Betsy Anderson, Sue Steen. "Spiritual care: reflecting God's love to children," *Journal of Christian Nursing* 12, no. 2 (Spring 1995): 12-17, 47. • The authors are writing primarily for nurses, helping them to clarify how they might support the spirituality of their pediatric patients; however, their approach applies to pediatric chaplains too. They emphasize the primacy of establishing a relationship with the child before discussing assessment questions which can be used to determine the development and nature of a child's beliefs and spiritual views. They illustrate the use of self in meeting spiritual needs as well as the use of touch. Also discussed are aspects of pastoral work which are more sensitive for nurses, e.g., use of prayer and scripture, whether or not the sharing of one's personal faith is appropriate.

Lodovico Balducci, Russell Meyer. "Spirituality and medicine: a proposal," *Cancer Control* 8, no. 4 (Jul/Aug 2001): 368-76. • This is a summary article, with a proposal. The authors—a physician and a parish minister—take the reader through the recent literature concerning spirituality and health, emphasizing the problems with defining spirituality and the question of how to understand the relationship between spirituality and psychology. In the first section a suggestion is made which is new to the medicine/spirituality dialogues. The proposal is "that the concept of sacrifice [be used] in medical investigations as a marker of defined spirituality perspectives." They provide a rationale for this suggestion. They then turn to the matter of how to study spirituality. They claim there are four basic issues which need to be studied, though they offer no basis as to why these four specifically were chosen, especially the second, which seems rather arbitrary: 1) the relationship of spirituality and public health, 2) the efficacy of a spiritual perspective in overcoming addictive disorders, 3) the influence of a patient's and practitioner's spirituality on disease outcomes, and 4) the influence of spirituality on patient-physician communication. They point out that research has already been completed on aspects of these topics and highlight fifteen studies already published. They note the implications for the practice of medicine, for medical education, and for future research. This article will help the reader understand how a thoroughgoing scientist/physician may look at the question of spirituality and medicine. This is perhaps an added reason for reading the article, framing as it does, the spirituality/health dialogue in new and unexpected ways.

Janet Bodell, Kelly Rhoades. "Long-range prevention of complicated grief: an approach to the foundational experience with death and dying," *Healing Ministry* 8, no. 2 (Mar/Apr 2001): 72-76. • The rather formidable title of this article also is somewhat misleading. The authors are concerned about ways in which young children can be helped to receive positive foundational experiences which will prepare them for later experiences with sickness, dying, and death. The information is intended for parents, teachers, and health care professionals. Bodell and Rhoades suggest that in order to help children, adults must be aware of their basic cognitive development processes, specifically those aspects which are related to memory and the short-term memory phenomenon of "chunking." The authors describe chunking (a term first coined by George Miller in his major review article on short-term memory) as the formation of permanent sets of associative connections that then reside in long-term memory and are part of the process that create the basis for fluency in speaking. They proceed to describe how children can group and chunk information, which they do at a very early
injury or injustice and its associated negative emotions and thoughts, becomes willing to relinquish and redirect negative energies, and derives freedom from the desire to retaliate and punish those responsible for the injury.”

In addition to its value as an examination of an important construct in ministry, the paper is a useful example of the strategy devised by Walker and Avant to clarify elusive concepts.

Eric J. Cassell. “The Principles of the Belmont Report Revisited: how have respect for persons, beneficence, and justice been applied to clinical medicine?” Hastings Center Report 30, no. 4 (Jul/Aug 2000): 12-21. • Cassell vividly describes the change in the doctor-patient relationship over the past fifty years. In the mid-fifties, when the Belmont Report was written stating ethical principles to guide medical research, physicians functioned on the basis of benevolence (and skill of course) and provided care to the whole patient according to their best judgment as to what that involved. At century’s end, care involves a series of treatment options, targeted at the patient but at the systems or organs under the control of the patient (somewhat) and is viewed as an exchange of resources, which are limited by the resource allocation requirements of various interested parties, most usually insurance companies. It is difficult in a summary of a paper of this scope and elegance to capture Cassell’s perceptiveness. Concerning truth telling, he writes, “From the destructiveness of complete lies (in the 1950s and 1960s) to the destructiveness of unmediated truth took less than three decades (p. 17).” Concerning our understanding of the physician’s activity: “We no longer understand the medical act as that of a individual clinician caring for an individual patient within a relationship, but as a commodity or a resource within a marketplace.” (p. 21) In his final section concerning making treatment decisions, as opposed to treating patients, he concludes with a sad story. I am taking the liberty of substituting a recent story of my own which illustrates his point. A woman was admitted to my hospital recently one Saturday morning. She was complaining of a burning sensation in her stomach when she ate. In fact, she had been unable to eat for several days. Over the weekend, she was worked up by means of the appropriate tests, and the results were to hand when the consultant made his rounds first thing Monday morning. He came into her room, noted to her that all her test results were within normal parameters, that she was now well hydrated, so he was going to discharge her. In passing, he noticed that she had eaten no breakfast from her tray. “You really should try to eat something,” he urged. “But that is why I came to the hospital, doctor. I can’t eat.” It was only at her husband’s insistence that she was not discharged.

