

## THE ORERE SOURCE

---

The Rev. W. Noel Brown is a recently retired hospital chaplain and former A.C.P.E. supervisor. He is the Convenor of the Research Committee of the Association of Professional Chaplains. He is also the Editor of *The Orere Source*, a bi-monthly publication of his abstracts from the pastoral care and health-care literature. There are over 16,000 abstracts in the database. Contact: [oreresource@rocketmail.com](mailto:oreresource@rocketmail.com)

---

**P. Burnard**  
**Sisyphus happy: the experience of depression**  
**J of Psychiatric and Mental Health Nursing**  
**Vol. 13 # 2 (Apr 2006) pp. 242-246**

What is it like to be seriously depressed? "I suspect that many psychologists, psychiatrists and theologians say too much about that which it is impossible to speak." (p.243)

This is among the observations about depression written by a man who describes his own symptoms and personal ideas about this common condition, which also happens to be his own. He raises questions about the legitimacy of psychiatric and psychological theorizing about depression, and draws upon a number of existential thinkers to support what he is describing. He claims that depression is not particularly a "learning experience," and, far less, a form of personal growth.

Burnard is a professor of nursing, and vice-dean of a school of nursing in Wales. (14 refs)

**Frederic C. Craigie**  
**Spiritual caregiving by health care professionals**  
**Health Progress**  
**Vol. 88 # 2 (Mar/Apr 2007) pp. 61-65**

Two themes run through Craigie's paper. One is the belief that spiritual care is ultimately grounded in the "embodiment" of the spirit in the practice of each health-care professional. It is not an add-on. Second, that while it is appropriate for health care professionals to defer to chaplains about spiritual issues and struggles, they themselves play a vital role in understanding and accepting patient's spiritual values and resources. Professionals must be mindful of this if they wish to practice whole-person medicine.

He writes about the first theme by distinguishing between what he calls "the specialty model" as opposed to "the embodiment model." The first approach defines spiritual care as a specific content area, an area of technical expertise. It is kind of like the idea that sometimes you may do it, and sometimes you may not. Craigie supports "the embodiment model" - it has to do with intention and presence, rather than specific content. "Qualities of spirit are, for better or worse, "embodied" in us..... in every interaction we have with our patients and our colleagues." (p. 62)  
He compares and contrasts the models. (18 refs)

**Jean deBlois**  
**Fr Kevin O'Rourke - the man and his work**  
**Health Progress**  
**Vol. 88 # 2 (Mar/Apr 2007) pp. 14-19**

Fr Kevin O'Rourke OP has been a pivotal figure in the modern world of health care ethics, especially in Roman Catholic health care ethics. On the occasion of his 80th birthday, *Health Progress* has created a special section of the publication to honor his life and work. deBlois is the first of 7 writers to describe various aspects of his thought concerning pastoral work. There is an introduction by Ron Hamel, and a select bibliography. deBlois then quickly sketches his early years, describes his development as a teacher of canon law and as a theologian, how he came to the field of medical ethics, and the landmark cases he has been involved in. (Quinlan, Cruzan, Busalacchi, Becker). While O'Rourke has addressed a wide range of ethical issues over the past 30 years, one issue has been of special concern: the question of the removal of life support. As the article shows, O'Rourke's thinking on this issue differs from that of many in the leadership of the Roman Catholic church. e.g. he supported Karen Anne Quinlan's parents who wished

to discontinue life support. In this, they were opposed by both the AMA, and the doctors who were caring for her! Later, officials of the St Louis Catholic diocese in the case of Pete Busalacchi. deBlois describes O'Rourke as having "been routinely vilified and accused of being a dissident Catholic ethicist bent on undermining the teaching of the church..." (p. 18)

The following article by Charles Bouchard describes what he characterizes as O'Rourke's "retrieval of an ethical method" which had been "neglected and distorted by philosophers, reformers, and even the church itself." (p. 20-25) Bouchard describes O'Rourke's "prudential personalism" and why this approach to ethical questions is important, even though the approach was abandoned after the Council of Trent (1545-1563) with Catholic ethicists often adopting a "manualist" approach to ethical problems. (7 refs)

**Ezekiel J. Emanuel, Alan Wertheimer**

**Who should get influence vaccine when not all can?**

**Science**

**Vol. 312 # 5775 (12 May 2006) pp. 854-855**

The potential threat to human life of a pandemic influenza is staggering: 1.9 million deaths, 90 million people sick, and nearly 10 million people hospitalized, with over 10% of the hospitalized needing to be in an ICU. And all of this is in the U.S. alone! The consequences are almost too painful to imagine.

