Susan J. Bartlett, Ralph Piedmont, Andrew Bilderback, Alan K. Matsumoto, Joan M. Bathon. "Spirituality, well-being, and quality of life in people with rheumatoid arthritis," *Arthritis and Rheumatism* 49, no. 6 (15 Dec 2003): 778-783. For people with rheumatoid arthritis, what are the connections, if any, between spirituality, well-being, and quality of life (QOL) and the individual's ability to function? Following physician assessment of their disease status, a group of women (n=62) and men (n=15) were given questionnaires to assess their affect, depression, QOL and spirituality. The last was assessed by a relatively new instrument called the Spiritual Transcendence Scale. (See R.L. Piedmont, "Does spirituality represent the sixth factor of personality? Spiritual transcendence and the Five-Factor Model," in the Journal of Personality (1999) 67:985-1013.) The main findings were that spirituality is a unique characteristic that varies among people with rheumatoid arthritis. Spirituality was associated with joy and happiness, as well as positive health perceptions. Even after controlling for disease effects, functional ability, depression, and age, spirituality was moderately associated with positive affect, and better self-ratings of health.

Patricia Blair. "Is family presence practical during emergency resuscitation?" *Nursing Management* 35, no. 6 (Jun 2004): 20,23,53. Blair, who is a nurse attorney, provides the strongest possible rationale for permitting family members to be present when a patient is being resuscitated. She lists reasons medical staff give for refusal: elevated stress, friction among staff, negative impact, and exposure to lawsuit risk for the trauma team; adverse effect on patient care, emotional impact and psychological trauma for the family; compromised confidentiality. Blair notes that none of these objections is evidence based. Moreover, the Emergency Nurses Association has endorsed the concept (1999), and the American Heart Association guidelines for codes (2000) recommends that family members be permitted to witness resuscitation attempts. Blair includes a strategic plan that could be followed by hospitals interested in exploring the creation of written policy in this area.

The Boston Healing Landscape Project. "Complementary and alternative medicine, spirituality, and culturally competent medicine," [http://www.bmc.org/pediatrics/special/bblp/](http://www.bmc.org/pediatrics/special/bblp/) (accessed 1 Aug 2004). Most chaplains trained in the US complete clinical pastoral education (CPE) in traditional medical settings. The biomedical understanding of healing is universally followed in those settings and this approach to healing is culturally based, though this is usually not acknowledged. It is also shaped by religious world views—usually of the Judeo-Christian tradition. The primary mission of the Boston Healing Landscape Project is to train health care providers to understand the culturally and religiously grounded complementary and alternative therapies used by patients from African diaspora communities in the US. The project integrates areas that, in traditional medical training, are usually viewed under the headings of complementary and alternative medicine, spirituality, and culturally competent medicine. The curricular materials of the Boston Project which can be found on the Web site represent the intersections of these three domains. The creators of the site say they have been

These abstracts have been selected from the database of THE ORERE SOURCE, a bimonthly publication of pastoral and related articles edited by W. Noel Brown. Chaplain Brown is a chaplain supervisor at Northwestern Memorial Hospital, Chicago, IL. Correspondence may be directed to oreresource@rocketmail.com or PO Box 362, Harbert MI 49115; fax 312.832.9739.
guided by an understanding that cultural issues are present in every medical encounter and must therefore be an integral part of every phase and facet of medical training; however, the information on this Web site is of value to any health care provider. Chaplains will be particularly interested in the spirituality aspects of the material. One thing that would improve the Web site would be to alter the layout and color of the texts and backgrounds.

