Deborah Antai-Otong. “Anxiety disorders: helping your patient conquer her fears,” Nursing 2003 33, no. 12 (Dec 2003): 36-41. • In the course of your ministry, you encounter a man who tells you that he feels that he has to pray for reassurance numerous times every day. In fact, he says his life is being disrupted by his need to pray so much. What would you think, and what would be your response to this man? This is one of a number of common situations described by Antai-Otong in her article about anxiety, the variety of its forms, and what can be done to help people who suffer from its ravages. Using examples, she describes six common ways that anxieties can appear. Though some of her suggestions will not apply to chaplains, e.g., use of medications, her suggestions regarding the care of these patients will inform the clinical chaplain.

Homer U. Ashby. “Being forgiven: toward a thicker description of forgiveness,” Journal of Pastoral Care & Counseling 57, no. 2 (Summer 2003): 143-152. • The last decade has seen a significant increase in interest in the general topic of forgiveness, leading to the appearance of several major books on different aspects of the subject, e.g., McCullough, Pargament, & Thoresen, eds., Forgiveness: Theory, Research, Practice (Guilford Press, 2000); Worthington, ed., Dimensions of Forgiveness: Psychological Research and Theological Perspectives (Templeton Foundation Press, 1998). Ashby notes that a less commonly studied aspect of this subject is the matter of seeking forgiveness from others. He describes the process of seeking forgiveness, and the being-forgiven process. He then gives examples of the processes and concludes by examining the specific steps of being forgiven.

Joe Baroody. “Should clinical pastoral education and professional chaplaincy become more scientific? It’s a matter of salt,” Journal of Health Care Chaplaincy 12, no. 1/2 (2002): 1-10. • In considering whether or in what ways science should relate to professional chaplaincy and clinical pastoral education (CPE), Baroody turns to the past for guidance, describing the work of Anton Boisen and Elwood Worcester. A Congregational minister, Boisen is perhaps the better known of the two. He relied on both psychology and medical science to illuminate and expand his vision of ministry, combining his evangelical faith with Freudian theory to create a new method of healing. Worcester, an Episcopal priest who organized the Emmanuel Movement, reacted to the impersonal nature of the Social Gospel as well as the healing claims of Christian Science and sought to “recover Christ’s healing ministry.” His response was the development of “scientific psychotherapy.” In the work of both men, Baroody finds permission to utilize science as a means for “continuing the priestly, healing ministry of Jesus ....” However, he warns against the uncritical use of some of the recent scientific studies which claim that faith leads to better health. “Accepting the so-called scientific faith claims of medical researchers like Dr. [Harold] Koenig may help professional chaplains survive health care reform, but in so doing, they will have traded the evangelical, liberal faith proclaimed by Elwood Worcester and Anton Boisen for an identity based on the pseudofaith created by science” (pp. 9-10). Baroody’s essay is the first of twenty-four which address the question stated in the title from a variety of perspectives.
William J. Baugh. "Spirituality and data: the need for a new paradigm," *Journal of Health Care Chaplaincy* 12, no. 1/2 (2002): 11-17. • “How I have resisted this day! I have wished that it would never come.” This is Baugh’s reaction to the suggestion that chaplains may need to make use of science to assess their ministry in some manner. “I have yearned for the good old days when holding a hand was an expression of my desire to care, my commitment to ministry and not a means to reduce the length of stay” (p. 12). He is full of caution for the chaplaincy profession as he remembers some of the missteps of the recent past when science was not as helpful as had been hoped or when its fruits were ignored by administrators. In the end, though, he suggests that chaplains will have to learn how the “blending of sensitive spiritual care, individualized to maximize each person’s coping skills” can be done alongside state of the art medicine. He believes that this could be the most significant breakthrough of the twenty-first century.

Howard J. Bennett. “Humor in medicine,” *Southern Medical Journal* 96, no. 12 (Dec 2003): 1257-1261. • Permeating this article is the line, “this has not been studied adequately,” through which Bennett notes that the health benefits of humor, while the subject of many claims, have never been validated by acceptable research. This is not to say that it does not have value, rather that its value has not been measured in an acceptable way. Bennett provides the reader with an overview of the field of humor in medicine under the following: humor and health, humor and patient-doctor communication, humor and patient care, humor and the health professional, humor in medical education, humor in medical literature. He covers the waterfront and finds the waters are not very deep. To date the most promising research is in the area of humor’s ability to lessen pain.

