Anne Aldridge, Derek J. Fraser, Keith Morrison. “What do people talk to chaplains about?,” Scottish Journal of Healthcare Chaplaincy 12, no. 2 (2009): 3-10. ● Chaplains in UK hospitals continue to heed the urgings of Mowatt, Swinton, as well as administrators of the National Health Service to conduct evidence-based research, which will demonstrate the efficacy of the roles they play in health care. This paper reports one such effort that collects basic, but nevertheless important, information about a hospital chaplain’s work: what do people talk to chaplains about? With verbatim writing a standard practice in one hospital, the authors took the forty-three verbatimas written by chaplains during a three-month period of 2007 and, with permission, gave them to two independent chaplains to review. The verbatimas had not been written for the project. The chaplains, independent of each other, read and identified the main themes from each verbatim, compared their findings and then did an additional check of the themes using the computer program NVivo. The fifty-seven categories identified fell into four major groups: spiritual themes/exploration, hospital experiences, life stories and emotional language. They give examples and discuss each of the groups in turn. The authors assert that the value of their research is, first of all, to show that the “contents” of a chaplain’s visit may be the subject of research and that the focus of the visit may be on the person of the patient. They also acknowledge that this project does not answer the question of whether the pastoral visits were beneficial to the patients.

Rodney Baxendale. “24 hours in the chaplaincy,” Scottish Journal of Healthcare Chaplaincy 12, no. 1 (2009): 28-31. ● This is the report of a straightforward study, undertaken by the head chaplain in a hospital in Plymouth, England. His aim was to find out about the usage of “chaplaincy real estate” in his hospital, a large, acute treatment center. To do so, an anonymous observer completed a 24-hour observation of the chapel and then the administrative/prayer room areas. The author provides a schematic plan of both areas so the reader may visualize them. He describes the process of the survey, reports the events observed, their frequency and the numbers of persons involved. He lists the limitations of the method, followed by the survey’s conclusions. A number of practical ideas have occurred to him based on the data collected. Best of all, it seems to have started Baxendale and his colleagues thinking about issues they might address to increase the effectiveness of their overall chaplaincy services. He also thinks that a second survey, growing out of what they now know they don’t know, would produce even more valuable findings. This is a good example of a research project that was quite straightforward in design and which has provided helpful information for the department involved.

Mary Q. Browne. “A significance of sacramental ministry among individuals with severe and persistent mental illness,” Journal of Religion, Disability & Health 13, no. 3/4 (Jul-Dec 2009): 260-73. ● Research has shown that people with serious mental illness are aided in their recovery by their spirituality. However, little is known about the role of sacramental ministry in such recovery. Using a structured interview method, Browne reports ways in which sacramental ministry functions in the lives of persons with severe and persisting mental illness. The narratives show how the concrete elements of bread, water and oil may contribute to recovery. Browne thinks of recovery in terms of an ongoing and highly personalized experience, rather than in terms of a
biomedical disease. She says that this is a new and somewhat radical concept in the mental health field. The sample size in this study was small, and the author hopes that it will be repeated with a larger sample. However, she also observes that with the shift in mental health care from inpatient to outpatient settings, it is increasingly the responsibility of local churches to understand and to provide for the spiritual and religious needs of this population. The article includes the interview questionnaire Browne used.

**Donald Capps.** “Relaxed bodies, emancipated minds and dominant calm,” *Journal of Religion and Health* 48, no. 4 (Dec 2009): 368-80. ● In May 2009, Donald Capps retired after an illustrious 40-year history as a pastoral theologian, teacher and mentor for countless ministers both in the United States and overseas. During this period, he published or coedited approximately forty books and hundreds of papers. This is perhaps the last piece he wrote before he retired. William James presented “The Gospel of Relaxation” to the 1896 graduating class of the Boston Normal School of Gymnastics and ten years later he delivered his presidential address, “The Energies of Men,” to the American Philosophical Association. In both lectures, James looks at the body’s influence on emotions and the liberating effects of live ideas on the human body’s natural energies. As Capps shows, James makes use of the popular spiritual hygiene thinking of his time to support his arguments. In his first, he draws on the ideas of Hannah Whitall Smith’s views on disregarding “negative” emotions and on Annie Playson Call’s writings, specifically her ideas about relaxation. In the second, he draws on ideas by a Horace Fletcher, especially with respect to anger and worry. Capps discusses the key ideas in the two lectures: the role of imitation in changing unhealthy physiological habits and the energy-releasing role of suggestive ideas. Though the title may strike you as being of naught but historical significance, you may find that this article has strangely important lessons for pastoral care and for one’s own life today.

