Anne Allan, Iain Macritchie. “Proactive or reactive chaplaincy,” *Scottish Journal of Healthcare Chaplaincy* 10, no. 2 (2007): 9-14. • Until the end of 2003, the style of Macritchie’s chaplaincy was to wait and respond to referrals before visiting patients. But in response to a National Health Board decision in September 2003, he decided to implement a more proactive form of chaplaincy in the renal unit of his hospital. He would visit every patient in the unit to ascertain whether further visits would be welcome or required. He did this with the cooperation of coauthor Allan, the ward manager of the hemodialysis unit, and the medical directorate general manager. In this article, Macritchie and Allan describe the needs found in patients and their relatives as well as in staff. The results from patients/relatives are impressionistic. The staff needs and reactions were obtained through survey. Though the authors assess this new approach to pastoral care as a success, they concede that replication requires sufficient resources; they had to add a chaplain-team volunteer. So should chaplains “go round...looking for clients? No other professional does so.” It could be argued that this is an inefficient approach. Furthermore, it adds to the workload by identifying more demands for pastoral care. These authors respond that “this example of proactive chaplaincy clearly resulted in better team work, fuller involvement of the chaplain and better spiritual care for the patients and staff. It began with the assumption that everyone has spiritual needs and sought to deliver spiritual care appropriate to the level of need encountered. It resulted in a busier chaplain, for sure, but one who felt greater job satisfaction particularly in this area of work because it was using his range of knowledge and skills more fully.” (p. 13.)

Dan Blazer. “Selected annotated bibliography on depression and suicide,” *Southern Medical Journal* 100, no. 7 (Jul 2007): 761-63. • Blazer provides summaries of thirteen major books and three articles on depression and suicide. The summaries are a motherlode of information and insights. His article is part of the *Southern Medical Journal’s* ongoing Spirituality/Medicine Interface Project.

Arjan W. Braam, Dorly J.H. Deeg, Jan L. Poppelaars, Aartjan T.F. Beekman, Willem van Tilburg. “Prayer and depressive symptoms in a period of secularization: patterns among older adults in The Netherlands,” *American Journal of Geriatric Psychiatry* 15, no. 4 (Apr 2007): 273-81. • There are few studies that have examined the relation between prayer and depressive symptoms in later life, and findings so far are mixed. Persons aged 60-91 were surveyed as part of the Longitudinal Aging Study Amsterdam, an ongoing study in the third and fourth cycles (three years apart). Data were collected concerning frequency of prayer (How often do you pray or meditate? choice of eight answers), the perceived meaningfulness of prayer (Do you think praying makes sense of you? Y/N), religious affiliation, church attendance, salience of religion, health variables and general demographics. The results for the group as a whole showed no significant association between frequency of prayer and depressive symptoms. Among those not religiously affiliated, prayer was associated with higher levels of depressive symptoms. This result was especially pronounced among nonaffiliated widows. The most important finding from this study would seem to be that there is a group which is especially at risk for depression in later life: persons who

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The following summaries of articles have been selected from the database of *The Orere Source*, a bi-monthly publication of summaries of pastoral and other literature of potential value to chaplains. The summaries are created by W. Noel Brown STM BCC.
oreresource@rocketmail.com
have not been, or are no longer, religiously affiliated, but who still turn to prayer in bereavement.

Beverley A. Caley. “Surgeons and robots,” *Cure: Cancer Updates, Research & Education* 6, no. 4 (Summer 2007): 32-39. • Chaplains are well acquainted with “minimally invasive surgery” because patients speak about it often, provided they have not been discharged before there is time for such conversations. This article graphically describes this type of surgery, the current capabilities and the potential for faster recovery times, shorter hospital stays and lowered risk of complications. For example, in traditional prostate surgery, surgeons make one incision of eight to ten inches; the da Vinci robot makes five half-centimeter incisions. Subsequent to the traditional procedure, erectile dysfunction results about 26 percent of the time, but just 3 percent of the time with da Vinci. Chaplains qualify as caregivers and may obtain a free subscription to this excellent publication. www.curetoday.com

