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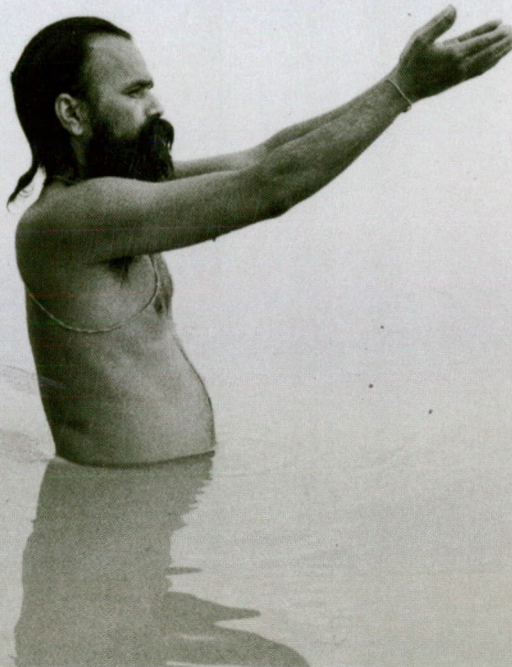
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Publisher	Laurence J. O'Connell
Editor	Martin E. Marty
Senior Editor	David B. McCurdy
Managing Editor	Therese Samodral
Production Editor	Ben McDonald Coltvet
Associate Editor	Kirston Fortune
Design	Haru Furuya
Editorial Committee	Philip J. Boyle Edwin R. DuBose Martha B. Holstein

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Contributing Editors Azizah Al-Hibri
Catherine L. Albanese
Darrel Amundsen
Mary Farrell Bednarowski
Kay Bessler Northcutt
Charles Bouchard
Don S. Browning
Lisa Sowle Cahill
Sidney Callahan
Courtney S. Campbell
Ronald A. Carson
Tod S. Chambers
James F. Childress
Thomas R. Cole
Bart J. Collopy
Dena S. Davis
Elliot N. Dorff
Marsha Fowler
Arthur W. Frank
Ronald M. Green
Christine E. Gudorf
Cathleen Kaveny
Arthur F. Kohrman
John D. Lantos
Karen A. Lebacqz
Lisa Lehmann
William F. May
Dennis McCann
Karen McCarthy-Brown
Mary Ann McDermott
Gilbert Meilaender
Bonnie Miller-McLemore
Kathryn Montgomery
David Novak
Ronald Numbers
Greg A. Sachs
Mary M. Solberg
Lawrence Sullivan
Daniel P. Sulmasy
Emilie M. Townes
Karma Lekshe Tsomo
Peter J. Whitehouse
Quentin Young
Laurie Zoloth

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CONTRIBUTORS

Mary Farrell Bednarowski, Ph.D., is Professor of Religious Studies at United Theological Seminary of the Twin Cities. She has a longtime interest in alternative American religions and spiritualities.

Avis Clendenen, D.Min., Ph.D., is an Associate Professor of Religious Studies at St. Xavier University in Chicago. She is a pastoral theologian who explores the spiritual roots and routes of human maturation in its terrifying wonder.

Edwin R. DuBose, Ph.D., is a Research Associate at the Park Ridge Center for the Study of Health, Faith, and Ethics, and Principal Investigator of the "Spiritual Care at the End of Life" project.

Arthur W. Frank, Ph.D., is the author of *The Wounded Storyteller: Body, Ethics, and Illness*, and is currently doing research on how serious illness can be a motivation to service. His first book, *At the Will of the Body*, will appear in a new edition in 2002.

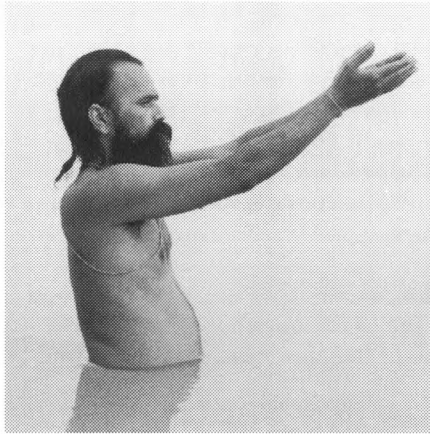
Charlene A. Galarneau, Ph.D., is a Lecturer of Community Health at Tufts University and Clinical Instructor at Tufts University School of Medicine. She is a member of the New England Medical Center Ethics Committee.

Anne Harrington, Ph.D., is Professor for the History of Science at Harvard University and Codirector of the Harvard University Interfaculty Mind, Brain, and Behavior Initiative. She is the author of *Medicine, Mind and the Double Brain* and *Reenchanted Science* and edited *The Placebo Effect*.

Mieke Holkeboer, M.Div., is a former Research Associate for the Park Ridge Center and is presently completing her doctorate in theology at the University of Chicago, writing a dissertation that takes a hermeneutical approach to human rights.

Cynthia D. Moe-Lobeda, M.S.W., Ph.D., is Adjunct Professor of Christian Ethics at the School of Theology and Ministry, Seattle University, and at Fuller Theological Seminary's Northwest Extension. Her forthcoming book is *Healing a Broken World: Globalization and God*.

Patricia Murphy, Ph.D., is a Religious of the Sacred Heart and Assistant Professor doing research in religion and health at Rush-Presbyterian-St. Luke's Medical Center in Chicago, Ill. She offers pastoral care on the adult psychiatric units at Rush.



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*Hindu man praying in the Ganges at
Varanasi, India.*

EDITOR'S NOTE

BY MARTIN E. MARTY

“The end of life” may mean many things, but it means at least two. This issue is devoted to a comprehensive and helpful address to care in the last days when people are terminally ill, and have heard from physicians that the end is near.

That meaning of “the end of life” is not completely disconnected from everyday concern about an end. It is possible to approach this meaning with a measure of good humor. We postpone confrontations with the final reality with lines like these:

Life is a sexually transmitted disease
with a terminal prognosis.

Blind pianist George Shearing was once asked, “Have you been blind all your life?” He answered: “Not yet.”

Schopenhauer says that we spend the first half of our lives living in such a way that, in effect, we are “writing the script”; then, during the second half of our lives we are interpreting it.

The problem, both the wags and serious calculators say, is this:

How do we know where the turn from “writing” to “interpretation” should come along? For some, it may be at age

eighteen, but the owner of that life will not know that until death is at hand at thirty-six; the forty-five-year-old cannot know she should start interpreting for a countdown that will end at ninety.

Get serious. Which is what we do at the real, imminent, “known” end of life. Yet even there, some people of profound spiritual outlook, moored in a faith tradition, surrounded by family and friends and chaplains who care, can afford a touch of levity, or can provide it.

Thus we hear of an aged mother of four past-middle-age daughters, who were visiting her at the end. The pastor led them in prayers and left the room. The girls kissed their mother, held hands, formed a figurative protective tent of arms over her, and looked down with eyes filled with tears—and love. So her moment for a last word came: “Too much lipstick!”

Anthologies of “Famous Last Words” include corollaries to that kind of talk by people who are conscious that they are engaging in it. Hugo Rahner has written of a certain personality type, God’s “grave-merry” person. He or she has taken the measure of the cramping borders of life and, aware of finitude, including imminent death, can

still affirm, can utter or signal the “Yes” gracefully, grace-fully.

Even where there have been chuckles and affirmations, however, the end of life represents the greatest challenge of life. One faces what Karl Rahner, Hugo’s brother, called “the abyss of mystery.” Some who indulge in extreme sports may have “daredeviled” with the risk of death. But when they confront not an abyss between the glaciers they are traversing or the canyon below where they are rock-climbing, but the chasm beyond their last mortal breath, they merit an utterly serious form of care.

My wife and I once flew to China next to an emergency room nurse anesthetist who had retired after thirty-six years in a major city hospital. One of her tales had to do with a Saturday night. The squads brought in a gravely wounded gang leader who had been stabbed repeatedly by rivals. The surgeons wanted to have a try at saving him. He “smarted off” to the nurse as she came near him, even as his breath was waning.

She took a chance: “In a way, the power of life and death in respect to you is in my and the surgeons’ hands. Don’t you think we’ve had enough posing? It’s time to get serious.” He became quiet,

and then mumbled, “Do you know the one about the ‘green pastures’?” He entered surgery with Psalm 23 in his ears and mind.

What she said and did is a lead-in to “A Special Report,” which follows. Edwin R. DuBose and his colleagues have brought together resources for dealing with the late stages of care in hospices, hospitals, special care units, or homes. What I take from the discourse on spirituality is that caregivers have to be expert and empathic listeners before anything else. They cannot be walking encyclopedias of religion or anthologists of “Great Spiritual Quotations.” They have no right to intrude on the delicate and frail consciousness of the dying. That means that they cannot come parachuting into the sphere where ministry and caregiving occur with their own answers to life-questions.

Such questions have ordinarily been nurtured, whether casually, intensely, or even in remote pasts—the sort the gang leader must have known in a Sunday School of his youth; and this means that more often than not they have been cultivated in some sort of religious community: a synagogue, a church, around a youth-group campfire, in classes. Some others, however, are spiritual in the do-it-yourself sense,

sojourners who have not known such community. Among them are those who may bring resources richer than those cultivated in indifferent and casual religious communities. In every case, they need and deserve the most attentive care. And that care begins with listening.

At the end of Leoš Janáček’s opera *The Makropulos Affair*, the heroine, a most beautiful woman and beautiful singer, “has to die.” She is 337 years old, an age reached because she drank an elixir whose formula has now been lost. Everything has happened to her. She is vain, corrupt, bored, and she is indifferent as to whether she lives or dies: it’s all the same to her. Then she turns to the others on stage and says that they are “fortunate mortals.” Fortunate, because, she sings, “you get to die. Therefore you can celebrate humanity, achievement, and love.”

At the end of life those who are involved with spiritual care, as givers and receivers, are celebrating humanity, achievement, and love. This special report elaborates. ■

A SPECIAL REPORT: SPIRITUAL CARE AT THE END OF LIFE

BY EDWIN R. DuBOSE

Challenges for Hospital, Hospice, and Congregational Clergy

Collaborating with hospitals, hospices, and congregations in the Chicago area, the Park Ridge Center for the Study of Health, Faith, and Ethics conducted a two-year qualitative research study to better understand spiritual care at the end of life and the clergy's role in meeting the spiritual needs of the dying.

Based on the study, this article reflects on the meaning of spiritual care at the end of life from the perspectives of religious leaders and the people whom they serve. It explores how members of

the clergy can work with each other and others to improve end-of-life care by defining spirituality, religion, and spiritual care in the context of end-of-life care. The article also helps caregivers identify and respond to the spiritual concerns of a person facing the end of life. It explores ways to create an environment where the dying patient's spiritual orientation can flourish. Finally, the article helps clergy and other caregivers reflect on their sense of spirituality, especially as it relates to end-of-life care.

To give voice to the people involved in the study, in this article we include the words of hospital and hospice patients as well as congregational members facing life-threatening illness. Clergy voices are captured, too, as are scenarios from the observational notes. As records of the thoughts, feelings, and experiences of patients wrestling with life-threatening illness and of their clergy caregivers, our hope is that these words will illustrate the challenges and possibilities involved in spiritual care at the end of life.

METHODOLOGY

To better understand spiritual care at the end of life and the clergy's role in providing it, the Park Ridge Center's qualitative research project incorporated

participant observation and semistructured interviews. The Center placed observers in three settings—a hospital, a hospice, and three congregations—to better understand the formal and informal interactions involved in identifying a desire for, and providing, end-of-life spiritual care. Field researchers examined clergy's understanding of spiritual care and how they cared for people facing life-threatening illness. Researchers also observed operational elements of these three types of organizations—their administrative rules, the informal practices associated with organizational culture, and ways staff interacted with clergy around end-of-life care.

Researchers conducted semistructured interviews with eighteen

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people facing life-threatening illness, exploring their understanding of spirituality and their spiritual needs as they faced their illness. In addition, researchers interviewed in depth fourteen hospital, hospice, and congregational clergy to learn their views on spiritual care at the end of life.

Results of the observations and interviews—including strategies formulated to help meet the spiritual needs of the dying—were presented for discussion to more than 200 clergy at workshops and focus groups. Their feedback validated the categories, interpretations, and conclusions.

SELECTION CRITERIA

During the field observations at each site, researchers identified potential patient and clergy interviewees. Additionally, in the congregations, clergy announced the project and requested volunteers for interviews. The sampling goal for the project was to interview nine clergy from the various care settings: six hospital and hospice chaplains and three congregational clergy. The researchers hoped for nine patient interviews from each of the care settings, for a total of twenty-seven. The study did not involve random sampling, but there was no effort to fill particular

categories, such as age, race, gender, religious or non-religious affiliation.

END OF LIFE DEFINITION

The most difficult and poorly handled issue in end-of-life research is the inconsistency and confusion about conceptual and operational definitions of “end of life,” “dying,” and “terminal illness.” Reviewing more than 400 research articles on end-of-life care, Linda George found a wide variety of operational definitions.¹ Some investigators categorized individuals as dying, facing the end of life, or terminally ill based on diagnosis alone. Other investigators used varying combinations of diagnosis, symptom expression, and functional capacity. Most frequently, investigators relied on physicians’ prognoses about life expectancy; this is especially true in randomized controlled trials, despite empirical evidence that physician prognosis is highly inaccurate.² Some studies relied on the prognostic assessments of the patients or their family members to define whether the patient was dying. In other studies, the healthcare setting defined who is dying—a significant number of studies used receipt of hospice care, palliative care, or even being in the intensive care unit as a definition of dying. Finally, in a large proportion of studies, no definition of dying

The most poorly handled issue in end-of-life care is inconsistent definitions.

or terminal illness was offered or could be discerned implicitly.

George also found a variety of conceptual models of the dying process to match these operational definitions. Among these theoretical frameworks are stage theories of dying,³ dying trajectory theories,⁴ task-based theories of dying,⁵ and Copp's readiness to die theory.⁶

The failure to develop congruent conceptual and operational definitions—or sets of definitions—of dying, end of life, or terminal illness has important methodological implications for empirical research on the end of life. It is difficult, for example, to compare findings across studies with accuracy or confidence, and to apply research to practice or policy.

In the Park Ridge Center study, investigators defined approaching end of life as having eighteen months or less to live. This determination was based on: diagnosis of a life-threatening illness, for example, stage four cancers or congestive heart failure; physician prognosis; health-care setting, for example, intensive care unit, cancer unit, or hospice; and patients'

own prognostic assessments. The patients interviewed were on a trajectory of eighteen months from diagnosis and treatment for a life-threatening illness to a prognosis of six months or less to live. End-of-life care was held to be the physical, social, emotional, or spiritual care that these patients received along this trajectory. The study focused on spiritual care. The researchers hypothesized that patients' spiritual concerns and the nature of spiritual care might vary across this end-of-life trajectory.

Unlike quantitative research, qualitative research like ours is not subject to George's concerns. We do not generalize the findings, interpretations, and recommendations to all hospital, hospice, and congregational clergy, or to all patients facing the end of life. We do not claim that our results are quantifiable; we would not compare our findings with other studies or offer them as empirical evidence for policy or practice changes. We believe, however, that these perceptions, stories, and words will resonate and be helpful as the reader reflects on the nature of spiritual care and support for people facing life-threatening illness.

INTRODUCTION

Throughout the history of religion, the clergy have found their vocation in

sustaining vital power among people bombarded by morbid and mortal forces. Most religions share a belief that life and breath are a divine gift. To be truly alive, the spirit must be animated. As representatives of faith communities, the clergy seek to imbue existence with a sense of verve by instilling meaning and value to experience across the life cycle. Yet, like medicine, religion is a field surrounded by death. Eventually everyone slides into death, the end of the human organism. Death, too, through its finality, threatens the end of human personality and forces us to grapple with the dread limits of our mortality.⁷ Religiously or spiritually charged figures have always played a key role as caregivers at the limits of life, supporting individuals' search for spiritual wholeness and meaning in the face of death.

Although clergy are associated with the care of people facing the end of life, whether in healthcare or congregational settings, studies in recent years show that many people in the United States are reluctant to turn to clergy for support during their dying. Explanations for this reluctance include social dislocation, the secularization of society, an ethos of individualism, and changing patterns of religious and spiritual expression. For many others, however, clergy remain culturally

Many people are reluctant
to turn to clergy
for support during
their dying.

powerful figures in the transition from life to death. Given the current cultural conversation about end-of-life care in America—with spiritual caregiving as a component—it is timely to review the role of the clergy in supporting dying people.

For hospital, hospice, and congregational clergy to be more responsive to dying people's spiritual needs, clearer understanding in three broad areas must be gained.

First, what constitutes spiritual support at the end of life? Second, what are dying people's spiritual needs? What do dying patients want from spiritual caregivers? What spiritual needs remain unmet by clergy and faith communities? Third, what challenges, barriers, or obstacles do the clergy face in meeting these spiritual needs?

BACKGROUND

When I entered the hospice program, a chaplain was offered to me. At first, I said, "No." I decided later to ask for a

chaplain, in order to have someone to
say prayers by my graveside after I die.

—a patient

People with life-threatening or terminal illness face a world turned upside down. If hospitalized, they suffer from anxiety, dislocation from familiar routines, and separation from family and friends. If able to live at home, they must deal with their physical condition and the social and emotional consequences of a deteriorating existence. Even with the optimal six months of hospice enrollment and all the support that hospice offers, people must still struggle with the pain and suffering that accompanies their dying.

Those who face death reach for medical and spiritual resources, among others, to make sense of what is happening to them. Healthcare organizations and providers, therefore, attend to both medical and spiritual needs. Spiritual and physical health have always been closely connected. In the past, responsibility for both spiritual and physical health rested in the same individual; clergy were often doctors, for example. Faith communities founded and sponsored medical endeavors, and nursing was perceived as a religious calling.

As health care developed, however, labor sharply divided, and by the begin-

ning of the last century, medicine and religion had clear boundaries and differing professional approaches. Physicians and nurses diagnosed and treated physical and mental disease. Clergy and pastoral caregivers attended to the soul.

Despite the contemporary chaplain's important role in caring for patients' spiritual needs, we cannot simply hand off spiritual issues at the end of life to chaplaincy services. Many people facing end-of-life issues, for example, are not hospitalized when their spiritual needs can best be met. Congregational clergy may be in a better position to support such individuals. Yet, as the result of specialization within clergy ranks, the rise of professional healthcare chaplains has modified traditional clergy involvement with the dying. Congregational clergy now concentrate on nurturing the religious and spiritual lives of their communities. As a result, these clergy are ill prepared to support the terminally ill through dying and death, according to a recent assessment by the American Medical Association.⁸

The gradual separation of medicine and religion reflects a shift in the way death is approached in our culture. Religious resources, through pastoral care services, are available to those dying patients and their families who request

The myth is that everyone will have a long, healthy life, and then die suddenly.

them. However, the ability of modern medicine to stave off death through aggressive medical intervention is truly impressive. In his book, *The Hour of Our Death*, Philippe Ariès proposed that the modern effort to bring “wild” death into the controlled environment of the hospital represents the effort to domesticate it.⁹ Medicine has succeeded at least in confining death to particular institutions: about 80 percent of Americans die in a hospital or long-term care facility. Ariès argued, however, that our fears and anxieties about death and dying seep through any levees we build to contain them. For example, while many people facing life-threatening illness seek aggressive medical care, they still fear losing control of their lives—and their deaths—to the medical machine.

THE MODERN AMERICAN ORGANIZATION OF DEATH

Health care in the United States is based on the myth that everyone will

have a long and healthy life, and then die suddenly. Today, however, most deaths—typically from cancer, congestive heart failure, or chronic obstructive lung disease—are long and slow, a process that the average person finds frightening. At the turn of the century, most Americans died at home, surrounded by their family and friends. There were rituals, traditions, and communities to support the dying person and family. By the 1950s, although more and more people were going to hospitals to try to get well, or to spend their final days, more than 50 percent of deaths still occurred at home. By the 1970s, however, a hospital room was where nearly all Americans died—one’s last glance took in ventilating machines, the ICU, or a dangling IV bag.

There is growing awareness that the prevailing model of death is one of medical and therapeutic management. Such aggressive care can raise healthcare costs and prolong human suffering. We pour as much as 80 percent of medical dollars into the last two years of life, and we all know stories of people who endured a mechanically supported, painful, and prolonged process of dying. Many people feel that something is not right with this model of dying in America.

For the past twenty-five years, those striving to reform the way medicine cares

for the dying have stressed legal and ethical issues, including questions of terminating treatment, euthanasia, and assisted suicide. Patient autonomy is the overriding concern as we try to manage death medically. Every state has now enacted legislation on advance directives, and a growing body of judicial opinion focuses on associated issues. Reformers have also focused on improving communication between patient and physician to combat seeming professional bias and insensitivity, promoting advance care planning, and defending the patient's right to refuse treatment. Unfortunately, there is little evidence that these efforts have succeeded.

In 1995 the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) was published. This four-year study collected data on thousands of very ill hospital patients and identified problems with the care they received in terms of pain management, use of advance directives, and do-not-resuscitate (DNR) orders. Investigators tried to rectify those problems by giving patients and families a bigger say in their care. To the disappointment of the investigators, none of the interventions seemed to make a difference.