Gregory J. Boyle, Jeanne M. Joss-Reid. “Relationship of humor to health: a psychometric investigation,” British Journal of Health Psychology 9 (1 Feb 2004): 51-66. Numerous small studies have suggested that a good sense of humor plays a positive role in physical health and well-being. (Norman Cousins, The Anatomy of An Illness, was perhaps the originator of this interest in the 1970s.) However, researchers have used multidimensional instruments to measure humor and have involved quite small numbers of people. These authors used a sample of 504 adults, aged eighteen to over sixty-five, which comprised three categories: well adults, nonstudents with a medical problem; students, some sick and some well. All were given a package of materials to take home, complete, and return via mail. Though the results are somewhat complicated, overall, the findings indicate that a better sense of humor is not particularly related to higher levels of health. Further, there was no support for the belief that humor and health are positively interrelated. Study results did suggest that persons who are basically healthy use and view humor differently than those who have actual health problems. Analysis of the total group suggested that humor is used as a personal coping mechanism in difficult situations and that it helps when it is used. This factor appeared to be even stronger among persons with health problems.

William Breitbart, Karen S. Heller. “Reframing hope: meaning-centered care for patients near the end of life,” Journal of Palliative Medicine 6, no. 6 (Dec 2003): 979-988. Breitbart, chief of the psychiatric service at Memorial Sloan-Kettering Cancer Center (New York City), has developed a meaning-centered psychotherapeutic intervention to help terminally ill cancer patients sustain hope and meaning as they draw near the end of life. He designed this eight-week, manual-based support group to see how effectively meaning-focused care addresses what he and others term “despair at the end of life.” Such despair has been found to comprise varying degrees of hopelessness, depression, loss of meaning, suicidal ideation, and desire for a hastened death. This article is an interview in which he describes how his thinking about despair near the end of life developed over the past seven years. Two of his comments are worthy of note. First, Breitbart says he deliberately did not involve chaplains in this venture because he wanted to make the groups more universally acceptable. Second, he found that the approach developed is one that appeals to men: “Men seem to like this kind of therapy and to be interested in it.” It was somewhat disconcerting to discover that Breitbart had not read Victor Frankl until he became involved in this work.

Gerard T. Broccolo, Larry VandeCreek. “How are health care chaplains helpful to bereaved family members? Telephone survey results,” Journal of Pastoral Care & Counseling 58, no. 1-2 (Spring/Summer 2004): 31-39. This research report describes how next-of-kin (n=130) whose loved ones had died in hospital, were or were not helped by a hospital chaplain. Information was gathered by telephone interview at least one month after the deaths. Two questions were asked: “What did the chaplain say or do that was particularly helpful?” and “How was that helpful?” The methodology and the analysis of the results is clear even for readers not very familiar with research methods. The responses showed that the chaplain helped the next-of-kin in five specific ways: by providing comfort and support; by helping with details before, during, and after the death; by acting as a surrogate until other family members arrived; by being available as a “safety net”; by functioning as a spiritual figure who provided a connection between heaven and earth. One family member summarized the ministry received in these words: “I will never forget what the chaplain said or did. It helps your heavy heart.”

Rod Burton. “Spiritual pain: a brief overview and an initial response within the Christian tradition,” Journal of Pastoral Care & Counseling 57, no. 4 (Winter 2004): 437-446. Burton makes use of a literature survey as well as his own experience in order to provide an overview of the current
research into the nature of spiritual pain. He acknowledges that while this kind of pain can be identified, it is not easy to define, nor does he attempt to do so. He describes several typologies of spiritual pain before addressing the problem of assessment. "An assessment of spiritual pain will have to depend at least as much upon the spirituality of the caregivers, and upon their capacity for contemplation, for close listening to narrative, for intuition, and for discernment" (p. 442). He also considers the practical issue of how to attend to spiritual pain in the persons to whom we minister.