But plans are being made to try and lessen these consequences. One plan is to vaccinate people. In the U.S. two committees (The National Vaccine Advisory Committee (NVAC), and the Advisory Committee on Immunization Policy (ACIP) have together recommended a plan that would prioritize who will get vaccinated. The plan, simply put - top to bottom - is vaccine production workers, health-care providers (including chaplains?) and the ill elderly at the top, with healthy people aged 2-64 years at the very bottom; even under embalmers. The larger the supply of vaccine at the time of the emergency, the further down the list people would be able to be vaccinated.

Emanuel and Wertheimer here propose a different order of ranking. Rather than thinking of saving the most lives, which is the intent of the above plan, they believe a better (i.e. more ethically sound) plan would be to maximize individuals' life span and opportunity to reach life goals. This would still

have vaccine production workers, health-care providers (including chaplains?) at the top, but then it would be the youngest first, with the final group (persons with life-limiting morbidities) prioritized according to expected longevity.

What do you think? Should you, as a chaplain - because you are a chaplain - receive priority? Presumably your partner wouldn't unless they are a chaplain. (14 refs)

**Christopher M. Faiver, Eugene M. O'Brien**

**Spirituality and counseling**

**\*\*\* American J of Pastoral Counseling**

**Vol. 7 # 4 (2004) pp. 25-49**

"Know thyself." The authors posit that a therapist or counselor must begin their therapeutic work with a self-examination regarding their own beliefs, especially within the realm of spirituality and religion, prior to initial contact with a client. They outline a five-step format for such self-assessment.

In the second half of their paper, the authors describe and illustrate 15 therapeutic interventions that they see as being rooted in spirituality: assessing, placing, confessing, disputing, forgiving and releasing, giving, guiding, praying, referring, relating, ritualizing, supporting, and teaching. In their conclusion, they present the case history of a couple who depended for support on their spiritual beliefs and their spiritual practices.

In an appendix, they list fourteen web sites, which focus on some aspect of counseling and therapy, and spirituality. (56 refs)

**Les Gallo-Silver, Michael O. Weiner**

**Survivors of childhood sexual abuse, diagnosed with cancer: managing the impact of early trauma on cancer treatment**

**\*\*\* J of Psychosocial Oncology**

**Vol. 24 # 1 (2006) pp. 107-134**

The number of persons diagnosed with cancer who are also survivors of childhood sexual abuse (CSA) is unknown. To date, the impact of childhood sexual abuse on the medical treatment of cancer patients has not been explored. Existing studies on female survivors diagnosed with cancer, have focused on the post-treatment experience, and their higher incidence of sexual dysfunction. This article describes the impact of CSA on the cancer treatment of 18 survivors and the clinical interventions that were used to address the unique psychosocial needs of this group during treatment. Anecdotal information suggests that CSA survivors may find aspects of their cancer

experience reminiscent of their history of abuse. All 18 survivors did experience distressing memories of their abuse during their cancer treatment. As practical guidance for the chaplain: the author reports that the containment of the intense affect and distressing thoughts, rather than exploration of the earlier events improved CSA survivors' adherence to their cancer treatment program. Teaching them how to acquire comforting skills also helped CSA survivors feel less victimized by their cancer experience. (123 refs)

**Barbara B. Gascho, Paul Derrickson**  
**Transforming life's web into a labyrinth: spiritual care for ALS patients and their families**  
**Chaplaincy Today**

**Vol. 22 # 2 (Autumn/Winter 2006) pp. 8-14**

Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's Disease, is a fast-developing, incurable paralyzing disease. After diagnosis, most persons with ALS will die within 3 years; only 10% live a decade or more. However, with slightly more effective treatments now available for symptom control, greater attention is now being paid to quality-of-life issues for these patients. That is the focus of this article, written by a chaplain (a former nurse) and a chaplain-supervisor.