A. Mark Clarfield, Michael Gordon, Hazel Markwell, Shahir M. Alibhai. “Ethical issues in end-of-life geriatric care: the approach of three monotheistic religions – Judaism, Catholicism, and Islam,” *Journal of the American Geriatrics Society* 51, no. 8 (Aug 2003): 1149-1154. • Ethical dilemmas are common in the care of the elderly, and an important consideration in many cases is the patient’s religion. The three Abrahamic monotheistic religions—Judaism, Christianity (in its Catholic variant), and Islam—have well considered positions on medical ethical issues. Although they hold much in common, there remain significant differences. This paper presents three relatively common clinical cases, each of which involves ethical dilemmas found in geriatrics care, especially near the end of life. Starting from those scenarios, the normative ethical position of each faith group is compared and contrasted. This is one of the scenarios: “An eighty-four-year-old woman with mild dementia and compensated congestive heart failure is admitted to a nursing home. Her husband, the surrogate decision-maker, presents the attending physician with a signed and witnessed advance directive that states that under no circumstances does she want resuscitation, antibiotic therapy for life-threatening infection, or transfer to an acute care hospital.”

There are several focus questions followed by a brief introduction to the medical ethic arising out of each of the three religions. This article presents useful teaching material.

George F. Flannelly, Andrew J. Weaver, George F. Handzo. “A three-year study of chaplains’ professional activities at Memorial Sloan-Kettering Cancer Center in New York City,” *Psycho-Oncology* 12, no. 8 (Dec 2003): 760-768. • There have been few published reports of the number and kind of interventions that chaplains perform over a period, nor have there been reports on the number and kind of referrals made to chaplains by other health care professionals. The purpose of this study was to find the answers to these questions. What are the relative numbers of referred to non-referral visits to patients? What are the patterns of referrals to and from chaplains, families, and staff? What are the reasons for the referrals? What type of pastoral activities do chaplains engage in? Do the lengths of chaplain visits vary under different circumstances? Are there patterns which develop over the course of a person’s hospitalization? Data was gathered during a two-week period in each of three consecutive years. The participants were three full-time certified chaplains, a Roman Catholic sister, a Lutheran minister, and a rabbi; a part-time certified imam; and chaplain residents, five in 1995, four in 1996, six in 1997. Among the findings: almost 20 percent of chaplain visits originated from referrals; most staff referrals came from nurses, very few from doctors; the percentage...
of referrals from nurses increased significantly during the study; more than one-third of chaplain contacts were with family/friends of the patients; pastoral visits were much shorter when the patient was not present; interventions provided by the chaplain varied according to the patient's religious faith; pre-op visits usually were much shorter than post-op visits. The most frequent intervention provided by the chaplain, even more than Bible reading or prayer, was described as "emotional enabling," defined as facilitation of the expression of feelings.

Linda Ganzini, Elizabeth R. Goy, Lois L. Miller, Theresa A. Harvath, Ann Jackson, Molly A. Delorit. "Nurses' experiences with hospice patients who refuse food and fluids to hasten death." *New England Journal of Medicine* 349, no. 4 (24 Jul 2003): 359-365. • There are well-known barriers preventing patients from being assisted in ending their lives. However, the choice to stop eating and drinking is an option for competent patients and does not necessarily require the participation of a physician. The authors are residents of Oregon where physician-assisted suicide is an option. They asked nurses in hospice programs whether they knew of persons who had chosen to end their lives by ceasing to eat and drink or who had asked for physician-assisted suicide, so that they could compare and contrast the two groups. One hundred and two nurses, 33 percent of those contacted, reported that they had cared for at least one patient who had hastened death by stopping all food and liquid intake. The nurses reported that persons had done so because they were ready to die, saw their continuing existence as pointless, and/or considered their quality of life poor. The nurses reported that 85 percent of the patients died within fifteen days, and on a 0 – 10 (very bad – very good) scale, the median rating for the quality of these deaths was eight. While there are ethical issues that need to be considered, the authors suggest that there should be further discussions about the choice to hasten death by refusing food/fluids and about standards for evaluating and caring for patients who make this choice.

