Paul Ballard. “Taking leave: the ‘good death’ today,” Contact 146 (2005): 46-51. • The concept of “the good death” is a very old one, as Ballard describes. It was a tradition observed by Christians well into the nineteenth century. However, as Ballard points out, a new kind of “good death” is now being established. It is the result of the growth of the palliative care movement, and the development of standards within that movement intended to ensure that when a person is dying they get the best care possible. While he is not critical of this development, Ballard points out that the implementation of such standards can lead to problems, that with norms, e.g., “best standards,” comes the possibility of failure, and that death may become anodyne, i.e., painless, or a commodity for the customer to choose. He raises the question of how to meet the realities of pluralism as well as the question of what he terms “the Beyond.” Will we, as chaplains, become merely players in a postmodern world where there is no “theology” within which people can make sense of their lives and deaths? Some of these issues obviously are practical in nature. Some however, go to the very heart of the question of the role of the chaplain in a postmodern world.

Herbert Benson, Jeffrey A. Dusek, Jane B. Sherwood, Peter Lam, Charles F. Bethea, William Carpenter, Sidney Levitsky, Peter C. Hill, Donald W. Clem, Manoj K. Jain, David Drumel, Stephen L. Kopecky, Paul S. Mueller, Dean Marek, Sue Rollins, Patricia L. Hibberd. “Study of the therapeutic effects of intercessory prayer (STEP) in cardiac bypass patients: a multicenter randomized trial of uncertainty and certainty of receiving intercessory prayer,” American Heart Journal 151, no. 4 (Apr 2006): 934-42. • This is the sixth study to report that intercessory prayer had no measurable effect on the well-being of patients. The results suggest that praying for the health of patients at a distance is not effective in reducing complications after heart surgery. Patients in six hospitals were randomly assigned to one of three groups. After they had been informed that they might or might not be prayed for, 604 patients were the focus of intercessory prayer; 597 were not prayed for. Individuals in the third group of 601 were informed that prayers would be offered on their behalf and were subsequently prayed for. Praying for the individual began the night before s/he underwent coronary artery bypass graft (CABG) surgery and continued for thirteen days. The intercessors were from three Christian groups: two Roman Catholic and one Protestant. Each day a fax was sent to the intercessors with the patient’s first name, the initial of the last name, and a site code. Those offering prayer agreed to begin before midnight each day and to add to their usual prayers the phrase “for a successful surgery with a quick, healthy recovery and no complications.” Complications occurred in 59 percent of those who had been certain of being the focus of prayers versus just 52 percent of those who were not certain whether they were prayed for or not. The paper is a model of clarity with the methods, definitions, and results reported in great detail. Three of the sixteen authors are hospital chaplains.

Rosalind Cairns. “The place and face of mental health care chaplaincy in our society… evolutionary and revolutionary?,” Ministry, Society and Theology 19, no. 1 (2005): 10-16. • This article describes mental health care chaplaincy today in the Australian state of Victoria. It includes a helpful historical backdrop detailing the dramatic,
state-mandated reduction in chaplaincy services which occurred in 1995. The Mental Healthcare Chaplaincy, an ecumenical body which functions under the auspices of the Health Care Chaplaincy Council of Victoria subsequently was created. The second half of Cairn’s article is an excellent description of the work of chaplains today in the revamped world of mental health care down under.

**Andy Calder.** “‘God has chosen this for you’ – ‘Really?’ A pastoral and theological appraisal for this and some other well-known clichés used in Australia to support people with disabilities,” *Journal of Religion, Disability and Health* 8, no. 1/2 (2004): 5-19. • Some phrases intended to comfort and support people with disabilities are problematic at best, and at worst “instill spiritual trauma upon the recipient, as they perpetuate a sense of victimhood and collusion by God in their suffering.” Examples include the following: We all have our crosses to carry; God has chosen this for you; It’s a test of your faith; God has blessed you with this gift. Calder explores some of the theology and healing stories in Christian scripture which lie behind these and similar clichés. He suggests that pastoral conversations need to include questions such as the following: What do you believe about this experience, about who you are? Where is God in this for you? Does it make sense to you? How does your journey/experience of faith help or hinder you in your current situation? Through this article, Calder offers a sound biblical approach to caring for the disabled.