Cassell concludes his paper with an extended discussion of the nature of justice in health care ethics. He shows how the rise of managed care during the nineties has highlighted the distributive issues that arise when cost becomes the primary value by which services are measured and allocated. Like

Barbara L. Brush, Eileen M. McGee, Bonnie Cavanagh, Mary Woodward. “Forgiveness: a concept analysis,” Journal of Holistic Nursing 19, no. 1 (Mar 2001): 27-41. • The authors provide an operational definition of forgiveness based on a study of the way it has been defined by others and of how it has been described in the nursing and theological literature. They summarize its antecedents, define its attributes, and identify some of the occurrences of forgiveness. Having done all that, they follow an approach devised by Walker and Avant (Strategies for Theory Construction in Nursing (1995) 3rd ed; Norwalk CT: Appleton and Lange) in order to illustrate the meaning of the concept of forgiveness. This involves using cases as examples of the concept; and this they do. Their theoretical definition of forgiveness is “a process whereby an individual and/or group acknowledges a past
all Cassell's work, his paper is an easy, but troubling read.

Melanie Cooper-Effa, Wayne Blount, Nadine Kaslow, Richard Rothenberg, James Eckman. "Role of spirituality in patients with sickle cell disease," Journal of American Board of Family Practice 14, no. 2 (2001): 116-22. • Sickle cell disease is a chronic and at times extremely painful disease. Historically it was also a dramatically life shortening disease, though improved medical care since the 1970s has helped this group of patients live longer. The median age of survival for men is now forty-two years, for women it is forty-eight years. It is most commonly found in African Americans. Patients have to find ways of coping with both the chronic pain and the acute, painful episodes for which they are often hospitalized. They do so in various ways: counseling, hypnosis, medication, and prayer. Spirituality is also a method of coping, and the authors of this study report how seventy-one patients in a sickle cell clinic cope with the pain and Ellison's Spiritual Wellbeing Scale (SWBS) to investigate their degree of spirituality. The authors define spirituality as “the capacity to rise above life experiences, to celebrate life and to experience joy.” To study the ability to cope with pain, they used an established pain inventory questionnaire. The results showed an association of spiritual well-being with better perception of life control for this group.

Stronger spirituality meant better ability to tolerate pain. While this research did show the importance of spiritual well-being in coping with complications of sickle cell, what was not clear was the method through which spiritual well-being works its effects. The authors, who are circumspect in their claims to understand what they have found will only say, “Spiritual well-being can help patients with sickle cell disease cope more effectively with the pain of the disease. This effect appears to be through a perception of more life control, measured in this study through the perception of social support. Considering oneself to be spiritual is correlated with perceiving oneself to have a supportive network. Spiritual well-being is not correlated with pain severity or life interference (p. 121).”

Edwin R. DuBose. “Preparing for death: linking medicine, spirituality and end-of-life care,” The Park Ridge Center Bulletin 21, (May/June 2001): 3-4. • There have been many changes in the care of the dying, with some interesting (and probably unexpected) consequences. For example, chaplains now know a great deal about pastoral care of the dying; community clergy do not. People are fearful of losing control of their lives as they are dying, and changes in health care delivery ensures that most of them do. Reformers have worked at improving communication between doctor and patient; but there is no evidence that doctors are less reluctant to talk about death and dying with their patients than they were a decade ago. The 1997 Gallup survey titled “Spiritual Beliefs and the Dying Process” also produced some surprising figures which DuBose quotes: Only 36 percent would look to clergy for spiritual support during their dying (no mention of chaplains); 30 percent would look to physicians, and 21 percent to nurses. For the majority, it would be to their family and friends that they would turn for their deeper spiritual needs as they were dying. Finally, DuBose turns to a paper by Bradshaw who has written about the “secularized spirituality” now to be found in health care. “The effort in health care to dissociate the spiritual dimension from religion produces a lowest common denominator that replaces the traditional notion of spirituality—the human being in relation to the transcendent—with a spirituality that is a personal and psychological search for meaning.” DuBose is concerned that this kind of spirituality can easily become a “silver bullet,” simply one particular kind of health benefit. “Even if spiritual care is important for dying people, does not the spiritual life need to be pursued in terms of its own goals—a deeper relationship with the transcendent—and not in terms of any beneficial effects?” This is a frustrating paper, with DuBose pointing out some important issues which are worthy of greater thought but which remain mostly undeveloped in this essay.