Ellen Gutter, Mary Marinaro. "Words ... the most powerful drug." *The Satisfaction Monitor* (Jan/Feb 2002): 1-3. • This article is the report from the emergency department of a 241-bed acute care facility in New Jersey, which wanted to increase the level of satisfaction reported by persons who had used their services to the ninetieth percentile. To do so, they began by creating "scripts," i.e., the exact words the doctors agreed they would all use in order to fully and appropriately respond to patient concerns, from having to wait too long in the waiting room, listening to what patients had to say, to discharge planning. They also set the following standard of service: if a nurse doesn’t talk to a patient within fifteen minutes of entering the ER, the bill is cut by 50 percent. If a doctor does not see the patient within thirty minutes, treatment is free. There were considerable benefits from this approach. Some were hoped for, e.g., an increase in the level of patient satisfaction, and some were unexpected. An unexpected benefit was that when doctors used the words of the scripts, they began to do the caring actions that they were expressing in the words. This publication can be read online; do a Google search for "The Satisfaction Monitor."

Dena Hassouneh-Phillips. "Strength and vulnerability: spirituality in abused American Muslim women's lives," *Issues in Mental Health Nursing* 24, no. 6/7 (Sept-Nov 2003): 681-694. • How does intimate partner violence affect the spiritual life of a woman survivor? This paper examines that question in American Muslim women. The study included a literature search and interviews with two groups of women (n=17), mostly Sunni. Hassouneh-Phillips found that spirituality provided an important means of coping with the ongoing violence the women experienced but that in many instances it also created barriers to their safety. For example, their faith suggested to them that their lives do not matter and that the acceptance of abuse will lead to greater reward from Allah. Secondly, the abusers’ use of religious texts to maintain power and control made it difficult for the women to react to the violence directed against them. Hassouneh-Phillips also describes the spiritual journeys taken by the women after their abusive relationships ended. She has identified a continuum of change on which she locates these women. She names and describes three positions on the continuum: the retainers, the reinterpreters, and the rejecters.

Beth Homicki, Eileen K. Joyce. "Art illuminates patients' experience at the Massachusetts General..." *Chaplaincy Today* • Volume 20 Number 1 • Spring/Summer 2004
Hospital Cancer Center," The Oncologist 9, no. 1 (Feb 2004): 111-114. • Even though there is no hard data to date, it is widely accepted that the arts have healing power. There are studies which have shown that patients exposed to views of nature, either via a painting or a window outlook, were less anxious, requested less pain medication, and made their postoperative recovery more quickly. While the search for more data continues, many hospitals are finding opportunities to use art in a variety of ways. For the past several years, the Cancer Center has worked to create a healing environment using a three-pronged approach: sight, sound, and expression. Each approach is described in this article and is accompanied by photos. The central piece is a rotating art exhibit called Illuminations, which has been developed to create "a visually healing environment." The authors have included steps that can be taken to start an exhibit in an institution or hospital. More information is available at http://www.massgeneral.org/cancer/illuminations.

Daniel C. Javitt, Joseph T. Coyle. "Decoding schizophrenia," Scientific American 290, no. 1 (Jan 2004): 48-55. • Schizophrenia is a mental illness that is widely misunderstood by the general public and only partially understood by scientists. Javitt and Coyle, two of the leading minds in the field of mental health research, describe its multiple symptoms, current understanding regarding its causes, new drugs which more effectively control symptoms, and current research regarding new treatment possibilities. Schizophrenia takes an enormous toll on US. society, affecting about two million persons. Because the disease often starts in young adulthood, it takes a long-term toll in lives, social disruption and economic status. About 10 percent of those with the illness commit suicide. About half abuse alcohol, marijuana, or cocaine. Fewer than one-third are capable of holding a job, and half of those can do so only with extensive social support. This is a review article for mental health chaplains and is of educational value for anyone concerned about the field of mental health.

Thomas Johnson-Medland. "The privacy of pain: identifying barriers to pain management," Healing Ministry 10, no. 2 (Spring 2003): 89-92. • People who are sick frequently refuse pain medication and resist efforts to encourage them to change their minds. This article will help chaplains recognize the barriers people erect when they must deal with pain: choose to see pain as being insignificant compared to the pain in the wider world; do not wish to appear weak or childish, i.e., if I don't acknowledge pain, it is either not present, or it isn't serious; do not wish to trouble others with the pain, i.e., a self-esteem issue; have a high pain threshold; believe suffering is payment for a karmic debt or to undo a wrong; pain is overwhelming, leading to belief that nothing can alleviate it; denial of emotional pain, only concentrating on the physical manifestation. Johnson-Medland includes a case study in which he demonstrates that through the chaplain's working to understand an individual patient's pain, she was able to change her mind about taking medication. He concludes that "Pain is a private issue. It can make people do things that seem ridiculous in the light of reason. This is to be accepted. It also makes people want to isolate themselves. This is another given. The reasons that drive people not to treat pain in themselves or others are their own. As caregivers, we can educate, provide therapeutic support and interventions, and enlist other caring professionals; but, in the end, the patient makes the choice to treat pain or not treat pain." Above all, he maintains that patients' rights to make such choices must be respected and supported (p. 92).