**Lindsay B. Carey, Christine Meese.** “Do pastoral care and spirituality services make a positive difference? Results from a quality assurance evaluation undertaken at the Royal Women’s Hospital in Melbourne,” *Ministry, Society and Theology* 19, no. 1 (2005): 114-28. • As part of its strategic planning and quality assurance, the Pastoral Care and Spirituality Services (PCSS) of Royal Women’s commissioned a survey of nurses, doctors, management, and allied health staff. Three factors were assessed: awareness of PCSS, satisfaction with PCSS, and perceived value of PCSS. Carey and Meese are detailed and thorough in their presentation of method, results, and recommendations. The findings include the following: 93 percent of the respondents value the pastoral support of PCSS; 66 percent said it is important to have a pastoral care worker available at all times; 96 percent said that PCSS makes a positive difference in the well-being of patients.

**Lindsay Carey, Mark Cobb, David Equeall.** “From ‘pastoral contacts’ to ‘pastoral interventions,’” *Scottish Journal of Health Care Chaplaincy* 8, no. 2 (2005): 14-20. • In 2005, Carey, an Australian chaplain and researcher, went to England where he worked with the chaplains of the five hospital units of an National Health Service Trust to develop a system for gathering information about the day-to-day activities of the chaplains so that “chaplaincy services could be reviewed, updated and tested.” (p.14) The authors utilized the World Health Organization Pastoral Interventions Coding system. Of interest to chaplains still using a contact-type counting system are the authors’ efforts to help U.K. chaplains migrate from this data model to an intervention-style model. The bibliography includes references to both systems of coding.

**Marie Carmichael.** “Bereavement assessment in palliative care: identifying those ‘at risk,’” *Scottish Journal of Health Care Chaplaincy* 8, no. 2 (2005): 21-25. • Carmichael compares and analyzes the development of several models and theories that have attempted to describe the processes of bereavement, e.g., Freud, Bowlby, Kubler-Ross, Worden, Walter. The last model, perhaps the least well known in the United States, takes a biographical approach, challenging the traditional theories which emphasize the working through of emotions with eventual detachment from the deceased. Walter believes it is important that we talk to others about their loss so that the past relationships are carried forward into their ongoing lives. Carmichael examines how family systems may influence bereavement assessment in a palliative care setting. She discusses the benefits of bereavement assessments, arguing that bereavement risk assessment in such a setting, i.e. hospice, is not an option, but “a mandatory clinical standard. ... The main family/carers of dying patients should have their bereavement needs assessed and addressed.” Carmichael includes a sample fifteen-item risk assessment questionnaire adapted from Jacob (Journal of Advanced Nursing 24, no. 2 [1996]: 280-86).

**Mohammad A. Cheraghi, Sheila Payne, Mahvash Salsali.** “Spiritual aspects of end-of-life care for Muslim patients: experiences from Iran,”
The primary value of the article lies in its insights regarding the religious belief processes of faithful Muslims, plus specific recommendations for spiritual care. The authors differentiate between Muslims of different faith groups, especially the Shia and the Sunni.

Harvey M. Chochinov, Thomas Hack, Thomas Hassard, Linda J. Kristjanson, Susan McClement. “Dignity therapy: a novel psychotherapeutic intervention for patients near the end of life,” Journal of Clinical Oncology 23, no. 24 (20 Aug 2005): 5520-25. • “Dignity therapy” is designed to help terminally ill patients find a sense of meaning and purpose, which may reduce their level of suffering as death approaches. Patients are given the opportunity to talk about issues that matter most to them and about the things they most want remembered. The process by which this is done is clearly described. (p. 5522) Using a format of open-ended questions, which are given to the patient ahead of time, a conversation between patient and an “interviewer” is recorded. The edited transcript is then read by the interviewer to the patient, providing an opportunity for the patient to explore issues that matter most. The questions are as follows: Tell me about your life history, particularly the parts that you either remember most or think are the most important. When did you feel most alive? Are there specific things that you want your family to know about you, and/or particular things you want them to remember? What are the most important roles you have played in life, such as family roles, vocational roles, community roles? Why were they so important to you, and what do you think you accomplished in those roles? What are your most important accomplishments, and what are you most proud of? Are there particular things that you still feel need to be said to your loved ones or things that you would want the time to say once again? What are your hopes and dreams for your loved ones? What have you learned about life that you want to pass along to others? What advice do you wish to pass along to your son/daughter/husband/wife/parents/others? Are there words or perhaps even instructions that you want to offer your family to help prepare them for the future? In creating this permanent record, are there other things that you want to include? The study was conducted in both Canada and Australia, and the results reported in the study were based on work with 110 patients in each country.