Mark Cobb. “Prayer research,” *www.jiscmail.ac.uk* (Oct 2007): 15 p. • Cobb created this PowerPoint presentation for the Research Network of U.K. Chaplains in October 2007. The slides may be located and downloaded from the “Files” area of the homepage at the above address. He describes the results of the Cochrane Collaboration study “Intercessory Prayer for the Alleviation of Ill Health.” Completed in 2007 by Roberts, Ahmed and Hall, it is arguably the most thorough examination of the prayer/health relationship to date. Cobb then critiques the methodology used as well as the study as a whole from a theological perspective, encompassing the nature of God, the purpose and practice of prayer, instrumentalism, reductionism, the practice of research and the practice of healthcare.

Farr A. Curlin, Ryan E. Lawrence, Marshall H. Chin, John D. Lantos. “Religion, conscience and controversial clinical practices,” *New England Journal of Medicine* 356, no. 6 (8 Feb 2007): 593-600. • Should patients expect physicians to tell them about a medical treatment they need based on their medical condition? If your answer to that question is “yes,” then the report in this paper will come as something of a surprise. Ten percent of the 1,144 physicians who participated in a survey did not believe that they had an obligation to inform patients of all treatment options. Their unwillingness was based on their personal or religious values. Almost 20 percent, for example, said they did not have an obligation to refer a patient to someone else for a procedure that they, in good conscience, were not willing to provide. According to the authors, a broader analysis of the data suggests that 14 percent of patients—more than forty million Americans—may be being cared for by such physicians. The authors provide a good analysis of the ethical issues involved in what is a struggle for doctors between paternalism and autonomy, and the possible doctor-patient models the authors believe would lead to a good ethical outcome for situations of this nature. This paper is one of a series written by Curlin (and different colleagues) concerning aspects of religion, ethics and healthcare.

R. Scott Dingeman, Elizabeth A. Mitchell, Elaine C. Meyer, Martha A.Q. Curley. “Parent presence during complex invasive procedures and cardiopulmonary resuscitation: a systematic review of the literature,” *Pediatrics* 120, no. 4 (Oct 2007): 842-54. • Whether parents should be allowed to remain when a code team arrives to attempt resuscitation of their child has been and remains controversial. Despite the endorsements of the American Academy of Pediatrics and the Society of Critical Care Medicine as well as the recommendation of the American Heart Association and a major nursing organization, few hospitals have crafted guidelines, conducted clinical education or committed staff to support the practice. This is a major review article; the journal calls it a “state-of-the-art review.” The authors have completed a systematic review of the literature describing parent presence during complex invasive pediatric procedures and/or resuscitation. They found fifteen papers meeting their research criteria. The results showed that parents prefer to have a choice as to whether they stay near their child and that doctors and nurses remain apprehensive about their remaining during a code response.

Kieren Faull, M.D. Hills. “The QE Health Scale (QEHS): assessment of the clinical reliability and validity of a spiritually based holistic health measure,” *Disability and Rehabilitation* 29, no. 9 (May 2007): 701-16. • Faull and Hills wanted to create an assessment and therapeutic tool that could be used to assess spirituality levels with people who have physical disabilities as they enter a three-week inpatient
rehabilitation program. In an earlier paper that has been accepted by *Disability and Rehabilitation* but not yet published, they described how they developed QEHS. This article is focused on assessing the scale’s reliability, validity and the applicability. Its use enables client-centered therapeutic interventions, helps ensure informed decision making and evaluates outcomes for persons being treated for physical disabilities.

The twenty-eight questions in the self-test instrument are included as an appendix to this paper. All of the questions are well worded and understand the concept of spirituality to be very inclusive.


• This paper was presented at the tenth anniversary conference of the *Scottish Journal of Healthcare Chaplaincy*, March 2007. Foggie writes about belief systems, describing the issues that arise when different belief systems collide. The systems she describes are those of two groups who must interact, specifically, doctors and their psychiatric patients. Foggie identifies an additional collision, which occurs when the patient has what the doctor-group describes as “delusion thinking.” She proceeds to describe how she functions as a chaplain who is a member of the mental health team and who also wishes to join the patient where s/he is. If not carefully managed, this dual role may place her at odds with one side or the other.