More than 50 percent of the study's patients were reported to be in substan-

Many patients never
give up hope of recovery
until the very end,
if at all.

tial pain during their last days. Most of the patients who died spent their last days in the ICU on a ventilator, unable to communicate with family or friends. Clinicians paid little attention to advance directives; a DNR order typically was written only a few days before a patient's death. Patients and families often seemed adrift and confused about the illness and care appropriate for it.¹⁰

Patients, families, and physicians still seem terribly reluctant to raise the subject of death. Many patients never give up hope of recovery until the very end, if at all. We have focused too much on patient-caregiver relationships and legislative reform to ensure patient autonomy in decision making. Death is just too overwhelming for any boundaries or controls that we try to place over it. Perhaps we need to take a new look at the spiritual resources the dying draw upon when facing the physical, emotional, and social pain and suffering that accompanies a life-threatening illness.

A WAKEUP CALL TO THE CLERGY

The 1997 Gallup survey *Spiritual Beliefs and the Dying Process* reinforced claims that American medicine often fails to provide what dying patients seem to want most, including death at home among close family and friends, recognition of and support for the deeper spiritual and meaning dimensions of dying and death, and assurance that their families will not be overburdened with their care or neglected in their loss. Not many respondents—only 36 percent—believe that the clergy would be “especially helpful” at the time of death, compared with 81 percent who cited family and 61 percent who cited friends.¹¹ Gallup described the findings as “a wakeup call to the clergy,” suggesting that the clergy must reconsider ways to meet people’s spiritual needs at the end of life.

Ironically, these findings come during a boom time for research on the potential effects of religion and spirituality in treatment interventions and outcomes, including the effects of spirituality on end-of-life care. Fueling interest in spiritual care at the end of life have been the palliative care movement—with its stress on physical, emotional, social, and spiritual support during dying—and the Joint Commission on Accreditation of Healthcare Organi-

The effort in health care
to disassociate the spiritual
from religion produces
the lowest common
denominator.

zations’ standards on a patient’s right to spiritual care.

But if spirituality is understood in this way, as a health benefit, there is the danger that spirituality will become one more instrumentality applied in an attempt to cure what ails the patient. Recent attention to spiritual care for dying patients in acute-care and hospice settings reveals a particular concept of secularized spirituality.¹² The effort in health care to disassociate the spiritual dimension from religion produces a lowest common denominator, replacing the traditional notion of spirituality—the human being in relation to the transcendent—with a personal and psychological search for meaning. In this way, the recent interest in spiritual care at the end of life may in fact represent the effort to domesticate spirit. Does not the spiritual life need to be pursued in terms of its own goals—a deeper relationship

with the transcendent—and not as a technique to produce beneficial effects?

If attention to spiritual care reflects an effort to manage the spiritual and emotional needs of the terminally ill, it is misplaced. Gabriel Marcel pointed out thirty-odd years ago that there is a distinction between problem and mystery.¹³ Problems are solved by use of techniques; mysteries admit no solution. Problems require a distance between the subject, the one with the technique, and the object, the puzzle to be solved. Healthcare practitioners see a person's illness as a series of problems to be overcome; they are masters of technique, so much so that the mystery of life is often unappreciated. Attention to the spiritual aspect of our nature puts us in touch with the mystery of which Marcel writes, and may better prepare us for death.

The Gallup poll did not probe deeply into the issues of spirituality and spiritual care at the end of life. Unanswered are such questions as: What do people mean by spirituality or by spiritual care? What spiritual needs do people have as they approach the end of life? Do these needs vary as people move from participation in a faith community to being cared for in or by a healthcare institution such as a hospital or hospice? What do dying people perceive as per-

sonal, cultural, and institutional barriers to recognition of and support for the deeper spiritual and meaning dimensions of dying and death? Also, since we cannot understand other people's spiritual needs until we have some understanding of our own spiritual views, similar questions must be asked of clergy: What do clergy understand spirituality to mean? What is their understanding of spiritual care at the end of life? What spiritual needs do clergy have as they seek to recognize and support the spiritual concerns of dying people? What personal and institutional barriers do clergy perceive to this type of care? These questions provide a more substantial foundation on which hospital, hospice, and congregational clergy can respond to dying people's spiritual needs.

Further, the Gallup findings suggest that faith communities need to address more effectively the concerns that people have about what happens after death and about matters such as guilt and forgiveness. Because of their unique involvement with parishioners over the life cycle, congregational clergy offer a potential resource for improved spiritual end-of-life care. However, the particular issues these clergy face in providing such care are not well understood. What obstacles to end-of-life care do they confront within the communities they serve?

Can spiritual care be coordinated among hospice, hospital, and congregation?

How can they help parishioners to prepare earlier, in a more comprehensive fashion, for the challenges to be faced at the end of life? What resources do religious traditions offer their clergy as a basis for end-of-life spiritual support?

Chaplains working in healthcare institutions have more training specifically related to the spiritual care of people who are very ill or who are dying. They may feel accepted by the hospital staff as part of the healthcare team.¹⁴ At the same time, they often experience systemic and personal constraints.¹⁵ What institutional, systemic, or personal barriers exist to impede a fuller participation with patients in the spiritual dimension of dying? What spiritual resources do hospital chaplains of various faiths draw upon in their work with seriously ill and dying patients who have diverse notions of spirituality?

For hospice chaplains, too, there is a need to better understand the problems and possibilities of providing spiritual

care at the end of life. There is a concern that hospice care is becoming bureaucratized, a trend that would compromise the movement's founding ideals.¹⁶ As the original cadre of dedicated idealists leave, the hospice movement is increasingly staffed by managers and therapists, and the focus is shifting to management skills and the values of efficiency and effectiveness that mainstream health care demands. Under these conditions, does the original commitment of all hospice workers to spiritual support of dying patients change?¹⁷

What, then, after thirty years of the hospice movement, do contemporary hospice chaplains understand spiritual care to mean? How do they measure success in providing spiritual care? What obstacles do hospice chaplains encounter in maintaining the quality of spiritual care on which the movement is based? More pragmatically, if a hospice program accepts that earlier referral to hospice is unlikely and commits to deliver rapid hospice response to patients who are likely to die within a week of referral, what spiritual care services are likely to be effective? Are there ways for hospice chaplains to better coordinate spiritual caregiving with their hospital or congregation based colleagues to improve continuity of care?

Given a more in-depth investigation of what end-of-life spiritual care means to people, what spiritual support they want, and what prevents the clergy from offering that support, we can learn what appropriate, practical responses by clergy might be.

DEFINITION OF TERMS

I would say that spirituality is the larger term—the more umbrella term—in which religion or religiosity can be encompassed . . . There's an element of the unknown, of the mystery. Whether it's God or Higher Power or Nature or human psychology, there's an element of the mysterious, and there's a fulfillment in seeking that mystery or exploring that mystery. Now religion, for me, is more formal, doctrinal; with prayer, communion, ritual. There's an external expression and an accepted structure.

—*a chaplain*

Spirituality asks what is the most important thing for people in life. What is it that keeps them going? What is it that has provided the spark in life for them? When they can't come up with the answers themselves, to whom do they turn to try to make sense out of what's happening to them? Religion is . . . how we express that spirituality. It's

a group of like-minded people that choose to worship together, be together, to reach out to each other and to support each other when we need it.

—*a chaplain*

Those words don't mean much to me.

—*a patient*

In the West, the word “spirit” traces back to the scriptures of Israel. The spirit of God refers, literally, to the fiery blast of the desert wind, the in-spiriting breath of God. For Judaism, Christianity, Islam, and other religious traditions, an animating spirit gives people direction, unifies their experience in community, and transforms their lives.

Yet we live in a religiously pluralist society that also includes those who are profoundly skeptical of religious belief; others who, while sympathetic to religion in their private lives, fear it as a profoundly divisive force in our public lives; and others whose dogmatic beliefs provide little room for other opinions. This is true of healthcare professionals as well as patients. So what do we do with religion in health care? Generally, in the world of health care, as well as in our larger culture, religion is seen as a private matter.

Remarkably, over the past generation the word “spirituality,” which forty

years ago was largely a technical term within Roman Catholic circles, has become a word of such broad usage that it implies a common sense meaning that no one can quite define. If religion often seems to have taken on ambiguous connotations today—wholesome for many, suspect for others—spirituality is usually used in a more optimistic and positive way. To be a spiritual person—that is, to have a spirituality of one sort or another—is eminently a good thing, almost as unsailable as motherhood and apple pie.

Many people equate spirituality with religion; to them the spiritual seems to pertain to their worship life or their membership in a particular faith tradition. For them spirituality can be appropriately expressed and experienced only through a faith community. However, even though they are conceptually related, these words are not synonymous. In one sense, spirituality is the broader term. One's spirituality may be defined simply as the characteristics and qualities of one's relationship to the transcendent. One person may call the transcendent God. Another person may live in relationship with the transcendent and refuse to personalize it or call it God. Even an atheist has a spirituality, because an atheist searches for personal meaning and value in light of his or her rejection of a

Spirituality is a
sense of the transcendent
and the lens through
which we see the world.

transcendent source of meaning and value in life. In this way everyone may be said to have a spirituality.

By contrast, a religion is a specific set of beliefs about the transcendent, usually in association with a particular language used to describe spiritual experiences, and a community sharing key beliefs, as well as certain practices, texts, rituals, and teachings. Not everyone has a religion. We've all heard someone say, "Oh, I'm not religious, but I'm very spiritual."

SPIRITUALITY

I'm not overly religious, but I do believe in God.

Spirituality—I think that means your overall view of life; you know, is the glass half full or half empty. You're not just thinking about water; you can apply that scenario to everything in your life. If you stub your toe, you can say it hurts like crazy or you can think

I'm lucky I've got a foot. That's your philosophy. Spirituality means a positive overall view of life and knowing that God doesn't give you more than you can handle, ever.

Well, I'm not a churchgoer now, you know, but I was raised Catholic. That has no meaning for me any more, but I pray and I try to get out into nature as often as I can.

—three patients

St. Gregory of Nyssa, in the fourth century, wrote, “Spirituality is liberation from necessity.” Our lives are made up of habitual actions and things to which we have become accustomed. Routine helps us get through the day; we are creatures of habit. Factoring in spirituality changes the equation a bit. As humans, we do not necessarily move from stimulus to response—our spiritual nature liberates us. Still, just what is spirituality? What is it that liberates us?¹⁸

Healthcare chaplain George Fitchett defines spirituality as “the dimension in life that reflects the need to find meaning in existence and in which we respond to the sacred.”¹⁹ Gordon Wakefield, in *The Westminster Dictionary of Christian Spirituality*, writes that spirituality is “those attitudes, beliefs, practices which

animate people's lives and help them to reach out towards super-sensible realities.”²⁰ Both definitions describe a spiritual essence to the person that does not necessarily include God-talk or religion.

Based on our interviews with clergy and people facing life-threatening illness, we can describe spirituality in another way: Spirituality is the way in which a person understands and lives life in view of his or her ultimate meaning, beliefs, and values. It is the unifying and integrative aspect of the person's life. When lived intentionally, it is experienced as increasingly unifying and integrative, as a process of growth and maturity. “It integrates, unifies, and vivifies the whole of a person's life story, thereby interacting with the physical, psychological, and social.”²¹ Spirituality includes a sense of the transcendent and is the interpretive lens through which the person sees the world. It is the basis for community, for it is in spirituality that we experience our co-participation and the shared feeling or condition that is both our vulnerability and our liberation from necessity. Spirituality may or may not be expressed or experienced in religious categories.

SPIRITUAL CARE

Spiritual care is that support provided by individuals or communities

that acknowledges the spiritual nature of people's lives and sustains them as they struggle to deepen their understanding of their relationships with the transcendent and with other people.

SPIRITUAL NEEDS AT THE END OF LIFE

What do you worry about as you face your illness? Do you have any spiritual concerns at this time?

—question from patient interview

I want my family taken care of.

I wonder what dying will be like. Will it hurt? Will I know what's happening?

I want someone to care what's happening to me.

I believe I'll go to heaven. Sometimes I worry about that. I want to go on living; I'm not dead yet.

I feel guilty about things I've done.

I'm angry about some things that were done to me.

I don't want to suffer. I'm tired of feeling scared.

—patient responses to the questions

Patients in our study expressed several common spiritual needs. Among these were the needs to love and be loved for who they are; to experience forgiveness and extend it to others; and to find meaning and purpose in life and hope for the future. Consolidating these concerns, we identified five themes as spiritual needs. These five themes clearly overlap; we present them discretely for purposes of discussion.

RECOGNITION

The last couple of weeks, I did go out a couple of times to see what my friends are doing. I enjoyed being out but sometimes it's very difficult to see them so well. That old jealousy thing, you know. I'm happy they're well, but it doesn't seem fair. What about me?

—a patient

[I] said, "If you're sick, you've got a handicap. You don't have that kind of faith if you're sick." Then I said [again], "Sickness is a handicap." The minister got up and said, "Whose fault is that?" My questions stopped. Whose fault? I didn't say whose fault it was, I just said it's a handicap. I don't mean a physical handicap. I says, "Your faith, you lose your faith." I was losing faith.

—a congregant

The need for recognition begins with the diagnosis of illness. Recognizing that the person has a life-threatening illness represents the beginning of support. This is why diagnosis is so important to the sick. As an undefined force, the illness is a potential threat to one's existence: something is wrong, but the person is not sure what to make of it. This is why patients are relieved when doctors give their complaint a name. To have their condition recognized—that is, defined—depersonalizes it. Their condition moves from a mystery to a problem with which to struggle; their illness becomes something to treat, perhaps to control or cure. This is the somewhat distanced, impersonal level of most clinician-patient relationships in health care. Patients, however, yearn for another kind of recognition.

People facing a life-threatening illness want to be respected as unique individuals undergoing a trying experience. Because they are marked by a diagnosis that sets them apart from healthy people, these patients find themselves in new relationships with physicians and other health caregivers. Preexisting relationships with others in their lives must now include a new awareness of mortality. Given the nature of health care in the hospital environment, some patients look

The dying want to be respected as unique individuals undergoing a trying experience.

to the chaplain to “give me the dignity that I don’t get from the medical staff.” Patients clearly do not want to be lost in the shuffle.

A person facing life-threatening illness needs others to recognize that he or she is not just one more patient receiving treatment. Arthur Frank makes this point in *The Wounded Storyteller*.²² He tells the story of a woman describing her first surgical experience in what was a long cancer treatment: “At pre-admission, what I wanted was for someone to say this must be awful for you, you must be scared. I’m sorry. Anything.” Instead her history was brusquely taken, instructions were given about fasting, about consent forms, admission, the bone scan, and follow-up. “Trapped inside me was a giant scream. I felt as though I’d been dropped from a great height and cracked open and nobody had noticed.”

One reason Frank likes this story is that nothing wrong is done. People act professionally; the system is working the

way it is supposed to. The people who treat and assist her will go home that night and think that they had an unremarkable day. The problem is precisely that everything proceeded in a thoroughly routine, professional way. Here is a central paradox of the hospital as a caring organization—as it can be in a hospice or a congregation. Surrounded by people who are caring for her, she paradoxically feels utterly alone. They are filling out forms; they are telling her how this and that are going to work, but while they treat her well, they do not attend to her. The woman with cancer is asking for recognition, from one human being to another, that this is happening to her and that it's thrown her life upside down.

William F. May, in *The Patient's Ordeal*,²³ writes of a friend whose husband died. She told May, "There wasn't much I could do about it. The only question was whether I could rise to the occasion." May argues that there are certain problems about which we ask, "What are we going to do?" But there are deeper problems in life for which the question is, "How does one rise to the occasion?" Serious illness and death raise that question. Each patient wants others to recognize that he is the one facing that mystery and trying to find the

Surrounded by people
who are caring for her,
the woman with cancer
feels utterly alone.

ways to rise to the occasion—with little preparation or practice.

A number of the people we interviewed also wanted caregivers to recognize that they were part of a family. Although there are patients with no family, or who are estranged from family, all of the ones interviewed in this study wanted family members included in discussions about treatment. They clearly put high value on the various kinds of support family members give and worried about the effect of their illness on family relationships. Several mentioned their appreciation for the support they received from neighbors and community members, especially when freely given.

Finally, recognition of the sick as individuals acknowledges their worth as human beings and is a necessary condition for them to experience the love of others. Also, as people who are appreciated and valued, they may be freed to experience the love of self and find self-forgiveness.

COMPANIONSHIP

I occasionally visit with folks who are facing the end of life, or their family and friends. Obviously, there are unique challenges to ministering in this kind of situation. I would like to be as helpful as I can be, but I am reminded that often there isn't much one can do other than be there.

—congregational clergy

I find spiritual support and comfort from my family. My husband and I are very close, and we didn't even think we needed anyone except ourselves. Now, though, as we started to plan for what would happen when I die, we realized that we wanted someone to say prayers over my grave, and we wanted to meet and get to know that person, so it would not be a stranger.

—a patient

The person facing a life-threatening illness wants to be in relationship with other people. Sometimes this desire is literally to enjoy the company of others; others act on their desire by helping people as expressions of their religious faith or spirituality. When asked how they express their spirituality at this time in their illness, or to whom they

would turn for spiritual support, study participants' answers included reference to work on a prayer line, an Alzheimer's support group, a sculpture class, or simply the desire for someone to be with them.

With the diagnosis of a life-threatening illness, patients struggle to understand that their lives are irrevocably changed. Most start out hoping that things will soon be back to normal, or saying things like: "I want my old self back." The old self is gone, however, and patients must struggle to recognize and reconcile themselves to the new self who is facing the end of life.

For many people, the clergy person is a familiar of death. On several occasions when the hospital chaplain and research observer (who procedurally was introduced as someone conducting a project on the chaplaincy program, but was often assumed by patients or family to be a clergy person himself) visited a patient, a common response was, "Uh oh. Am I doing worse than I thought?" or "I must really be sick." Because of this link, people facing life-threatening illness, especially those who know they are dying, look to the clergy to witness their dying. The hard but real comfort that the clergy offer is fraternity with those who

have experienced death; the clergy is one who has traveled this road before.

Recognition calls for companionship, someone to walk with the dying person as he or she grapples with the changes, with “the new me.” Even through the bad times—perhaps most importantly through the bad times—it is reassuring for the ill to know that someone will stick by them, will deal with the physical manifestations of their illness and treatment, will allow them their emotions. Patients need someone who will commit to the relationship and be faithful—someone they can trust.

HOPE

A fundamental question for me, and there may possibly be numerous questions related to this, has to do with how to be present with people who are not apparently grounded in a sense of hope beyond death. It is much easier to be present with people of deep faith who affirm my presence and prayers. With this kind of feedback, one has a sense of pastoral direction. I have at times, however, been in situations when feedback was practically nil. I have dealt with these patients somehow, and silently affirmed God’s presence. But under such circumstances there’s usually a question—at

least, subconsciously: What can I say or do to offer a sense of hope?

—congregational clergy

Most of the interviewed patients in the congregational and hospital settings hold out some hope that medical treatment would prove beneficial for them. Even when the interviewer knew from the physician or other members of the care team that an individual was not likely to benefit from therapy, or live much longer, the patient spoke optimistically about the future. It may be that many patients do not give up hope of recovery until the very end, if at all, or do not “hear” what their caregivers are saying about their situation. Hope for these people may carry a note of bargaining or wish fulfillment: If I remain hopeful, all will be well. Hope becomes an attempt to control what is happening. In essence, the person may be saying: “Don’t give up on me, I’m not dead yet.”

When asked about a time when their religion or spirituality was important to them during their illness, or to imagine a time when this might be so, many recounted moments of pain or doubt when their spiritual faith or religious beliefs supported the hope that their lives had value or that there was meaning in their experience. Several

People facing the end of life hope that someone will accompany them through to their death.

people spoke of what their religious tradition had to say about hope. For some, that hope was expressed in an understanding of life after death—an eternal life transcending finite life. Some spoke with a certain wistfulness, hoping perhaps that existence continues after death; others spoke with a sure acceptance of seeing loved ones again in heaven. Quite a few hoped that they would be remembered after their deaths for having lived a good life and having had a positive effect on others or the world.

Finally, several patients, when they spoke about their illness or about dying, said that they feared losing their capacity to care for themselves and hoped that they would not become dependent on family members or others. Along with recognition, people facing the end of life need reassurance that they will not be abandoned. They hope that someone will accompany them through to their death.

DYING APPROPRIATELY

I hear things like: “It’s okay not to hit me with an I.V. I have done what I’ve needed to do in my life. I am at peace now, I’ve never felt as much at peace as what I am now.” I hear families say, “He’s more peaceful,” or “She’s more peaceful in the last couple of days.” I have folks say to me, “I know where I’m going.” Or . . . “I’m going to be with my God.” And they express that in those kind of spiritual terms, “It’s okay. You don’t have to worry about me. My life is complete now. I’m ready.” Often they smile. So when I hear, “I’m ready,” I can only smile back and keep my mouth shut.

I’ll never forget one lady. She was very close to death, maybe the day before she died. She said [to her niece], “You know, I owe you thirty-nine dollars for that dress you bought me two weeks ago, so I want you to go home today and make a check from my checkbook for thirty-nine dollars, because I don’t want to leave this world if I have any debts.” Then she laughed. But she really wanted her to do it! The next day she went to sleep and died. But she wanted that, you know, like pulling together her little business.

—two chaplains

A common phrase in end-of-life care literature is “death with dignity.” Proponents of greater choice and control advance this term, assuming that all agree on its content. While the values of a death with dignity—pain-free death at home, untethered from the apparatus of high-tech, aggressive medicine—are appealing, in some ways it has become a rhetorical device in the debates about the right to die a death of one’s own choice.