They describe the typical progress of the illness, the problems of learning to cope, the challenge for the chaplain of becoming fully-integrated into an ALS clinic, and most importantly, the themes of spiritual caregiving they have identified. The paper reflects a robust awareness of the literature dealing with issues of coping in this population.

Having highlighted these themes, the tasks of spiritual interventions are described; also the impact that ministering to this group of people have had on the chaplain. (Even though the paper is co-authored, it is likely that the first author of this paper is the one who has reflected on the effect these persons have had on she and her ministry. (16 refs)

**Florence Gelo**  
**Three days before Christmas**  
**Chaplaincy Today**

**Vol. 22 # 2 (Autumn/Winter 2006) pp. 41-42**

Do you have an interest in theological reflection? How chaplains grow in their spiritual sensitivity to pain, and in their ability to make (theological) sense of their responses? Then this short piece will provide you with food for reflection. (0 refs)

**Alex H.S. Harris, Frederic Luskin, Sonya B. Norman, Sam Standard, Jennifer Bruning, Stephanie**  
**Effects of a group forgiveness intervention on forgiveness, perceived stress, and trait anger**

**J of Clinical Psychology**

**Vol. 62 # 6 (2006) pp. 715-733**

Can a person be trained to forgive? There has been an explosion of interest in the forgiveness within both the scientific and general community of the past 10 years. In that time, the number of empirical student studies on forgiveness has nearly quadrupled. There is still disagreement about the definition of forgiveness and no gold standard definition currently exists. The authors of this article conceptualize forgiveness as involving both the reduction of unforgiveness, and an increase of positive emotions and perspectives, such as empathy, hope, and compassion.

This article is a report of a study they conducted to evaluate the effects of the six weeks, forgiveness training program. At no time in the program did participants have to describe the event(s) about which they were concerned. The outcomes of the program showed that it had been two to three times more effective than that of the no-treatment control condition in the reduction of unforgiveness, and to a small degree, it increased forgiveness related positive states. However, it is worth noting that many people in both groups failed to recover or improve. There is an appendix containing the questionnaire used to measure the changes effected by the program; 14 questions to rate the confidence of a participant in being able to complete various tasks relating to a perceived offense.

In addition to the significance of the specific results of the study, this paper could serve as a useful introduction to the overall field of forgiveness research as it currently stands. (39 refs)

**J Irene Harris, Sean W Schoneman, Stephanie R. Carrera**

**Preferred prayer styles and anxiety control**  
**J of Religion and Health**

**Vol. 44 # 4 (Winter 2005) pp. 403-412**

Research concerning prayer is still relatively undeveloped. Basic questions such as: how do we define "prayer"? what "results" or "outcomes" should be looked for? how exactly should we go about "measuring" prayer? - these and other issues are still being discussed. And this all presupposes that prayer is an appropriate matter for research anyway, a question that is still being hotly debated.

In The Orere Source, we are going to assume that research concerning prayer is a legitimate subject for research and discussion, if for no other reason than to keep readers abreast of what others are thinking.

This paper concerns the relationships between the ways people pray and the levels of anxiety that accompany their praying. Development of a new instrument, the Prayer Functions Scale (PFS) by Bade and Cook enabled the authors to better measure individual's prayer styles, which were then correlated with anxiety levels. The PFS instrument identifies four styles of praying, and we list here two statements linked to each style: a. Seeking Acceptance style of praying: "Ask God to direct my life and actions in ways that God wants." "Prays that the difficulty will lead me to a closer relationship with God." A style that provides calm and focus: "Pray that I might be able to deal with obstacles." "Allows me to reflect on the issues." Deferring/Avoiding style: "Pray for God to change the situation." "Pray for things to get better." Providing Assistance style: "Ask God to help me face difficult situations." "Put things in God's hands when I can't handle them alone." The subjects were 85 students in introductory psychology classes in the southwest U.S.