**Maria Friedrichsen, Anna Milberg.** “Concerns about losing control when breaking bad news to terminally ill patients with cancer: physicians’ perspective,” *Journal of Palliative Medicine* 9, no. 3 (Jun 2006): 673-82. • We know that not all physicians are comfortable when breaking the news about discontinuing or not offering a specific treatment to a patient with incurable cancer. The goal of this study, involving thirty Swedish physicians with differing demographic characteristics, was to better understand the reasons for their discomfort in such situations. According to the physicians, conveying this “bad news” was perceived as involving a risk of losing control regarding one’s emotions, one’s self, one’s confidence, one’s professionalism and patient trust. The doctors described one goal in speaking with patients as an attempt to reach some kind of agreement or at least an understanding of the facts. Creating and maintaining adequate control as they did this was of great importance. One doctor stated that one cause for anxiety “is that you don’t know what will happen, what direction the dialogue will take.” (p. 676) The writers present a great deal of detail about the doctors’ fears, and an understanding of these dynamics may assist the chaplain to provide pastoral care more effectively to medical colleagues, especially those who have had less experience in these situations.

**Daniel H. Grossoehme, Judith R. Ragsdale, Christine L. McHenry, Celia Thurston, Thomas DeWitt, Larry VandeCreek.** “Pediatrician characteristics associated with attention to spirituality and religion in clinical practice,” *Pediatrics* 119, no. 1 (Jan 2007): 117-23. • As the authors correctly point out, a majority of pediatricians believe that spirituality and religion (S/R) are relevant to their clinical practice, while in actual practice, only a minority tend to these aspects of their patients’ lives. Believing that this was a situation worthy of greater study, the authors—three chaplains and three physicians—surveyed by questionnaire all of the pediatricians in three academic pediatric hospitals in the Midwest: interns, residents and community pediatricians who had hospital staff privileges. A questionnaire, devised by the authors, requested information on ten personal or professional characteristics that may be associated with giving heed to S/R in clinical practice. A total of 1,275 questionnaires were mailed with a 58 percent response rate. The results support the disparity noted above and reveal that whether a particular pediatrician attends to spiritual and religious matters is associated with a mix of personal and professional characteristics. Some of these relate to the pediatricians’ personal investment in spirituality or religion; others relate to their discomfort with religious and spiritual issues and practices. The paper includes four tables, which detail the results. A version of this article was published in *Chaplaincy Today* 23, no. 2 (Autumn/Winter 2007).


• This issue of *Health Progress* has a special section devoted to the subject of preparing for pandemics and disasters. All the writers in the section are agreed that a flu pandemic is inevitable and so appropriate preparedness is required. Pandemics occur three to four times a century, and North America is overdue.
Hamel’s ethics column addresses one particular ethical issue, pointing out that the fact that we are a ruggedly individualistic society may quickly cause problems, both in planning for, and responding to, disasters. He quotes Lawrence Gostin: “The balance between individual interests and common goods needs to be recalibrated in an age of terrorism.” (See Gostin in “Public health law in an age of terrorism: rethinking individual rights and common goods” Health Affairs 21, no. 6 (Nov/Dec 2002) p. 84.) Hamel believes that Catholic healthcare is in a unique position to help in that recalibration because it views persons not as isolated individuals but as being in and flourishing through relationships. This is a system that recognizes the individual’s responsibilities toward the common good and also emphasizes solidarity with, and concern for, others, especially the disadvantaged. Hamel points out that the burdens following catastrophes are not equally distributed across a population as the aftermath of Katrina has shown.

Idethia S. Harvey, Myrna Silverman. “The role of spirituality in the self-management of chronic illness among older Africans and Whites,” Journal of Cross Cultural Gerontology 22, no. 2 (Jun 2007): 205-20. • What role does spirituality play, if any, in the self-management of chronic illness among older persons? Are there differences in this regard between whites and blacks? These were the questions behind this study. The authors gathered information from eighty-eight persons in Pennsylvania, sixty-five years of age and older. They found a number of core themes related to the link between spirituality and self-management: God as healer, God as enabler through doctors, faith in God, prayer as a mediator, spirituality as a coping mechanism, traditional medicine combined with spiritual practices and empowerment of people in the practice of healthy eating habits. As for differences, African American seniors were more likely to hold a belief in divine intervention. White seniors were more likely to merge their spirituality with various self-management practices. Overall, spirituality was found to play an integral part in the health and well-being of chronically ill seniors in both groups.