From our interviews, people wanted to die pain free, with unfinished business or loose ends tied up, and not alone. In a more nuanced expression, patients expressed a desire to die “appropriately.”²⁴ In other words, people want to die in ways consistent with their own self-identity, after a period in which they could achieve a unity and integrity to their lives. Their death should in some way be theirs, uniquely—in some sense the natural culmination of their life’s course. Here, again, they want their deaths to be meaningful, meaningful both to themselves and as final expressions of their life’s values. A real concern for people in this study is that they might die in a way incommensurate with this wish. Physical pain is a fear, but so is a death in which they suffer inappropriately or, following Eric Cassell

People want to die
in ways consistent with
their own self-identity.

in *The Nature of Suffering*, suffer in ways that would negate their sense of “self.”²⁵

Dying appropriately seemed especially pertinent to the hospice patients in this study. Unlike the congregants and hospital patients who still had expectations of therapeutic treatment, perhaps concrete hopes for a cure, the nine people in hospice all faced a terminal prognosis. As they prepared for death, each wanted to make choices in synch with his or her personal values. One woman expressed a sense of completion in her relationships with family and friends, in part by passing on her relish recipe to her children. Others spoke of a desire for reconciliation, for communication with family and closure of important relationships in their lives. Others expressed regrets and spoke of a desire for forgiveness. One described his feelings of gratitude and appreciation for all that he had received in his life. Several were working on finishing business: making a will or funeral arrangements,

tending to legal or financial matters, or taking trips.

For these patients, it was important to talk about death with their family and others, to discuss specific treatments, rituals, or requests. Although to some extent these efforts represent a way to assert control over their dying, in acknowledging a desire to die appropriately we should not think of managing the dying process so that a person meets a goal of “dying well.” The key point is that the experience is of value and is meaningful for the person and their family.

MEANING

I remember when Joe built the Titanic. You know, Joe was the first patient that I really, really came close to that died. He had built this 3-D Titanic puzzle while he was leukemic . . . He didn't have anything else to do, so his wife bought him these 3-D puzzles and he built a Titanic. That's what he was, he was the Titanic! I mean, everything that could go wrong, went wrong for him. And I remember one of the nurses, when he finished it, she went and got this big Styrofoam cup and filled it with ice and put it in front of the Titanic. (Laughter) It was the iceberg . . . You know, and it was like this underlying—nobody would say it—but it

was this underlying metaphor for what was happening to him.

—a chaplain

People facing the end of life usually return to long-neglected questions of what really counts in life. Faced with the ultimate end, one's mind turns to questions such as: Why is this happening to me? What has my life been all about? How is all this meaningful to me, to the person I've been, am now, and will be as my death approaches? There is a need to make sense of what's happening, to find some purpose that will enable them to reconcile their feelings and restore a sense of connection to self, God, and others.

Many see little meaning in their narrowed and shortened future as they are forced to deal with friends, family, and caregivers in new and embarrassing ways. Where once they helped lift burdens from others, they have now become a burden. They may feel betrayed by their own bodies, or feel cast out from the society of the healthy. Some seemed overwhelmed by feelings of isolation, abandonment, even self-hatred, fear, and anger. Some spoke of healing as the restoration of wholeness or the integration of their illness into their lives in a way that restored purpose and value. Spirituality seeks meaning; it also seeks

completion, fulfillment, wholeness, integration, and harmony. One can experience completeness, even in the midst of disease or while dying. On the spiritual plane, this spiritual sense of meaning is at the heart of end-of-life care.

UNMET SPIRITUAL NEEDS

And I want someone to say, “It really doesn’t matter to me in this relationship”—or something along those lines—“It really doesn’t matter to me in this relationship, but I still like you, I’m still with you, and I’m not going to abandon you.”

—a congregant

Based on the interviews and observations, virtually every patient in the hospital, hospice, or congregations had lost at least some elements of their routine forms of religious expression. For some, the physical or cognitive challenges associated with their life-threatening illness—or with the palliation—limited their ability to pray or to participate in other religious activities.

Others found that religious leaders distanced themselves because of fear and stigma, or failed to realize their needs or the needs of their family caregivers for comfort or spiritual support. Patients were angry at the failure to rec-

While clergy
expressed hope,
patients also wanted
their presence.

ognize and appreciate their need for ongoing, sustained support. While clergy offered expressions of hope, usually couched in theological terms, patients also wanted their presence as committed companions. That the clergy, broadly speaking, sometimes do not meet these spiritual needs, may contribute to people’s reluctance to trust clergy with their spiritual lives during the trajectory of their illness—the reluctance captured in the Gallup survey.

People want to be able to tell their stories and to be heard. Due to restrictions on caregivers’ time and other distractions, however, patients often do not feel that they are heard. In the face of life-altering events, they feel as if their unique identity or self is in danger of being lost or overlooked, especially by those who profess to care for them.

Also unmet is the patient’s desire to be recognized in the moment, apart from preconceptions or some category assigned to them by their caregivers. Based on the

observations and interviews, staff can demonstrate institutional “blindness,” appearing more concerned with getting their jobs done than with being present and available to the patient.

If patients feel that the chaplain or clergy person is not genuinely present or attentive, they may not share their concerns. They know when the caregiver is asking questions taken “off an institutional sheet.” People suspect that if they told the truth—that “everything’s falling apart,” that “I’m feeling estranged from my family” or “from my pastor,” that “I hate what’s happening to me”—if they open themselves up that way, they reveal their vulnerability and a need for a lot of support from the institution. Some patients fear that they would not receive that support.

If traditional spiritual beliefs or practices do not provide the support and meaning that patients want, they will seek that support outside their tradition. For example, hospital chaplains note individualistic innovation among patients and families, underscoring the suspicion that at least some patients desire more personal meaning making. Hospital and hospice chaplains take note of increasing expressions of spirituality from outside mainstream religion, for example, references to Mother Earth and Nature, the

use of stones, crystals, open flames, and so forth, as a focus for spiritual activity. One hospice patient with cancer had developed a “home-made” activity in which he and his family would “anoint” him with holy water or oil, while meditating on health and healing.

One congregational clergy person mentioned that some congregants are exploring the use of crystals. He said that he wanted to learn more about such New Age approaches, to offer something more appealing to his congregation’s members who are searching for something “more” than what the tradition offers. Other congregational clergy did not indicate any particular experience with alternative beliefs or practices in caring for congregants. This observation is not really surprising. First, the sample of congregational clergy in the study was small. Second, these congregational clergy most directly represented established religious traditions, with their theological and institutional beliefs, and were more particular in their understanding of spirituality and spiritual practices than were hospital or hospice chaplains. Congregants who adopt alternative expressions of spirituality might be reluctant to share them with their pastor.

The nature of the relationship or connection between clergy caregiver and

the person facing the end of life is a key component of spiritual care. As already suggested, the nature of the relationship between clergy and patient enhanced or hindered the scope and depth of spiritual care. The more trust and comfort established between the two parties, the more intimate and open the connections seemed. Although it can be apparent immediately, such rapport usually takes time and effort to establish. Unfortunately, a number of obstacles impinge on the relationship and on spiritual care.

OBSTACLES TO SPIRITUAL CARE AT THE END OF LIFE

What are the barriers, obstacles, or challenges to spiritual care at the end of life? Are these part of society generally in this country?

Have you experienced barriers, obstacles, or challenges at your institution, such as heavy case loads, paperwork, lack of staff support, lack of privacy?

Have you reflected on your own personal barriers, for example, your own anxiety about death or an uncertainty about what to say?

*—questions from the clergy
interviews*

Researchers asked these questions of the hospital, hospice, and congregational clergy. There was ample evidence in their answers—and in the observations at the various sites—of a number of social, institutional, and personal barriers to spiritual care.

SOCIAL OBSTACLES

People expect too much from medicine. They get angry when no miracle appears. They don't want to give up, until it's too late.

—a chaplain

One chaplain shared his dismay and even anger at the many lapsed Catholic patients who all of a sudden want rituals performed in their crisis time. He knows they have no ties to the church and that they have only a vague sense of theology. They want last rites, for example, even though they don't know what it's called or that Vatican II [recast the rite as Sacrament of the Sick]. When he tells them they should contact their parish priest, they say, "No," since they haven't attended for years.

—hospital observation

The clergy who participated in the study identified a number of social barriers or obstacles to spiritual care at the

end of life. One is a general unwillingness by many people to admit their mortality. The SUPPORT study showed that patients, families, and physicians are terribly reluctant to raise the subject of death and to talk honestly with each other about end-of-life care. It is as if death and dying are taboo subjects. Much of the effort to educate physicians about patients' decision making overlooks the fact that many patients and their families never give up hope of recovery until the very end, if at all. In part this reluctance is due to the very successes of biomedicine over the last decades; people seem to have an unrealistic expectation that medicine can always provide another treatment or a miracle cure.

Given the general movement towards secularism within the American society, another barrier that chaplains encounter are "lapsed" patients and families unconnected with a religious tradition or faith community. These people find themselves in crisis, facing life-threatening illness, without the investment in and support of a community sharing at least similar beliefs, values, and practices. While many people who reject religion have an avowed spiritual orientation, they may lack a community that would support them in their illness.

People seem to have an unrealistic expectation that medicine can provide a miracle cure.

A factor that may contribute to a lack of religious or spiritual community is the widespread social mobility of people. Due in part to changes in work expectations, a more mobile society may put down shallower roots in community. Many of the patients in the study had moved several times in their lives, and a number presently were away from their homes, being cared for by relatives. As a result, even those affiliated with a faith community found themselves cut off from familiar relationships and environments.

Clergy also noted changes in the American family structure that contribute to the challenges they face in supporting patients during their illness. Patients may be estranged from their families or they may live far away from them. Other patients worry about the stresses that life-threatening illness places on their families, such as the burdens on a spouse who must work, look after the family, and care for the sick person.

Finally, the diverse nature of our society represents a challenge to hospital and hospice chaplains. Several chaplains noted increasing contact with staff, patients, and families of different cultures, whose religious or spiritual beliefs and values can differ from those of the clergy person. They admitted not knowing or being unsure of what is meaningful to people of another religion. Can patients or staff members of other religions expect a clergy representative of a particular tradition, typically Christian, to be helpful in dealing with their spiritual issues at the end of life? Sensitivity to and respect for this diversity are necessary since values can vary so widely regarding the understanding of death, the appropriate way to discuss negative information, the role of the family in decision making, and other issues that chaplains may encounter.

INSTITUTIONAL OBSTACLES

The widespread cultural conversation in American society on autonomy and “a good death,” which focuses on the individual person as the unit of authority and action, ignores the power of the hospital as an institution and bureaucratic system—one that shapes the dying experience in particular ways. As other examples of institutions and

bureaucratic systems, hospices and congregations also shape the way in which people experience death. To appreciate why some spiritual needs remain unmet, we must recognize the institutional factors that shape the way spiritual care is provided in the hospital, hospice, and congregational settings.

The Hospital

There are a number of obstacles that the hospital presents to chaplains. Some are obvious: the rhythms and physical features of a healthcare institution establish the terrain in which pastoral care occurs. There is a great deal of diversity among the patients and families, and among the staff. There is limited time, space, and privacy available for the encounters between chaplains, patients, and families. Patient rooms are typically shared, so that staff or visitors frequently interrupt conversations. Often the chaplains’ work takes place in the halls or waiting areas. In addition, a good amount of the chaplains’ time is taken up in administrative functions, such as paperwork, securing patient valuables, providing information, or answering questions.

Adequate pastoral care staffing and support is another issue. Chaplains reported on occasion that they felt sometimes overwhelmed by their work; for

The chaplain, associated with the hospital, faces suspicion, but can also be an ally in an alien place.

several these feelings were most acute at times of patient deaths. The language with which chaplains described their work was revealing. “Madhouse,” “one big ICU,” “another busy night,” “I feel like a ‘lone ranger,’” and “crazy” all were used by chaplains to describe events during their shift. This language indicates the chaplains’ feelings of stress and overload.

Another obstacle for the chaplains is an outgrowth of the patient’s phenomenological experience of the hospital. One chaplain described the patient’s experience as a combination of a sojourn in a foreign land and a sentence to jail. The chaplain is interacting with someone who finds herself in a strange environment, populated with people speaking a different language, with different customs. Moreover, the patient is usually not there by choice, and has given up her identity markers: clothes, freedom, and routine. Thus, because of his association with the institution, the chaplain faces a certain amount of suspicion—to

whom is his principal allegiance, the patient or the hospital? At the same time, the presence of the clergy offers many patients and families a symbolic ally in this alien place. Establishing trust among the chaplain, the patient, and family is a key element in spiritual care giving.

Other staff can create obstacles for clergy in providing spiritual care for patients and families. With other members of the medical team, or with other hospital personnel, chaplains we observed encountered problems in communication, such as occasionally not being informed of a patient’s status. This lack of communication was not apparent in the hospice setting. However, in both locations chaplains are to some extent dependent on other staff for referrals, since the chaplains cannot routinely visit all new admissions. Staff, especially nurses (and in the hospice, social workers), play a role in assessment of people who have spiritual needs; to a large extent this referral system depends on the relationship between the staff member and the chaplain.

An important observation, confirmed in an interview, is the frustration that chaplains experience when patients are told “so late” that they are dying. The chaplain knows the medical prognosis, but when the physician will not

inform the patient or family, the chaplain is hindered in the kind of care she can provide. Other staff run the risk of unwitting disclosure and must deal with a patient's anxiety. Occasionally, staff, patients, and family become caught up in relationships of mutual pretense—all sides know but pretend otherwise.

Finally, the strain placed on hospitals by financial constraints affect pastoral or spiritual care programs as much as other departments. The pressure to be more cost-conscious and efficient, to find new ways to do things, often means doing more with limited staff.

The Hospice

Within the hospice, these obstacles seem less prominent, perhaps because the organization is smaller, with many fewer disciplines and a more focused mission than the hospital. Perhaps because the hospice philosophy emphasizes sharing responsibility for spiritual care with the hospice staff and the patient's family, the load is not primarily on the chaplain's shoulders. Hospice staff seemed more familiar with and supportive of each other. Several team members noted that the chaplains provided spiritual support to them, performing weddings, funerals, and baptisms, and serving as a spiritual leader in their lives. Intra-staff conflicts

In hospice care, unlike the hospital or congregation, death is not the enemy.

occurred more often between care providers in the hospital.

Although the average hospice length of stay ranged between 20.2 and 41.4 days during the study period, the median length of stay consistently was just over nine days. However, hospice chaplains and staff spoke of their frustrations at not having more time with the patients. While the hospice chaplains also speak of being overextended, they seem able to spend the time to achieve more intense interactions. Other factors, of course, contribute to this perception. The nature of hospital care lends itself to shorter stays, and the nature of the hospice patients' terminal conditions likely supports an emphasis on the quantity and quality of the interaction. Also, hospice chaplains often visit patients in their homes, a setting in which the patient may feel more comfortable or confident.

One hospice chaplain recognized that his hospice culture was predominantly white and middle class—that while it served diverse patients, the staff needed

to continue to learn how other religious and ethnic traditions deal with death and how hospice can be a resource in supporting those customs and practices.

The attitude toward death appears to be different across the three institutions. Two hospital chaplains noted that they are becoming familiar, but not comfortable, with death; that they are afraid that they will forget the details of the cases they experience. The main focus of hospice care is the end of life—death is not the enemy as it might be in a hospital or a congregation. This makes a profound difference in how hospice workers understand and carry out their work. It makes a dramatic difference in their feelings and responses to the people for whom they care. One of the hospice chaplains was part of a hospital-based Clinical Pastoral Education (CPE) training program. His fellow CPE students criticized him for accepting death as a part of life, for talking about death as a matter of fact, and even talking about it—at times—as a welcome friend, releasing some individuals from their suffering. To the other CPE trainees, many of whom had years of experience in congregational ministry, death was the enemy.

That death seems typically to be construed more as an enemy in the hos-

pital and the congregation and more as a friend in the hospice certainly makes sense. Hospitals are institutions largely devoted to the medical model of aggressive attempts to cure illness or restore function. The widely known difficulties in shifting from cure to care were apparent in the hospital studied. Hospital chaplains in many ways are in the center of this shift, given the nature of their role as religious representatives and their institutional role assignments. Hospice chaplains operate in an atmosphere in which death is in the picture; the patient's life is heading toward an inevitable demise—although we should note that even in hospice there are cases where family members try to shield the patient from the awareness that the disease has progressed to a terminal phase.

The Congregation

The one area of ministry that scares the heck out of me is this right here [ministering to the dying].

—congregational clergy

What do folks think and worry about as they near the end of life?

—congregational clergy

Out of a deliberate approach, it's premeditated, I am not at every bedside;

and I'm not going to try to be. I work through my associates and try to apply myself where I am needed the most. It's a triage ministry. There are members who resent that. And I was told last night of a lady who is in surgery now who called on one of the associates with the instructions not to tell me, because if I wasn't going to be there, she didn't even want me to know. But that's the practice I put in place and despite those kinds of drawbacks, I'm not inclined to change it.

—congregational clergy

In our observations and interviews, congregational clergy were the least prepared by training for intense, sustained support of congregants facing death. Unlike their chaplain colleagues who work so closely and so often with seriously ill patients and their families, the congregational clergy of course have different roles and responsibilities. There were some signs that in the congregational setting, clergy functioned as chief executive officers of their institutions, coordinating and delegating care to staff and volunteers. In this management model, their attention is more immediately directed to the socialization of the young, and developing and fostering religious identity

and involvement, because without these activities the congregation and religious life would not continue. As one senior clergy said:

There's preaching that you've got to prepare; there's studying that you got to do in order to teach and preach; there's meetings because there's the daily administration and committees of the congregation that meet; then there are the inevitable interruptions of a funeral or someone coming in needing to talk for counseling. There are the many different facets of congregational life such that it's impossible to expect to be totally present to these people as a care provider.

Acknowledging that the symbolic presence of their "office" carries a certain value or significance for congregants, because of their busy schedules and the various demands placed on them as clergy leaders, they delegate care for the seriously ill to other staff members or lay volunteers. In the congregational settings we studied, the senior clergy's interaction with congregants intensifies as the person's condition deteriorates, culminating with the most intense time spent as death approaches or spent on bereavement care.

From the clergy's point of view, this approach to end of life care is a necessary allocation of resources. One rabbi said:

What I've learned in the congregational realm is that we really cannot do as congregational rabbis what I think would be any kind of sustained meaningful pastoral care. I call us the "spiritual ambulance chasers." No, we're worse than that, we're really what should be called "spiritual EMTs" [emergency medical technicians]; we are short-term care providers. We have to either try and deal with the crisis, or we're not able to deal with the crisis.

This clergy person leads a congregation of about 1,000 families, and sustained support and care for the seriously ill and their families are impossible given his other duties. His pastoral care takes place when the hospital discharges the patient to home and again when a congregant is in the acute phase of dying. In between, lay people provide a wide range of supportive counseling and other services to the sick in the congregation.

A Protestant pastor noted that "what I want our congregation to sense is that God has gifted people for ministry; some of them are on staff, some of them are not. If it happens to be you received

ministry from me, that's fine, but mine isn't any better than anybody else's." Rather than depending on the pastor's presence, in Christian theological terms congregants should look to the ministry of the word. Otherwise, if the care ministry of his church revolves around him—"Boy, thank God, pastor, you're here, you know, you've ridden in on your white horse to rescue us. Where would we be without you?"—the church would be unable to fulfill its mission as he sees it. As a result, this pastor tries to cultivate the cultural expectation that "it doesn't really matter whether [I'm] there or not."

Given this approach to his ministry, the pastor viewed the 1997 Gallup finding as very positive. Differing with Gallup's interpretation that the clergy need to "wake up," he believes the finding shows the empowerment of the laity and the fact that nonclergy are important to people. At the same time, he realized that he has become a bit more insulated from the lives of people broadly, as he has moved more and more into a senior pastor's role, so that other staff members who work with certain groups go more deeply into those relationships. Due to his role as senior pastor, dealing with so many people, so broadly, he cannot delve so deeply with the few who are seriously ill in his congregation.

Despite the genuine spiritual care that staff and lay volunteers provide, the senior clergy's approach of "empowering the laity" to be spiritually supportive to sick and dying congregants was not particularly well received by the sick themselves. For example, Mrs. B felt that while individuals who are appropriately trained could provide counseling and support, there was a specific threshold—of serious, life-threatening illness or of prolonged duress from a chronic caregiving role—that challenged individuals' spiritual beliefs and values. She felt that at this significant level, individuals and their caregivers required a visit from someone who shared their belief system. Mrs. B acknowledged that the clergy—in her case an overworked parish priest—might be too busy to visit all those who are ill. She mentioned that her parish sends lay people to distribute the Eucharist. However, she described these individuals as "technicians," who do not notice any broader needs among those whom they visit. She mentioned that the hospice sends a "counselor" to talk with her. However, she indicated that she needs to talk with a priest—or someone well versed in her own religious tradition—who could reassure her that she is not being punished by God and that God is still with her.

**Mrs. B vowed to
tell the priest that
he has been neglecting
both her and her husband.**

Mrs. B vowed that when she feels better, she would walk over to the parish and tell the priest that he has been neglecting both her and her husband. She wants the priest to know that she feels that her husband—despite his resolve to be optimistic in the face of death—needs to talk with a priest. She wants to tell the priest that she feels that she needs spiritual support and counsel from someone who shares her faith tradition. She believes that she merited such support for a while because of her prolonged duress from caregiving, which she blames for bringing on her recent heart problems. Her recent bypass surgery made her face her own mortality and vulnerability, and made her question God and doubt God. Mrs. B feels that her parish priest does not recognize the long-term needs of caregivers or the acute needs of individuals recovering from significant illness. She implied that the priest got involved only when an individual is actively dying, or after the death.