Rod Burton. "Spiritual pain: origins, nature and management," Contact 143 (2004): 3-13. • As he believes that all pastoral theology is immediately personal, Burton begins this article with a description of his own spiritual pain, which stems from a physical limitation. He also describes this and what it means for him. Thus his model for explaining possible origins, nature, and management of spiritual pain is built upon an attempt to describe his own condition. This is both a strength and a weakness of the paper. Burton asserts that the principal characteristics of spiritual pain include either "eccentric" personal development or "disintegration" within various dimensions of being human: disruption of, or failure to establish, adequate interpersonal relationships; incidents of unresolved injury, distortion, or waywardness within one's personal narrative(s); failure to develop or maintain a relationship of personal unity with God in the Spirit; sharing in the growing pains of the cosmos through an interconnectedness in the Spirit; experiences of growth and transition in one's own life. He says that spiritual pain can be noticed in a wide variety of symptoms such as constant and chronic physical pain, withdrawal or isolation from spiritual support systems, conflict with family or friends, anxiety, fear or mistrust, anger, depression, self-loathing, feelings of failure in respect of one's life, lack of a sense of humor, unforgiveness, despair. Many of these are difficult to distinguish from other dimensions of pain. Burton's paper is structured by a series of questions, e.g., where, how, and why does spiritual pain occur? The model that he presents incorporates insights from Howard Clinebell, "wholeness centered in the spirit"; MacLeod, "the concept of the self within a narrative," and Athenagoras, "the Spirit as the bond of unity." This last idea is central to Burton's model. He also quotes from Narrative and Psychotherapy by Anderson and McLeod: "The human person is an ecologically constructed of physical, spiritual and social being wherein if one part of the construct is dissolved or alienated the total system is in pain." To conclude he looks at the implications of his ideas for the pastoral management of pain.

Janet E. Gregory, Robert J. Gregory. "The spirit feather: an ecologically based celebration of life," Journal of Palliative Medicine 7, no. 2 (Apr 2004): 297-300. • The final moments of life can be special and important, providing both the dying patient and family members with a harmonious transition event. This paper describes such a death with a case study which powerfully illustrates the concepts referred to in the discussion that follows. "When the death was not too far away, a younger sister arrived where her older sister was dying. 'Hello, older sister, I have come a long way to be with you,' the younger sister announced. 'I am so happy you are here, younger sister,' the elder sister smiled a welcome that warmed the heart of the younger sister and the attending nurses. The younger sister then, with pain in her heart and a lump in her throat, spoke: 'Older sister, one of my friends knew I was coming to see you,' and here she whispered, 'for the last time. This special friend gave me a gift to share with you. This gift, a feather, is to provide a safe journey to the spirit world.' She embraced her older sister's hands with her own and gently placed the feather in her sister's hand, so she could feel and hold it. The younger sister added: 'I give you this feather now, so when the time comes, you will be able to fly beyond, to where your spirit seeks to go.' Later that night, the dying woman indicated that she wanted to hold the feather. 'It's time,' she said. When she was given it, she looked at her sister and whispered, 'Thank you for the feather. I am ready to fly now.' Holding the feather tightly, she managed one last smile, a smile that filled the younger sister with hope and the knowledge that her older sister had been and would always be a part of who she was."

Jerome Groopman. "The grief industry," The New Yorker (26 Jan 2004): 30-38. • Critical incident stress debriefing (CISD) has become a widely used method of helping people in the immediate
aftermath of crises. Chaplains and clergy have been trained in its use. Groopman describes how Jeffrey Mitchell developed CISD, a seven-step debriefing procedure. He then reports how it was used after 9/11, or rather, how it was misused, and why it is probably unnecessary as an intervention technique. The Departments of Defense, Justice, Veterans Affairs, the American Red Cross, and the Department of Health and Human Services all have abandoned it as a therapeutic intervention. Groopman suggests that most persons who have experienced a traumatic event recover quickly and without help. The most helpful approach is to employ a public health model, using people in the community who aren’t diagnosing you” (p. 34). He proposes that CISD is not really necessary and that help should be offered when individuals begin to show signs that they have been affected to the extent that their ability to function in life or in work is being impaired. Groopman also reports the latest research into posttraumatic stress disorder (PTSD), which suggests that working to restore resiliency appears to be more helpful than critical incident debriefing.

Christopher H. Grundmann. “To be with them: a hospital chaplain’s reflections of the bedside ministry to terminally ill and dying people,” Christian Bioethics 9, no. 1 (Apr 2003): 79-90. • Grundmann is an American, Lutheran minister (specific synod not stated) and in this paper he reflects on his chaplaincy experiences in a one hundred plus bed hospital in southwestern Germany. He does not say how long he worked there, nor whether he had any preparation for this specialized ministry, outside of his seminary studies. It seems fairly clear that he did not. As he notes, this ministry “challenged [him] to go beyond the confines of any fixed theological system or counseling technique” (p. 79). It is out of this challenge that the insights he have come which he describes in this article. Grundmann discovered three essentials which became the basis for his ministry: acknowledgment that what is expected of the chaplain is existential solidarity which eases emotional and spiritual distress, desire to become a companion, and a confident belief even in situations where holding on to any genuine perspective on life is deemed ridiculous.

