial Oncology
Vol. 22 # 1 (2004) pp. 19-37
This study was conducted in order to better understand how different coping methods may moderate the psychological distress experienced by parents who have a child with a serious (possibly fatal) illness. The psychologist Kenneth Pargament has identified five ways people use religion to seek control of the outcomes of difficult situations. The five are: (1) collaborative religious coping - seeking control in solving problems through a partnership with God; (2) active religious surrender - turning control over to God after all else has failed; (3) pleading for direct intercession; (4) passive religious deferral - waiting for God to control the situation; and (5) self-directing religious coping - believing that God gives individuals the tools and resources to solve problem. There is a helpful 2-page section which describes what is meant by each of the five categories and the degree to which each of the five is supported by research. They use his model in order to understand and describe the interplay

and describe the interplay between believing and coping in the parents.
The parents of 166 children took part in the study, completing a number of surveys to identify their levels of distress and hope as they were coping. As had been predicted, collaborative religious coping was especially associated with lower distress, while, contrary to prediction, pleading for direct intervention was associated with a greater reported distress.
(Note: the take-home lesson for chaplains from this paper seems to be the importance of asking parents two questions: (a) how distressed are you? (b) what ways do you use to cope? (33 refs)

James W. Carson, Francis J. Keefe, Veeraindar Goli, Anne M. Fras, Thomas R. Lynch, Steven R.
Forgiveness and chronic low back pain: a preliminary study examining the relationship of forgiveness to pain, anger and psychological distress
J of Pain
Vol. 6 # 2 (Feb 2005) pp. 84-91
A study undertaken to confirm (or disprove) the common clinical observation that many patients who have chronic pain also have difficulty forgiving persons they perceive as having unjustly offended them in some way.
A group of patients (n=61) with chronic low back pain were examined to assess their current level of forgiveness, their forgiveness self-efficacy (which is defined as "self- confidence in one's ability to forgive another"), pain, anger, and psychological distress. The different questionnaires used to measure these are well-described in the article.
The authors found that forgiveness-related outcomes could indeed be reliably assessed in this group of patients. It was also learned that patients do vary considerably along the forgiveness scales. Further, patients who had the high scores of forgiveness-related variables reported the lower levels of pain, anger, and psychological distress. There is also a useful discussion about the inter-workings between pain, anger and forgiveness. (27 refs)

Andy Coghlan
Do you believe in miracles?
New Scientist
Vol. 184 # 2468 (9 Oct 2004) pp. 36-40
True health miracles may be in the making in India, according to Coghlan in her story. A little-known biotech company says it has been able to rescue patients from the brink of death by creating personalised stem call therapies from the person's own blood. If it is found to be true, it will lead to the re-writing of the textbooks and a Nobel prize. Some reputable scientists who have reviewed the work are comparing it to the discovery of penicillin 77 years ago.
Immediate treatment has been given to patients with aplastic anaemia. The plan is to work on spinal cord injuries, heart disease and leukaemia next.
The name of the company is TriStem. It may be a harbinger of hope for many who now face a limited survival time. On the other hand, it may ultimately be assigned a place alongside "cold fusion". The discoverer of this process is an Indian woman physician, which may be fuelling the reluctance of some researchers to accept her claims. (0 refs)

The Coventry Pain Clinic
Information on pain control
www.coventrypainclinic.org.uk
Downloaded 6 Feb 2005
This is a website intended primarily for patients. It provides information about pain and ways in which pain can be successfully treated. Established by a doctor in the Midlands (U.K.) it is a comprehensive site on which is information which is easily understandable by non-medical health care professionals.
A notable feature is a flowchart describing the medications which best treat pain. At the site's home page, select "treatment" and then click on the "Analgesic flow chart" in the text on the top of the page. For U.S. readers; because the site is for English readers, some of the medications have unfamiliar names. Drug names are hyperlinked for more complete explanations.