The paper is up the usual high standard of this journal with a clearly stated rationale for the project, a review of the existing literature (and the currently confusing picture about the effects of prayer in those who pray), followed by method and results.

Those results suggest that persons whose prayer style is characteristically to actively seek assistance from God – as opposed to seeking assistance to defer or avoid situations that could cause anxiety – seemed to have better control of their anxiety and lower levels of trait anxiety.

The findings suggest that persons whose prayers were more deferring/avoiding in nature, were coping with their stressors less effectively. (35 refs)

**Peter W. Hawkins**

**The Buddhist insight of emptiness as an antidote for the model of deficient humanness contained within the label "intellectually disabled"**

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

**Vol. 8 # 1/2 (2004) pp. 45-54**

There is in Buddhism, a teaching called "sunyata", which means emptiness. It is a teaching presented

in a Mahayana text referred to as "the heart sutra." The theme of the sutra is that all phenomena are empty of separate being, and this is the basis for resolving all the apparent dualisms that can be found in life, in this case the dualism of intellectually disability and being not intellectually disabled. Sunyata positively understood is called "interbeing", and it critiques hierarchical notions that derive from dualistic notions.

The author's critique of disability is described within an open and loving relationship between a person who has been labelled as "intellectually disabled" and another person, the author, who is not so labeled, and who moves from being a support worker in the man's life, to being a lifelong friend. (1 ref)

**Earl E. Johnson**

**Between the storms: reflections on chaplaincy during natural and human-caused disasters**  
**Chaplaincy Today**

**Vol. 22 # 2 (Autumn/Winter 2006) pp. 3-7**

Chaplains have been responding to community-disasters forever. It has only been in recent times, that special training has been provided to better equip them for their ministry in these difficult situations. This has been done under the auspices of the American Red Cross (ARC), as members of ARC's Spiritual Care Aviation Response (SAIR), recently renamed the Spiritual Care Response Team (SRT). Johnson has been involved in this effort from the start, and he is now the national U.S. coordinator for SRT.

To date there have been 17 complete or partial deployments to disasters, train derailments and 9/11. With his broad involvement, he describes the development of this effort, especially the lessons that have been learned following hurricane Katrina. Johnson then turns to the future, urging that disaster training become a part of all chaplaincy education programs. He adds a postscript, the letter he sent to the 7 chaplains who responded to the 27 Aug crash of a flight in Kentucky. (0 refs)

**Rajeev Mehta, Joshua Hauser**

**Hospital chaplains reflect on spirituality in end-of-life care**

**Healing Ministry**

**Vol. 12 # 3 (Summer 2005) pp. 35-43**

The objective of this study was to explore what a group of hospital chaplains believe is important in spiritual care at the end-of-life. The intent of the

authors was to understand in a nuanced way, the spiritual care that should be considered by all members of interdisciplinary teams for the benefit of their patients. Individual interviews were conducted with all six of the full-time chaplains of a mid-west hospital. Each chaplain had had at least 10 years of experience working in palliative care. The chaplains were of Protestant, Catholic, and Jewish backgrounds. There were 3 questions being clarified. 1. Can contact with religious figures be helpful? 2. Can contact with a religious figure or religious concerns in general be harmful? 3. What is the role of specific religious beliefs for the chaplain and the patient? The interviewer (RM) asked two open-ended questions in order to open discussion regarding each category. Using the methods of grounded theory, salient themes from the interview notes were then assessed. The results are presented in this paper.

The authors present in detail their findings about: firstly, the positive outcomes of chaplaincy; secondly, chaplaincy for those without specific beliefs; thirdly, negative associations with religion; and finally, the role of specific religious beliefs.