Stephen Kiesling. "A simple prayer, a profound freedom," Spirituality & Health 6, no. 4 (Oct 2003): 39-41. • An interview with the Trappist monk, Thomas Keating, in which he talks about contemplative prayer and its power to help people. There is a sidebar with guidelines for centering prayer which could be used by a chaplain to teach this style of praying in one pastoral visit.

Alan Kolp. "Hospice: The via dolorosa ad pacem (The way of sorrow to peace)," Healing Ministry 10, no. 2 (Spring 2003): 77-82. • Kolp, who grew up a Quaker, describes the life of his father—from discovery of terminal illness to his deathbed—within the perspective of the Stations of the Cross.

Simon J. C. Lee. "In a secular spirit: strategies of clinical pastoral education," Health Care Analysis 10, no. 4 (2002): 339-356. • Lee is an anthropologist who has been studying the pastoral work of people in two unidentified hospitals in California. The hospitals
differ in that one is a faith-based institution (Roman Catholic), and the other is a secular, community-based nonprofit hospital which in 1994 was forced for economic reasons to become part of a large religiously-sponsored health care system. Lee has been studying the philosophy and methods of chaplaincy in the two hospitals in order to compare them. Based on his interviews and observations, he concludes that the clinical pastoral education (CPE) model for the provision of spiritual care represents the emergence of what he describes as “a secularized professional practice from a religiously-based theological practice of ministry.” He sees the word spiritual as a label that is being “strategically displayed” in order to extend the chaplains’ sphere of interest from the more narrow world of “religion,” thus allowing them to move from being religious functionaries to a limited group of patients, to being health care professionals with the potential to contribute to all patients. “Such a secularized professional practice is necessary to demonstrate the relevance and utility of spiritual care for all hospital patients in an era of cost-containment priorities and managed care economies.” Such a transformation is the result of clinical pastoral education, which Lee sees as “the means to establishing chaplaincy as a codified method of patient care that, rather than being purely revelatory or intuitive, is a routinized and systematic process that can be taught, evaluated and its providers tested and certified. CPE represents a secularized model of one aspect of religiously-motivated healthcare.” While the flow of this paper is a little choppy—perhaps edited from a larger document—Lee’s perspectives may trigger useful debate concerning the future relationship of chaplains to the religious bodies in which they were ordained or commissioned.

Ruth Macklin. “Dignity is a useless concept – editorial,” British Medical Journal 327, no. 7429 (20 Dec 2003): 1419. • Macklin claims that dignity, a word widely used in medical ethics, is not a useful concept. She argues that appeals to dignity are either vague restatements of other, more precise concepts or mere slogans that “add nothing to an understanding of the topic.” She suggests that its extensive use might be because it appears so often in religious writings. However, she admits that this does not explain why the notion of dignity has “crept into the medical literature.” Macklin’s provocative suggestion received over thirty responses to BMJ’s Web site in the ten days after this issue of the journal appeared.

Wilfred McSherry, Keith Cash. “The language of spirituality: an emerging taxonomy,” International Journal of Nursing Studies 41, no. 2 (Feb 2004): 151-161. • The word spirituality is in danger of becoming meaningless. These authors argue that the definition of this word differs with an individual’s interpretation or worldview. Thus, they are concerned that this word will lose any real significance in discussions about the health care of patients. To counteract this possibility, they developed what they call a “spiritual taxonomy” that clarifies the different meanings they identified, and how these meanings exist alongside each other. At one end of the taxonomy is a spirituality based on religious and theist ideals, while at the other end is a spirituality based in secular, humanistic, existential elements. A middle ground contains elements from each, though these are not as fundamental or radical as the extremes. However, having completed their taxonomy and examined its implications for both practice and education, they conclude that a universal definition of spirituality does not exist. Further, the theoretical probability creating one is essentially nil. They propose that one way to proceed would be to shift the focus from “the restrictive arguments of definition.” Through qualitative research, conceptual discussion, and examination of “the reciprocal interactions of persons and patients, practitioners, and diverse cultures,” they hope to move the discussion from the cognitive and academic to a place that embraces social practice.