David C. Duncombe. "Prayer and fasting in the halls of Congress: a pastoral approach to lobbying," Journal of Pastoral Care 55, no. 1 (Spring 2001): 7-16. • Over the years, David Duncombe has established his credibility as a pastor and chaplain with a social conscience, who sometimes acts on his beliefs in very public ways. In five earlier articles in the JPC he
has described those activities. In this paper he describes a ministry of prayer and fasting in Washington, DC in support of congressional legislation intended to permit debt relief for forty of the world's most impoverished countries. Duncombe describes a "compelling parallel" between hospital visitation and lobbying. "The trust engendered by the pastoral process...becomes the foundation for whatever advice (or legislative recommendation) is later given (p. 14)." And the outcome? Duncombe seems reluctant to take much credit for himself, but he does report what others have called the "Wednesday night miracle" during which the House Appropriations Committee "resembled more of a revival meeting than a sleepy late night legislative session. Speaker after speaker rose to talk about the need for human compassion, human justice, and 'doing what is right before God.'" The House eventually voted to more than triple debt relief, where the commonly held belief had been that the proposal would be lost.

In a postscript written in October 2000, Duncombe reports that both houses had passed and the President had signed funding for debt forgiveness totaling $435 million, a figure far exceeding that originally hoped for and contrary to pundits' expectations for the outcome of this legislation's passage before Duncombe's lobbying and prayer.

**Garry Hamilton.** "Dead man walking," *New Scientist* 171, no. 2303 (11 Aug 2001): 31-33. • Seventeen years ago, Barry Marshall gave himself a cup of microbe-laced water. He was a trainee-doctor in Perth, Australia. A week or so later, over Easter, an examination of the lining of his stomach showed that he was developing gastritis, the first step toward a life threatening ulcer, or even stomach cancer. This was the first step in showing that gastric ulcers are not caused by spicy food or stress, but by a bacterium, Helicobacter pylori. The upshot has been that taking a course of antibiotics cures people of ulcers, whereas beforehand, they have had to take medication for life. Now, however, there are some doubts. It turns out that H. pylori may not be a total bad guy, after all. There is growing evidence that H. pylori may protect us from diarrhea, as well as a rare cancer now rising fast and mysteriously throughout the western world.

**Cathy Hasty.** "Using a modification of the classic drama triangle to enhance pastoral care," *Journal of Pastoral Care* 55, no. 2 (Summer 2001): 147-157. • In the late 1960s Stephen Karpman described a model of inter-personal interactions which were both repetitive and destructive in nature. The roles of persecutor, victim, and rescuer, which together came to be known as Karpman's Triangle, could be used to understand certain relationships and also could become the basis for helping people relate in different and more healthy ways. Hasty, a hospital chaplain, introduces the concept of the triangle, describes the characteristics of the roles, complements the psychological theory with her own theological insights, and then shows how this concept can be used in clinical situations.

**Laura Helmuth.** "Moral reasoning relies on emotion," *Science* 293, no. 5537 (14 Sept 2001): 1971-1972. • Helmuth discusses the findings in a study published in the same issue (J. D. Greene, R. Brian Somerville, et al., pp. 2105-07) which show that, in at least some situations, a person's emotions are hard at work when faced with an ethical dilemma. The brain imaging study by Greene and his colleagues revealed that even when an ethical problem is stated in strictly rational terms, people's emotions guide their solutions. Helmuth gives an illustration for the reader to use on themselves: you see a trolley with five frightened people heading for disaster. But you can save them if you throw a switch and send the trolley onto another track which will not take the trolley over the cliff, but where, tragically, another person is standing and who would be killed by the trolley. What would you do? Most people think they would throw the switch. However, what if there was not a second track or a switch, but a person standing in front of you whose bulk would stop the trolley if you pushed them into the trolley's path. Would you push the person? Most people think it would be wrong to save the people by stopping the trolley that way. This paradox has been puzzling ethicists for a long time. Why is it sometimes O.K. to kill one person to save five whereas at other times it is not? Helmuth refers to philosopher Stephen Stich's (Rutgers University) statement that the Greene results will not sit well with the majority of ethicists and moral philosophers who argue that moral decisions must be
based on pure reason alone. But it's an encouraging story for chaplains who know that emotions can never be removed from difficult ethical decisions, and yet another piece of research looking at different aspects of the biological substrate of faith and values.