The authors conclude that since other studies have demonstrated that patients desire for their physician's involvement in spiritual matters at the end of life, that physicians should be aware of how another important worker of the care team - the chaplain - sees his/her role. Important factors uncovered by this study include understanding that the chaplain acts as a listener for the patient, help-patients avoid a sense of guilt and feelings of isolation, and provides meaning and purpose for patients. They suggest that physicians should be aware of the patient's own spiritual resources, and also encourage patients be referred to hospital chaplains, as was suggested in Daaleman and Frey's study. (*Prevalence and patterns of physician referral to clergy and pastoral care providers* in Archives of Family Medicine Vol 7 # 6 (1998) p.548-553). They also remind physicians that they need to keep in mind that many hospital chaplains maintain a separateness from the hospital with its medical agendas, this often being central in how they comfort patients. Such a boundary, they suggest, needs to be respected as a way in which the hospital chaplain is distinct from other health care professionals, who are also involved in caring for the needs of the patient.

They suggest that further work in this area should be done to understand specific ways that physicians

and hospital chaplains can relate to one another concerning the religious and spiritual needs of their patients. (24 refs) (*Disclosure comment*: I was one of the chaplains interviewed for this study.)

**Ann Neale**

**Who really wants health-care justice?**

**Health Progress**

**Vol. 88 # 1 (Jan/Feb 2007) pp. 40-43**

This article is a "conscience exercise", designed by a member of the Center for Clinical Bioethics at Georgetown University.

She suggests that one reason that efforts to reform health care have not been successful is that we have not brought to those efforts sufficient reflection about the deeper values, attitudes and dispositions that we bring to the tasks of reform. Rather, the reform movement has been concentrated on promoting particular policy solutions.

So she has created a "conscience work exercise" designed to help a person or group examine the values, attitudes, and dispositions that, if unexamined, may contribute or inhibit the progress of their efforts for health care justice.

The exercise is a one-page work-sheet. Persons who undertake it are invited to share their findings with the author, and further details can be seen on the CHA website at:

[www.chausa.org/consciencework](http://www.chausa.org/consciencework) (0 refs)

**Louise D. Palmer**

**Growing hope**

**Spirituality & Health**

**Vol. 10 # 1 (Jan/Feb 2007) pp. 40-43**

How would you characterize or label "hope"? Is that a belief, or an attitude? An inward disposition, or a gift? Anthony Scioli believes that it is most helpful to think of hope as a skill one can acquire. He believes that it is active: you can tend and nourish it. It is multifaceted: he suggests there are 14 distinct aspects to hope. It is self-perpetuating: hopeful people tend to be more resilient, more trusting, more open, and more motivated than people who are less hopeful - so they receive more from the world, which confirms them in their hopefulness.

A clearer understanding of hopefulness has been developing from early in the 1990s, through the work of Kenneth Pargament and the late C.S. Snyder. Now Scioli has developed his own Hope Scale which, along with the theory behind it, provides us with an expanded understanding of the nature of hope. For him, hope is complex: it has its roots in our deepest

self, its foundation in relationships, and it has a spiritual core. In his mind, hope sustains our intimate bonds, gives life purpose and meaning, and determines our prospects for survival and health.

Scioli has recently published a number of interesting studies. In one he studied the relative importance of age, hope and gratitude as predictors of well-being in a sample of 75 persons aged 18 to 65 years. Using three different measurement scales, he found that a high level of hope was the most powerful predictor of well-being, no matter the age.

In the second recent study, he found that hope appears to buffer anxiety about death and dying. In this study, he showed a growth group of young people, a 10 minute segment from Tom Hank's movie Philadelphia. In this film, Hanks plays a young man dying of AIDS. Scioli then measured the fear of death and dying in the young people who had viewed the film. Those with a high hope score showed less death anxiety than those with a low hope score.

Finally, he completed a study to see if hope is reflected in the body-mind connection. In a study that included thyroid cancer patients, and HIV-positive patients, he found that the hopeful participants reported better health and less distress/worry about their health. To get some external confirmation of the subjective reports of the patients, he interviewed each person's case manager, and did a blood test to determine their immune cell count (CD4). The findings strongly support the belief that hope affects general health, as well as of the immune system itself.