Indeed, generally the congregational clergy saw themselves most clearly involved toward the end of a parishioner's life. As representatives of the church and its tradition, some clergy felt that it was their responsibility to shepherd the parishioner through the active phase of dying. Senior pastors might delegate visitations to subordinates, but when death entered the room, they wanted to be there. This approach angered some patients and family members: while patient and family deferred to visiting associate clergy or to lay "counselors" or "Eucharistic ministers," they wanted the senior clergy's presence. Patients expressed anger that the pastor was not accompanying them on their journey, and was showing up toward the end of their lives almost "as the messenger of death." Clearly, the role of the clergy person, the titular "leader" of the person's congregation, is a significant one for people facing the end of life. They may appreciate the limits on that clergy person's time, but under the circumstances in which they find themselves, they want tangible expression of the religious leader's commitment to them. While a complicated set of variables is involved—including the patient's and family's views about organized religion, their previous experience with cler-

gy, personal dynamics, and so forth—peer support is not enough. While the clergy assume varying significance in different religious traditions, in a situation where the clergy is endowed with particular authority, such as Roman Catholicism, a layperson—even a parish nurse—might be a poor substitute to those who feel a strong need for the special service that only an ordained priest can provide.

In this study the trend among congregational clergy to delegate care for the ill to lay ministers or congregational volunteers was not well received by congregants facing serious illness. There were expressions of anger toward the senior clergy for delegating this responsibility. While the clergy spoke of "empowering the laity" to provide spiritual support for the seriously ill, congregants' anger may represent a call for clergy to reconsider their essential pastoral or spiritual care responsibilities.

PERSONAL CONCERNS WITH END OF LIFE

How do I talk to someone about dying?
Do I wait for the patient to mention his/her diagnosis and prognosis? Am I supposed to raise the issue? Will it be too upsetting? Do I have to talk about death? What do I say to someone who

is afraid? Is it all right to talk about what I believe about the end of life?

—congregational clergy

How can I provide an environment in which people feel freer to speak about the concerns on their minds? How do I give people permission to talk about tough questions?

—a chaplain

Congregational clergy expressed some anxiety about care for the dying, especially in knowing what to say. Others said they rely on techniques, sticking to prayers and scripture reading. For example, one congregational clergy felt a responsibility to ask directly about salvation. Others said they let the words of Scripture comfort and elicit a response from dying patients; they, as one pastor put it, “let God act.”

Often the clergy’s own anxieties or fears about dying affect their care and support for dying people. They may seek to control death’s sting in many ways. It’s common for people to avoid topics that make them feel nervous or uncomfortable; many worry about finding the right thing to say. Some chaplains or congregational clergy find a way to distance themselves from death by wrapping themselves in set prayers or formal ritu-

als. Some just talk a lot as a way of feeling more in control of the situation.

These responses become emotional shields, denying patients the recognition and companionship they need by imposing on the dying what we ourselves think they need or want. Once clergy become comfortable with their own concerns about death and dying, they will be better able to hear the other person’s expressions of anxiety, to let the patient set the agenda and determine the pace for her own dying. If the clergy can reflect on their personal concerns about death, it will not be a matter of giving people permission to talk about tough questions, but of simply being present to hear what the dying person has to say.

It is helpful to distinguish between a professional and a personal agenda in considering spiritual care at the end of life. In a professional agenda, one may be more concerned with understanding the processes of adjusting to death and dying and acquiring appropriate helping skills to make this process easier for patients. However, we each have our own personal issues and concerns with death, issues that spring from our experiences with the deaths of others or from the contemplation of our own demise. From time to time we may find that the personal intrudes and makes it

Reducing the experience of dying to a manageable problem does not show respect.

difficult to remain within the professional role. Such feelings and grief in our own lives can easily get in the way and lead to self-protection designed to ensure that the patient or family does not affect us deeply. Time needs to be given to identifying and understanding those parts of our personal agenda that make us uncomfortable in the face of death.

COMPONENTS OF SPIRITUAL CARE

Becoming comfortable with one's own end-of-life issues is a necessary process for clergy who care for people facing death. At the same time, by reflecting on the social and institutional obstacles that inhibit care and support for people as they strive to integrate the starkness of death into their lives—to revivify themselves in the face of death—clergy may well become more confident in caring for dying people. Based on observations and interviews in the hospital, hospice, or congregational setting, there are five ways

to provide such end-of-life care. These components of spiritual care are intertwined and occur concurrently, but we separate them for the purpose of discussion. Just as the spiritual needs of people facing life-threatening illness vary from person to person, there are no cookie-cutter approaches to spiritual care at the end of life.

RESPECT FOR THE DYING PERSON'S STORY

Respect for persons is a common notion in healthcare ethics these days, but is still one that needs review when we discuss spiritual care for dying people—it is fundamental to the other components of care. Reducing the experience of dying to a manageable problem does not show respect. For example, the Kübler-Ross thesis that the dying pass through stages can become a way to deny their self-determination in interpreting the meaning of their own death. Out of respect, we should pay attention to what the dying tell us; any further intervention should fit into the patient's interpretation of the illness. The experiences of the dying are best understood as stories, and we show respect for the dying person by taking these stories seriously as an expression of their spiritual values, preferences, and needs.

The Story

Recent years have seen a proliferation of a multidisciplinary literature concerned with story. A precise definition of story appears to be elusive.²⁶ For our purposes, there are several aspects of story that seem fruitful. First, stories meet “the human need to bring the past and future into coherence (even if it is only illusory) with the present . . . Narratives reassure us.”²⁷ They do so by providing people with a sense of connectedness in their lives, imposing order from without on the natural chaos of experience. Second, stories carry personal meaning to those who live, create, or interpret them. They become a mode of self-declaration, in which the patient demands a hearing, a recognition, from others: “This is my story, I’m telling you about me.” Finally, stories also function as a mode for self-understanding. In the relationship between the patient storyteller and the caregiver, the patient can test out his ongoing narrative, gaining perspective to make the rendition more meaningful.²⁸ In the process spiritual issues will emerge.

These issues do not have to be dramatic; often they are not easily perceived. However, if the caregiver allows it, the patient’s stories enable her to review and integrate aspects of life in a new per-

spective. Issues such as anger, anxiety, or bitterness, and passion, praise, prayer, pride, reconciliation, or sacrifice will surface to become topics for further story telling. The stories foster companionship between the caregiver and patient. The trust and intimacy that mark such companionship takes time to develop, time that almost everyone noted was never adequate. The willingness, however, to listen and avoid judgment and a sense of humor foster the conditions for storytelling.

The idea is not a novel one. Spiritual caregivers encourage reminiscing; they help the dying patient and family tell their stories. This aspect of spiritual care requires going beneath work histories and photo albums. It uncovers the transcendent decisions that committed dying people to some path in life—one that liberated or thwarted them at significant points—and enables them to name those persons with whom they share an awareness of value in their lives. Even with religious people, it is important to peel back their religious practices and uncover these elements of their story. The payoff is to help the dying become more aware and more appreciative of the values and relationships that shaped—and still shape—their lives. It may be valuable to encourage

Spiritual caregivers help the dying patients and family tell their stories.

those able to record their stories—by audio or videotape or in writing—so family and friends inherit a record of the loved one.

In medicine, the story is often confused with the medical history. One's history is what the physician needs to treat that patient. The story, in contrast, is what the ill person needs to make sense of what's happening. The story, however, is not there to be told, but is discovered in the act of telling. The patient is literally making it up as he goes along, because the story happens on three levels—past, present, and future—all at the same time.

The Past

The past may be there within the story in several ways. Certainly there may be hints of guilt or shame about something or someone in the past. These feelings may be specific or nonspecific and may reveal themselves in a comment such as, "I don't want visitors. They must not see me

like this." The feelings may be caused by the loss of control over bodily functions. As a result, the person feels unclean and unacceptable to self or others.

Sometimes the dying person feels that her condition, with its pain and suffering, is God's punishment for some reason: "I must have done something wrong for this illness to have happened." For many, there may be particular words, thoughts, or deeds for which the person feels accountable. For others, as with Job, the reason may be unfathomable and lead to statements like: "This is so unfair." Unfairness raises the issue of trust. If God has let me down, whom can I trust? Often the person does not want to show doubt or anger at God—or clinical caregivers—yet the feelings are there and may include a loss of faith and confidence.

In this aspect of a person's story, the spiritual caregiver recognizes the need for acceptance and forgiveness. Those who experience doubt and anger need reassurance that they are still acceptable to God. Advising a patient to "forget the past" does not work. Helping the person name and feel the hurt, see and understand the incident more fully, then reaching out with love and concern to the person who has been hurt is a way to integrate the past with the present. For all people, religious or not, it is important to

Margaret, who joined the
Lutheran church,
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Catholic bedtime prayers.

bolster trust by giving clear and accurate information, along with appropriate reassurance of the help or treatment available, and importantly, to convey that there will be consistent, genuine companionship from family members, physicians, and clergy.

There are two more ways in which the past may figure into patients' efforts to integrate their present experience into their ongoing lives. Some may be able to reconnect with old patterns and customs. Others construct their own meaningful rituals.

We saw reconnection expressed as a return to the prayer, values, and recollections of childhood experiences, where for most of the patients religion was deeply rooted. The patients seemed drawn to expressions of religious activity that were associated with a time when they experienced the security and comfort of their parents' love. One patient, Margaret, who had joined the Lutheran church, still recited, in Polish, the Catholic bed-

time prayers she'd learned as a toddler.

Margaret was one of several patients who showed signs of syncretism. She and several others found comfort by borrowing from other traditions, either because curiosity fueled personal exploration or because of contact with family or friends of other faith traditions. Margaret had always felt a special bond with the Holy Mother. When she married a Lutheran man, she interviewed his pastor, to see if he would allow her to continue her devotional practices, which included contemplative prayer surrounded by her home shrine with statues and candles to the Holy Mother. Decades later, she found comfort in the ability to maintain cherished parts of her childhood tradition.

On the other hand, for some patients there was less comfort in the traditional religious patterns, beliefs, or customs of their childhood. They found other ways to construct their own spiritually meaningful practices. Peter is still a member of his childhood church. He finds comfort, however, in monthly healing services around the region. He and his wife designed a special bedtime ritual. Each evening they gather the family together. As he revealed:

We have our own prayer where we,
you know, we thank God and ask Him

for whatever we want. And then, well, I put Holy Water . . . on both my wounds, and ask the Virgin Mary to please continue praying to her son on our behalf, and then my wife applies Holy Oil and says a prayer . . . It's just, that it is a ritual that, you know . . . as much as sometimes the kids can think, oh I'm so tired and everything, and they didn't want to stay up late, but it enriches all of us.

To Peter, skipping the prayers is like forgetting to take a dose of medication.

The Present

Bringing the past into the present, finding ways to help and support the patient as he struggles to reconcile and integrate a confusion of experience into his ongoing narrative, is one part of spiritual care that clergy and other spiritual caregivers can provide. In the present dimension, there are other aspects of the story that clergy need to attend.

Anger with God, the illness, or seemingly ineffective medical personnel is an expression of rejection—it is as if patients are saying, “I reject you because I feel rejected. Now you'll know something of what I'm feeling.” The patient is suffering in the present, under the threat of death. All that was once taken for

granted—the health of the body, relationships with others, a future—is now called into question. Along with this disintegration of the self, there may a growing sense of hopelessness. People facing the end of life may need support to explore feelings and test new interpretations. The clergy caregiver needs to be nonjudgmental and not take things personally, but recognize that the patient may be testing: Will you stick with me no matter what?

The Future

Respect for the person who is dying, and the story she is telling to reconstruct a meaningful existence, involves a commitment to the future. Patients have a need to express hope into the future, whether this hope is for oneself, or for one's family and others who will be left behind. The hope of a physical restoration is natural, but such expectation must be realistic. There is often hope for reconciliation with others in the patient's life; there is hope that one will be cared for and hope that meaning in death can be found. As the clergy person becomes part of the patient's ongoing story, she becomes part of the patient's hopes for the future.

Because their stories include a sense of the future, the stories become a source of vision. In this sense, people make up their stories as they go along;

stories are continually revised. Telling and retelling conceals as much as it reveals. Therefore, what the story means to someone, as well as what the listener hears, is always open to interpretation and revision. Listening carefully to what patients say, seeking clarification, and helping the storyteller make sense of his or her narrative, is a vital part of spiritual support.

LISTEN AND RESPOND

As a component of spiritual care, respect for patients as they try to tell stories that integrate past, present, and future issues, requires the skill of listening. From our patient interviews, we identified two things that caregivers can do to provide spiritual support and care: listen carefully and sensitively to the dying person, and respond appropriately and genuinely, person to person.

Listening

Patients said time after time, “Please, listen to me.” Everyone does not experience the dying process in the same way. This point undercuts any characterization of “the good death” as one size fits all. Therefore, one must listen carefully to hear what’s going on behind the patient’s verbal or nonverbal communication. When a patient facing the end of

Listen carefully
to the dying person, and
respond genuinely.

life talks, the clergy and other caregivers need to listen.

There are barriers to careful listening. Often healthcare practitioners’ own anxieties or fears about dying can interfere with careful and attentive listening. It is common for many people to “not hear” that which makes them nervous or uncomfortable, or to change the subject as a way of feeling in control of the situation.

Predetermined agendas may also create barriers to listening. Advance directive forms, for example, don’t take care of everything. Physicians or nurses may become so focused on securing the signature that they neglect the conversation with patient and family that can lead to a better understanding of what patients prefer in end-of-life care.

Spiritual caregivers must stay focused, be mostly silent, be receptive, and ask open-ended questions to elicit feelings, memories, personal experiences. Ask: How does that make you feel? What is that like for you? What do you think that means? Can you explain that to me? How were things before? Don’t lead;

don't judge; don't interrupt; don't advise; don't say, "I know how you feel" or "Don't feel that way."

Attentive listening takes time. The story cannot emerge all in one piece. A sick call, a visit to the patient, can help pull things together, but the story has been running before—and will continue after the visit.

Responding

As with any medical intervention, the first rule of spiritual care should be: do no harm. Given our ethical commitment to respect persons, it is improper to impose any personal religious or spiritual belief on a vulnerable patient. Also, caregivers often feel that a dying person ought to be talking about dying or spiritual matters, and that the person's refusal to do so is "denial." In these situations, the need to talk about dying may be the practitioner's need—not the patient's—and this usually arises from a practitioner's feeling of helplessness. The practitioner who respects the patient will simply be present, allowing the patient to decide what to discuss and how to die.

Briefly, here are some ways to show respect for dying persons: Be honest, genuine—don't use scripts because patients can tell. Avoid judgment, be willing to listen, and don't promise more

than you can deliver. Think about what it means for a friend to visit a seriously ill person. A friend is there not out of duty or obligation, or because he fulfills a specific social role. Friends visit because they care about the person who is now very ill—the person with a history, with particular needs, experiences, and idiosyncrasies. Friends are honest, but in a way that conveys respect and concern for the patient's well being. In this kind of relationship, the patient is affirmed as a unique individual. One hospice chaplain described his visits to a patient who liked to sit with him, watching baseball on television and drinking beer, in companionable silence. The man was surrounded by women caregivers and wanted male companionship. Over time, as the level of trust became established, conversations deepened, and the man's story unfolded.

COMMUNICATION AND EDUCATION

Clergy act as agents of communication among patients, families, and other caregivers. They can foster mutual understanding among all parties of the patient's preferences in end-of-life care. Other caregivers—nurses, social workers—can do something like this, but clergy are particularly well situated for this purpose.

While a patient may experience the healthcare institution as an alien place, clergy can offer a relationship of trust in which the patient can admit questions and concerns. This aspect of care assumes the ability to listen attentively and respond genuinely and appropriately.

Clergy can also enhance communication among parties, whether from patient to clinicians to family, or between patient and family, about the various aspects of care. Such a role calls for familiarity with the clinical and moral language used in health care. There are many resources available to clergy to familiarize them with the clinical world.²⁹

Many clergy are taught “that theology is conversation, a conversation between past and present, text and event, between the reading of the Bible and the daily newspapers.”³⁰ In the contribution of pastoral care to spiritual care at the end of life, this conversation includes an expanded set of participants with a particular set of questions. The clergy person becomes a theological interpreter and educator, helping patients understand their religious tradition and find theological meaning in their experience. Am I being punished? Do I somehow deserve this suffering? Where is God in this? Clergy can be conversational partners and, when appropriate, guides in

this search for meaning. At times, they may have to challenge a patient’s or family’s theological assumptions.

Differences in race, ethnicity, gender, and cultural background of clergy and their patients were one of the most challenging aspects of end-of-life care in our study. When the chaplain and the patient and family shared the same or similar backgrounds, the quality of the rapport and communication process—openness, empathy, and trust—seemed better. Cultural congruence between patient and chaplain should minimize misunderstandings about attitudes, beliefs, and values regarding end-of-life issues, including individual versus collective decision making, distinctive cultural meanings of death, and the importance of collective psychosocial support in some cultures.

Several chaplains noted that matters of gender, ethnicity, cultural background, and religious or spiritual beliefs were less important than more individual, interpersonal caregiver traits, such as genuineness, acceptance, and empathy. Most important, in this view, is the clergy’s willingness to become acquainted with the patient’s culture, social class, and spirituality. By being open to what the patient believes, chaplains build confidence, credibility, and trust. The more the clergy

**No matter our beliefs
about what may lie beyond,
the finality of death is
dreadful.**

know about the patient and family, the better they can communicate with and educate staff about patient preferences.

EMOTIONAL SUPPORT

On the day Keith received the news that the end was near, [the chaplain] asked whether he would like [them] to pray together. He said yes, and he and his wife both cried, for the first time.

—hospital observation

How do we help those who are dying?
What is the experience of the dying person?

—congregational clergy

What is blocking death from happening peacefully?

—a chaplain

Death means both the biological end of the organism and, certainly for human beings, the end of one's person-ality. For us, then, no matter our beliefs

about what may lie beyond, the finality of death is dreadful.³¹ Emotional support and the amelioration of fear or anxiety are key features of spiritual care for dying people. Such support can be given in different ways. For example, Dave—who juggled half-time hospice chaplaincy with CPE training—happened to have musical talent and interest. He found himself bringing a guitar to some of his hospice visits. Dave explained that he was not trained in music therapy, a discipline that he recognized and was not trying to usurp. However, music helped him; it provided comfort, and it enabled him to express himself more effectively. When he brought his guitar along, he was able to reach patients in another way.

One patient we visited was an eighty-year-old man with terminal Parkinson's disease. His illness blocked his ability to use language, but he and his wife bickered constantly nevertheless. Frustrated at being unable to communicate clearly and undergoing turmoil in his marriage, the patient was clearly upset and fearful as death loomed larger during his life's last weeks. When Dave brought out the guitar and played some favorite tunes from the decade when the couple had courted, something special occurred. The years seem to melt away, and they enjoyed some rem-

iniscences of a time when they were happy, healthy, and looking forward to many years together. This man was able to talk haltingly about the accomplishments that gave him pride—his work, his children’s accomplishments. Little by little, he told us his life story. In doing so, he seemed heartened. He was gaining a sense of closure, as he prepared to take the next step in his journey. His wife was able to move her attention away from his disabilities. They shared some tender moments as they sang together. Although Dave brought along one song from his Sunday school youth group days, most of the tunes had no religious content. Even though there was no explicit discussion of religious or spiritual issues in the songs, they managed to accomplish a spiritual task. The songs helped this couple to recapture long-neglected feelings and long-forgotten memories, giving them a remission from the attention to bedpans and medication regimens. The songs helped him to recount his life story, and in doing so, they facilitated a spiritual activity.

COORDINATION AND INTEGRATION

When faced with critical illness or a terminal prognosis, and especially when they find themselves in the strange and demanding hospital environment,

patients and families worry about death and hope for recovery. They do not often feel in control of very much in the hospital setting, and they rarely ponder a style or type of death. Desperate to know what is wrong, anxious, exhausted, confused, hopeful, and prodded by the medical staff, however gently, to focus on the next decision, they seldom consider what “a good death” would entail or how to facilitate it.³²

Chaplains and congregational clergy can act as prophetic voices, challenging patients to live and die in a way consistent with what is important in their lives. A good death is one that occurs on their own terms, one that is meaningful to them. In supporting an appropriate death, clergy may have to support the patient’s preferences even when the family or clinicians disagree. Clergy can also explicitly advocate with the staff for patients whose voices are ignored, such as an elderly patient who is afraid to complain of inadequate pain management, or a scared, confused woman who is unable to walk but will be discharged to an unsupervised apartment. Clergy can remind staff that respect for persons is violated not only when physicians ignore advance directives, but also by smaller gestures, like the failure to close the door, pull the curtain, or use a sheet to cover a patient.

Spiritual care is not just the province of pastoral care providers.

Dying appropriately also takes into account the patient's web of relationships with family, friends, and clinical caregivers. Committed to supporting and representing the patient, the clergy may enhance communication among these parties to maintain, even strengthen, these relationships.

Given the importance of relationships as a component of spirituality, it is important to note that spiritual care is not just the province of pastoral care providers. Chaplains and pastoral counselors are professionally trained spiritual caregivers, typically representing organized religious traditions. Other healthcare practitioners or congregational volunteers, however, can provide spiritual care and support for people facing life-threatening illness. Indeed, many patients are open to and might prefer support from non-clergy caregivers.

On a multi-disciplinary medical team in the hospital, for example, the chaplain is not the only one giving spiritual care. One patient, when interviewed, named her mother as the person to whom

she turned for spiritual support, because of a close relationship based on a lifetime of shared experiences. When asked if she felt that clergy could provide the spiritual support she needed, she said, no, that the clergy she had known were too narrow in their thinking. Often a spouse appeared to play a vital role in supporting the sick partner's spiritual concerns.