E. Wayne Hill. “A collaborative pastoral care and counseling supervisory model,” Journal of Pastoral Care 55, no. 1 (Spring 2001): 69-80. • Hill's purpose is to present a collaborative model of pastoral supervision that demonstrates a relational, educational, and theological construct and facilitates a therapeutic process in supervision. He also wishes to emphasize that supervision involves a process that is integrative and implies an unfolding and evolving process. “Integration in supervision is an unfolding intrapersonal and interpersonal learning process (p.71).” He lays the groundwork for the model by discussing such issues as cognition, learning theory, and anxiety. He grounds his understanding of the supervisory relationship in the attachment theory of John Bowlby. He comments on a number of attachment styles that can be identified in the supervisory process. Finally, he discusses the supervisory implications of his understanding of attachment theory, describing them in five stages, which he says he has identified from his observations of the supervisory process. Hill concludes with a theological reflection based on Luke 15:11-32, the parable of the prodigal son. He draws attention to the theological significance and relevance of attachment theory in this parable.

Douglas MacDonald. “Hope and Hanukkah,” Healing Ministry 8, no. 2 (Mar/Apr 2001): 57-59. • An exploration of the theme of hope, "as it stubbornly manifests itself in seemingly hopeless situations." It is written by a hospice social worker who is on the admissions team of a hospice in New York state. He and a nurse have the task of "enrolling" a man for hospice care. His wife is not ready for that step. MacDonald tells the story of their involvement.

Kenneth Pargament, Harold G. Koenig, Nalini Tarakeshwar, June Hahn. "Religious struggle as a predictor of mortality among medically ill elderly patients: a two-year longitudinal study," Archives of Internal Medicine 161, no. 15 (13-27 Aug 2001): 1881-85. • There have been many studies published showing that frequent church attendance is associated with increased life span (though many of these same studies have been dismissed for their lack of sophistication.) In some ways, this study reports the opposite effect. Pargament and his colleagues show in this research that religious struggle as the result of an illness increases the risk of dying. This is the first empirical study to identify religious variables that increase, rather than decrease the risk of dying. They studied 596 patients over a two-year period and examined their mortality rate. Mortality during the study period was higher in those persons who said they were feeling abandoned or punished by God, those who questioned God's love for them, those who felt abandoned by their church, those who believed that the devil was at work in their illness, and those who questioned the power of God. The mortality risk increased by 6 percent for every point scored on a 0 to 21 point negative religious coping scale. The revelation of the significant impact of these negative beliefs suggests an important area of ministry which chaplains will need to address in a more systematic way.

David Paulk. “Munchausen syndrome by proxy: tall tales and real hurts,” Clinician Reviews 11, no. 8 (2001): 51-56. • Children tortured by their parents. We would like to think that this only happens in other countries. Paulk shows that it does not as he describes a form of child abuse in which a parent or a caretaker, usually the mother, systematically fabricates information about a child's health, or intentionally makes the child ill, in order to assume the sick person's role, by proxy. By forcing the sick role onto the child, the perpetrator gains gratification through the surrogate patient, i.e., by proxy. Munchausen syndrome by proxy (MSBP) or “factitious disorder by proxy” was first described in 1977. It is a formal psychiatric disorder. It is hard to spot. Lying to cover up physical abuse is not MSBP. There is no “personality profile” that can be used to identify the perpetrators; the family environment usually gives no clues. Faulk describes some objective characteristics of the victim, the victim's siblings, and the perpetrator, which can serve as warning signs of MSBP. There is an important ethical issue related to this problem. Covert video surveillance (CVS) is a recommended tool
when MSBP is a strong consideration. Most hospitals do not have a CVS policy, and so when the issue arises, there are often two problems to deal with simultaneously, both of which are emotionally charged. Chaplains can be of substantial help by being aware of this syndrome and of the need for the creation of a policy if the institution does not already have one.