Kathi E. Hanna. “Senate passes genetic nondiscrimination bill,” Hastings Center Report 33, no. 6 (Nov/Dec 2003): 8. • October 14, 2003: the Senate passed “The Genetic Information Nondiscrimination Act” (S.1053), which bans the use of genetic information by insurance companies or employers to restrict coverage or to make hiring decisions. It was six years in process, and a companion bill in the House faces an uphill battle.

Shehan Hettiaratchy, Peter E.M. Butler. “Expanding the boundaries of transplantation,” British Medical Journal 326, no. 7401 (7 June 2003): 1226-1227. • Organ transplantation is now routine in many hospitals, with even the most complex heart transplants being undertaken, even though it is only thirty-five years since the first successful heart transplant was performed. Drugs to control the problem of rejection have made the difference. Now, some surgeons suggest that transplants should be done for other than life threatening problems. Some have begun to use tissue from cadavers to reconstruct structural defects of the body, e.g., hand, knee, nerve, and laryngeal transplants. Because these surgeries have been performed on patients who suffer from serious limitations but are not in life threatening situations, critics say that such surgeries are not ethically acceptable. This paper lays out, in fairly nontechnical language, the heart of this debate. The central concern is the fact that the long-term risks associated with rejection of transplanted body parts are still not fully known.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO). “Quality Check,” PRNewswire 15 Jul 2004:1. JCAHO has unveiled its plan to allow anyone to check the quality and safety of the 4,579 accredited hospitals in the United States. Their Web site allows anyone to compare hospitals concerning the care of heart attack, heart failure, pneumonia, pregnancy, and related conditions and can be accessed at http://www.qualitycheck.org. A visit to this Web site provides first-hand experience of how a very good idea can fail even at the point of execution.

Logan C. Jones. “What language shall I borrow? The poetry of Rainer Maria Rilke and the care of souls,” Journal of Pastoral Care and Counseling 58, no. 1-2 (Spring/Summer 2004): 11-21. • Jones writes that “words shape and
form our worlds." He suggests that those who provide pastoral care should turn to the words of a poet in order to construct their world of seeing and being and doing in ministry rather than allowing their thinking to be shaped by the words/metaphors of current health care management. He chooses Rainer Maria Rilke, providing a brief biography of this nineteenth century Czech poet. Using Rilke's poetry, Jones lifts up images of the interior life, grief and death, and images of God. He then turns to the practice of the care of souls, suggesting that Rilke's poetry "invites us into a new world, a world where the depths of the interior life are honored and not just measured, a world where defeat leads to transformation, not humiliation, a world where there is a deep longing to live our unlived lives. ... The construction of Rilke's world is found in new images, like Grief being as sister, or God as a dark net threading through us, and of being held softly in the hands of the One who holds us in our falling" (p. 21).

Thomas Joseph. "Secular vs. Orthodox chaplaincy: taking the kingdom of heaven seriously," Christian Bioethics 4, no. 3 (Dec 1998): 276-278. • "Do not let me be deceived by the corrupting delights of this world, but rather strengthen in me the desire to attain the treasures of the world to come" (St. Basil the Great). With this admonition in his mind and heart, the author, an Orthodox priest, describes how the modern Orthodox chaplain is different from other chaplains, "which is to be expected." He states that there is a "gulf" between Orthodox chaplaincy and secular chaplaincy—by which he means everyone who is not Orthodox. The more serious the illness is, the greater the difference between the two approaches. To illustrate, he describes what the Orthodox priest does when a patient is dying and how he sees this as differing from the ministries of other Christian chaplains. Through this article, readers will gain a clear understanding of what Orthodox patients anticipate in the way of pastoral care when they are dying.