The article concludes with a copy of the Hope Test, which the reader can take. The 14 aspects of hope are included, with two questions for each aspect. The test itself and your own results can be found at: [www.spiritualityhealth.com/hopetest](http://www.spiritualityhealth.com/hopetest)

In the following section (p. 46-47) there are a set of practices recommended by Scioli, one for each of the hope traits Scioli has identified. For the chaplain seeking to develop hopefulness in their own spiritual lives, there may be opportunity here. For the chaplain seeking to be a doctor to the soul of her/his patients, there may be interventions here for future use. Number 11 could be the basis for a research project in a hospital.

**Kenneth I. Pargament, Gene G. Ano**  
**Spiritual resources and struggles in coping with medical illness**  
**Southern Medical J**

**Vol. 99 # 10 (Oct 2006) pp. 1161-2**

In this brief review article, designed to be read by busy physicians, the authors describe (a) how in the face of medical illness, many people turn to their faith for hope, comfort, strength and meaning, while (b) for a small number, illness is the start of a spiritual struggle.

The authors describe how spirituality can be both resource and struggle, and conclude with some practical suggestions for physicians who wish to address the issue of spirituality with their patients. Their focus question: "Spirituality often influences how people deal with illness. How, if at all, has your spirituality influenced how you have dealt with your medical condition?"

(*Comment:* If you are looking for an interesting research project, asking this question might be a useful starting point.) (5 refs)

**Louise Penkman, Laura Scott-Lane, Wendy Pelletier**

**A psychosocial program for pediatric oncology patients; a pilot study of "The Beaded Journey"**

**\*\*\* J of Psychosocial Oncology**

**Vol. 24 # 2 (2006) pp. 103-115**

"The Beaded Journey" program is a new approach to providing psychosocial support to children with cancer. This study reports its first formal evaluation.

In the program, newly diagnosed children receive a beaded rope with letter beads that spelled out their name. They also receive a bead for different aspects of their treatment - thirty-one different kinds of beads all told - one for every different kind of event during their work-up and treatment. The children and their parents were also given a diary in which they were asked to record their experiences. The diary was introduced as an additional way of recording, validating, and honoring the child's cancer journey. Forty-five families participated in the study.

Response to the program was very strong. The expected benefits from the activity were realized, and some unexpected benefits were also discovered. e.g. some children took their beads to school to help them explain to classmates what was happening to them in their illness and treatment course. A small group felt that participation in the program was an added burden to what was already a difficult experience. (15 refs)

**Timothy Quill, Sally Norton, Mindy Shah, Yvonne Lam, Charlotte Fridd, Marsha Buckley**

**What is most important to you to achieve? An analysis of patient responses when receiving palliative care consultation**

**J of Palliative Medicine**

**Vol. 9 # 2 (Apr 2006) pp. 382-388**

This report comes from a palliative care team which apparently takes its patients seriously by asking what they hope to get out of their program. One of the ways in which they do this is simply to ask each person, when they are seen for the first time, "What is most important for you to achieve?" The answers to this question were found in 215 patient records, and the responses could be separated into four categories: 1. Improving quality and meaning ("I want to be able to sit on the front porch and watch the farm go by" (52%) 2. Achieving comfort and relief ("Can you get rid of my pain?" (34%) 3. Altering the course of the illness ("If there is a treatment that can make me well, I want it" (22%) 4. Preparing for dying ("I am not afraid of dying. I just don't want to suffer." (11%) A small group (5%) gave responses that could not be easily categorized.

(*Comment:* Is not this also a pastoral question, to be asked on an initial visit?) (16 refs)

**Shane Sinclair, Jose Perreira, Shelley Raffin**

**A thematic review of the spirituality literature within palliative care**

**J of Palliative Medicine**

**Vol. 9 # 2 (Apr 2006) pp. 464-479**

This paper presents a review of the literature related to spirituality and health, with a special focus on spirituality within palliative and end-of-life care. Literature was located by searching the CINHALL and Medline databases using the keywords "spirituality" and "palliative".

An initial review revealed five overarching themes that have previously been found in the general spirituality and health literature: the nature of the general relationship between the spirituality and religion; the conceptual difficulties relating to the term spirituality; the relationship between the spirituality and health; the general subjects usually included in the spirituality related research; and, the provision of spiritual care,

However, the authors also located six other specific thematic areas unique to the palliative literature; 1. general discussions of spirituality in palliative care; 2. the spiritual needs of palliative care patients; 3. the nature of hope in palliative care; 4. tools and therapies related to spirituality; 5. the effects of

religion in palliative care; and, 6. spirituality, and palliative care professionals. Within these headings, Sinclair and his colleagues summarize the literature, comprising 159 articles.