Staff also offered spiritual support to patients and families. Several chaplains noted that nurses sit and hold a patient's hand when they are upset, as a form of caring. One mentioned that the doctors who take a patient's talk of religion seriously and refer to the chaplain are helping with spiritual care. On one occasion, upon a patient's death, his nurse joined the chaplain and the family in a prayer, an act that clearly meant a good deal to the family. On another occasion, following the death of a patient, the neurologist on the case told the family that he had recently experienced a similar situation with his mother and noted that he had been praying for the patient. The chaplain relaying this anecdote then stated that he had been trying to understand the physician's action, and now believed that he had been offering spiritual care. The avowed faith-based nature of this particular hospital may foster an atmo-

sphere in which healthcare personnel take spirituality and spiritual care more seriously than caregivers in a secular institution.

One patient seemed to have a spiritual orientation, but for whatever reason he rejected a referral to a hospital chaplain. Possibly all that the patient wanted from his nurse was for her to say, "I'm sorry; this must be hard for you. You must be scared. How are you dealing with all of this?" Genuine human concern and a few minutes of time can become the basis for further conversations as patients struggle to make sense of what's happening to them. This is not to suggest that expertise and accountability in spiritual care are unnecessary: not every expression of spirituality is positive, and not every self-appointed caregiver is adequate for the responsibility. Professional ethics and the value of partnership demand that staff know the limitations of their expertise and refer patients to others more competent in a particular area of care. In some end-of-life care situations, some pairings of patients with caregivers work better than others. On a well-functioning healthcare team, for example, chaplains often both provide and coordinate spiritual care.

Hospice philosophy stresses the need of the whole agency, the entire staff,

to seek to understand and support the spiritual systems within which the patient and family work, because those are the resources that have helped them through crisis in the past, and it is those systems that will get them through this time, beyond the staff's intervention. Hospice staff work with the patient's (and family's) spiritual beliefs and practices to augment these resources. In this way, the Gallup finding that 81 percent of patients look to family for spiritual support, and 61 percent to close friends, makes clearer sense. These are the people who know the dying person the best; the hospice staff, for example, the chaplain, support these people in caring for the patient.

SUPPORTING TRANSITIONS

Within a healthcare facility clergy are important figures in supporting the transition from aggressive treatment to comfort or palliative care, and certainly in the transition of existence that death represents.

The relationship of a dying person with a member of the clergy is different from one with a social worker or nurse. Ordination confers a special authority. It serves as a counterpoint to medical authority. In our day, medicine and psychology provide the major metaphors for healing, and laity heed medical advice

with the sort of deference given religious advice in earlier times. By symbolically representing God's presence, however, the clergy can help patients take medicine less seriously by reminding them that there is mystery beyond technical trappings.

A twenty-two-year-old man had come in earlier with serious trauma from a motorcycle accident. The patient had been in surgery for three hours by that time, and the medical staff straightforwardly told the family that the situation was grim. Ten family members were gathered in the waiting room, most of whom spoke only Polish. Mary, the hospital chaplain, was speaking with the family through a translator. Immediately as we entered the room, the uncle asked: "Are you doctors?" They expressed anxiety that it had been so long without any word, and [said] that they wanted to speak to a doctor. Mary explained that we had no news and that, in some cases, it takes a long time.

An hour or so later Mary told me about the meeting between the doctor and the family. She said the doctor informed the family that the patient was not going to survive. The family reacted very emo-

tionally and vocally, which she thought was a healthy expression of grief. When the doctor mentioned organ donation, the father vehemently opposed the idea. Mary told me that she "said a lot of prayers with them."

Mary paged the on-call Catholic priest to come for the Sacrament of the Sick [a ritual for the sick or dying, once popularly known as last rites]; we joined while the ritual was in progress. The immediate family was present, and they participated fully, following the priest's instructions and reciting the appropriate responses in English. They also said the Lord's Prayer in Polish when encouraged to do so by the priest. I found their compliance to be in sharp contrast to their hesitancy in dealing with Mary earlier. This ritual was clearly supporting the family's transition and a commissioning to eternity, not simply a healing ceremony.

—hospital observation

This story illustrates two forms of spiritual care that have a powerful effect and represent the priestly function that clergy offer to patients, families, and staff: one is prayer and the other is ritual. Prayer is a significant feature of the religious and spiritual lives of the patients

and families we observed and interviewed across the three settings. Facing a life-threatening illness or an impending death, people seem to feel estranged from life's mainstream: "I feel very isolated, even though people have been great." Prayer is a means of spiritual support. Whether the patient was an active member of a religious community or not, whether they described prayer to a transcendent God or spoke of words "thrown out there," prayer was mentioned by everybody as a way to express important words that need to be said. Whatever the words one uses, the time of prayer represents a time set aside in the ordinary day during which they can express their innermost thoughts.

Along with prayer, ritual serves another important function as a transitional activity in spiritual care at the end of life. The SUPPORT study failed to confirm the conventional wisdom that better communication and respect for autonomy will make a "good death" possible. Larry Churchill argues that communication and advance directives will not lead to the kind of death that the SUPPORT researchers find desirable, specifically, one not mechanically supported, painful, or prolonged.³³ People want aggressive care until the end. To change patterns of dying, we need ritu-

**Patients viewed prayer
as a way to express
important words that
need to be said.**

als to help with the various transitions that occur over the trajectory that is the end of life.

Recall William F. May's description of the deeper kind of problem in life, where the question is not "What are we going to do about it?" but "How do we behave towards it?" These are the problems that you don't simply solve and put behind you. They don't admit to technical, pragmatic solutions. This second question poses a deeper challenge that no specific policy, strategy, or behavior can dissolve because the problem, frankly, will persist. It requires behavior that sensitively and appropriately fits the challenge that won't go away. According to Marcel, this type of problem resembles a mystery more than a puzzle: "It demands a response that resembles a ritual repeated more than a technique applied."³⁴

Ritual is sometimes dismissed as habitual and essentially meaningless activity. In spiritual care, it is "the established form of a ceremony."³⁵ Ceremonies

allow participants to dwell in meanings, creating integration and wholeness, community and order, in the context of the particular religious tradition. Rituals divorced from religion—perhaps solitary ritual acts—can serve similar purposes. They may put less emphasis on community and more stress on the self-defining meaning. Rituals give to ceremonial events an order to follow. This ordering is especially useful when the life events being interpreted are stressful, involving passages into the unknown, uncertain, or dangerous.³⁶

The importance of ritual activity is very pronounced in end-of-life care. Rituals create a special time and space and, thus, offer a way for participants to experience the mystery of human existence while transitioning from life to death. Clergy purposefully create conditions for that experience. Whether they take place on a formal or informal basis, rituals are crucial in restoring a sense of order and meaning to the experiences of patients, families, staff, and the clergy.

For particular patients, hospitalization exacerbates the threat that their illness represents to their ordinary lives. For those patients enrolled in the study under hospice or congregational care, their illness “marked” or disrupted their existential and social lives in tangible and

intangible ways. Ritual activity seemed to be an effective way to help restore a sense of control or order to their lives. Ritual did not eliminate the illness, but made the “fact” of it more bearable.

Tom Driver writes, “Rituals are primarily instruments designed to change a situation: They are more like washing machines than books. A book may be about washing, but the machine takes in dirty clothes and, if all goes well, transforms them into cleaner ones.”³⁷ Ritual activity consists of a series of transitions, taking one out of the self and bringing him back again, helping him to a different understanding or perspective on his situation.

For example, a family gathered in the hospital following their father’s serious heart attack. When told of his “grave” prognosis—a term that conjures up images of death, and in fact the man died several hours later—the family clearly expressed the anger, fear, confusion, and grief associated with this experience. Each person, to some extent, felt the disruption of their normal life caused by such a sudden and devastating event. The chaplain on call offered his presence and prayer, but he was rejected. When the family’s priest arrived, prayed with the family, and led them through the Catholic ritual of anointing the sick, a sense of order

was restored. The ritual interaction between family and priest served to control potentially overpowering emotions, allowing for their release, while restoring order to the situation. One interesting feature of this observation was the public nature of the prayer and anointing ceremony. While ritual activity may occur between two parties—the patient and clergy person, for example—often the ritual activity has a public nature. Thus, ritual has a community function.

Because rituals are matters of display, they are interactive and social. As such, rituals establish or enhance solidarity and relationship among the participants. Ritual's rhythms, displays, and other techniques can summon energies together, fuse them, and increase their power, steered by norms that guide their expression. While their loss was all too real and disruptive, the family in this scenario was able to experience the sudden, unexpected death as a family, in a way that acknowledged what they were going through while reminding them of their bonds and their history together. In this case, while it was not the hospital chaplain who facilitated this dynamic, the words and actions of a clergy person, the parish priest, greatly benefited the family.

Ritual acts offer a sense of familiarity, meaning, and reasonableness to

events and feelings that otherwise disrupt the fabric of our "normal" experience. In the case of death, of course, these feelings can be very upsetting. Traditionally, rituals that accompanied death and dying were guided by socially sanctioned figures, such as clergy. They involved family and community members, and offered participants an opportunity to say goodbye, to express themselves through prayers or other acts. Rituals allowed the dying to give final instructions or counsel to survivors. In a sense ritual activity represented a ceremonial preparation for death in which the dying person was never alone.

Can clergy help the nonreligious person, or a person from a non-ritual tradition, through prayer and ritual activity? Although the element of trust in their relationship is crucial, the lowest common denominator of ritual is a rite of passage in which the participants are taken out of and then brought back into their everyday lives, for a common purpose. As a result, rituals promote solidarity among participants, creating a community bond and validating the importance of their relationships with each other. Rituals are a means to recognize the patient as person. They enhance communication by providing a normative way to talk about stressful, life-changing events. Dying is

Rituals give us something to do when feeling powerless.

dangerous to the modern sensibility; rituals give people confidence and hope in the face of that danger. They give us something to do in the face of feelings of powerlessness. Rituals, therefore, provide us with the power of active participation in the course of events.

As people near death, they enter what may well be the most vulnerable and potentially isolated period of their lives. For many people death is alien, to be feared and resisted. The presence in a ritual of those whom the dying person trusts makes several things clear. First, dying is not an individual and isolated event; it is a community event and responsibility. Further, dying is not an alien part of life. Finally, dying within community can be life giving because immediate human needs—being greeted, touched, heard, and accompanied—are addressed at this crucial time. The intent of prayer and ritual is not to say magical words to open the door to an afterlife that would otherwise be closed. The intent is to let the dying know how important they are to family, friends,

and other caregivers, and how important their emotional and spiritual well being are as they make the transition from life to death.

Whether earlier or later, there are ways to create the conditions for effective transitions along the end-of-life trajectory. Megory Anderson describes the importance of establishing a special space in the patient's home or hospital room.³⁸ She suggests cleaning the area to create a sense of purpose and participation. Special touches, such as flowers and an open window, add to the sense of space. The important task is to create movement from outside to inside, and to create borders with actions that signify transition by washing hands or taking off shoes. The patient's bed becomes the center of the sacred space, surrounded by family, friends, and caregivers.

Anderson also emphasizes the importance of the senses in ritual activity. Sight, sound, and smell all play a part. Visual images are important reminders of who we are and of God's presence. Why have the television on? Put something meaningful in the patient's line of sight. Pictures, candles, or prayer objects offer comfort and reassurance. Silence, the spoken word, and music can be powerful. Minimize phone calls; ask people outside to be quiet.

Out of respect for the patient, there should be no idle chatter. Consider the sense of smell. Institutional odors are distinctive; masking them with “sweeter” smells may be overwhelming to the ill. Yet, smells do evoke memories. Incense is mentioned in Scripture—Psalm 141: Let my prayer be counted as incense before thee. Lighting and extinguishing candles can symbolize a beginning and end to the ceremony.

As Churchill describes the medical and hospital ritual of cardiopulmonary resuscitation in his article, there are rituals that may work against better care of the dying and serve as challenges to clergy offering spiritual care. For the components of spiritual care to become ritualized they must be part of the customary way of caring for the dying—one of the first things that comes to mind, rather than an alternative that is considered after all else fails.³⁹ Too often, now, spiritual care for the dying occurs after medical care fails. It needs to be integrated into patient care plans, early in the end-of-life trajectory.

COOPERATION AND COORDINATION

When I was growing up I was a member of a Lutheran congregation. I felt close to that pastor and his wife. He died a number of years ago. I don’t feel

a connection to the new pastor or to the congregation.

—a patient

I have good relationships with the hospital chaplain. One night a parishioner was badly hurt in a car accident. The chaplain helped his wife call me, oriented me to what was going on when I got there; he helped, then faded out, and respected the unique relationship I had with these people. I’m very respectful of them [chaplains].

—congregational clergy

Seriously ill people often move back and forth from their home to the hospital, to a step-down unit or a long-term care facility. These moves may occur over many months and occur several times, until the person enrolls in a hospice program or death occurs. For patients who are not religious, or who are separated from their congregation, the clergy can still represent continuity with values that may help them in their need for recognition, companionship, hope, and meaning in their illness. However, while clergy spoke of good relations with colleagues outside of their own arena of care, there is some evidence that hospital, hospice, and congregational clergy are not wholly coordinated and interactive.

There are factors that work against the continuity and coordination of spiritual care. As we have seen, personal and institutional issues work against such care. Overworked clergy, with little time, stretched in many ways, tend to concentrate on the demands of their particular care setting, and leave others to concentrate on their own setting.

In addition, the division of labor in clergy ranks between health care and congregational care may foster turf issues. For example, healthcare chaplains are trained to be “patient-centered,” open to and inclusive of people with diverse spiritual and religious beliefs. Congregational clergy are trained to be “tradition-specific”; their approach to care in that sense is more narrowly focused. This difference creates tension. As one minister said, “I don’t want some Unitarian chaplain to corrupt my Baptist parishioner. I have to evangelize to be faithful to my tradition, and be here for you. That’s what I do for you.” How can these two clergy persons work together to better coordinate care?

Another example: A hospital CPE student develops a relationship with a patient and family who are members of a particular faith community. Because he or she is walking the acute care journey with them, that chaplain, not the con-

gregational pastor, may become the one to whom the patient looks for care. If the family asks him or her to do the funeral, will the community clergy person be upset? What is the chaplain’s role in bereavement care? Should the chaplain hand off the funeral and follow-up care to the congregational clergy person? How can they work together to develop the most comprehensive care plan possible for end-of-life and bereavement care?

Because of confidentiality and privacy issues, hospital and hospice clergy feel that they must ask whether the patient wants them to contact the patient’s congregational clergy. This respect for patients’ wishes is understandable; there are many patients who, for various reasons, do not want their clergy to know of their illness. Also, due to the particular nature of relationships within congregations, congregants with serious illness may not want others in the community to know of their situation. How can clergy cultivate the relationships that will reassure patients and families that their spiritual needs will be met, across settings, throughout the end-of-life trajectory?

If a patient had an affiliation with a religious community and a relationship with its clergy, there was agreement in our study that congregational clergy were

the best to support the sick person and family.

What I basically try to do is once I know a parish clergy person is in there, I try to get out of it and support the parish clergy as much as I can. This is the place where [the patient and family] live. They've chosen to go to this church. They've chosen this guy as a pastor. This pastor has come to be with his flock, and I'd better be able to provide the resources to this pastor as best as I can that's going to help him or her get their parishioner to where their parishioner needs to be. But at least to get information out to their pastor so they can do their job, hopefully as effectively, and probably more effectively than what I can do, because he or she has the benefit of prior relationship. I don't.

—hospital chaplain

Both chaplains and congregational clergy recognize the importance of this prior relationship. One congregational clergy described visiting the family of a hospitalized parishioner gravely injured in a car accident.

It's personal relationship . . . If I been the chaplain last night, all I would

have known was, here was an African American man who was 60 years old who was in a car accident, and he had a wife who was very upset. I, on the other hand, know parts of his story. I married them three years ago. I remember him breaking out in a cold sweat during the wedding ceremony. The faith stuff that moved them from living together to, "this is outside of the will of God," and the decision to get married. And so there's a whole story that's frequently connected with it. It's a real strong passion for me that I'm in ministry to real people, and not to "things in a situation."

Another pastor spoke more assertively of the way in which he coordinated his pastoral support with hospital chaplains.

I have had more encounters with hospital chaplains than I've had with fellow clergy and in working with hospital chaplains, I take the position of speaking to the chaplain and asking for the lead role. If I am present, I do not want the chaplain to take the lead role. I consider that to be my responsibility, and if it's in the case of the dying and the family need to be talked to, I would rather do that because I would want it

to come from someone they have a relationship with, rather than a stranger . . . I do get cooperation from them [chaplains]. I find most of them, as long as they are present, they are comfortable, but they give me the lead.

However, other congregational clergy spoke of some discomfort with the hospital environment. Others seemed to have a sense of protectiveness toward hospitalized congregants, in some ways reminiscent of concern for one's own family members. At least one chaplain noted that such discomfort or protectiveness produces a distance between pastor and chaplain.

A lot of times I don't see them . . . they're here but I don't see them. But when I do, I offer myself as hospitable . . . "We're glad you're here. Is there anything I can do to help you be here?" I find—it's very interesting—I find most congregational pastors to be very turfey. They do not want my input.

—a chaplain

There are several ways for chaplains and congregational clergy to know each other. First, hospice and hospital chaplains should be attentive when congregational clergy visit their congregants.

Second, respecting patients' confidentiality, chaplains should consistently ask patients if they want their congregational clergy contacted. Third, with patients' permission, clergy should have follow-up contacts with each other to check on a patient's status. A fourth way is through active participation in clergy associations. Clergy can also work to create a local network of hospitals, hospices, and congregations to bring together clergy from the different settings interested in end-of-life issues. Sixth, chaplains might offer to speak at Sunday school classes, or participate in congregational worship services, giving sermons or reflections on the spiritual concerns of people facing the end of life. Finally, hospital, hospice, and congregational clergy should respect each other, appreciating the important work each is doing on behalf of people facing life-threatening illness.

RECOMMENDATIONS

There are a number of points to keep in mind when thinking about spiritual care at the end of life.

Clergy should be alert to a range of spiritual needs

For patients with a life-threatening illness and their families, the world has been turned upside down. A person's

The dying seek to transform their experience from disorder to order.

awareness of his own mortality changes how he thinks about his life. While humans generally block knowledge that they will die, facing the end of life makes a person acutely aware that death is not simply something that happens in the world, but something that will happen to “me.”

The diagnosis of illness transforms a person’s story, shakes her out of the taken-for-granted attitude of her everyday life. The person with an illness has a new way to think about herself, and the more extreme the diagnosis in its implications, the more imposing this new identity is. In a very real sense, the new identity is one already scripted by medicine. Medicine hardly creates renal disease, for example, but it creates the career of the renal patient—it has scripted a story. Being a person with a life-threatening illness, a person who is facing death, carries with it certain social expectations.

People often resist becoming the story that medicine wants them to be. They want something else. They want someone who will care about them all the

way through. They want recognition of their suffering from those who see suffering most clearly.

Acutely ill people or dying people want to make sense of what is happening to them. We live our lives on a certain map. It is a geographical map, of course, but it is also a map of purposes—a map of everything we have done, everything we are now, and everything that we hope for. Few people have a spot for cancer, renal disease, or even old age on that map.⁴⁰ Illness requires people to redraw their maps, requires them to incorporate these territories, requires them to find a new destination and a way to get there. This is the process of making sense. How does the patient begin to make sense of what has happened?

The story we talk about is this new map; the story is the attempt to find a new destination. The curious thing about this story as a map is that because the territory is unexplored, patients are like the very earliest cartographers—they are drawing the map as they make the exploration. In religious and spiritual language, in relationship to the transcendent and to others, they seek some means to reestablish their identity and to transform their experience from disorder to order, so that they can regain some control over their lives and perhaps over their deaths. They

want someone to care for them, to accept their fears, and to allow them to speak the words they need to say, in whatever way they need to say them, without fear of rejection or platitudes. The spiritual needs of patients and families are for acceptance, compassion, and understanding. They need companionship, someone who is willing to accompany them, to reassure them that they will not be abandoned, even to their death.

The clergy's role in providing spiritual care for dying people is to provide that companionship. Due to their office, and their presence in the hospital, hospice, nursing home, or faith community, they occupy a position juxtaposed between life and death, between health and illness. Even though much of a chaplain's work, in particular, would not appear spiritual at first glance, it is such nonetheless. Completing paperwork, being entrusted with valuables, being there for people and giving them permission to talk about both mundane and ultimate concerns, translating medical terminology, serving as go-betweens for patients and medical team members—these are expressions of spiritual care. No one else in the hospital has this unique set of duties. Who would pick up these duties if chaplains were removed? At times chaplains serve as managers of a

The clergy's role is to provide companionship.

patient's dying, orchestrating the process, enlisting family, physicians, nurses, and others. Through all this, chaplains offer a unique perspective to patients, families, and staff. In the face of death, chaplains recall the values and blessings that make the dying person's life meaningful, and they help the patient reconcile with himself and others.

The clergy should not underestimate their symbolic power

When it comes to the end of life, the clergy have powerful roles—priest, prophet, communicator, translator—that are sanctioned by our society. In this work, clearly the figure, role, and presence of clergy are significant. As administrators and facilitators of ritual, for example, the clergy demonstrate their power of naming, articulating what others cannot or are afraid to say, in a way that channels the dying experience. It is important to recognize the status and role of chaplains: Invested with roles that no one else in the hospital or hospice has, they can be identified with

When the clergy is present, the patient sees the community as present.

illness and death in ways that others are not.