Kristine L. Kwekkeboom, Jenn Kneip, Laura Pearson. "A pilot study to predict success with guided imagery for cancer pain," Pain Management Nursing 4, no. 3 (Sept 2003): 112-123. • Chaplains who have used guided imagery have discovered that it is not a helpful intervention for certain patients. To date, however, there has been no validated method to predict who is likely to benefit from its use. This paper reports a pilot study which tested a model of how to distinguish between those who likely would be helped and those who likely would not. The major concepts the study tested include the following: imaging ability, outcome expectancy, history of imagery use, matching with preferred coping style, and the perceived credibility of the imagery provider—all of which are important considerations for persons wishing to offer guided imagery for any purpose. The leading predictor of success in using guided imagery to help with pain reduction was—not surprisingly—a person's ability to create mental images. This suggests that patients should always be asked about their capability in this area, and the authors have suggestions about the best ways to do this. While this article was written for nurses, these findings easily are translated for use in pastoral work.

David B. Larson, Susan S. Larson. "Spirituality's potential relevance to physical and emotional health: a brief review of quantitative research," Journal of Psychology and Theology 31, no. 1 (Spring 2003): 37-51. • This article reviews the research which has explored the potential relevance of a person's spirituality/religion as a factor in health. Overall, the authors see this area as an "opportunity for potential collaboration with trained chaplains as part of the health care team to provide spiritual support or to deal with spiritual distress for particular patient needs." They highlight the matter of spiritual distress and its negative links with mortality among the physically ill and also discuss the question of the spiritual needs of mentally ill patients.

This is one of the last articles David Larson worked on before his unexpected death in March 2002, and a brief biographical note describing his life and contributions is included.

Philip LeMasters. "The practice of medicine as theosis," Theology Today 61, no. 2 (Jul 2004): 173-186. • The pastoral care literature suffers from a serious lack of papers written from an Eastern Orthodox perspective. For the chaplain who is not Orthodox or has had little contact with persons of this tradition, LeMaster's article should prove to be very rewarding reading. The word "theosis" refers to the Eastern Orthodox
understanding of "salvation." LeMasters describes the process of healing from within that tradition. It becomes apparent that all pastoral care, from an Orthodox perspective, is bound up with this concept. This article describes the relationship between illness and the Fall, the approach to ethical thinking about health issues from this perspective, the place of Orthodox bioethics in the public arena, and the understanding of personhood in health care.

Thomas St. J. O' Connor. "Pastoral counseling and pastoral care: Is there a difference?" Journal of Pastoral Care and Counseling 57, no. 1 (Spring 2003): 3-14. * Is there a difference between pastoral care and pastoral counseling? What is it?* Over the past fifty years, these questions have been discussed, often with great passion and at great length. Now O'Connor provides an historical review of ideas and events which leads him to conclude: "For nineteen hundred years, there has been no distinction between pastoral care and pastoral counseling in the Christian tradition. The difference developed in the twentieth century, and became embedded in history with the formation of American Association of Pastoral Counselors and Association for Clinical Pastoral Education" (p.13). To reach this conclusion, he reports on the writings of a number of pastoral theologians: McNeill, Clebsch and Jackle, Kemp, Gerkin, Stokes, Clinebell, Hiltner, Browning, Hunter, Oden, Purves, Glaz and Moessner, Stone. This article provides a careful assessment of their ideas, supplemented by O'Connor's experiences in ministry and in teaching.

Gretchen Reynolds. "Why were doctors afraid to treat Rebecca McLester?" New York Times Magazine Section 6 (16 Apr 2004): 32-35, 76, 82-86. * A little girl arrives at the hospital with a medical problem that is little understood, could be quite contagious, and may be lethal. Others who might have been infected will arrive shortly. Would you be willing to provide pastoral care to this child, to her family, to the medical/nursing staff who have to care for them? No chaplain appears in this story from Rockford, Illinois, where in June 2003, a ten-year-old girl was brought to Swedish-American Hospital with monkey-pox. If you had been there, would you have been willing to become involved? Would it make a difference if you had had a smallpox shot? This provides some protection, though for how long is not certain. Would it make a difference if you had children? It is a contagious disease. Reynolds tells the story of the outbreak of this deadly disease and of the reluctance of staff to provide care for various reasons. This also was true during the SARS outbreak in Toronto. Incidentally, having a smallpox vaccination raises the chances of one's becoming a first-responder in some emergencies. Would you be willing to have one, or have an old one renewed?*