In their conclusion, the authors suggest that a more integrated approach needs to be developed that will highlight the experiential nature of spirituality that is shared by patients, family members, and healthcare professionals alike. They make several comments critical of the way spirituality is sometimes characterized in the health-care literature: "...spirituality as a result has been reduced largely to a concept void of religion, an instrument to be utilized in improving health, and focused predominantly on the self... While spirituality is uniquely understood and experienced by individuals, it is also a chord that can serve to bind humanity together. This collective component of spirituality has not been explored, and is largely overshadowed by an individualistic approach that has failed to take into account the common threads that may bind patient's families and healthcare professionals together, through shared experience.....while spirituality in palliative care is a central aspect of the discipline's history and takes on a different meaning from other areas of health care, these tendencies are still very much apparent, propagating a form of practice that reduces spirituality to simply another tool in our treatment repertoire, having been stripped of its mystery by empiricism, to be administered to the dying patient by the skilled practitioner." (p.475)

The article's lead author is a hospital chaplain in Calgary, Canada. (159 refs)

**Mildred Z. Solomon**

**Realizing bioethics' goals in practice: 10 ways "is" can help "ought"**

**The Hastings Center Report**

**Vol. 35 # 4 (Jul/Aug 2005) pp. 40-47**

It is a familiar criticism leveled at bioethics: that it is more intellectual than practical, having little application in the "real world." In this article, Solomon replies to such critical voices and suggests how bioethics can keep its feet on the ground. She says that bioethics must use the social sciences more effectively, and that empirical research could provide a bridge between conceiving a moral vision of a better world, and actually making that world a reality.

To facilitate the move from ethical analysis to ethically justifiable behavior she makes these suggestions.

1. The gaps between espoused ideals and actual practice need to be documented.
  2. The nature of individuals' moral reflections, and the level of their personal skill and ethical analysis needs to be made more transparent.
  3. There needs to be a better description of the institutional and environmental context that mediates moral action.
  4. Data needs to be provided to stimulate individual and institutional moral accountability.
  5. Consequentialist claims need to be tested.
  6. There needs to be validation, refutation, or modification of principals in the light of their relevance to moral agents.
  7. We need to recognize of the relevance of otherwise neglected ethical principles.
- She continues by suggesting that we must generate new normative concerns.
8. There needs to be an identification and documentation of new moral problems.
  9. There needs to be clearer specifying and acknowledging of problems.
  10. There needs to be greater clarification of causal mechanisms within the process of ethical analysis.
- Each of these suggestions is illustrated and discussed. Solomon concludes that bioethicists need what empirical researchers can offer, namely, a variety of powerful means for helping get "from here to there". (32 refs)

### **Steven Spidell**

#### **Improvisation and the pastoral conversation Chaplaincy Today**

**Vol. 22 # 2 (Autumn/Winter 2006) pp. 15-19**

Poor ministry in chaplaincy occurs when a chaplain responds to people in formulaic and predictable ways. In order to try and make this clear, pastoral education has highlighted the need for "active listening", or "skilled helping" or any one of several other paradigms.

Spidell introduces a new and creative approach. "Rather than a scripted narrative, pastoral conversation relies on the listening skills of the chaplain to unfold the just-now created story of the patient's experience." To do this, he uses Frank Barrett's seven characteristics of jazz improvisation to illustrate the qualities of effective pastoral care conversation and practice. He takes each of the seven characteristics in turn, and describes what each means for pastoral conversation.

He concludes that this approach "... opens rich new dimensions in exploring this music we call chaplaincy." (6 refs)

### **Liwliwa R. Villagomez**

#### **Spiritual distress in adult cancer patients - toward conceptual clarity**

##### **Holistic Nursing Practice**

**Vol. 19 # 6 (Nov/Dec 2005) pp. 285-294**

How does one recognize spiritual distress in the practice of chaplaincy/ministry? This a well-written article which uses a seven-construct model to describe spirituality. Villagomez then provides cues for recognizing spiritual distress in adult patients with cancer.