A.R. Gatrad
Muslim customs surrounding death, bereavement, post-mortem examinations, and organ transplants
British Medical J
Vol. 309 (20 Aug 1994) pp. 521-523
Despite its age, this article has legs and contains a great amount of information for the chaplain who wishes to learn about Muslim culture as it concerns death. The author, a Muslim physician, practices in England. Consequently some of the statistical references refer to that country.
Note: at the time Gatrad wrote this article there was a split in the Muslim world concerning the correctness of organ transplantation. Jurists from the Indian sub-continent being opposed and those from the

Middle-eastern Arab world being in support. (13 refs)

John J Gleason
Pastoral research: past, present and future
J of Pastoral Care & Counselling
Vol. 58 # 4 (Winter 2004) pp. 295-306

Gleason, a hospital chaplain, knows that research in pastoral care is not at the top of most chaplains' "to do" list - or even near it. However, in this article he asserts that chaplains have a "moral imperative" to examine their practice of ministry, and to share their findings with their colleagues. He hopes that chaplains will reconsider their priorities because, by definition, "pastoral research is the disciplined study of religious experience by pastoral practitioners toward increased effectiveness in ministry...." (p. 296)

He looks at the work of pioneers in research, starting with Jonathon Edwards, and moving toward Robert Reeves and John Florell nearer our own time.

He examines the present - what he calls "a picture of burgeoning interest, expanding literature and hazards for the practitioners of pastoral care." (p.299) Finally, he turns to the future, which he calls "the chaplain's moral imperative." He writes: "Like it or not, ready or not, all clinical chaplains have a four-fold moral imperative: (1) to stay abreast of religious and pastoral research findings; (2) to test these findings in the cause of improving the quality of care; (3) to further examine their practices; and (4) to share what they discover.

Gleason then writes very practically describing what needs to be done. In three pages he outlines what he believes chaplain must do, and has practical suggestions for getting started. (48 refs)

Louis M. Guenin
The morality of unenabled embryo use - arguments that work and arguments that don't
Mayo Clinic Proceedings
Vol. 79 # 6 (Jun 2004) pp. 801-808

Guenin, a molecular geneticist, weighs into the debate about the use of human embryos in both research and therapy. He looks at six of the arguments that do not work to support the use of embryos for these purposes. He says that while he supports such research, he thinks that all six of the arguments are unsound. He then goes on to outline arguments that he believes are sound, and ends with some thoughts about cloning in particular, and also comments about the risk of abuses.

An "unenabled" embryo is one that will never enter a uterus, a term he has used in an earlier paper, "Morals and primordials" in Science (2001) Vol. 292, Pp 1659-1660.

(Note: The writing style of this author makes the complex arguments about this subject remarkably accessible.) (13 refs)

George Handzo, Harold G. Koenig
Spiritual care: whose job is it anyway?
Southern Medical J
Vol. 97 # 12 (Dec 2004) pp. 1242-1244

This is the lead article in an issue in which the featured topic for continuing medical education credits is "spirituality". The authors' message to physicians is that spiritual/religious concerns should be attended to in every patient's treatment plan; that the role of the physician is to make sure that the patient's spirituality is assessed, and that referrals to a professional chaplain should be made if necessary; and finally, that it is the chaplain's role, "as the spiritual care specialist on the treatment team, to assess the patient in depth and provide spiritual support and treatment as appropriate." They suggest that the physician is the "generalist" in spiritual care and the chaplain is the "specialist." (12 refs)

Martin Leever, Bridget Deegan-Krause, Richard M. Leliaert, Kenneth Richter, Peggy Nelson
"Baptizing" deceased infants?
Health Progress
Vol. 85 # 6 (Nov/Dec 2004) pp. 44-49

The request of grieving parents that the chaplain baptize their recently deceased baby is very troubling when the chaplain strongly wishes to provide comfort, but at the same time, to do so would be inconsistent with the doctrine of the chaplain's faith group.

The authors of this article write about this dilemma from within the teachings of the Roman Catholic Church but it will be of value to any chaplain whose denomination teaches that it is improper to baptize a deceased child. The authors argue that: "while it is imperative to attend to the grief of the bereaved parents, there are strong reasons to refrain from baptizing deceased infants." (p. 44) In defending this view, they discuss the nature and purpose of Baptism, and the importance of maintaining the integrity of the sacrament. They also anticipate some of the objections they anticipate will be raised concerning their position.

In a side-bar, the naming ceremony ritual used at St Jospeh Mercy Oakland's Hospital in Pontiac MI is included. (18 refs)

Mari Lloyd-Williams, Mick Dennis
A prospective study to compare three depression screening tools in patients who are terminally ill
General Hospital Psychiatry
Vol. 26 (Sept/Oct 2004) pp. 384-389

Depression is a significant problem for about 1 in 4 palliative care patients. In this paper, the authors report their findings from a study (n=74) to find out how reliable three of the most commonly used screening tools are for identifying depression.