Michael Rowe. "The structure of the situation: a narrative on high-intensity medical care," Hastings Center Report 33, no. 6 (Nov/Dec 2003): 37-44. * Rowe's son died at age twenty after a second liver transplant failed. This is an account of the crucial four days when major mistakes were made that were to set the stage for his son's death. Rowe, a sociologist, seeks to describe the overall context of the intensive care unit (ICU) in which his son was a patient, specifically that which was created by the interpersonal world of the doctors who were involved in his son's care. He looks at the unspoken but powerful rules which apply between doctors. Technical and surgical competence can be taught and improved upon through residency training; moral competence, the character which shows whether a person is fit to belong to the surgical profession is invisible, but powerful, as Rowe describes. This paper may help chaplains understand the sometimes unsettling behavior of their surgical colleagues.*

Kurt W. Schmidt, Gisela Egler. "A Christian for the Christians, a Muslim for the Muslims? Reflections on a Protestant view of pastoral care for all religions," Christian Bioethics 4, no. 3 (Dec 1998): 239-256. * In the first half of the twentieth century, proclamation was the focus of pastoral care in Germany, and indeed in western Protestantism. (Recall Karl Barth and Edward Thurneysen.) However, the 1970s saw German chaplains embrace the U.S. pastoral care movement, which placed a greater focus on the spiritual dimension. By the end of the century, Christian chaplains in Europe were encountering increasing numbers of patients from different religious communities. In this article, various approaches are proposed to help them find an authentic form of pastoral care which will be appropriate for all to whom they minister. However, the authors believe that until Christianity's demands of absolut-
ism are resolved, none of these approaches will be satisfactory. They describe three ways in which they believe the absolutism claim may be resolved: the exclusive model, the inclusive model, and the pluralistic model. The implications for chaplains are included with each description. Schmidt and Egler then consider the practical consequences for pastoral care of patients with other faiths, based on encounters with Muslim patients. Written in German with German chaplains in mind, this article nevertheless has implications for chaplains in other countries. The final section concerning Muslim patients will be of significant interest to non-Muslim chaplains.


• Does offering an ethics consultation reduce the use of nonbeneficial life sustaining treatments, mainly ventilation, or reduce hospital days when compared to the usual care for patients in an intensive care unit (ICU) who subsequently die before discharge? In a word, yes. Further, there was no difference in outcomes among patients who survived to hospital discharge, suggesting that ethics consultations did not lead to premature deaths. As has been said elsewhere, the quality of care in the US is highly variable, and there is a substantial amount of unnecessary care. In this case, the involvement of ethics teams reduced the amount of unnecessary care and thus presumably decreased the amount of suffering for patients and families.

Suzanne C. Segerstrom, Gregory E. Miller. "Psychological stress and the human immune system: a meta-analytic study of thirty years of inquiry," Psychological Bulletin 130 no. 4 (Jul 2004): 601-630. • This paper reports on a major piece of research undertaken to clarify how stress affects the body's immunity. The work was done by meta-analysis, i.e., a study of other studies. Stressors are divided into five categories: acute time-limited, e.g., a mental math test, public speaking; brief naturalistic, e.g., end-of-semester examinations; event sequences, e.g., death of a spouse, a major natural disaster; chronic, e.g., an injury resulting in permanent disability, caring for a spouse with severe dementia; distant, e.g., having suffered child abuse or been a prisoner of war. Three major findings emerged from this study. First, the results of stress are not all in the head. Second, there is a distinctive pattern associated with stress. Short-term stress "reverses" the immune system, an adaptive response to potential injury or infection, but long-term stress causes too much wear and tear, and the system breaks down. Third, the immune systems of persons who are older or already sick are more prone to stress-related change. To summarize, human beings evolved to be able to sustain a short-term flight or flight mode. The immune system is not equipped to cope with a long-term response in either mode. The groundwork has now been laid to examine more precisely how behavior affects the stress-immune pathways, e.g., how optimism and coping affect the immune response to stress.