Michael H. Monroe, Deborah Bynum, Beth Susi, Nancy Pfifer, Linda Schultz, Mark Franco, Charles D. MacLean, Sam Cybert, Joanne Garrett. “Primary care physician preferences regarding spiritual behavior in medical practice,” Archives of Internal Medicine 163 (8/22 Dec 2003): 2751-2756. • This article presents the results of a research project by a group of doctors to determine the willingness of internists and family physicians to be involved in spiritual and/or religious behaviors in various clinical settings. The data were gathered from six teaching hospitals in North Carolina, Vermont, and Florida with responses from 476 physicians for a rate of 62 percent. The results indicate that 84.5 percent of the
doctors thought they should be aware of their patients' spirituality, but most would not ask about spiritual matters unless their patient was dying. Less than one-third would pray with their patients even if the patient was dying; though 77 percent would pray if the patient asked. Family practitioners were more likely to take a spiritual history than general internists. Regardless of the intervention—spiritual history taking, silent prayer, vocal prayer—physicians were more likely to agree to participate as the severity of the patient's illness increased. Interestingly, physicians were not asked if they would refer a patient with a prayer request to a chaplain or religious leader if they were unwilling to offer prayer themselves.

Jill Neimark, "New life for near-death," Spirituality & Health 6, no. 4 (Oct 2003): 42-45,73. • When Moody wrote his book about near-death experiences (NDE) over thirty years ago, many people were intrigued and many were highly skeptical about what he reported. Chaplains were somewhat less skeptical, especially if they had heard stories from patients who had experienced NDE. Today, there is a desire to better understand these experiences. Neimark recounts the growing interest in these stories, including the work of Pim van Lommel in the Netherlands, whose paper in The Lancet (January 2001) sparked the first serious public discussions by doctors. A major observation in this paper was the fact that people reported experiences after all their brain activity should have ceased. Neimark also describes research which may add to the understanding of this phenomenon, but adds, "There is a mystery at the heart of these experiences that no electrode or PET scan has yet explained."

Ellen M. Redinburgh, Amy M. Sullivan, Susan D. Block, Nina M. Gadmer, Matthew Lakoma, Ann M. Mitchell, Deborah Seltzer, Jennifer Wolford, Robert M. Arnold. "Doctors' emotional reactions to recent death of a patient: cross sectional study of hospital doctors," British Medical Journal 327, no. 7408 (26 Jul 2003): 185-191. • What are the emotional reactions of doctors to the death of patients in their care? Are the reactions different if the doctor is a man or a woman, or has practiced medicine for a long versus short period of time? Do senior doctors help junior doctors cope with deaths? The results of this study, conducted in two teaching hospitals in the US, found that 74 percent of the doctors surveyed had satisfying experiences caring for the dying. They reported moderate levels of emotional impact: mean 4.7 on a 0-10 low-high scale. Women doctors and male doctors who had cared for a person for a longer time experienced stronger emotional reactions. Fifty-five percent of the doctors reported that a patient's death disturbed them very little, while 23 percent reported they were very disturbed by a death. On average, doctors reported experiencing two out of a possible fourteen symptoms of grief after a death, e.g., 47 percent reported feeling upset when thinking about the patient. Though interns reported that they needed significantly more emotional support than did attending physicians, chaplains who wish to provide pastoral support to doctors should not assume automatically that interns are more in need of pastoral care.

Susan A. Sallahay, "Medical futility - When is enough, enough?,” Journal of Christian Nursing 20, no. 4 (Fall 2003): 25-28. • In the last year, there have been reports in the media that medical futility is not Christian. Some speakers and educators have linked futility with euthanasia, even confusing them. A nurse educator, Sallahay unravels the confusion as she differentiates between the two and explains how Christian nurses can and should support hospital policies on medical futility.

Robert W. Stuard, "The spiritual journey of an organ transplant patient," Journal of Pastoral Care & Counseling 57, no. 2 (Summer 2003): 191-196. • This article is a hospital chaplain's detailed description of the psychological, emotional, and spiritual dynamics of an organ transplant patient who was the recipient of a new liver. The patient, a former fireman in his early sixties, had been at death's door a number of times before he received his transplant. We are told how his life and the life of his two daughters have been affected by his illness and how these effects have continued long after the surgery, as a result of posttransplant routines.