Stephen G. Post. “Tube feeding and advanced dementia,” Hastings Center Report 31, no. 1 (Jan/Feb 2001): 36-42. • In the late 1970s, Michael Gauderer developed the concept and use of the PEG, the percutaneous endoscopic gastrostomy, which allows long-term tube feeding. The number of persons being provided nutrition and hydration by this method has risen dramatically, to the point where Gauderer himself has called for greater attention to the ethics of the use of PEGs. The problem is not its use when a person is likely to recover from an acute health crisis. The issue is when, and for how long, should a feeding tube be used when a person is certainly but slowly dying. To move toward an answer to this question, Post analyzes the benefits and burdens of the use of tube feeding from the patient’s perspective. He looks at the burdens of such feeding, which in Post’s mind have always been minimized and overlooked. There are six issues to be considered, which he does in turn. The desire to give food and water to any living person has deep emotional roots for all who work around patients. For either care givers or family members to stop providing them is often exceedingly difficult. Such situations call for the presence of a chaplain, both to address the ethical issues and to provide good pastoral care.

Julia D. Quiring-Emblen. “When pills won’t work—one couple’s struggle for health through homeopathy,” Journal of Christian Nursing 18, no. 4 (Fall 2001): 4-7. • In a personal story, Quiring-Emblen, herself chair of nursing at a university in British Columbia Canada, describes the medical history of her husband, their friendship and marriage when he was in his mid-thirties. Her husband John had been raised in a family which used homeopathic medicine when they became sick, and which he used to treat his severe rheumatoid arthritis. Quiring-Emblen, whose background had always been around conventional (allopathic) medicine helps us understand how she struggled to be supportive of the beliefs of her husband about treatment, and what she thought were its limitations. Eventually her husband died after their thirteen-month marriage, and Quiring-Emblen has concluded that homeopathy should only be used for less serious conditions, and that when a problem becomes more acute, conventional medicine’s help should be sought. This article is the first in an entire issue of JCN which has been designed to help Christian nurses make informed judgments about complementary and alternative medicines (CAM). There are articles on touch healing, homeopathy, energy medicine, and herbal remedies.

Michele Le D. Sakurai. “Regulations impacting spiritual care in health care,” Vision 11, no. 9 (Oct 2001): 4. • There has been a significant amount of misinformation with accompanying anxiety in chaplains who have heard recently about the new HIPAA (Health Insurance Portability and Accountability Act of 1996). Sakurai, who is chair of JCAPS, sets the record straight. The issue has been privacy, but it is not true that chaplains need a patient’s permission before they enter that person’s room, a claim that some ill-informed hospital administrators have been making. Chaplains who are employed by a health care entity may function as they always have with regard to access to information about patients. What has changed is the disclosure of information to community clergy. Community clergy are treated differently than members of the general public. Clergy may now be given a patient’s name and general condition (as long as it does not contain specific information), the person’s location in a facility, and the person’s religious affiliation. It is referred to as “directory information.” Additional information about this legislation can be found at: <http://www.hhs.gov/ocr/hipaa> Sakurai states, “The final rule distinguishes between staff in the health care entity and those who operate outside the walls of the entity.” Inside-the-walls staff definitely includes chaplains.

Susan A. Salladay. “Tristam Englehardt’s Christian Bioethics—a physician-philosopher confronts health care in the light of faith,” Journal of Christian Nursing 18, no. 4 (Fall 2001): 28-30. • Tristam Englehardt’s name is well known in medical ethics circles. He has published twenty-five books on
bioethics, and more than 250 articles over the past twenty-five years. He was trained as a physician, and he has a doctorate in philosophy. Until 1991, his work in bioethics had been secular in character and often very critical of religious belief. Then he became a Christian, being baptized into the Greek Orthodox tradition. He began a new journal, *Christian Bioethics*, and in 1999 published his book *The Foundations of Christian Bioethics*. He says that the book “attempts to clarify what it is to be a Christian in today’s world, a world that is post-Christian, post-traditional, and postmodern. These ‘posts’ mark a fundamental rupture in culture. We have moved from a Christian to a neo-pagan moral context.” Salladay interviews him about how his thinking has changed since his religious conversion, and as you may have guessed from the tone of the above quote, he is highly critical of much of what passes for religion and spirituality in health care today.