Puneet Singh, Kearsley Stewart, Scott Moses. "Pastoral care following pregnancy loss: the role of ritual," Journal of Pastoral Care and Counseling 58, no. 1-2 (Spring/Summer 2004): 41-53. • The authors, two medical doctors and an anthropologist sought to answer the question: How do clergy today ritualize pregnancy loss? Surveys were sent to five hundred clergy in Chicago, followed by a reminder postcard, but only twenty-three were returned! Bearing in mind the implications of the very low numbers, their paper is nevertheless an important examination of a pastoral care issue which rarely is addressed. Their findings allowed them to divide their clergy respondents into three groups: those who do not ritualize pregnancy loss at all, those who adapt existing rituals, and those who create new rituals. The authors quote their respondents liberally, which provides a fairly clear overview of the factors that make this issue an important one for the religious community. The data suggest that while the religious affiliation of a clergyperson influences which of the three approaches is taken, individual preferences and theologies are the key factors driving what pastoral care a clergyperson provides. The authors conclude: "As leaders in their communities, clergy are in a particularly well-suited position to create an environment in which the silence surrounding pregnancy loss is no longer acceptable" (p. 53).
The authors highlight two books as providing the most disciplined reflection on the issues discussed in this paper. Rabbi Nina Cardin, *Tears of Sorrow, Seeds of Hope* (Jewish Lights Publishing, 1999) and Astrid Andersson Wrethmark, *Perinatal Death as a Pastoral Problem* (Stockholm, Sweden: Almqvist & Wiskell International, 1993). It should be noted that Chaplain Richard B. Gilbert, BCC, has produced a major bibliography on the subject of pregnancy and early infant loss (www.twpcc.org).

Author Unknown. “Genetic testing in assisted reproduction: case study,” *Hastings Center Report* 33, no. 6 (Nov/Dec 2003): 11-12. • A twenty-year-old student replies to an advertisement offering money to young women willing to donate ova to infertile couples. The young woman, Z, needs money to pay her college tuition, and she likes the idea of helping someone to have a family. In drawing up an agreement about costs and the parameters concerning Z’s relationship with the couple, Z’s attorney learns that the couple is insisting that she undergo genetic testing for certain abnormalities and disorders: cystic fibrosis, fragile X, thalassemia. Z is readily willing to sign such an agreement. The lawyer urges caution, asking if she has considered the implications of this testing, e.g., what it may show, how the results may affect her health insurance, how the knowledge may affect her family members? Cynthia E. Fruchtman and Caroline Lieber comment on this scenario and include a list of implications of such testing. They raise important ethical issues, and the question remains: what are the obligations of the professionals working with the infertile couple and with a young woman donor?

Michael J. Ward. “Partners in service to God”: Torrance’s scientific method in healthcare chaplaincy,” *Scottish Journal of Health Care Chaplaincy* 7, no. 1 (2004): 12-16. • Ward argues that “spiritual” approaches in health care are based on a Cartesian dualism that is outdated in today’s Maxwellian-Einsteinian cosmology. Yet his examination of the scientific method suggests that modern science is more congenial to Christian theology than is often supposed by the proponents of spiritual care. He takes Scottish theologian T.F. Torrance’s doctrine of man as an example of how a modern scientific method, employed in theology, allows us to regain a better understanding of the mystery and uniqueness of humanity. Ward shows that Torrance’s reconstructed natural theology of humankind allows healthcare professionals to view each other in a new way. Especially important is his paradigm that allows health care professionals to consider themselves “complementary” to each other, not for pragmatic reasons but for theological reasons. There are no answers in this paper; rather it is a novel challenge to think theologically in a different way than is commonly done. The reader is introduced to what Ward calls: “the Keostler-Polanyi-Torrance axis of wholeness and healing.”