The writer uses Walker and Avant method of theory construction in order to clarify what is meant by the concept "spiritual distress." It is an eight-step approach, which, as it is described, allows the reader to both understand the nature of the construction theory being used, as well as to more fully understand the complexity of what is called "spiritual distress."

Villagomez begins by identifying the nature of spirituality. This involves examining seven overlapping but distinct constructs that together comprise spirituality. They are:

- connectedness.
  - faith and religious belief system.
  - value system.
  - sense of meaning and purpose in everyday life and amidst suffering.
  - sense of self transcendence.
  - sense of inner peace and harmony amidst the chaos of life and fear and uncertainty when experiencing life-altering or life-threatening illnesses.
  - sense of inner peace strength and energy that is integrative and unifying beyond the physical realm.
- She then describes spiritual distress in apposition to the concept she has just described. This leads to a consideration of the empirical referents or "cues", which suggests to a nurse or chaplain that a person may be spiritually distressed. Each of the seven constructs is associated with between three and eleven cues.

Consistent with Walker and Avanti's approach to theory construction, four cases studies are included which further clarify the nature of the construct. Included are: a model case; a borderline case; a related case; a contrary case. (48 refs)

**Douglas B. White, J. Randall Curtis, Bernard Lo,  
John M. Luce**

**Decisions to limit life-sustaining treatment for critically ill patients who lack both decision-making capacity and surrogate decision-makers**

**Critical Care Medicine**

**Vol. 34 # 8 (Aug 2006) pp. 2053-2059**

Many intensive care unit physicians have withdrawn life support from a patient who lacked decision-making capacity, and who also did not have a surrogate decision maker. However, little is known about the decision-making process for these patients. In this study, the authors sought to discover how often such patients were admitted to the intensive care unit of city hospital on the west coast of the US, and how the end-of-life decisions were made for them. The study took place during a 28 week in 2003- 2004. A total of 303 patients were admitted. A DNR order was considered for 18 of the patients and actually written for 13 patients. In most cases, the medical team made decisions, often with input from a second attending physician. The study showed that the hospital ethics committee gave input in just one case, and in another, a court-appointed guardian was obtained. The attending physician withdrew life support from eight patients, all of whom died. They considered withdrawing life-support from seven more but did not do so, citing legal concerns, and disagreement among physicians. Of these, all but one survived.

The conclusion of the study was that 16% of the patients admitted to the ICU lacked both decision-making capacity and a surrogate decision maker, and that decisions to limit life support was generally made by physicians without judicial or institutional review.

In an editorial in the same issue, Mark Siegel, the ethicist, comments that this study has important implications, which he outlines. He concludes as

follows: "The continuation of ineffective, costly, painful, and perhaps unwanted care, just because patients cannot speak for themselves, is not the answer. Clearly, exhaustive attempts must be made to find surrogates for these patients."

Comment: How different might the results be from your institution? (38 refs)

**James H. Wood**

**Interventional narratology: form and function of the narrative medical write-up**

**Literature and Medicine**

**Vol. 24 # 2 (Fall 2005) pp. 283-296**

Wood describes the purpose of an emerging movement in medicine known as "narrative-based medicine." (It is a movement that began about 10 years ago, look for the name of Rita Charon.) He explains that the goal of this movement is to "counteract the deterioration of effective listening by attempting a vision beyond mere information, focusing on the narrative aspects of each medical interaction."

The supporters of this approach hope that "by teaching students and physicians to be more insightful readers of literature and more skilful creative writers, their students will be better equipped to understand and respond to patients' experiences." He describes the process of write-ups, including the search for meaning. And what comes afterwards. (26 refs and 15 notes)

\*\*\* Journal names marked in this manner are published by The Haworth Press. They publish many journals relating to chaplaincy and pastoral ministry. Information about reprints of articles can be obtained at: [www.HaworthPress.com](http://www.HaworthPress.com)