The three tests are: (1) the simple question: "Are you depressed?" (2) the Edinburgh Depression Scale (a 10-item, self-assessment questionnaire) (3) a self-rating scale on a scale of 0- 10 when the person was asked to rate their mood. The answers obtained by the three methods were then checked against the results of a semi-structured interview that followed DSM-IV criteria.

The Edinburgh Scale proved the most reliable tool, and the simple question the least reliable. They also conclude that the question "Are you depressed?" should really be understood as a question which checks for psychological distress, a more encompassing question. (28 refs)

Jenny Makros, Marita McCabe
The relationship between religion, spirituality, psychological adjustment, and quality of life among people with multiple sclerosis
J of Religion and Health
Vol. 42 # 2 (Summer 2003) pp. 143-159

Research concerning the relationships between religion and health continues to occupy the attention of behavioural scientists, with the methodologies they use becoming increasing sophisticated, and the results more robust. The body of research showing that religion and spirituality are associated with better mental health is referenced in this article which examines the impact of religious factors on the adjustments people make to having multiple sclerosis.

The authors' research was designed to investigate the relationship between various aspects and expressions of spirituality and religion, and the accompanying adjustment to, and quality of life among persons suffering with this illness. Two studies are reported in this article.

The findings are not consistent with previous research concerning religious coping and religious orientation. Until now, intrinsic religious orientation has been positively associated to well-being, and negatively associated to depression. The results here do not support these relationships. The authors discuss why this might be so. It is a discussion that provides a useful window into the relationship between religion/spirituality, and health. It is a relationship that is far more complicated than some have realized or would want to acknowledge. (50 refs)

Dennis McCann
Should the family be present during resuscitation attempts?
Vision
Vol. 14 # 6 (Jun 2004) pp. 9

McCann, a hospital chaplain, notes that the formal guidelines on CPR and emergency cardiovascular intervention, all of them relatively recent support the idea of the presence of family members during a "code" - if those family members wish to be present. However, by his own admission, he wasn't too sure about the practice until he was with a patient's wife during the "code" that involved her husband. The husband died. He now thinks it can be a positive experience for all concerned and he describes why. (0 refs)

Michael Merry
On evil, sin and suffering: toward a hermeneutic of their relation
J of Pastoral Care & Counselling
Vol. 58 # 1/2 (Spring-Summer 2004) pp. 75-82

Merry boldly plunges into an exploration of the ramifications of linking together "suffering" and "sin." He notes that while historically evil and suffering have been linked in one of a variety of ways to Providence, such connections are proving to be increasingly difficult for many religious persons in the western world. Suffering, as such, is no longer embraced for its "purifying effect" as it once was. He takes some of the ways in which they have been linked in Christian thought, and in striking metaphors challenges their credibility.

Merry examines and questions the underlying assumptions that run through many Christian communities, especially the sacramental ones, who continue to hold that evil, illness and suffering should be linked to notions on sin and healing, with the argument that suffering should be embraced for its value.

After his explorations he concludes that: "Suffering is an inexplicable mystery that even Christianity in her most sublime moment - the Passion and death

of Christ - cannot explain or ultimately make sense of. He approvingly quotes Paul Evdokinov: "We are before the central mystery of the divine economy, but how the love and justice of God are reconciled, this for us is inaccessible." (In, L'Orthodoxie Pub: Delachaus & Niestle (1959) p.324, Evdokinov's accurate translation from the French. (46 refs)

Kenneth I. Pargament, Crystal L. Park
Merely a defence? The variety of religious means and ends
J of Social Issues
Vol. 51 # 2 (1995) pp. 13-32

"Although emotional gains obviously accrue from being religious, there is a distinct possibility that the psychological defence strategies recommended by the religion may impair realistic behaviour, and may only be maintained at a cost to physical and psychological health." This quote (from a 1980 book on stress) expresses a belief that was consistent with the general tenor of the thinking of behavioural scientists until the middle of the 1990s, the period in which many of today's psychologists and psychiatrists were trained.