Katy Human. “No smoking,” Cure: Cancer Updates, Research & Education 6, no. 4 (Summer 2007): 52-59. • How often have you been asked by a patient who has been diagnosed with lung cancer, “Why did this happen to me, I’ve never smoked a day in my life?” Approximately 25,000 nonsmokers are diagnosed each year in the United States and this article includes a description of an additional reality they have to face. It is frequently assumed that because they have lung cancer, they must have smoked and thus have brought their illness on themselves. The article concludes with a list of resources for patients and families affected by lung cancer as well as a list of the current clinical trials for four drug therapy studies. As previously noted, chaplains may obtain free subscriptions to this publication (www.curetoday) as they are considered caregivers.

Chun-Fu Lai, Tze-Wan Kao, Ming-Shiou Wu, Shou-Shang Chiang, Chung-Hsin Chang, Chia-Sheng Lu, Chwei-Shiun Yang, et al. “Impact of near-death experiences on dialysis patients: a multicenter collaborative study,” American Journal of Kidney Diseases 50, no. 1 (Jul 2007): 124-32. • Papers in the peer-reviewed literature concerning near-death experiences (NDE) still are relatively rare, even though they were brought to the
attention of the American public in 1975 with the publication of Life After Life by R. A. Moody (NY: Bantam Books). Dr Bruce Greyson also has published a number of foundational articles, four of which are cited in this paper. In this multicenter project just forty-five of 710 dialysis patients reported having NDEs. The experiences themselves were different from those reported by patients in the United States. For example, descriptions of the awareness of being dead—the tunnel experiences—were uncommon. Behaviors following NDEs were similar, however. Patients reported that they became kinder to others as well as more motivated in their living. This article will encourage dialysis chaplains to listen for indications that patients have had NDEs as other research has shown that patients are selective as to how they share news about such events for fear they will be considered “crazy.”

Ray M. Merrill, R. Justin Brown, Stephen Alder, Randy K. Baker, A Dean Byrd, George L. White Jr, Joseph L. Lyon. “Psychological disorders among children and the parents of children undergoing cancer workup,” Journal of Psychosocial Oncology 25, no. 3 (2007): 1-18. • A cancer workup alone is sufficient to markedly increase the level of anxiety and/or the risk of depression in children and also in their parents. This paper reports a study using the medical claims data of a health insurance company which provides healthcare coverage for employees of the Church of Jesus Christ of Latter Day Saints (LDS). Most of the insured are LDS. For the period of the study, 222 children were found who had had a cancer workup. The findings show that a significant number of children experience anxiety/depression simply by undergoing an initial workup and that this reaction is triggered in their mothers as well. Further, if one or both of the parents suffer from anxiety/depression, the child is more likely to have the same response as the parent. Chaplains often do not extend their ministry into outpatient clinics, and this is a clear indicator of the need for pastoral support in such settings.

Graham Monteith. “Professionalisation and disclosure - an outsider’s viewpoint,” Scottish Journal of Healthcare Chaplaincy 9, no. 1 (2006): 31-32. • The author, a recently retired parish minister, begins by welcoming the professionalization of chaplaincy. He adds that for such a ministry to succeed in healthcare settings, more is required than the exercise of professional skills. He maintains that chaplaincy requires the involvement of a unique personality and a degree of disclosure of the essential self, which goes beyond the professional persona. It is his opinion that the chaplain must exercise a certain freedom to use the self as a means of giving spiritual care.