**Carl E. Schneider.** “Gang aft agley,” Hastings Center Report 31, no. 1 (Jan/Feb 2001): 27-28. Schneider begins with a quote from columnist Walter Lippman (from A Preface to Morals): “the amount of law is relatively small which a written legislature can successfully impose.” Schneider proceeds to examine how the law requiring advance directives has been so successfully unsuccessful in the United States, in spite of determined efforts in hospitals to implement systems to encourage their completion and use. He describes the chain of circumstances necessary for a living will to be used. He identifies five, and failure at any step means total failure. He concludes, “In sum, failures confound every step along the path toward a successful regime of advance directives and show how challenging it can be for the law to affect behavior even in apparently simple and desirable ways.”

**Marna L. Skinner.** “Confrontational communication,” The 2001 Annual: Consulting 2, (2001): 167-71. As chaplains, we regularly encounter and minister to persons who are angry for any number of different reasons. Skinner’s brief article describes the dynamics of such encounters and provides us with a framework within which we can function effectively. Skinner is writing for managers in business; however, her four-step process is immediately applicable to ministry situations. The four steps: inquire, empathize, ask permission, and explain or offer choices. She gives examples.

**Sandie Soldwisch.** “Building confidence in spiritual care – strategies and outcomes,” Journal of Christian Nursing 18, no. 4 (Fall 2001): 24-27. A nurse educator describes the development of her school’s curriculum to ensure that spirituality can be adequately addressed by all students in their nursing practices. Central to the essay is her description of one student’s work in planning the care of a patient, with the assessment and care plan presented in detail both before and after the course. There is a marked difference between the two plans and, as a chaplain, I would like to have nurses around me who can do such thorough assessments.

**Anastasia Toufexis.** “A pioneer in the battle to avert needless suffering,” New York Times (6 Nov 2001): D5. This story features the work of Dr. Kathleen Foley, a neurologist at Sloan-Kettering Cancer Center in New York since 1974, and the founder (in 1981) of the first pain service in a cancer center. However, since 1983 she has been the director of the Open Society Institute’s Project on Death in America. The work of the project is to alter the culture of dying in American society through initiatives and research. In this interview she describes what palliative care is, what it tries to accomplish, and the problems it still faces. Inserted in the story is a reference to a report which chaplains might be aware of. Published in June 2001, it is a “stunning indictment of the care offered to cancer patients...at the end of life...Many of the 550,000 patients who die of cancer each year spend their last days in distress, suffering from pain, nausea, fatigue, and depression.” According to the authors, much of this distress easily can be avoided. The report can be found at <www.oim.edu> and is titled “Improving Palliative Care for Cancer.” It was published by the National Cancer Policy Board of the Institute of Medicine and National Research Council. The entire report can be printed, though navigating the site takes a little effort. There is nothing in the report that chaplains can act on, except to be aware of the existence and political importance of this document at a time when cancer care in general is still provided so poorly.
Larry VandeCreek, Karolyann Siegel, Eileen Gorey, Sharon Brown, Rhoda Toperez. "How many chaplains per 100 inpatients? Benchmarks of health care chaplaincy departments," Journal of Pastoral Care 55, no. 3 (Fall 2001): 289-301. • What is the ratio of chaplains to patients needed to provide good pastoral care in a hospital? This is a question which is regularly asked, and for which there are a variety of answers. This paper reports the results of a research project which, while it does not answer the above question, does reflect the current practices in a large number of hospitals across the United States. A questionnaire survey was sent to 500 pastoral care department directors, and responses were received from 370. They were drawn from the Association of Professional Chaplains, the National Association of Catholic Chaplains, and the Association of Mental Health Clergy. Questions asked included the following: How many chaplains do you have per one hundred inpatients? What is the relationship between the number of employed chaplains and your CPE program if you have one? How much outpatient ministry do you provide? What percentage of your pastoral effort is provided by volunteer chaplains? The results from the study, and there are many, are detailed, reflecting the customary attention to detail paid by VandeCreek, the lead author. The results provide chaplains with reliable information that will assist them in their strategic planning processes.

Melissa G. West. "Building a playground for your spirit," Spirituality & Health 4, no.3 (Fall 2001): 54-55. • Labyrinths, ancient devices found in medieval cathedrals and remote hilltops around Europe can now be found in many modern places, including hospitals. West describes how wooden finger labyrinths can be used by hospital patients. Finger labyrinths, also known as "Troy Stones" were used in Cornwall, England at least five hundred years ago. Etched in slate, they were considered sacred, and either handed on to following generations or destroyed upon the owner's death. West describes their use by hospital patients, tells where they can be purchased, and provides a template for those who wish to make their own. This issue of Spirituality and Health also contains photos and comments on over a dozen full-sized labyrinths, in addition to those in West's article.