Quoted by Pargament and Park at the start of this article, theirs was one of the first to challenge the belief that religion served only as a defence. The authors present evidence that religion is not simply a form of denial, not merely a passive form of coping, and not simply associated with resistance to social change, as had previously been believed. Pargament and Crystal show that it is more helpful not to mention, more accurate to think of religion as a way of coping. Whether such thinking is effective or ineffective is another issue. They urge us to be aware that religion has both helpful and harmful roles in the lives of individuals and in communities.

This is one of the early articles in the behavioural science literature where religious faith is not discounted, or worse. In the years since, Kenneth Pargament has continued to study how religious faith helps people to cope.(80 refs)

Richard T. Penson, Lidia Shapira, Kristy J. Daniels, Bruce A. Chabner, Thomas J. Lynch
Cancer as metaphor
The Oncologist
Vol. 9 # 6 (Nov 2004) pp. 708-716

When cancer patients talk to their doctors and other health care professionals (including chaplains) the imagery of warfare is often used to refer to treatment and outcomes. There are "killer" cells, "magic bullets," "battles" etc.

However, is the use of such language wise or helpful? Several oncologists, a psychiatrist and a psychologist discuss the potential and the perils of metaphors in patient care. They quote Czechmeister who has called the metaphor "a two-edged sword," suggesting that, while metaphors are fundamental to individual and collective expression, they are also capable of creating negative forces, such as confusion, stereotype and stigma. Examples of this are given in the discussion.

The bottom line: Chaplain, watch your language.

Mark Repenshek, John Paul Slosar
Medically assisted nutrition and hydration: a contribution to the dialogue
Hastings Center Report
Vol. 34 # 6 (Nov/Dec 2004) pp. 13-16

In March 2004, Pope John Paul II addressed an International Congress on "Life sustaining treatments and the vegetative state: scientific advances and ethical dilemmas." Reports of the address have sparked much discussion and debate. (Note: Contact the editor for a full English copy of his address. 5 pages.)

The authors begin with what they believe is "the most fundamental tenet of the Roman Catholic moral tradition... that life is a precious gift from God" and "the basis for a duty to protect and preserve our lives." They show how this thread runs through the contemporary teaching of the Catholic church.

Next they turn to the origins of certain principles in Dominican thinking in the early 1500s. The ideas of Spanish Dominican Francisco de Vitoria (1486-1546) were expanded on by Domingo Banez, and John de Lugo. It was they who introduced the distinction between "ordinary" and extra-ordinary", words which are now synonymous with the more commonly used "proportionate" and "disproportionate."

The authors look closely at the five criteria which separate the two concepts. Having done so, they are now ready to examine the comments of Pope John Paul II. Their main thesis is that his remarks were intended to address two extreme views which have developed in medical ethics concerning nutrition and hydration for persons in a persistent vegetative state (PVS), and that he has taken a middle course on the issue. They suggests that a correct reading of the Pope's remarks should be to see them as support-

ing a presumption in favour of providing nutrition and hydration to patients as long as this is of sufficient benefit to outweigh the burdens to the patient. "The address holds quite simply that medically assisted nutrition and hydration for PVS cannot always and everywhere be considered either proportionate or disproportionate; instead, its status depends on the circumstances of individual cases," which the authors believe is consistent with earlier teaching of the Roman Catholic church. (25 refs)

Jennifer Rosner
Lullabies for Sophia
Hastings Centre Report
Vol. 34 # 6 (Nov/Dec 2004) pp. 20-21

Sophia was born perfect; she was also born deaf. Rosner describes the anguish of she and her husband as they struggle to know whether they should provide their daughter with hearing aids, or raise her as a member of the deaf community.

As a chaplain or pastoral counsellor, how would you help a mother and/or father to clarify the questions so intimately related to their youngster's identity?

Allan Savage
The link between spirituality and health: holistic outcomes and religious practice in clinical health care
Quodlibet J
Vol. 6 # 3 (Jul/Sept 2004) pp. 1-7

Savage, a Roman Catholic chaplain in the north of Ontario, Canada approaches the relationship between spirituality and health in a strikingly different way than do most psychologists and physicians; also many chaplains. His starting point is the premise that the nature of Christian health care spirituality differs from that of other religious traditions in terms of both the intervening agent, and the expected spiritual outcomes. And any model of teaching about spiritual health care that is to be developed for clinical intervention will need to take into account this difference in a multifaith context.