Harriet Mowat. “Gerontological chaplaincy: the spiritual needs of older people and staff who work with them,” Scottish Journal of Healthcare Chaplaincy 10, no. 1 (2007): 27-31. • Mowat presented this paper at the international meeting of Scottish chaplains who celebrated the tenth anniversary of their journal in March 2007. Her paper builds on two of her recent studies. The first focused on staff who work with older persons; the second focused on older persons and their spiritual needs as well as the implications of these needs for the ministry of healthcare chaplains. Using the concept “successful aging,” Mowat suggests a link between spiritual support and successful aging and then considers empirical data from residents and staff in light of this link. Mowat suggests that chaplains have an opportunity to develop specific support interventions based on researched need, both for older persons and for staff who work with them. She also raises the question of whether gerontological chaplaincy should now be a fully recognized subspecialty.

Aaron Murray-Swank, Richard Goldberg, Faith Dickerson, Deborah Medoff, Karen Wohlheiter, Lisa Dixon. “Correlates of religious service attendance and contact with religious leaders among persons with co-occurring serious mental illness and type-2 diabetes,” Journal of Nervous and Mental Disease 195, no. 5 (May 2007): 382-88. • People suffering serious mental illnesses (SMI) are more likely than the general population also to suffer from a variety of medical conditions. In particular, type-2 diabetes is highly prevalent among persons with serious mental illnesses, such as schizophrenia and major mood disorders. The authors note that previous research into the contribution of religious participation in helping people in their daily lives and its influence on quality of life and health status has focused only on persons with diabetes; no studies have been conducted with persons suffering from both SMI and type-2 diabetes. For this study, over two hundred persons were
interviewed in public and private outpatient mental health clinics in Baltimore. The findings will interest chaplains who work either with the mentally ill or with diabetics. Persons with diabetes plus SMI seem to be as religiously active as those who suffer from diabetes alone. Among persons with SMI, the rates of religious participation vary across diagnoses: persons with schizophrenia are more likely than those with affective disorders to attend worship and to have regular contact with a religious leader. African-Americans in this group were more likely to be religiously involved than were Caucasians; however, this does not mean they will seek help and support from their religious leaders. (There are competing findings in the literature about this.) Overall, the findings suggest that race and ethnicity are important contextual variables that may influence relationships between religion, help seeking and adjustment to illness, but these relationships still are not fully understood. The bottom line, according to these researchers, is that “it is important … for healthcare providers to appreciate the potentially health-promoting aspects of religious participation for patients with co-occurring serious mental illnesses and diabetes.” (p. 387)

Jo A. Nettleton, Gordon Self. “Recovering from a flu pandemic,” Health Progress 88, no. 6 (Nov/Dec 2007): 32-37. • This is another article in the special section of Health Progress devoted to the subject of preparing for pandemics and disasters. When the pandemic has passed, there will inevitably be issues left in its wake, including issues within workplaces. How should staff absences in the midst of the pandemic be treated? How does an organization deal with staff members’ differing responses to the crisis? The authors, from Caritas Health Group, Edmonton, Alberta, Canada, believe that trust will be a crucial issue to be addressed at such a time. Alberta is known to be one of the most prepared locales, and this article describes what Caritas has been doing internally with staff and externally with community groups to prepare for difficulties that they foresee could, but hope never will, occur.