**Carl Elliott.** “The drug pushers,” *The Atlantic Monthly* (Apr 2006): 2-13. ● In 2004, Elliott, who teaches at the Center for Bioethics at the University of Minnesota, published a paper on the efforts of the pharmaceutical industry to influence the medical world concerning the use and effectiveness of specific drugs. He documented in *The Hastings Center Report* the use of ghostwriters, the placement of journal articles over the names of prominent physicians (for a fee) and the general use of inducements to influence the prescribing patterns of physicians. In this article, he presents more evidence showing how the pharmaceutical drug industry supports the spiraling drug costs in American society. Although this article is now a little dated, the information it contains is still relevant as recent discussions with fourth-year medical students made very clear. If you wish to talk to someone from the pharmaceutical industry in your hospital or facility, look for someone who is young and immaculately dressed. However, you will need to look quickly because the new drug reps are becoming the doctors themselves. This is a disturbing paper.

**George Fitchett, Kenneth Rasinski, Wendy Cadge, Farr A. Curlin.** “Physicians’ experience and satisfaction with chaplains: a national survey,” *Archives of Internal Medicine* 169, no. 19 (26 Oct 2009): 1808-10. ● Chaplains have just received a clear nod of approval from doctors in the United States. This comes from a study that uses data collected in 2004 from over 1,100 medical doctors representing all specialties. How the initial data were gathered is described in a paper cited in this article. While the doctors responding were mostly male (74 percent), they practiced across a variety of settings. The authors chose to concentrate their study on the relationship between the physicians’ practice location, their religious/spiritual (R/S) views and their experiences with chaplains. Concerning their interactions with chaplains, 89 percent of the physicians reported experience with chaplains, and 90 percent of these said they were satisfied or very satisfied. On the other hand, physicians from the northeast, and those who noted more negative effects of R/S on patients, were less likely to be satisfied with chaplains.

**Tom Gordon.** “Reflections on aspects of health, wholeness, suffering and healing,” *Scottish Journal of Health Care Chaplaincy* 12, no. 2 (2009): 60-62. ● In 2008, the Church of Scotland established a working group to examine issues of health and healing within the context of that Church’s ministry and mission. This paper, written by a recently retired hospice chaplain in
Scotland and a leading figure in chaplaincy in that country, is his contribution to that discussion. Writing from a hospice context, he makes ten declarative statements that individually may be understood as "strands" in his thinking. Together they form the basis for wise discussion on subjects about which there is still polarization among people of religious faith, such as the following: illness, suffering, pain and death are not a consequence of sin; God wills us to be whole—he does not will us to be cured; expectations of physical healing may cause more harm than good; there is an arbitrariness to God’s love and intervention.

**Donald E. Healy Jr.** "Rediscovering the mysteria: sacramental stories from persons with disabilities, their families and their faith communities," *Journal of Religion, Disability and Health* 13, no. 3/4 (Jul-Dec 2009): 194-235. • When Healy requested stories about the communion experience from the disability community, he received an outpouring of letters and stories about all of the seven sacraments of his church. One common theme was an appreciation of the experience: the presence of persons with disabilities receiving or administering them, which resulted in transcendent insights and emotions that "passed all understanding." Healy is not interested in simply retelling moving stories. He wishes to explore the possible activating mechanisms that underlie the levels of insight shared by the storytellers. He begins with his own literature review concerning sacraments and disability, which is not limited to theological writings. Then he uses a synthesis of Corbon’s construct of the synergy of worship as well as David and Rebecca Nye’s relational consciousness theory to prepare the reader to attend to some of the stories he has received. In the final section of his essay, Healy reproduces some of the stories he has been sent, using them as exemplar stories across each of the seven sacraments.

**David U. Himmelstein, Deborah Thorne, Elizabeth Warren, Steffie Woolhandler.** "Medical bankruptcy in the United States, 2007: Results of a national study," *American Journal of Medicine* 122, no. 8 (Aug 2009): 741-46. • This study examines the impact of health care costs on personal bankruptcies. The authors surveyed 2,314 persons who declared bankruptcy in 2007, interviewing just over 1,000. The findings: In 2007, just over 62 percent of personal bankruptcies in the United States were caused by health care expenses, and this figure continues to climb. In contrast, in 1981, it was 8 percent. In an accompanying editorial, James Dalen asks, "Why is the United States, one of the richest countries in the world, the only major industrial nation that is unable to provide access to health care for all its citizens?"