James Duffy, Gillian Munro. “Measuring the effectiveness of chaplaincy,” Scottish Journal of Health Care Chaplaincy 8, no. 2 (2005): 9-13. • The authors describe their use of the Körner Tool to monitor their ministry and to assess the effectiveness of their chaplaincy team. Fraser is a realist—he is, after all, a chaplain—and he describes both the advantages and the disadvantages of this tool, which in his institution is used for just one month every year to monitor chaplaincy activities. He states that he finds that the benefits of the tool “far outweigh” Scotland-style “audit.” This article is a clear presentation of their audit system, which could be used anywhere with minor adaptations. For those chaplains who are still doing “activity counts,” or as Deming would say, “have degenerated into counting,” this approach will be both welcome and useful. The article concludes with two lists: what should be measured and what should not be counted.

A. Andrew Fleming, Christiaan J. Mulder. “Surveying pastoral care in residential aged care,” Ministry, Society and Theology 19, no. 1 (2005): 104-13. • This paper reports follow-up work to a 1999 study which sought to determine the pastoral care needs of the residents of a 300-person, not-for-profit, Roman Catholic residential care setting for the aged in Australia. Its purpose is to assess improvements made since the earlier study. The paper has sufficient detail to provide inspiration for chaplains who wish to conduct such studies in their respective institutions. It also will be of value to chaplains who do not have research experience.
any disadvantages, adding, “I always find senior, i.e., administrative, staff amazed that we are able to demonstrate in such a familiar manner how our time is spent and the quantifiable and measurable outcomes of the department.” The article includes a copy of the Körner tool presently in use.

Kathleen Galek, Kevin J. Flannelly, Adam Vane, Rose M. Galek. “Assessing a patient’s spiritual needs: a comprehensive instrument,” *Holistic Nurse Practitioner* 19, no. 2 (Mar/Apr 2005): 62-69. This paper details the creation of an instrument to measure the spiritual needs of patients. The authors began by analyzing the literature in which others have described their spiritual needs. They identified the following major constructs (themes): belonging, meaning, hope, the sacred, beauty, and acceptance of dying. They worked these into a twenty-nine-item survey designed to accommodate both religious and nonreligious persons. This article includes the survey questions as well as definitions of the terms they used. It is valuable not only for the findings it reports, but also for the steps which need to be taken in order to develop a useful research instrument.

Terry L. Gall, Karen Grant. “Spiritual disposition and understanding illness,” *Pastoral Psychology* 53, no. 6 (Jul 2005): 515-33. This article attempts to conceptualize the factors which may be grouped under the heading of “spirituality” in order to understand how they change or influence people’s understanding of illness. It is a little dated as it does not reflect some of the work done in the last five years; nevertheless, as a result of the authors’ careful, clear descriptions and use of concepts, it is a refreshing examination of the spirituality/illness relationship. They understand spirituality to be a multidimensional construct, a “spiritual disposition,” which they suggest is grounded in several aspects of personality, e.g., coping styles, as well as in specific beliefs and attitudes, e.g., hope. Spiritual dispositional factors are thought of as the context, or backdrop, to all life events, including illnesses. These factors affect numerous aspects of an illness: the initial illness appraisal, the selection of coping processes, reliance (or not) on support mechanisms, and the ultimate meaning attributed to the event. The article reviews each of these.

David Glenister. “Less than human,” *Ministry, Society and Theology* 19 no. 1 (2005): 65-75. With considerable reluctance, Glenister decides to take a job at a day-care center for persons with disabilities. In this article, he describes his reactions to the people among whom he worked. As a framework, he uses the fifteen propositions that Joseph Fletcher believed to be “the profile of a man.” This was one of the important essays in the modern bioethics era when the question “What does it mean to be human?” was being heatedly discussed. (See *Humanhood: Essays in Biomedical Ethics* (Prometheus Books, 1979)). What Glenister gives us in this paper is a dialogue between Fletcher and the disabled persons at the center with whom he (Glenister) interacts every day. Near the end, he writes: “time would fail me to tell of Kim and of George, and of Diane, and of John and of Clare also, and Sam, and of the other non-profits (in the world’s view), who through faith learned to assist themselves to do the simplest things, such as drink from a cup; learned to be able to make others aware of their choices; through seemingly insurmountable obstacles, learned how to bridge the distance between me and the other; were stoned (by uncomprehending eyes); were sawn asunder (by surgeon’s knives); were slain with the sword (of blind words); they wandered about in sheepskins, but mostly goatskins, being destitute, afflicted, tormented (of whom the word was not worthy).”