Mary R. Robinson, Mary M. Thiel, Meghan M. Backus, Elaine C. Meyer. “Matters of spirituality at the end of life in the pediatric intensive care unit,” Pediatrics 118, no. 3 (Sept 2006): 719-29. • This study examines perspectives of end-of-life care from fifty-six parents who experienced the death of a child in the pediatric intensive care unit (PICU) at Children’s Hospital (Boston), Massachusetts General Hospital or Tufts New England Hospital. The deceased children ranged from newborn to eighteen years, and the parents completed questionnaires twelve to forty-five months after the child’s death. The following five open ended questions were asked in anonymous questionnaires, and the responses were separated according to themes describing the nature and role of parental spirituality at the end of the child’s life: What was most helpful to you in getting through that time at the end of your child’s life? What was the least helpful to you in getting through the time at the end of your child’s life? How can the hospital staff improve their communication with parents at this difficult time? What advice do you have for hospital staff members in helping parents during this difficult time? What advice do you have for parents who face a similar situation? Although the questions do not ask directly about spirituality or religion (S/R) four explicit S/R themes were identified from the responses: prayer, faith, access to and care from chaplains and clergy, belief that there is a transcendent quality to the parent-child relationship that endures beyond death. Implicit spiritual themes identified included wisdom, values, hope, trust and love. The article provides examples that illustrate each of these themes. There are a number of valuable insights to be gained from the responses. It really does take time for a parent to make meaning concerning their child’s death, and a premature attempt at making meaning by someone else—even a chaplain—may be distressing. Parents take very seriously identifying and doing what is right for their child and their family in these situations. The value of the chaplain and community clergy working together was emphasized by a number of parents. The authors of this study conclude: “Our data lend additional support to studies that have documented the immediacy and the abundance of parental spiritual needs in the PICU. In their groundbreaking book When Children Die, the American Academy of Pediatrics and the Institute of Medicine emphasize the clinical and ethical imperatives of incorporating spiritual needs assessment and care at the end of life. The Joint Commission on the Accreditation of Healthcare Organizations mandates that a patient’s spiritual needs be both assessed and accommodated.” (p. 727) This article will
be of interest to pediatric chaplains; the first two authors are chaplains. It also provides a model paper for other chaplains to emulate as they work toward the publication of their own research.

**Marilyn Smith-Stoner.** “End-of-life preferences for atheists,” *Journal of Palliative Medicine* 10, no. 4 (Aug 2007): 923-28. • Little is known about the end-of-life (EOL) preferences of atheists, and chaplains rarely write about the pastoral care of such individuals. An exception was one presentation at the 2004 Association of Professional Chaplains conference. Perhaps this article will encourage additional work, especially as regulatory standards require an individualized plan of care for each patient/family. The aims of this pilot study were two-fold: to explore the EOL preferences for atheists and to apply a three-fold model of spiritual care—intrapersonal, interpersonal, natural connectedness—to assess the appropriateness of potential interventions for this group. Eighty-eight persons completed either an online or a paper survey. The findings provide concrete guidance to chaplains. For instance, some atheists find the use of the term “spirituality” acceptable and appropriate, others do not.

**Venus Y.H. Tang, Antionette M. Lee, Cecilia L.W. Chan, Pamela P.Y. Leung, Jonathan S.T. Sham, Judy W.C. Ho, Josephine Y.Y. Cheng.** “Disorientation and reconstruction: the meaning searching pathways of patients with colorectal cancer,” *Journal of Psychosocial Oncology* 25, no. 2 (2007): 77-102. • This report is a continuation of the work of these oncologists and psychologists in Hong Kong who seek to understand how Chinese patients make meaning of their situations and life when they are being treated for colorectal cancer. They know that meaning making may lead to growth and transformation. They wish to understand more clearly how this process occurs and what they can do to encourage it. Twenty-six patients were interviewed. It was found that they experienced two main kinds of disorientation during their treatment: cognitive and emotional. Factors that facilitated meaning searching also fell into two groups: personal factors and external factors. Unfortunately, the conclusions drawn by these authors are not as robust as one would wish. They conclude that three factors were important: supportive networks, such as family, friends and healthcare professionals; the ability to think positively and to reappraise life and life priorities; fulfilling religious and cultural beliefs. Patients who reported these tended to be better able to make sense of and derive benefit from their cancer experiences. They ultimately were able to reconstruct the whole experience in a way that usually resulted in growth and transformation. The authors conclude that these factors should be kept in mind in designing psychosocial interventions for cancer patients.