**Julie M. Jones.** "How one system defines quality," *Health Progress* 90, no. 3 (May/Jun 2009): 39-43. • Since 2006, the chaplains in the Sisters of Mercy Health System have been tracking how they spend their time and discussing the implications. The results led to questions and decisions about priorities and patient care and, subsequently, to more questions about patterns of practice and to the measurement of quality of care. Jones, who is director of mission and spirituality for the system, lists the primary questions that have been discussed, following a natural process of inquiry as chaplains talked about activities in their individual institutions and then across the system. The questioning began with the following: What is the measure of quality for pastoral services departments? Pastoral care directors discovered that a variety of different methods had been used to try and find an answer. This led to question two: What services do chaplains provide? They started with the work of Dean Marek and the chaplains at the Mayo Clinic. (See Vision, July 2005.) This eventually led to question three: How long does it take to deliver these services? This involved the tedious, but necessary, work of tracking each chaplain’s activities over an extended period, which raised some concerns on their part. However, there proved to be three benefits from this phase: chaplains had a common language to describe what they did; they became aware of how they were using their time; and a foundation was set for great system-wide collaboration. This information prompted the fourth question: What do the differences between departments tell us? Jones describes a variety of valuable knowledge gained here, not the least of which was having the information needed to obtain funding for a new chaplaincy service when one hospital opened a new service. Finally, they asked the following: What are the current priorities? What should be the current priorities? From the start, some of the chaplains had feared that this process was simply a way for their institutions’ administrations to force them to do what they, the administrators,
wanted the chaplains to do. The chaplain directors had been firm is assuring their staff that the process was being driven from within chaplaincy, and that they would be the decision makers with respect to change. As Jones indicates, new goals emerged from discussions of priorities. As each department—and each institution—was different, each had to establish unique goals—and they did. This is a brief paper that has insights for chaplains who have not made thinking about standards of care a priority and reflects the type of accountability questions administrators are asking.

Neziha Karabulut, Behice Erci. “Sexual desire and satisfaction in sexual life affecting factors in breast cancer survivors after mastectomy,” Journal of Psychosocial Oncology 27, no. 3 (Jul-Sept 2009): 332-43. • This study reports the impact of treatment, personality characteristics and support needs around femininity and body image issues in women with breast cancer. The group of women studied (n=123, married) had undergone mastectomies and were being followed in the oncology clinics of a university hospital. Results showed that the sexual desire of the women was low and that they were only “slightly satisfied” with their sexual lives. As a result, they needed support around femininity and body image issues. The authors state that their findings are important because most of the staff working with this population seem to find it easier to focus on management of treatment side effects rather than to address issues related to sexual behavior. This study and other research show that issues of survival are not more important than issues of sexuality.

Jen Lumsdaine, Anne Mulligan. “Live donor kidney transplantation and the place of chaplaincy in the donor advocacy team,” Scottish Journal of Healthcare Chaplaincy 12, no. 2 (2009): 11-15. • This article is essentially two essays about live donor kidney transplantation. Lumsdaine writes from the perspective of the transplant coordinator. She outlines a process of assessing the physical aspects of a live donor, e.g., immuno-compatability, general health, renal function, and some of the ethical issues that also need to be considered. Mulligan, a chaplain, has been appointed one of four persons who together comprise the donor advocacy team (DAT) for the Scottish Liver Transplant Unit. She describes her role on this team as being responsible for evaluating a person’s medical, psychosocial and social stability as well as general suitability to be a donor. DAT follows a model created in the United States after the suicide of a live donor in New York in 2002. This team works independently of the transplant team and all four members must agree before a person is accepted for organ donation.

Robert Mundle. “Religious pluralism and the hospital chaplain,” Scottish Journal of Healthcare Chaplaincy 12, no. 2 (2009): 16-20. • How can a chaplain possibly serve and be spiritually available to persons of other religious traditions while remaining grounded in and faithful to his/her own religious tradition? This is the central question of Mundle’s essay. A chaplain in the Toronto Rehabilitation Institute in Canada and himself a married Roman Catholic priest, he grows his thinking out of the work of Raimon Panikkar, a contemporary Catholic theologian who is the son of a Catholic Catalan mother and a Hindu Indian father. Mundle describes how Pannikar’s dialogical approach to religious pluralism provides a useful methodology for chaplains to use in thinking about their own ministries. To illustrate, he describes sacramental ministry from the perspective of a Roman Catholic chaplain toward a Hindu patient. With respect to the offering of prayers to persons of other-than-one’s-own tradition, Mundle, after Pannikar, emphasizes “embodied alterity,” i.e. embodied otherness, pointing out that chaplains already know the experience of alterity/otherness. This is because of their peculiar position in the modern health care team: they are at once members of the team and yet not members of the team. Mundle writes: “By training and temperament, hospital chaplains embodied as “intimate strangers” in the strange land of health care are indeed able to tolerate and sustain the live creative tension of incommensurable religious beliefs in both interpersonal and intrapersonal relationships. Thus they offer a vibrant model of Panikkar’s dialogical approach in action. From their direct experiences of ‘spiritual availability’ and ‘communion’ with a great variety of ‘others,’ including even themselves, chaplains stand to broaden understandings of sacramental ministry and prayer that no longer can be contained or explained within isolated traditions.” (p. 19)
The Organization for Economic Cooperation and Development. “OECD at a glance 2009: Key findings for the US” http://www.oecd.org (Accessed 4 Jan 2009) 2p • This site provides highlights from a larger report released at the end of last year by the Organization for Economic Cooperation and Development (OECD), with data from 2007. It contains the following facts: People in the United States may expect to live a shorter life than people in half of the thirty countries in the OECD. On average, they will live just slightly longer than people in Poland, the Czech Republic and Mexico. In 2007, persons in the US spent an average of $7,290 on health care, almost 2½ times the OECD average of $2,984, to reach an average of 79.1 years. The US far outspent Norway and Switzerland but life expectancies there were two and four years longer respectively. At 6.7 deaths/1,000 births, the US infant mortality rate was worse than the OECD average of 3.9/1,000. Only Mexico and Turkey had higher infant mortality rates, and Luxembourg had the lowest (1.8/1,000). The report notes that factors beyond the quality of the system and the amount of money for the system affect these figures; income inequality, individual lifestyles and attitudes all affect infant mortality. In addition, the US spent an average of $878 per person per year on prescribed medications, while the OECD average was $461. The public sector is the main source of health funding in all OECD countries, with the exception of the US and Mexico. In 2007, 45 percent of US health spending was funded by public sources, significantly lower than the OECD average of 73 percent.