The publication is an online journal of Christian theology and philosophy. They can be found at: < http://www.quodlibet.net/savage-spirituality.shtml > (24 refs)

Thomas A. Shannon, James J. Walter
Implications of the Papal allocution on feeding tubes
Hastings Centre Report
Vol. 34 # 4 (Jul/Aug 2004) pp. 18-20

The remarks of Pope John Paul II (20 March 2004) to the International Congress on Life- Sustaining Treatment and Vegetative State: Scientific Advances and Ethical Dilemmas has led to a great deal of discussion (and also dismay in some circles.) Briefly, what the Pope stated was that artificial feeding tubes for hydration and nutrition are "not a medical act" and that their use "always represents a natural means of preserving life," and is part of "normal care." Therefore their use is to be morally evaluated as ordinary and obligatory. "If done knowingly and willingly," the removal of such feeding tubes "euthanasia by omission." The person's medical condition is not relevant in making a determination about the use of these tubes because the water and food delivered through them is ordinary care and provides a benefit - "nourishment to the patient and alleviation of suffering."

Shannon and Walter who appear (at the least) dismayed about this announcement make several points. First, in speaking as he did, John Paul II appears to have departed from a 400+ year practice in the Roman Catholic church in terms of both the methods and basis on which such medical-ethical decisions have been made. The method he has used in this instance is deontological: artificial hydration and nutrition, he simply declares to be "ordinary." Historically, the method for making a decision such as this has been to consider the proportional benefits of a situation - a teleological approach.

Coming out of the blue as it did also makes it different from past statements. Most ethical statements from prior times have been made after a consensus has been reached within the wider church, at least among bishops. But this blunt statement arrived unexpectedly. It leaves many questions unanswered: what is the authority of the text of this statement? Should it be read broadly or narrowly? How will the decision be implemented?

Shannon and Wakter continue with another group of questions which concern people and institutions. They list these questions, and if their fears are warranted, this document will pose problems for faithful Roman Catholics and the institutions they support into the foreseeable future. (5 refs)

Andrew Sims
Mysterious ways: spirituality and British psychiatry in the 20th century
Spirituality and Psychiatry Special Interest Group Newsletter
Vol. 13 (Oct 2003) pp. 1-7

The Royal College of Psychiatrists has a Special Interest Group which focuses on the subject of spirituality in psychiatry. The group first met in February 2000, and to the amazement of many, the numbers participating in the group are much greater than was initially predicted. The membership in the group currently totals almost 850.

In this paper, Sims describes the changing attitudes towards religion, faith and spirituality within British psychiatry over the past 50 years. The extent of the change has been such that he takes William Cowper's phrase to summarize what has happened: "God moves in a mysterious way His wonders to perform."

- the 1950s: psychiatry viewed religious faith and spiritual concerns with suspicion and even hostility. Some psychiatrists believed religion was "bad for your health". The church distrusted psychiatrists for "leading people astray".
- the 1960s: religious sentiment often equated with neuroticism. Religious beliefs were not considered important by psychiatrists.
- the 1970s: some psychiatrists becoming consultants began to discuss the relationship between their Christian faith and their practice as psychiatrists.
- the 1980s: increasing confidence in a minority of psychiatrists that there was some overlap between psychiatry and religion, and some meetings took place.
- the 1990s: a continuation of what had begun in the previous decade.
- Feb 2000 - first meeting of SIG within the Royal College of Psychiatrists.

Sims is a former President of the College, and was formerly at the University of Leeds. (15 refs)

David E. Tucker
Rewriting the story-myth: a rehab experience
Chaplaincy Today
Vol. 20 # 1 (Spring/Summer 2004) pp. 23-26

The work of the staff in a rehab setting inevitably focuses on the limitations of patients. Tucker suggests that chaplains can and should approach patients with a different orientation. By focusing on a person's strengths, the chaplain can immediately draw upon the positive known qualities in a person's life.

In order to do this, Tucker suggests, people can be helped to begin rewriting their life stories - the creating of new "story-myths." He describes this task as helping the patient "view their circumstances through a different, less limiting, lens," which has the potential for helping a person to cope with, and adjust to a lifetime of disability.