As representatives of the religious and the spiritual, clergy offer the symbolic presence of the congregation, too, in caring for people facing death. Patients who are members of faith communities often view the religious community as virtually absent—irrespective of how many congregational members or hospital chaplains visit—until the congregational clergy person appears. When the clergy is present, the patient sees the community as present. For these patients, clergy represent the religious community and symbolize God's presence and fidelity. Clergy need not apologize for their presence in health-care institutions, whether as visitors or as members of the healthcare team.

The clergy should be available as faithful companions to the dying

As I listen to people some of the things I hear are that "at this point my religion doesn't seem to offer me any support. The priest comes by and gives me com-

munion; the rabbi comes and teaches; the pastor comes, and he seems more uncomfortable than I do." I think we're not training people who are in ministerial positions well enough on this issue. I think we could really educate that minister that seems uncomfortable, we could help rabbis, priests, or pastors be more attuned to what their religion offers to the dying. But there's also just some genuine personal spiritual needs that people have. They need to have someone listen to them and hold their hand and help them walk through whatever their religious tradition has in a way that's helpful rather than dogmatic.

—a chaplain

Among the qualities mentioned by patients as important in their spiritual caregivers—genuineness, humor, flexibility, attentiveness, empathy, and a listening presence—one that seemed particularly important was fidelity. Patients wanted someone on whom they could count as a companion through their illness. In a way the spiritual caregiver becomes a co-sufferer with the patient, someone who signals that she will remain faithful no matter what. Given the clergy's symbolic power, to have that companion be a clergy person to whom the patient can bare

all is a blessing, a confirmation of God's presence.

Spiritual care at the end of life demands a wakeup call at the institutional level

Both healthcare and ecclesiastical institutions must attend to the barriers and obstacles that inhibit spiritual care of the dying. There is excellent medical care at the end of life and excellent spiritual care when the relationships among the patient, families, and caregivers are cultivated. Building relationships of trust between patient and caregiver is the key to good medical and spiritual care. Building trust takes time, however, and something of a stable environment. Institutions need to take a long look at the value of spiritual care for people moving across the trajectory of end-of-life care. There are several questions that institutional leadership must ask.⁴¹

- Do these institutions recognize and compensate for the strains on dying people that exist along the continuum of care? Institutions in which seriously ill people receive care are in transition, revising patient services and reshaping the way in which these services are delivered. Due to the forces of managed care, patients constantly find themselves in relationships with new physicians. As

their care needs change, so do their relationships with clergy. Patients may move some distance to live with relatives, to receive care from new and unfamiliar faces. People go through stages in their illness, moving from home to hospital to other care facility; they become sicker and able to attend religious services less often. Over the course of their illness their congregation may engage a new clergy person. If the person now goes into the hospital or hospice, he or she may not feel a connection with that clergy. If asked, "Do you want us to call your pastor?" the patient may well answer, "No, I don't know her very well." Under these circumstances, chaplains become essential. Healthcare institutions need to provide the resources necessary to support all patients, particularly those facing the end of life, as they wrestle with their illness.

- Do these institutions attend to diversity issues and staff training associated with those issues? Cultural, socioeconomic, religious, and ethnic differences between patients and chaplains are apparent and can affect spiritual care. In hospital, hospice, and congregations, the opportunities for spiritual caregiving are enhanced when clergy's access to the dying person rests on trust, and most importantly on a relationship that develops over time. Our data

indicate that there is a benefit when “common ground” exists between the spiritual caregiver and the patient or family. But this optimal scenario is not possible in many circumstances. Even when little is shared by the parties in terms of language, culture, and so forth, spiritual support is not impossible. Patients rank empathy, warmth, sense of humor, and flexibility as central features of spiritual care. These factors can be independent of “common ground.” Nonetheless institutions need to provide culturally competent training and support to caregivers.

It is not uncommon for chaplains to feel frustrated and unable to find appropriate words to respond to patients from different religious traditions, those of no tradition, or those who express a different spiritual orientation. Perhaps they feel that prayer is universally welcomed, or that tolerance for others’ spiritual beliefs should elicit only respectful silence.

Yet the language and symbolism of spirituality, or religion, frequently convey vital information to the clergy caregiver about patients’ or families’ inner experience—what they are going through emotionally, mentally, spiritually, and psychosocially. It does not help when dialogue comes to a halt simply because patients and families express

Does the institution recognize the stresses of providing end-of-life care?

what they are going through in spiritual terms.

- Do these institutions care for their staff? Does leadership recognize the unique stresses in end-of-life care and provide emotional and spiritual support for staff? Does it encourage self-care and provide appropriate in-service opportunities to support the caregiver?

- Does the healthcare institution integrate spiritual care into all levels of care and look to its chaplains and clergy to participate in leadership?

- Does the institution or faith community welcome and encourage non-professional (volunteers or lay members) participation in end-of-life care under the guidance of a chaplain/clergy?

- Do these institutions value and support the use of ritual with patients, congregants, and staff?

- Does the institution or faith community value spiritual care sufficiently to provide for adequate professional staffing?

In the congregational setting, clergy leaders need to reflect on their role in

end-of-life care. Congregants facing serious illness look to their senior clergy for care. Given all that these figures have to do, stewardship or a sound use of resources may suggest the use of lay members or volunteer care teams to support the sick until the acute phase of dying when the clergy can intervene. But the seriously ill may want more than that: How can the clergy leadership work with the system to better meet their needs? What kind of leadership in end-of-life care can the clergy provide? Religious traditions have so much to say about pain, suffering, and comfort, and the clergy is central to that message.

When does spiritual preparation for dying begin? The thanatological literature conceptualizes death systems as the way in which people “live their dying,” a multifactorial and longitudinal process over the life course. If this is true, it seems that spiritual care at the end of life is “too little, too late” and that the intervention(s) should come much earlier.⁴² Congregational clergy should initiate earlier, recurring talks with congregants about the role of the clergy and congregation, and the support they have to offer. Such conversations might make it easier in times of crisis for people to raise their concerns. Clergy should work to overcome the taboo of death. For example, an occa-

sional sermon can offer the community the chance to reflect on death, what the tradition offers as support, and the clergy’s thoughts on the subject. Brainstorming with the congregation, through focus groups, will elicit their questions and concerns about spiritual issues and end-of-life care. Education about advance directives, in the context of the religious community, gives people the opportunity to raise spiritual issues.

Spiritual care needs to begin earlier, before the onset of illness. Clergy must help people frame their lives in the larger context, so that death is understood in a larger perspective. Congregational clergy seem to have a distinct advantage over hospital and hospice chaplains, in that the former know patients in the larger context of their lives. Although a chaplain might know a patient from a previous hospitalization, in our study most of the visits by hospital chaplains were “cold.” Patients typically leave the hospital before a relationship can be well established. A hospice chaplain may come to know patients, sometimes intimately, in the course of their dying, but clearly this relationship comes into existence because of the particular context for the person’s care.

Ideally, congregational clergy give care from cradle to grave. The recent

phenomenon of mega-churches or of “church shopping” might make this familiarity harder to achieve. One factor that may overcome the disadvantage here is shared religious or ethnic identity between chaplain and patient or family. In some cases people may not know each other personally, but they share a common identity that mitigates the “stranger” label.

There were examples of good working relationships between hospital or hospice chaplains and a patient’s congregational clergy person. Hospice chaplains mentioned the contributions that congregational clergy can make to spiritual care for hospice patients. However, these occasions seemed the exception, rather than the rule; the chaplains also made note of their perception that congregational clergy “seemed so busy” that they became involved towards the end of the parishioner’s life, as the person was actively dying.

One concern of congregational clergy was straightforward: Several noted that they felt like “outsiders” when then entered the strange environment of the hospital. One church pastor had encouraged lay people to undertake visitation to hospitalized patients. As a result, he did not visit hospitals much anymore, unless

a death was imminent. One felt that he was viewed with suspicion by hospital staff, as if his presence was unwarranted. Clergy from all settings acknowledged the need for better communication and peer support.

*It’s OK to be unprofessional—
Be a person*

Chaplain H. makes me feel good. He’s a happy sort of guy . . . Tell the clergy they shouldn’t get too deep into religious stuff. They should say prayers, but not focus only on religion all the time. Tell them to keep it light.

—a patient

Spiritual care at the end of life is not rocket science. Time after time, patients noted the importance of humor. They want clergy not always to be solemn, but to “meet me where I am.” Humor transforms the moment, often opening the way to conversation about deeper concerns.

The heading on this final section is not “It’s OK to be funny.” Many professionals who are concerned with improving end-of-life care focus on the importance of bolstering the patient’s authority to make decisions that physicians will respect at various points along the way to a good death. Stressing deci-

To hide within a professional role is to miss the theological truth.

sions to be made and problems to be solved, however, makes care external to the patient. Spiritual care recognizes that the end of life involves the patient's internal and external lives—one directed to the relationship between the self and the transcendent, the other to relationships with other people. For patients fortunate enough to have committed, sensitive support and guidance, the two dimensions can deepen and resonate with each other. Although decisions need to be made, dying is not primarily a problem to be solved or a process to control, but a mystery that must be lived with and confronted. We must formulate a provisional stance toward this mystery, without assuming that it is something that we can understand and manage.

Given their symbolic authority at the end of life, clergy have an opportunity to support patients in taking such an approach. But how? Patients in our study suggest that if, as clergy, you are in doubt

about your response to the person facing life-threatening illness, it is all right sometimes to forget your training, to forget everything that your colleagues or your profession seems to require of you. Be flexible; listen and respond with an attentive ear. Ask: What does human decency and thoughtfulness call for? How does one human respond to another in this situation? How do you love your neighbor as yourself?

Lonnie Kliever writes, "Both the Jewish and Christian emphasis on death is, in reality, the obverse of an even greater emphasis on life. At best death serves as a motive for a creative and responsible life. At worst, death looms as a menace to a courageous and generous life. Either way, death lends urgency to life that would be utterly lacking without it. Death enhances rather than cheapens the value of life."⁴³ To hide within a professional role or agenda, to focus too strongly on managing a good death, is to miss the theological truth that the emphasis of the spirit is on life, on the mystery of living unto death. The spirit animates until it leaves the body. Respecting the patient's cues, feel free to laugh, tell stories, be serious and offer your perspective when it's appropriate, be a friend—that is the key to spiritual care at the end of life.

CONCLUSION

Clergy can play an important role in providing spiritual care to people facing life-threatening illness and the mystery of death. Local clergy may offer care from their specific tradition by providing supportive counsel and appropriate rites. Professional chaplains generally do not displace local religious leaders, but their more specialized training for the requirements of the hospital and hospice environment enables them to complement a patient's local clergy person.

Many religiously active people, however, do not notify their local clergy of their hospitalization or enrollment in hospice. Additionally, many patients do not have an active involvement in a religious community to which they can look during healthcare crises. Therefore, the professional chaplains offer important support to dying people.

HOSPITAL CHAPLAINS

Hospital-based chaplains generally had a positive view of opportunities for spiritual care at the end of life. They saw themselves as "transitional" figures, working between the formal, organizational structures, to "assuage anxiety," "witness," and otherwise serve a symbolic role in providing spiritual care to patients, families, and staff. As such, the chap-

lains felt that the staff accepts them as part of the healthcare team, albeit in a particular, even specialized, role. Most of these clergy reflected their Clinical Pastoral Education training, speaking of being an "authentic presence," of the importance of listening and responding to the individual's needs. By being open to the patient's and family's experience, the chaplains felt they could build a connection that allowed them to help make sense of the person's life and death. Therefore, they didn't assume a common understanding of spirituality, perhaps because they interact with a diversity of people; rather, they were willing for the dying person to choose the pace, content, and rules of engagement.

The barriers the chaplains felt were not so much relational, as systemic or personal. They spoke of inadequate space and time set aside within their institutions for dying patients and families; the system's needs for "control" (for data, for policy, for adherence to Joint Commission on Accreditation of Healthcare Organizations standards); and their own personal struggles with feelings of inadequacy, dishonesty, and the sometime ambiguities involved in being priestly and prophetic.

Their description of dying well spiritually included peacefulness, tying up

loose ends, personal meaningfulness, and the presence of family and friends. If a person and family have prepared well for death by addressing their emotional, physical, economic, and spiritual concerns, and if the system and institution makes “room” for the fulfillment of personal wishes surrounding death, then good spiritual care at the end of life can take place.

HOSPICE CHAPLAINS

Because hospice calls for palliative care at the end of life, hospice chaplains find themselves in intimate relation with their patients or clients. Perhaps because patients are freed as much as possible from physical pain, while recognizing they are dying, they are able to consider spiritual issues. They have the opportunity to address life issues, and to try to narrate and make sense of their life story. Encouraging individuals at the end of life to tell a life story is a central feature of the work that the hospice chaplains described as “spiritual care.”

Although hospice chaplains try to meet the spiritual needs of all patients, spiritual care in their context is not primarily about denomination, creed, or belief. Hospice chaplains are sometimes called in to provide spiritual care and support for atheists, agnostics, and those

estranged from a particular denomination; such care is also offered in the hospital setting. Hospice chaplains are focused on meeting patients’ needs—for connection, comfort, support, and companionship. In many of the visits we observed and others that we heard about, chaplains were called in, not to fulfill an expressly “religious” role or duty, but to provide what on the surface might seem like mundane support. Hospice chaplains reveal that they are able to meet patients’ needs because they are the only members of the hospice team who are not called in to perform some other duty. They are available to listen. By listening, they can identify patients’ interests and meet their needs for attention, support, compassion, and so forth.

CONGREGATION-BASED CLERGY

The congregational clergy certainly recognize the need for spiritual resources at the end of life; in providing ongoing care for their congregations or communities, these clergy are constrained by their community members’ general reluctance to discuss death and by inadequate educational resources. While making assertive statements about their approaches to end-of-life care, these clergy also expressed more doubts about their abilities to provide quality spiritual

care at the end of life, possibly because in their congregational settings they are less frequently called upon to provide specific end-of-life care. Generally, they are so busy with a variety of tasks that concentrating on end-of-life care is difficult: they react to their parishioners' needs, drawing upon traditional words and practices. They acknowledge their important role at such times. Clearly the congregation-based clergy felt that they often could be a resource, as one who knew the patient and family, who had knowledge of things that need to be done and can be of comfort.

But to some extent these clergy feel a lack of education about end-of-life issues, a lack of back-up support, and occasionally a sense of isolation in their own religious communities when it comes to the realities of providing end-of-life care to patients and families. They spoke of a general reluctance of people to discuss death, and the general public perception that the clergy is seen as antiquated, irrelevant, and too identified with organized religion to be helpful in spiritual care.

Significantly, some congregation-based clergy felt rather uneasy in the medical environment that is charged with providing end-of-life care. The principal barrier they described was a suspicion on

You need time
to understand the patient's
struggles with
spiritual questions.

the part of healthcare providers about their presence in the hospital. Some felt excluded from participating in a mutual fashion with the healthcare team, including hospital and hospice chaplains, in caring for parishioners at the end of life. The hospice chaplains, one of whom was also on staff at an area hospital, did not share this view.

Hospital and hospice policies on confidentiality and privacy do not allow a healthcare institution routinely to inform local clergy that a congregant is under care. Hospice chaplains routinely asked patients about any existing clergy contacts in the community and offered—with the patient's permission—to contact the congregational clergy. In this way they were at times able to connect or reconnect not only the patient but also the family to a community resource that could help with ongoing spiritual growth and support even in bereavement. The two hospice chaplains who had been on staff for many years were extremely well

connected to community clergy of all faiths. One participates actively in several neighborhood-based, multi-faith clergy groups. The hospice also had played a role in organizing a network of care, linking congregational clergy with hospice and hospital services for people at the end of their lives. Some of the area clergy were more actively involved than others, but this resource helped some congregations provide social and spiritual support at the end of life.

All clergy must recognize that because patients struggle to make sense of what is happening to them, spiritual care at the end of life does not fit into a cookie-cutter or assembly line mode. Individuals facing the end of life have a wide range of spiritual needs. In order to understand a patient's spiritual life history, therefore, a spiritual care provider needs the time to establish a rapport with a patient and to identify and understand what has satisfied—or frustrated—her efforts to resolve spiritual questions and concerns in the past. Some patients might face a life-threatening illness with longstanding anger at God. Of that group, some might have learned to cope in a particular way, struggling with their frustration and anger but remaining connected to the faith community. Others might have become estranged from for-

mal religious expression. Other patients might never have questioned God and might feel frightened with the feelings their questions arouse now. To some, spiritual expression has always meant a rote recital of prayers or attending services, without questioning or reflecting. One patient noted that he never questioned God until the moment when his wife suffered a heart attack while caring for him. In eighty-eight years, that is the first time he remembered questioning God, and he was not sure how to cope. At some point in the interview, this patient mentioned that the chaplain's visits were helpful, because the chaplain listened and allowed him to talk through things. The chaplain's ability to support this patient serves as one more reminder of the clergy's power to help the dying.

I think for whatever reason, when we have that title of clergy, we carry with us something that other people look for (and it's not the same as with a social worker or nurse). If there's somebody at my congregation as trained as I am in pastoral care, in how to counsel and how to comfort the [seriously ill], the visits don't seem to carry the same weight if they come from the lay person as they do when they come from the clergy person. It's as though for some

reason somehow the hands of God have touched us, and therefore our words carry more significance.

—congregational clergy



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—E. R. DuBose

NOTES

1. George, "Research Design in End of Life Research."
2. Christakis and Lamont, "Extent and Determinants of Error."
3. See for example Buckman, "Communication in Palliative Care"; Kübler-Ross, *On Death and Dying*.
4. For example, Glaser and Strauss, *Time for Dying*.
5. For example, Kalish, "Onset of the Dying Process"; Corr, "Task-based Approach."
6. Copp, "Patients' and Nurses' Constructions."
7. Ramsey, "Indignity."
8. AMA-Institute on Ethics, "Education for Physicians."
9. Ariès, *The Hour of Our Death*.
10. See SUPPORT Principal Investigators, "A Controlled Trial."
11. If one includes Gallup's second highest mark for the clergy, the number of respondents who would seek some support from clergy rises to 71 percent.
12. Bradshaw, "Spiritual Dimension of Hospice."
13. Marcel, *Man Against Mass Society*.
14. VandeCreek, "Collaboration Between Nurses and Chaplains."
15. DuBose, "Final Report."
16. Field, *Nursing the Dying*.
17. Bradshaw, "Spiritual Dimension."
18. Appreciation for this insight goes to Marsha Fowler.
19. Fitchett, *Assessing Spiritual Needs*.
20. Wakefield, "Spirituality."
21. Fowler and Peterson, "Spiritual Themes."
22. Frank, *The Wounded Storyteller*.
23. May, *The Patient's Ordeal*.
24. Doka, "Spiritual Needs of the Dying," 146.
25. Cassell, *The Nature of Suffering*.
26. For a full discussion of story, see McCurdy, "Respecting Persons," 74–99.
27. Nelson, *Narrative and Morality*, 100; cited in McCurdy, "Respecting Persons," 79.
28. McCurdy, "Respecting Persons," 87–88.

29. See, for example, Hart, "The Contribution of Pastoral Care."
30. Ibid., 7.
31. See Ramsey, "Indignity."
32. Kaufman, "The Experience of Dying/Spirituality," 3.
33. Churchill, "Patient Multiplicity."
34. Marcel, *Man Against Mass Society*.
35. Churchill, "Patient Multiplicity," 41.
36. Ibid.
37. Driver, *Liberating Rites*, 93.
38. Anderson, *Sacred Dying*.
39. Churchill, "Patient Multiplicity," 44.
40. Frank, "Listening for the Patient's Story."
41. Tim Daaleman, personal correspondence, August 27, 2001.
42. John Schumacher, personal correspondence, September 10, 2001.
43. Kliever, "Death," 512.

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FAITH AND HEALTH

BY PATRICIA MURPHY

Current Views

Books Reviewed

God, Faith, and Health: Exploring the Spirituality-Healing Connection.

Jeff Levin.

New York: John Wiley and Sons, 2001.

272 pp. \$24.95 (Hardcover).

Handbook of Religion and Health.

Harold G. Koenig, Michael E. McCullough, and David B. Larson.

New York: Oxford University Press, 2000.

712 pp. \$65 (Hardcover).

The Healing Connection.

Harold Koenig and Gregg Lewis.

Nashville, Tenn.: Word Publishing, 2000.

240 pp. \$21.99 (Hardcover).

Never has religion and health as a topic appeared in the public press and in major medical, psychiatric, and psychological journals as frequently as in the past five years. There are bold claims that religious people are less likely to die from a variety of disorders than those who are nonreligious and that religious folk are likely to have lower blood pressure. Some medical and religious professionals find these conclusions hard to believe. The research can be methodologically weak, often the author has a bias, and results are often used to draw conclusions the

data do not support. Yet, some of this research is exactly what is needed to clarify the need for spiritual care and the tasks facing those involved in it.

The books reviewed here provide entrée into the role of faith in medicine from the differing perspectives of major contributors to the dialogue. In *God, Faith, and Health: Exploring the Spirituality-Healing Connection*, Jeff Levin provides the religious reader with a clear summary of findings in a way that proposes why religion may be beneficial. Harold Koenig, Michael E. McCullough, and David B. Larson provide a deeper approach in the masterpiece *Handbook of Religion and Health*. Koenig and Lewis's *The Healing Connection* seems to flow from Koenig's zeal—he is clearly the book's primary author—and lacks the tight, critical perspective about the relation of religion and health that is so evident in his research with other coauthors. Yet some readers will find that Koenig's autobiographical material offers insight into the personality of one of the most prolific researchers in the field. I will start this review with Levin's book to set the backdrop for the more scientific approach in the *Handbook* and will then conclude with comments on Koenig and Lewis's work.