Tom Gordon, David Mitchell. “A competency model for the assessment and delivery of spiritual care,” *Palliative Medicine* 18, no. 7 (Oct 2004): 646-51. For the best part of a decade, hospital chaplains have been thinking about how to conceptualize and assess spiritual care. Gordon and Mitchell, two hospice chaplains in Scotland, bring to their article a clear knowledge of the problems associated with this aspect of ministry and a willingness to break ground with their approach. They are aware of the questions that need to be weighed. Who should provide spiritual care – chaplains, nurses, all staff? How should such care to be assessed? How is it to be measured and audited? (As used in the U.K. these terms refer to actually knowing what has been done.) What knowledge and skills are required in order to provide spiritual care? The authors start with the problem of the definition and assessment of spirituality, casting their lot with a growing minority of people, including chaplains and nurses, who think that the lack of a definition of spirituality may be a good thing.
They present their “competence-based model,” developed by a multidisciplinary group from five Marie Curie Hospices and their nursing service. Clearly, they have been influenced by the difficulty of capturing the essence of spirituality and spiritual care and instead offer a “model [that] seeks to integrate spiritual care into all care rather than assess it as an individual element …. An important part of the process is to encourage individuals to be aware of their own level of competence and to have a clear referral path to the next level of competence.” (p. 647) They describe a four-level competency framework based on knowledge, skills, and actions. In the second half of the article, they describe a pilot study they created to educate staff regarding the purpose, language, and content of the competencies; to help them consider the implications of the model for the delivery of spiritual and religious care; to use the competencies document as a tool to reflect on and improve current practice; and to identify future educational needs. They make this observation: “The competencies served to define and quantify what staff already were doing by intuition, training, and experience. Consequently, the competency framework was not seen as being burdensome or prescriptive, rather it was considered by those participating to be nonthreatening.” (p. 649) They make one further observation: “This article has sought to earth the often ethereal vagueness of spirituality into palliative care practice by taking seriously the issues of definition and the assessment and addressing of spiritual needs. Although the practice of developing assessment tools is well established and has many advantages, not least of which is regularizing specific assessments in the care of patients, spiritual care does not lend itself to such a form of assessment. Instead, it requires an individually focused approach that is continual rather than being utilized at set points in our involvement with the patient.” (p. 650)

Ron Hamel. “Ethics committees: pursuing enhanced effectiveness,” Health Progress 87, no. 2 (Mar/Apr 2006): 17. • Hamel provides the introduction to a special section in this issue of Health Progress. Since their origin around 1980, healthcare ethics committees (HECs) have increased in number across the United States but not necessarily in their effectiveness. Hamel has drawn together five articles to examine what HECs are doing and how their effectiveness may be increased.

Bruce Jennings. “Preface,” The Hastings Center Report (Special Report) 35, no. 6 (Nov/Dec 2005): 2-4. • In his introduction to this special issue, Jennings reviews the changes that have been made in the care of the dying in the United States over the past three decades. Thirty years ago, death was often a “horror, prolonged by powerful but mindless drugs and machines.” Two strategies were adopted in order to rectify this situation: laws were changed to allow individuals greater freedom in deciding how they wish to die; medicine was changed through improved skills in treating pain and suffering. This included the financing of hospices and palliative care programs. As Jennings shows, progress has been made concerning both, but the work has not been completed, and there is danger of a backlash. “Our systems of decision making need to be redesigned.” (p. S2) He describes the dangers ahead in sufficient detail for readers to understand the importance of the thinking of the ten authors who contributed to this special supplement.

Stavros Kafinas. “Spiritual health care and the European Union (EU),” Scottish Journal of Health Care Chaplaincy 8, no. 3 (2005): 40-43. • This article is the text of a submission the European Network of Health Care Chaplaincy, made in June 2005 to top officials of the European Union. It describes the steps which need to be taken to assure spiritual health care within the healthcare systems of EU countries. It is a careful exposition of the nature of chaplaincy, the European Network, the status of the chaplain within the healthcare community in Europe, and the patient’s rights to spiritual care. Kafinas is the coordinator of the European Network, and the full report is available at http://www.eurochaplains.org/brussels05.htm

Soo-Young Kwon. “Homecoming rituals: weaving multicultural funeral narratives,” Journal of Pastoral Care & Counseling 57, no. 4 (Winter 2003): 405-14. • This is an essay about funerals: a comparison and discussion about the funerals described in the book of Genesis, contemporary American funerals, and Korean traditional funeral rituals. Kwon asks a central question: How do we in different cultures conceive death in rites of farewell and commemoration? During Kwon’s service as a parish minister in the United States, his father died while visiting. Kwon describes the cultural differences his family experienced as they prepared to take his body back to Korea for burial. Among those he notes are dying at the hospital versus dying at home; embalming versus sup’yom (the washing/binding