Katherine M. Piderman, Mary E. Johnson. “Hospital chaplains’ involvement in a randomized controlled multidisciplinary trial: Implications for spiritual care and research,” Journal of Pastoral Care & Counseling 63, no. 3/4 (2009): 6p. Piderman is a psychologist and the coordinator of research for the Department of Chaplain Services at the Mayo Clinic College of Medicine and Johnson serves as chaplain and the coordinator of education in the same department. Based on their own experiences, they describe how a chaplain’s involvement in spirituality and health research may bring vital and unique contributions and also may result in valuable professional growth and increased effectiveness. They focus on a particular project that involved patients with a life expectancy of less than five years who were receiving radiation therapy for their cancer. They describe what they learned through this research that has been important in providing pastoral care to such patients.

Claire Tuck. “Assessment and documentation of religion and spirituality in the Liverpool Care Pathway for the dying patient—how well is it done?,“ Scottish Journal of Healthcare Chaplaincy 12, no. 1 (2009): 52-59. • The Liverpool Care Pathway for the Dying (LCP) was created in the late 1990s by the palliative care teams in two hospitals and a hospice, located in the general Liverpool area of England. LCP lists the specific interventions that are to be made with all patients and their families, and which are to be documented in ways that will allow subsequent retrieval of the data to confirm whether the standard of care has been met. This paper reports on a study to learn whether or not Goal 6 of LCP, which deals with religion and spirituality, was being met. Results clearly demonstrate that compliance with an 80 percent standard of care, set before the data were gathered, was not met. Although 50 percent of patients and 74 percent of their relatives had their tradition/spiritual needs identified, it is unclear what happened with that information as only 42 percent were offered chaplaincy support. The author reports that hospice staff were “not necessarily comfortable discussing religion/spirituality, especially at the first patient meeting,” something the survey results make abundantly clear. The results were the basis for Tuck’s nine specific suggestions for improvement to this system, which is the point of having a pathway in the first place.

Laraine Winter, Marie P. Dennis, Barbara Parker. “Preferences for life-prolonging medical treatments and deference to the will of God,” Journal of Religion and Health 48, no. 4 (Dec 2009): 418-30. • How does personal belief in the “will of God” play a part in the thinking of persons who must decide whether to continue life-prolonging medical treatment? Contradictory relationships between preferences for treatment and commitment to such a belief are conceivable. If life-prolonging interventions are perceived as artificial and unnatural, acceptance of them may be seen as opposition to God’s will. Highly religious persons also may be less willing to accept a
treatment because of a stronger belief in the power of direct divine intervention or because of a diminished fear of death. On the other hand, refusal of life-treatments may be seen as a decision to end life, which some regard as God’s prerogative. In the latter situation, greater religiosity would indicate a stronger preference for life-prolonging medical intervention. In this study, the authors defined and measured a dimension of religiosity that chaplains hear families speak about in end-of-life situations—deference to God’s will (GW)—and examined its relationship to preferences for life-prolonging treatments. This involved 35-minute phone interviews with 304 older men and women, who were given the 5-item GW scale the authors had created. In addition to some personal data, participants were queried on three attitude items concerning length of life followed by measures of two health indices, depression and life-prolonging treatment preferences. The overall results showed that deference to GW was associated with stronger preferences for life-prolonging treatments in poor-prognosis scenarios. The situation in which the decision was being made is important as the results did not hold up when there was a chance for the person’s recovery. This is a paper that increases understanding about the use of religious faith. Rather than merely inquiring as to whether the person was religious—or to what extent—this work specifically defined “religious” in the context of GW.