Don't skip the introduction to *God, Faith, and Health*. It sets a friendly tone

The causal chain Levin proposes has solid backing, though not proof, in the research literature.

by inviting the reader into the community of researchers in Levin's network and offers a sense that researchers are often sincere about religion as well as qualified in their scientific field. Levin, a devout Jew, was the first scientist to receive a grant from the National Institutes of Health for an epidemiological study of the religion-health connection. As is true throughout the book, Levin carefully explains what epidemiologists do and specifies the limits to the conclusions that can be drawn from their findings. This is an important warning. Generally studies show there are associations between religion and health, but they cannot definitively claim a direct link. The causal chain Levin proposes in his "theosomatic principle" has solid backing, though not proof, in the research literature.

The religious person will find the organization of the book appealing. The first section starts with the external aspect of religion, attendance at worship, and

examines why this can be beneficial. The next section examines private spirituality, and the last tackles the mystical. Each chapter begins with a vignette exemplifying the topic at hand and ends with questions for discussion.

God, Faith, and Health provides widely accepted evidence for the first theosomatic principle: "Religious affiliation and membership benefit health by promoting healthy behavior and lifestyles." Brief summaries of some of the research makes the evidence digestible for the person unfamiliar with empirical studies. The arguments themselves are intuitively appealing. Half seriously, half tongue in cheek, Levin asks the question some critics raise: Does this mean people should join a religious group in order to be healthier? His commonsense response is that people make faith decisions on a very different basis and are not likely to choose religion for the sake of health.

Sociologists like Chris Ellison, another important researcher in this area, often point to the social support that public participation in worship provides. Principle 2, "Regular religious fellowship benefits health by offering support that buffers the effects of stress and isolation," is an appealing argument even for the nonbeliever. Studies show that

this aspect of religion is particularly important for aging populations.

In part two, Levin looks at the benefits of private spirituality, beginning with the personal benefits of worship and prayer. Research published in mainline scientific journals relies on evidence obtained by some kind of measurement. So far, worship and private prayer are measured by frequency of activity or their importance to the person responding. The reader who attends worship knows there is much more to public participation than social support. The benefits of songs, prayers, ritual, and other aspects of worship have yet to be studied. Some of these benefits are probably physiological, an aspect that secular studies have only begun to measure. Using a review by Michael McCullough in *Journal of Psychology and Theology*, Levin offers his third principle: "Participation in worship and prayer benefits health through the physiological effects of positive emotions."

It is fairly common in general studies that relate faith to health to focus on beliefs. In an interesting discussion of the fourth principle, "Religious beliefs benefit health by their similarity to health-promoting beliefs and personality styles," the author suggests some beliefs that could be harmful to health,

such as a belief that God will heal without using healthcare services. While he is honest about the possible downside of some beliefs, he offers well accepted evidence for the general benefits of religious belief for health. This positive influence on health seems related to the social and moral teachings of many religions. Members of religious groups that teach free will are more internally directed and more likely to take responsibility for seeking health care when they are ill. The field of psychosomatic medicine links psychological traits and states of individuals to their physiological reactions and symptoms. Many denominations offer religious tenets that promote self-esteem and offer ways of coping with illness or stress. Psychological well-being derived from religion, in turn, affects physical health.

Another dimension of religion that is included in many large surveys is the person's own sense of religiousness measured by a question like, "How religious are you?" with possible responses from "very" to "not at all." In several surveys of varied ethnic groups, persons who were more strongly religious were healthier and expressed a greater sense of well-being. Levin cites passages about hope from many world scriptures and links hope with better health. This leads

him to offer his fifth principle: "Simple faith benefits health by leading to thoughts of hope, optimism, and positive expectation."

In part three, Levin ventures into less commonly accepted dimensions of religion in relation to health, the mystical and the transpersonal. Nonetheless, for the religious person, these dimensions offer an interesting possibility. The reader needs to remember the warnings that the data available suggest association, not causes. While generally the author proposes that better health results from mystical experience, numinous experience could also be the result of the openness of a healthy mind. Furthermore, as Levin notes, intense experiences of good and evil like the ones described in this chapter can be symptoms of psychological problems. Until we do more careful work that takes into account markers of mental health, the mystical link between religion and health will remain fuzzy. We are fortunate to be living in a time when scientists are exploring the relationship of spirituality and health through sophisticated methods such as monitoring blood pressure. There is, for example, evidence that meditation lowers blood pressure. The future probably holds ways to explore better the sixth principle: "Mystical experiences

The Handbook of Religion and Health could become one of the most valuable tools available.

benefit health by activating a healing bioenergy or life force or altered states of consciousness.”

The final principle, “Absent prayer for others is capable of healing by paranormal means or by divine intervention,” is offered with the acknowledgment that the evidence available, so far, is not conclusive. This section describes many of the investigations that have attempted to explore the phenomenon of intercessory prayer. Although these studies are less apt to be taken seriously in the field of medicine, their collection and description in one place is very worthwhile.

Levin offers a clear summary of the tremendous amount of work exploring a link between faith and health. Levin’s cautions about how to understand results keep his contributions within the parameters of what has been largely accepted by other scientists. The goal of most research in the medical field is to promote better health or better quality of life for those with dimin-

ished health. The discussion questions for reflection at the end of each chapter take this work from the realm of theory into application.

Koenig and Larson, who are specialists in psychiatry, and McCullough, a psychologist, are solid researchers in their own right. Their outstanding publication, *Handbook of Religion and Health*, could become one of the most valuable tools available for those wanting to undertake research themselves or to understand better work that has been undertaken so far. The solid scientific quality of their work is demonstrated in the fact that a very positive review of the handbook has already appeared in the *Journal of the American Medical Association*.¹ Although the scientist will find this book the most pleasing of the three reviewed here, the writing style makes the material accessible not only to researchers but to healthcare and religious professionals as well.

The trio takes on the daunting task of critically reviewing the research conducted between 1900 and 2000 that measures the relationship between religion and various mental and physical health outcomes. The introduction explains why there is growing interest in this field, and, more importantly, provides an explanation of how the 1,200

Along with summaries of the research on health issues, this book contains other treasures.

studies reviewed were selected. The criteria for evaluation reflect the reality that not all research, even if it is published, is good research. A table at the end of the book highlights each study and rates its quality. Not every reader will pore over this table, but this critical ranking offers validity to contents of the handbook.

Along with summaries of the research, organized according to health issues, this book contains other treasures. An important and recent development in research is the attempt to clarify the terms “religious” and “spiritual.” According to the book, religion is an organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent—God, higher power, or ultimate truth/reality—and (b) to foster understanding of one’s relationship and responsibility to others living together in community; while spirituality is the personal quest for understanding answers to ultimate questions about life, about

meaning, and about relationship to the sacred or transcendent, which may or may not lead to or arise from the development of religious rituals and the formation of community.

A diagram clarifies the distinction and overlap of the two for five major religious groups: Islam, Buddhism, Christianity, Judaism, and Hinduism; and a table tells how many adherents each of these religions have, both in the United States and in the world. This is followed by an explanation of different dimensions of religion: religious belief, denomination, organizational religiosity, nonorganizational religiosity, subjective religiosity, religious commitment/motivation, religious quest, religious experience, religious well-being, religious coping, religious knowledge, and religious consequences. A comprehensive history of religion, science, and medicine going back as far as 6000 B.C. locates the current sense that there is a link with a very long and old tradition. This history is worth reading in its own right.

Reflecting twentieth-century debate on whether religion is helpful or harmful to its participants, a chapter is devoted to the positive effects of religion. After a selection of scriptural passages and quotations of religious writers, there is a brief history of the pastoral care move-

ment. In order to understand the debate about religion and health, it is important to read the ensuing chapter on the negative effects of religion. This includes the classic opposition by Freud as well as the more current objections by Albert Ellis, the founder of the Rational Emotive Therapy technique. The latter discussion is already outdated because of Ellis's recent article claiming that some religious beliefs are quite similar to his healthy beliefs.² That Ellis changed his approach reflects the convincing evidence of the overall benefits of religion for persons of faith. Nonetheless, the treatment of negative consequences of religion provides a balanced approach by the authors who approach their task as scientists.

This handbook is intended to serve as a reference and is accessible because of good organization. In the section titled "Research on Religion and Mental Health," the volume covers the topics of well-being, depression, suicide, anxiety disorders, schizophrenia and other psychoses, alcohol and drug use, delinquency, marital instability, and personality. The next part, "Research on Religion and Physical Disorders," includes heart disease, hypertension, cerebrovascular disease and the brain, immune system dysfunction, cancer,

mortality, religion and disability, pain and other somatic symptoms, and health behaviors. The authors provide enough statistical information to satisfy the expert in research, but not in a way that might overwhelm the average reader.

The section on clinical implications for health professionals suggests that the health professional explore with patients whether religion would help them cope or heal. It also strongly emphasizes the importance of chaplains on the healthcare team and advocates the use of local clergy. After a gloomy description of the cutback in chaplaincy services in many hospitals, this section points to the need to investigate the impact of chaplaincy services on healthcare costs. The authors would like to see chaplains integrated into the multidisciplinary care team by participating in morning and evening rounds; supporting patients, family, and hospital staff; participating in discharge planning, especially by connecting with the person's home religious community; providing spiritual assessment of all incoming patients; and providing religious services and sacraments. Having provided suggestions for pastoral counselors and religious educators, the book uses the overall results of research in religion and health to identify some of the most important

tasks for local clergy in educating congregants about health care.

Not only researchers, but all concerned about health, should be grateful for the wealth of information this volume provides to support better research in the future. The section on priorities for further research is a gold mine in itself. Besides pointing to specific topics that could enhance our knowledge, the section outlines design issues and provides a thorough treatment of measurement tools. For serious investigators, this section in itself is worth the cost of the book. Although the size and cost of the book might discourage its purchase, taken as a whole it is an invaluable reference for healthcare providers, chaplaincy departments, and local clergy.

As for *The Healing Connection*, many readers probably would not get past the first two chapters. This part of the book would certainly cause the skeptic to be critical of any of Koenig's work. The first section, an autobiography, provides a complex picture of someone who seems fairly intense and driven. I found myself wondering about the nature of some of the spiritual experiences Koenig describes. Koenig himself acknowledges that some behaviors earlier in his life, before his healing, show signs of mental illness. The high

need for achievement and perfection that Koenig portrays makes clear why his work is of such high quality.

"Publish His Glorious Acts," the first chapter in the section on Koenig's research, reflects this book's theme of witnessing to God's healing power. The author provides information about his studies in a simple way, illustrating findings with stories. Because some of the stories he tells border on the miraculous, the scientist and the less fervent reader—someone who is not Christian—might question the benefits of religion in everyday situations.

The final section of the book, "The Link for Us," is definitely worthwhile. Koenig looks at common types of negative coping that can be associated with poorer prognoses. With each type, he offers ways to address the problem that results from the negative coping. Any person providing spiritual care would do well to read this section. In a chapter summarizing the meaning of his research, Koenig acknowledges that research in no way proves that God exists, nor does it guarantee that faith heals physically in every individual case. As other believers know, faith can always heal in some way at a deep level of our being. He concludes the book with very practical suggestions for pro-

viding spiritual care for individuals and congregations.

These books appear at a very important time in our country. Fifty-six percent of Americans³ report that religion is very important in their lives, and 68 percent of Americans over 50 have some religious affiliation. The link between religion and health has important implications in the face of limited access to health care and the growing number of elderly. Faith is a resource we cannot overlook. All three of these books take research to the level of practice. Levin makes the research interesting and readily understandable. Koenig and colleagues present probably the most valuable contribution to this field written to date. Unfortunately, Koenig and Lewis's work could provide ammunition for critics of studies linking religion to better health. Nonetheless, read carefully, it has the merit of providing beneficial suggestions. ■

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NOTES

1. Harriet S. Meyer. Review of *Handbook of Religion and Health*, by Harold Koenig, Michael McCullough, and David B. Larson, *Journal of the American Medical Association* 286 (2001): 465–466.
2. Albert Ellis, "Can Rational Emotive Behavior Therapy (REBT) Be Effectively

BEING HUMAN ON EARTH

BY CYNTHIA D. MOE-LOBEDA

Our Role in Reversing Environmental Degradation

Books Reviewed

Being Human: Ethics, Environment, and Our Place in the World.

Anna Lisa Peterson.

Berkeley: University of California Press, 2001. 300 pp. \$18.95 (Hardcover).

The Care of Creation: Focusing Concern and Action.

R. J. Berry, ed.

Downers Grove, Ill.: InterVarsity Press, 2000. 213 pp. \$17.99 (Softcover).

The last third of the twentieth century witnessed an unprecedented shift in Earth-human relations. Human impact now threatens Earth's capacity to regenerate life as we know and love it. These two books face that stark reality, and breathe hope in the midst of it. They respond to a profound need for theological, ethical, and spiritual grounding for transformation in the human species' relationship to planet Earth.

An abundance of books probing roots and implications of the ecological crisis has appeared in the last decade. The works span disciplines, transgress conceptual boundaries, and invite unlikely conversation partners. The terrain is both rich and chaotic. My intent is to locate *Being Human* and *Care of Creation* in that landscape.

Being Human reflects on religious dimensions of ecological ethics and on debates about nature—human nature, other-than-human nature, and the relationship between the two. Anna Lisa Peterson rightly describes her approach as “ethical anthropology” in relation to Christian theological anthropology, as both bear on environmental ethics. She moves artfully and self-consciously between the questions and contributions of multiple disciplines including theology, feminist and ecofeminist theory, anthropology, political philosophy, environmental ethics, comparative ethics, and evolutionary and ecological sciences.

The risk in spanning disciplinary and conceptual ground is great, especially when that terrain is replete with landmines from both conservative and progressive perspectives. Such breadth requires treating more theoretical issues than can be addressed thoroughly in a single volume. Yet the risks certainly are

not worth surrendering the conceptual breadth, and Peterson negotiates the dilemmas with integrity and insight. She identifies theoretical and methodological issues central to her argument, and addresses them succinctly. In fact, her mind is delightful. She asks both the evident and the obscure questions, draws unlikely connections, probes nuance, admits ambiguity and paradox, and refuses reductionism. While on a few occasions, her foray into multiple territories results in too thin an account, those gaps do not invalidate her overall theses.

Peterson’s basic premise is that ideas and convictions about what it means to be human and about nature bear crucial moral weight. They shape ethical systems and practices. More specific to her project, reigning Western ideas about humanness and about nature shape ecologically unsustainable ways of life. If we hope to change these ways of living, we must examine their undergirding anthropologies, and construct or reconstruct alternative notions of humanness.

The author’s aims are two. First, she seeks to disclose the ecologically destructive consequences of certain anthropological notions, and to propose alternatives that “might help us find less harmful ways of being human in the

“Many, even most, lived ethics in human history have been religious.”

midst of nonhuman nature.” Secondly, she aims at uncovering internal dynamics that enable an ethic actually to challenge, transform, and sustain lived practices.

To these ends she undertakes two tasks. The first and substantive task is to explore visions of different natures—human nature, “nonhuman” nature, and the nature of relationship between the two—in six cultural traditions. Her intent is not comprehensive treatment of these traditions, but exploration of their anthropological claims and the potential implications of those claims for environmental ethics. The first tradition explored is the “established Western Christian and modernist narratives” of human uniqueness, domination of nature, and individual autonomy. The second is recent social constructionist theory that paradoxically both critiques the former and reproduces its notion that some exclusively human quality—language, culture, soul, or rationality—renders humanity both unique and superior to the “natural” world. She then examines four traditions challenging

these Western perspectives on humanness and humanity’s place in nature: Buddhism, Taoism, and the traditions of the Navajo and the Koyukon people of Alaska. Peterson moves from these “external” challenges to the “internal” challenges launched by feminist and ecofeminist theory, and by recent natural sciences and their questioning of a “wide, definitive, and unbridgeable gap” between humans and all other species. Here she draws primarily on cultural and physical evolutionary theory.

Peterson’s second task is to probe the book’s central metaethical question: What qualities, and particularly what structural dimensions, of some ethical systems make them livable and compelling, especially for enabling people to “change their ways of understanding and living on the earth”? Her more particular subquestion—When religious ethics catalyze positive social and ecological transformation, what factors lead to that effectiveness?—is grounded in her premise that “many, even most, lived ethics in human history have been religious.” (One wonders a little about this premise, but fortunately the author notes exceptions to it.) She responds that a key factor is a narrative quality: “Ethical ideas are embedded in narratives and receive their coherence and force from them.”

The appeal to narrative as the structure of effective ethics, while fruitful, is problematic. Peterson identifies most of these problematic aspects, with the characteristic thoroughness that I came to expect and enjoy. She focuses on one. Narratives with the power to shape or reshape lifeways cannot necessarily be borrowed or invented; they emerge from context, worldviews, and lifeways themselves. How then, are we to “identify and implement alternative ethical narratives” that will shape life? In response, Peterson points to bioregionalism and becoming “native to place.”¹ Yet space does not allow her coverage to be deep, and her greater contribution is in posing this question and identifying other difficulties pervading the now frequent appeal to narrative ethics.

Peterson artfully weaves together the two tasks of exploring different natures and metaethical questions with one tertiary thread, the issue of “risks that arise in regard to comparative ethics.” Unfolding as a matrix of response to these concerns, this book rightly places theory staunchly in the service of socio-ecological transformation. Peterson’s metaethical question is crucial, although not necessarily recognized as such by many, for both religious and philosophical ethics.

Peterson artfully weaves together the two tasks of exploring different natures and metaethical questions.

Pursuing it is one of her major contributions.

In two concluding chapters the author fleshes out an alternative to dominant Western anthropological assumptions, drawing upon the traditions previously examined. Her proposed framework sees humans as a species within nature; attributes intrinsic value to the nonhuman world; and emphasizes similarity or continuity between humans and the rest of nature, while not denying the obvious existence of difference. Finally, having delinked the intrinsic value of human being and human features from exclusiveness, she delinks difference from the right to dominate.

In the final pages, Peterson’s intellectual agility introduces too many new concepts without providing sufficient theoretical grounding. Most notable is her effort to link relational understanding of human selfhood to mothering practices, and both to experiences of community in contexts of multivalent

difference. Yet her point, well constructed in the course of the book, remains: Challenges to dominant Western constructions of the human and of nature (her substantive point) and the turn to narrative structure in ethics (her metaethical point) are two elements of environmental ethics that can contribute to a new and sustainable relationship between the human species and the planet. A second weak point is her brief account of Martin Luther's moral anthropology, which more accurately reflects later Lutheran theology than Luther himself.

A third point needing stronger work is Peterson's appeal to feminist ethics. She rightly turns there for a powerful critique of dominant Western anthropological claims, recognizing that "reconceptualizing what it means to be human lies at the heart of feminist ethics." Yet drawing upon a category as intricate and internally conflicted as feminist ethics raises complex issues—definitional, categorical, and functional. They require the kind of astute and succinctly expressed methodological grounding that Peterson provides for other issues. She has proven herself to be skilled, and powerfully so, at identifying methodological pitfalls in drawing upon complex bodies of theory. That skill needs to play

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out also in her appeal to feminist theory. One issue of import is her reference to "most women" or "the characteristic experiences of women," while in fact addressing largely the concerns and scholarship of white, educated, Western feminists. This contradiction replays a central mistake of Euro-American feminism: essentializing women and women's experience in the shape of some women and some women's experience. Many feminist scholars and activists currently seek to undo that universal "we," which is in fact a very particular "we." Secondly, frequent reference to feminist ethics, feminists, or feminist theorists coupled with a close focus on one contested trajectory of feminist thought must situate that trajectory in critiques of it and in the multiplicity of feminist theoretical perspectives, more fully than Peterson does. Not to do so implies that the strand to which she refers is representative or is the

most salient regarding the issues at hand. This omission may obscure (albeit unintentionally) other, possibly more relevant, strands of feminist ethics. To appeal to an ethic of care and to the work of Gilligan, Noddings, and Ruddick is not a problem. To portray it as the primary source within the category of feminist theory (until her category of ecofeminism), without acknowledging significant challenges to that work by other feminists, is.² On the whole, however, this gap does not undermine the strength of Peterson's constructive proposal.

The value of any good venture in ethics is not only what it does but where it leads, in terms of what doors it opens and what is required methodologically to go through them with integrity and accountability. Peterson does not disappoint in either. I speak first to the latter. I agree with Peterson that if humanity is to reverse its course of ecological destruction, it is important for dominant Western cultures to examine other ethical traditions. Yet, any foray by Western scholars into cultures colonized or marginalized by Western powers, for the purpose of comparative ethics, is fraught with landmines. Peterson acknowledges many of those perils, while also identifying good reasons to proceed. Her main attention is to the intellectual perils of

comparative ethics, rather than to the material and cultural survival issues related to cultural appropriation. Attention to the latter is a crucial next step. That is, if the knowledge of indigenous and other colonized cultures may be vital to sustainable Earth-human relations, then how are scholars and activists from colonizing cultures to draw upon them without inadvertently misappropriating, misrepresenting, silencing, or erasing them?