**Nalini Tarakeshwar, Lauren C. Vanderwerker, Elizabeth Paulk, Michelle J. Pearce, Stanislav V. Kasl, Holly G. Prigerson.** “Religious coping is associated with the quality of life of patients with advanced cancer,” *Journal of Palliative Medicine* 9, no. 3 (Jun 2006): 646-57. • The main purpose of this research project was to learn more about the association between religious coping and quality of life (QOL). Both positive and negative forms of religious coping were included in the study. Multiple dimensions of QOL were included in the study: physical, physical symptom, psychological, existential and support. Structured interviews were conducted with 170 patients who completed the McGill QOL Questionnaire, the Brief Measure of Religious Coping (RCOPE), the Multidimensional Measure of Religion/ Spirituality and the General Self-Efficacy Scale. The conclusions were clear. Religious coping plays an important role in the QOL of patients, and the types of religious coping strategies used are related to better or poorer QOL. The following statement by the authors is worthy of attention: “Even though the use of negative coping with religious coping might be rare, it is important to attend to issues such as anger at God and feelings of abandonment by God, so as to increase the likelihood of improving patient psychological and existential QOL (sense of meaning and control) and reducing the likelihood of negative outcomes. On the other hand, for patients who turn to positive religious coping, it would be important to ensure that related resources (for example, opportunity for worship) are available so that they can maintain their QOL by enhancing the sense of support and existential meaning.” (p. 653) The authors include the religious coping and McGill Quality of Life items in an appendix.

2007): 20-25. • This is an article in a special section of *Health Progress* devoted to the subject of preparing for pandemics and disasters. Tuohy has been a member of Oregon’s Medical Advisory Group (MAG) which was established by Oregon’s Dept of Health Services in 2006. MAG’s work was to create an emergency preparedness plan which would look at the ethical aspects of ensuring access to basic health resources as well as describe the duties of professionals were a community or state-wide emergency to arise. Tuohy begins with the problem of context, describing how accepted values relating to the social, psychological, political and economic spheres of life would be put at risk in such an emergency. He then describes the construction of an ethical decision matrix and its final characteristics, which include social solidarity, professionalism—defined as adherence to the standards of one’s profession—and justice.

Heather L. Van Epps. “In whose best interest?,” *Cure: Cancer Updates, Research & Education* 6, no. 4 (Summer 2007): 40-46, 50. • This article describes the ethical dilemmas around clinical trials of new drugs. Van Epps describes the tug-of-war between the three competing parties: the researchers who want to advance medicine, the drug companies who want to get their drugs to market in order to make money and the patients who want access to the most potent medications. This is a helpful background article for any chaplain whose institution participates in clinical trials. A sidebar, headed “Should I take part in a clinical trial?,” accompanies the article. It contains four questions to ask oneself and twenty-two questions to ask the doctor. It is somewhat doubtful, however, whether such lists have much value as most patients report that when there is nothing else available, and they are offered the possibility of entering a clinical trial, emotions click in, and they quickly agree.

Lori S. Wiener, Emilie Steffen-Smith, Terry Fry, Alan S. Wayne. “Hematopoietic stem cell donation in children: a review of the sibling donor experience,” *Journal of Psychosocial Oncology* 25 (2007): 45-66. • Hematopoietic stem cells (HSC) are stem cells which give rise to all the blood cell types. Understanding them and how best to use them has changed considerably over the past twenty years. A full description may be found on Wikipedia. There are two kinds of hematopoietic stem cell transplants (HSCT): one in which patients donate cells to themselves, the other in which a donor has been found to have cells that are not likely to be rejected by the patient’s body. It is critically important to understand the psychological needs of donors of such stem cells, especially sibling donors. At the moment, this group provides the largest percentage of matched donors for allogeneic transplants. This paper presents the results of a study conducted to gain insights into the dynamics involved in such donation transactions. It is clear that young donors experience psychological distress before, during and after donation and transplantation. The authors maintain that ongoing assessment and support needs to be provided to them.

Theresa Wiseman. “Toward a holistic conceptualization of empathy for nursing practice,” *Advances in Nursing Science* 30, no. 3 (Jul/Sept 2007): E61-E72. • As Wiseman noted in an earlier paper, which was published before she completed her PhD, there is great confusion as to how best to understand the nature of empathy. Based on her own research on an oncology ward, she proposes a new holistic conceptualization of empathy that allows different aspects of the confusion to be better understood. She begins by describing current ways of understanding empathy, then presents her study methodology followed by her model. This paper was written for the nursing profession, but its insights apply directly to chaplaincy. It will be of interest to chaplains who seek to better understand their own empathic skills and to chaplain-educators who wish to more effectively develop this skill in their supervisees.