Tucker, a chaplain, describes the process that he has developed, including how he uses the "Tree of Me," a helping tool created by a staff member of Orlando Regional Healthcare. (7 refs)

Larry VandeCreek
How satisfied are patients with the ministry of chaplains?
J of Pastoral Care & Counselling
Vol. 58 # 4 (Winter 2004) pp. 335-342

VandeCreek believes chaplains should be interested in whether or not patients are satisfied with the ministry they are providing. He gives a number of reasons why: first, patients bring their religious and spiritual concerns with them to the hospital, so they have a vested interest in whether or not the designated expert can respond. Second, some administrators see chaplains as less than essential to the operations of the institution, so patient satisfaction is not unrelated to this issue. Third, some patients want nothing to do with a chaplain, and the chaplain who is not sensitive to this reality risks offending patients and families, which may be reflected in patient satisfaction. Finally, unlike nurses and doctors, as a profession chaplains lack best practice standards. Feedback as to satisfaction from patients can assist a chaplain in improving his/her ministry.

Unfortunately, the commercial questionnaires used to find patient satisfaction levels with chaplain are unsophisticated and unhelpful - even harmful. VandeCreek's research reported here is of a different order, and the results indicate that what chaplains do in helpful to patients.

Fourteen general hospitals, sized 50 to 500 beds, participated in the survey. VandeCreek got 1440 completed questionnaires which contained 23 questions, plus some demographics. He lists the questions asked and describes the research process clearly.

Patients expressed the most satisfaction in response to the statement: "The chaplain seemed to be a person of spiritual sensitivity." Eighty-three percent of

respondents to the item: "The chaplain helped me to realize that God cares for me."
The results also revealed that the pastoral care was more satisfying in some hospitals than it was in others.
The questionnaire is available to other chaplains worldwide upon request. See the article or contact this editor. (7 refs)

Andrew J. Weaver, Kevin J. Flannelly
The role of religion/spirituality for cancer patients and their caregivers
Southern Medical J
Vol. 97 # 12 (Dec 2004) pp. 1210-1214
This article was written by two researchers from The Healthcare Chaplaincy in New York. It is intended for doctors. The authors summarize what research has shown about the role of spirituality and/or religion in the lives of cancer patients and their caregivers. Chaplains who read it will find it to be a useful summary about the contributions they can make to the care of such patients.
According to Weaver and Flannelly, they wish to highlight that: faith can give a cancer patient a framework within which they can find meaning and perspective concerning their situation; that religious practice opens access to supportive social networks; that spiritual well-being has been associated with the ability to enjoy life, even when the person is experiencing negative symptoms; that patients highly value interactions with clergy; and that faith-based programs can be useful in promoting health screening and educating people about cancer.
The paper is meticulously footnoted. (64 refs)

Andrew J. Weaver, Kevin J. Flannelly, Harold G. Koenig, Fred D. Smith
A review of research on chaplains and community-based clergy in The Journal of the American Medical Association, Lancet, and The New England Journal of Medicine: 1998-2000
J of Pastoral Care & Counselling
Vol. 58 # 4 (Winter 2004) pp. 343-350
In the medical worlds in both the U.K. and in the U.S. there has been a significant increase in the level of interest in spirituality in health care. These authors wondered if this increase was being reflected in the medical research literature.
They examined every article in the named journals (see above), a total of 2385 in the period 1998-2000. Of each article they asked: does this article contain any descriptive statistics which evaluates any aspect of the work of a clergyperson or chaplain? (or can statistics be inferred from indirect implications?)
They found just two (2) articles. The number of articles in nursing journals far exceeds the numbers published by doctors. They speculate as to why this is so.
The authors contend that research is now needed that will expand the partnership between the medical and faith communities in order to promote healthy behaviour. (64 refs)

Douglas R. Wilson
Virtual visiting seminar replaces verbatim seminar in clinical pastoral education (CPE)
J of Pastoral Care & Counselling
Vol. 58 # 1/2 (Spring-Summer 2004) pp. 95-100
In CPE programs in the U.S. the verbatim seminar has long held an important, if not the central place. Wilson, a Canadian CPE supervisor reports an experiment in his training centre in which he has replaced the written verbatim with "the Virtual Visit." He defines this kind of visit thus: "A Virtual Visit takes place when a student has a pastoral visit with a volunteer/patient who has come with the expressed intention of helping the student learn how to be pastoral. "
The article is a thick description of how the program was set up and conducted, as well as the reactions of Douglas and his colleagues. Wilson exposed the method to the review of his supervisory peers by including the seminar for the 10-yearly site review committee when they examined his program and training centre. He includes the high praise and encouragement of those who saw the V.V. in process. (1 ref)