Peterson notes the need to address "the practical and the *'political'* demands of an ecologically damaged world" (italics added), and observes that prevailing Western anthropological assumptions exist "within a larger Western capitalist, industrial, consumer culture . . . [and] are deeply intertwined with this culture, and, to a considerable extent, freed from their original religious roots." These observations point toward subsequent inquiries that would fill in other pieces of the puzzle that Peterson aptly pursues. One is this: If anthropological frameworks are grounded in narratives, then challenging those frameworks may require (1) understanding their embeddedness not only in religious narrative, but also in the powerful political-economic narratives of advanced global capitalism that define the human as "economic man"

and as consumer; (2) historicizing those narratives; and (3) unraveling their role in legitimizing ecological destruction. One almost hopes that Peterson would lend her extensive expertise in moral anthropology to that task.

Like *Being Human*, *The Care of Creation* probes the nature of human being, other-than-human being, and the relations between the two, but does so specifically from theological and biblical perspectives. This edited volume contains chapters by nearly twenty theologians, ethicists, scientists, professionals in environmental work, and others largely situated within traditions of evangelical Christianity. Predominantly British, the authors also include continental European and North American scholars. The collection is a substantial theological commentary on *An Evangelical Declaration on the Care of Creation*, issued in 1994 by the newly formed Evangelical Environmental Network (EEN). That network arose from a gathering of evangelical Christians who disagreed with a conclusion of the World Council of Churches' consultation on its Justice, Peace, and Integrity of Creation Programme. They objected to that assembly's challenge to humanity's unique role as "image of God." The *Declaration* calls followers of Jesus Christ to repent for their

role in ecological degradation, and asserts a biblically-based stewardship ethic, otherwise referred to as "creation care."

R. J. Berry's volume explores central biblical themes related to creation care that are opened in the *Declaration*, and includes constructive critical perspectives on it. Taken as a whole, the book argues that the Bible, read in its entirety, mandates the caretaking of creation, condemns humanity's exploitation of it as contrary to the obligations of biblical faith, and provides "a number of biblical principles . . . to help bring disciples of Jesus Christ into proper relationship to creation." The book argues, from within the evangelical community, against two commonly held assumptions: that the Bible does not call for creation care, and that the Genesis reference to dominion constitutes a divine mandate for human domination of the rest of nature.

Written largely to the evangelical Christian community worldwide, this work is refreshingly honest and self-critical, admitting and seeking to undo what one author refers to as a tendency among evangelical Christians to be "laggardly" in response to the imperative of creation care, to be "entirely indifferent to environmental issues," or even to line up against the environmental movement. The volume is addressed also to

“God’s cosmic plan for restoration includes the whole creation, not just individual ‘souls.’”

the broader Christian community and secular audiences as testimony to the fact that “biblical faith can be a positive force for the solution of the environmental crisis, rather than the negative force that is has often been accused of [being].”

Identifying and respectfully addressing “troublesome stumbling blocks in the way of creation-keeping discipleship” common to evangelical Christians is one of the book’s valuable contributions. Several contributors focus on barriers related to “unbiblical beliefs” or faulty biblical interpretation. The power of this focus, of course, lies with the audience—evangelical Christians who see themselves as people “who follow the commands in Scripture.”

Striking is the authors’ near consensus in affirming the “cosmic significance of the incarnation, death, and resurrection of Jesus Christ,” and contesting as unbiblical the tendency to “reduce the whole point of the gospel to

human salvation.” “According to Biblical faith,” many of the contributors insist, “God’s cosmic plan of restoration includes the whole creation, not just individual ‘souls.’” The ethical corollary, also explicitly made, is that humankind is to relate to creation in terms of “its relation to divine love.” According to that relation, creation not only is included in salvation, but also is indwelt by the Spirit of God, is messenger of God’s love, and praises God. This valuation of creation, combined with the evangelical assertion of “the lordship of Christ in every area of life,” means that social and ecological relationships are a “place of redemption, and not merely the two-dimensional backdrop for the drama of human salvation.” Theological consensus in linking personal righteousness to social and ecological righteousness, and connecting personal redemption to the redemption of creation, stands staunchly in keeping with some strains of evangelical Christianity, and in opposition to others. Bringing it to the front burner of theo-ethical thought in the evangelical community may be the book’s most theologically significant and volatile contribution.

The volume’s further contributions are many. First, it offers firm biblical grounding for its claims, both by reinterpreting the controversial Genesis texts,

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and by insisting that all of Scripture, not just a few texts, be considered in probing the normative relationship of humanity to the Earth. Moreover, the book is to be valued for integrating voices of scientists and theologians discussing the same issues with respect for each other and for the significant role that each has to play. To the authors' credit, they take on debates within the evangelical community, always in a constructive voice. Most notable is a direct address to "the rift in evangelical Christianity in the U.S." between Christians opposed to the environmental movement and those who see action on behalf of ecological well-being to be inherent in Christian discipleship. Finally, commendable is the linkage made by many contributors between ecological degradation and economic injustice. Some of the authors explicitly fault the "growing engine of economic globalization, with its tendency to ignore the limits of creation in pursuit of the creation of wealth."

One of the volume's shortcomings also characterizes the *Declaration* itself. Neither attends significantly to the effective roles that other faith communities—beyond the Christian community—might and do play in reversing the ecological crisis. This point is made gently and forcefully within the volume. More effective on a global scale would be a stance that sees all the great faith traditions as resources to be plumbed for the sake of building sustainable relations between humanity and the Earth.

One striking discrepancy between the *Declaration* and *Care of Creation*: The former uses no gendered language for God, while the latter portrays an exclusively male God. That limitation in the book is a weakness, and one wonders what dynamics are responsible for its failure to mirror the *Declaration* in this matter. Finally, the book would be strengthened by admitting more ambiguity about the mandates of "biblical faith" and the "apparent clarity of scriptural teaching." For example, the argument that the Bible calls humans to care lovingly for the Earth would, in the long run, be stronger by admitting the ambiguity presented not only by the Genesis texts but also by others such as the dominion perspective in Psalm 8, and the otherworldly bent of

some Johannine and even Pauline literature.

The book's value extends beyond the evangelical community to the larger Christian community and broader secular society. It speaks to the moral power of taking Scripture seriously as norm for life, and makes a strong biblically based case for radical transformation in human relations with the rest of creation.

Like all good work, this volume calls for more. Will the evangelical community offer to ecological ethics more of the biblically based critique that its serious attention to Scripture's normative role enables it to offer? For example, evangelical scholarship might examine how other aspects of presupposed theologies and biblical interpretation also contribute to the desecration of God's good creation. How, for example, might male privilege, white privilege, or Eurocentrism in theological assumptions and biblical interpretation be linked to ecological degradation?

Often the best conversation partners are unlikely ones. Such are *Being Human* and *Care of Creation*. Both hold that understandings regarding human beings and humanity's relationship with the rest of creation are central to environmental degradation and in its reversal. Yet Peterson's work de-emphasizes

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humanity's difference from the rest of nature and delinks that difference from human superiority, while Berry's edited volume largely affirms an "exalted status [of humanity] within creation." In *Care of Creation*, the primary category employed for the normative human relationship to the rest of creation is "stewardship." *Being Human*, in contrast, recounts both the potential in stewardship ethics and its limitations, grounded largely in its dependence on human superiority. Notably, one contributor from the edited volume also adopts a stance both critical and appreciative of the stewardship paradigm, and offers biblical grounding for that position.

The shared shortcoming of both books is perhaps unavoidable in a single volume. While both do a superb job with an important task, demystifying certain factors within Christian traditions that undergird ecological degradation,

neither volume takes seriously the necessary complementary task of demystifying political-economic ideologies and power structures accompanying those theological underpinnings. The aims of, in Peterson's words, "changing the way we live in the world," or as Berry puts it, "environmental stewardship [as] parcel of everything that Christians do," challenge core aspects of daily life in the global North. To move toward these changes requires identifying not only theological and hermeneutical barriers, but also their alignment with political and economic arrangements mitigating against "environmental stewardship." Peterson and numerous contributors to *Care of Creation* allude to these factors and their interconnections. Only one author (and he in the edited volume) digs into them deeply, attributing the "anti-environmentalism" of some evangelical Christians to "political commitments" linked with "free-enterprise capitalism." Finally, a critical word about words. Given the serious challenge to anthropocentrism issued by both books, subsequent work might relinquish "environmental ethics" in favor of language that does not portray the other-than-human world primarily as "environment" for human beings.

These volumes are daring, intellectually responsible, and highly read-

able. Both are invaluable resources for forging paths toward sustainable ways of being human in the greater community of life on Earth, today and for generations to come. ■

NOTES

1. Bioregionalism refers to efforts in the environmental movement to build sustainable human communities that are an integral part of and in harmony with the broader natural community of an ecological region or ecosystem.
2. The critique relevant here is the opposition between justice and care implied by Gilligan and by any ethics of care insofar as it upholds that opposition.

BOOKS IN BRIEF

Evocations of Ordinary Death

A Troubled Guest: Life and Death Stories.

Nancy Mairs.

Boston, Mass.: Beacon Press, 2001.

240 pp., \$23 (Hardcover).

In one of the scenes of dying that frames this book, Nancy Mairs's family has decided, on the basis of her stepfather's living will, not to intubate him when he becomes semicomatose. His death, however, is not expected to be imminent, and various family members get on with their lives.

Exhausted, Sally headed back to Green Valley for water exercise she needs in

managing a ruptured disk, and George went home to take a shower. "I just sit anyway," I said. "I might as well sit here." So I bought a detective novel in the hospital gift shop and parked my chair within reach of Dad's hand, still elegant in old age, with long, slender fingers and shapely nails.

Such detail does not enter medical charts or bioethics case descriptions, which is the first reason medicine and bioethics need Mairs's writing.

In her brief description, Mairs first shows us how, for people living through the death of a family member, crisis mixes with the mundane. A loved one is dying,

but people still need to exercise their bad backs and take showers. They still pass the time with detective novels. Mairs also shows us something crucial about herself. Her “chair” is a wheelchair, because Mairs is disabled with deteriorating multiple sclerosis. Her statement, “I just sit anyway,” is not self-deprecation but an expression of the life she evoked in her previous book *Waist-High in the World*. Moreover, in Mairs’s spiritually attuned world, to “just sit” carries connotations of meditative sitting. That she “might as well sit here” is not an indifference to where “here” is. Rather the phrase expresses her almost mystical capacity to see life anywhere and everywhere.

Mairs is one of our greatest prose poets of the everyday. Part of what we are shown in the details about Sally going for her exercise and George taking a shower is that life never stops for anything; death is part of a larger flow. In this flow, everything counts. Like most genuine insights, this one sounds thin when stated abstractly. Mairs’s genius is not to tell us such things, but to lead us to experience them with her.

The “troubled guest” of Mairs’s title—an allusion to a poem by Goethe—is not death itself, but those who live their lives without an awareness that they will die. This awareness is central to

Mairs’s Christianity (the focus of an earlier book, *Ordinary Time*). Several of the essays that form *A Troubled Guest* end with brief meditations on familiar parables and sayings of Jesus. Mairs’s point is not to make a point, but to allow the gospel to open the situation we find ourselves in with her. “I have embraced a faith with crucifixion at its heart,” she writes; in consequence of this, “I do not consider suffering an aberration or an outrage to be eliminated at any cost, even the cost of my life. It strikes me as an element intrinsic to the human condition. I don’t like it. I’m not asked to like it. I must simply endure in order to learn from it.” Death also is not an outrage to be eliminated, but an intrinsic element of the human condition. That this simple point no longer goes without saying is a significant commentary on our culture.

In my ideal curriculum on the ethics and care of the dying, professionals-in-training would begin with this book. Until we had worked through whatever impatience we may feel with its details and apparent digressions (on pets, for example), we too would be troubled guests of life, unable to be at home in our mortality and thus unable to offer hospitality to those whose lives are ending.

—Arthur W. Frank

Spiritual Knowing Through the Body, Heart, Will, and Mind

American Spiritualities: A Reader.

Catherine L. Albanese, ed.

Bloomington: Indiana University Press, 2001. 552 pp. \$65 (Softcover).

The plural form in the title, “spiritualities,” gives the reader an immediate clue that variety is a major characteristic of this reader, edited by Catherine L. Albanese, a well-known historian of American religion at the University of California at Santa Barbara. The essays were initially put together for an undergraduate course, but this volume is not just for beginning students of American religion. This collection will be provocative for readers coming from many different entry points, in part because of Albanese’s sophisticated general introduction and her introductions to each of the four sections, but also because selections are written by authors from a variety of traditions using both popular and academic approaches.

In the introduction Albanese offers some reasons why spirituality and religion have become separated from each other in recent years. In the process she

traces the history of spirituality’s emergence from an institutional, mostly devotional Catholic grounding through the 1940s to the changes that have made it a cultural buzzword with multiple and sometimes contradictory meanings at present. The twenty-seven essays—by authors ranging from Thoreau and Thomas Merton to Dhyani Ywahoo and Shirley MacLaine—help Albanese make her case that no matter how far-flung their approaches, these offerings can be understood in terms of a definitional principle like the following: “Spirituality will emerge as a kind of quality of ‘knowledge,’ with knowledge standing for lived encounters that involve people as whole human beings, often to deeply transformative ends.” Although many of the authors would insist that they are free of religion, careful attention reveals that often “the spiritual-but-not-religious [are] heavily engaged in what any scholar of religion would call religious acts and [are] predicating them on what would equally be called religious beliefs.” Albanese’s approach, though, is not argumentative. She is not out to prove these authors wrong about themselves, but to provide what she calls markers for a widespread cultural phenomenon that appears to many to be more diffuse and chaotic than comprehensible.

Albanese uses the concept of knowledge as the organizing concept for this volume. The four sections—knowing through the body, knowing through the heart, knowing through the will, and knowing through the mind—are not arbitrarily imposed but correlate to Albanese’s understanding of dominant patterns in American religion, or, as she puts it, “what has transpired spiritually on these shores.” The first essay in each section is by a scholar who gives a general sense of the territory, even if from a particular perspective, and after that multiple voices are heard. “Body knowledge” encompasses ritual, usually publicly enacted, and the essays in this section range from Puritan worship and Jewish life to the Sun Dance. “Heart knowledge” points to a spirituality in which strongly felt emotion is primary, from nineteenth-century evangelicalism to the story of a late twentieth-century convert to Hare Krishna. “Will knowledge” is the province of prophets and social reformers, among them Carrie Nation, Emma Goldman, and Martin Luther King Jr. Finally, “mind knowledge,” the arena of metaphysics and a large population of the spiritual-but-not-religious, puts Thomas Merton in company with Ralph Waldo Trine and Annie Dillard with yoga teacher B. K. Iyengar.

Traveling through this reader could be a wild ride without the sure guidance of Catherine Albanese. Her categories of spiritual knowledge offer more than signposts and reassurance. They stir up adventure and generate unlikely conversation partners. Early in the book Albanese declares that her goal is not to answer all or most questions about American spiritualities. It is to inspire the reader to stay on the trail of these various experiential forms of knowledge, to seek out the differences and distinctions among them, and to resist too-easy definitions. She achieves that goal with aplomb.

—*Mary Farrell Bednarowski*

■ ■

Men's Voices, Men's Choices

What Men Owe to Women: Men's Voices from World Religions.

John C. Raines and Daniel C. Maguire, eds.
Albany: State University of New York Press, 2001. 303 pp. \$59.50 (Hardcover).

Identifying patriarchy in religious traditions is not new. Nor is the combining of sacred texts and traditions for resources affirmative of women's equality. What is remarkable is a group of men doing these things together as self-styled advocates of gender justice. Under the rubric of the Religious Consultation on Population, Reproductive Health, and Ethics, ten scholars address eight religious traditions: Christianity and Islam (each has two representatives), Hinduism, Judaism, Buddhism, Taoism, and African and Native North American traditions. These ten chapters are accompanied by introductory and concluding essays by John Raines and Daniel Maguire, respectively.

The focal question here is "How can our Scriptures, how can our founding Prophets, how can our ancestors be used today to further justice in relations between the genders?" Beyond a promise of critical analyses, these authors declare, "As authors, we intend to be advocates. We intend to pursue

gender justice." Foundation monies enabled the writers to meet with feminist scholars of religion to discuss their works in progress. More on this unusual process follows.

Steeped as each author is in a particular religious tradition, the chapters vary in focus, scope, depth, and audience, as well as in type and degree of critical analysis and advocacy. All authors discern specific textual passages and ideals they understand to support gender justice. Several authors exempt certain sacred texts from critique and locate patriarchy in culture or theology, while others subject all texts—and contexts such as global capitalism—to criticism. Some suggest concrete actions for religious adherents in the name of gender justice while a few specify men's work. All ten chapters are instructive and accessible. Those by Marvin M. Ellison and Mutombo Nkulu-N'Sengha are especially illuminating in their reach beyond conventional critical/constructive analyses to grapple with the effects of sexism on men, male privilege and dis/empowerment, and the need for men to work together.

Choices, or perhaps non-choices, about the project's overarching framework limit the *collective* strength of these men's voices. Key concepts are

not critically analyzed: “gender” and “gender justice” are typically synonymous with women and women’s justice, women are treated as a homogeneous group, and justice remains underexamined. Moreover, the volume offers precious little dialogue between the authors. While the individual chapters surely benefited from the authors’ conversations, readers are not made privy to the insights accumulated from, and about, such an association. Ultimately we hear twelve men’s voices in serial monologue.

“What men owe to women,” as stated at the book’s outset, is “not more paternalism but more honesty, and based upon that honesty active collaboration with women in culturally specific struggles for gender justice.” Thus it is especially salient to notice the gender relations integral to the book’s production. Four women feminist scholars of religion representing four religious traditions reviewed and critiqued ten men’s work in eight religious traditions. Thus half the religious traditions did not receive the benefit of critical feminist scholarship from within their traditions. No explanation for this partial collaboration is offered. Also, not so subtle hints about the tenor of the conversations between the authors and feminists that occurred surface in the editors’ defensive, even com-

bative, words regarding male authorship and other issues: for example, “We invite you as our readers to pick a fight with us. That is what we’ve done with each other. A good argument is . . . the only thing that can knock us off balance and make us take the next step.” And in the book’s final paragraph, a female scholar of religion is quoted criticizing feminist (ostensibly female) scholars of religion for excluding men. The editor follows, “Gynocentrism is no better than androcentrism. *Macha* is not superior to *macho*. The goal is dialogue, not conquest.” The important question is whether this volume’s dialogue displays “more honesty and based upon that honesty active collaboration with women in culturally specific struggles for gender justice.”

One explicitly acknowledged contribution of these feminist women was their insistence on the contextualization of the authors. Unfortunately, the effort made in the text largely defeats this aim: A litany of ten personal narratives told mostly in the third person constitutes much of the introduction, separate from the authors’ chapters. Adding misplacement to displacement, their stories are not “presented in the order in which the authors appear in the text.”

In sum, these ten individual chapters are dense and useful resources for

addressing gender justice within eight religious traditions. While a group of male scholars of religion working together on behalf of gender justice certainly can be a worthy endeavor, more honest *collective* attention to *how* men work together and in solidarity with women is needed to discern truly “what men owe to women.”

—Charlene A. Galarneau

■ ■

God, the Brain, and the Question of the Real

Why God Won't Go Away: Brain Science and the Biology of Belief.

Andrew Newberg, Eugene G. D'Aquili, and Vince Rause.

New York: Ballantine Books, 2001.

320 pp., \$24.95 (Hardcover).

In the 1990s, radiologist Andrew Newberg and (now deceased) psychiatrist Eugene D'Aquili collaborated on novel brain imaging studies at the University of Pennsylvania. Practicing Tibetan Buddhists and Franciscan nuns were asked to meditate or pray intensively and then single photon emission computed tomography (SPECT) was used to create an image of localized metabolic changes in their brains. The researchers found that most, though not all, of the subjects showed increased activity in the prefrontal areas of their brains and decreased activity in the inferior parietal lobes when compared to baseline.

What could this mean? Evidence from clinical neurology has long suggested that the inferior parietal lobe area plays a major role in integrating visual, tactile, and proprioceptive information in a way that allows us to orient ourselves in physical space. People suffering damage to the parietal lobes may be unable to

dress themselves, may experience distortions of their body image, lose the ability to draw or recognize the same object from different angles, and even lose all capacity to perceive physical objects in one half of their visual field. The prefrontal lobes of the brain are importantly involved with “executive” functions involving attention, including the inhibition of extraneous sensory inputs from conscious awareness, so a person can concentrate on a selected task.

Against the background of these kinds of understandings, Newberg and D’Aquili asked: Is it possible that the spiritual practice of meditation and prayer cultivates such a state of focused attention as to inhibit sensory inputs to the parietal regions of the brain that normally generate an ongoing awareness of the self in physical space? If so, could this be a neurological explanation for the characteristic sense of timelessness and infinity, of oneness with all reality and with the divine, variously described by the meditators and nuns?

So far, so good. It is a bold interpretation, but brain imaging research has been more frequently criticized for being insufficiently bold and experimentally imaginative in the ways it employs its powerful technologies. Newberg and D’Aquili, in contrast, used

those technologies to develop an intriguing model of an important human experience, one that their colleagues could then challenge, engage with, and further test.

In the end, however, Newberg and D’Aquili went still further. Their book *Why God Won’t Go Away*, which they wrote with the assistance of science journalist Vincent Rause, is an exploration of mystical experience and belief in God that begins in the SPECT laboratory and concludes with the assertion that “neurology can reconcile the rift between science and religion by showing them to be powerful but incomplete pathways to the same ultimate reality.” Along the way, the book draws on evolutionary theory, epistemology, the relationship between religiosity and mental and physical health, the anthropology of myth and ritual, and the origins of religion.

The end product is richly affirming of the value of spiritual practice and experience, but in a way that is not enough to rescue the book from logical murkiness at critical junctures. The following is what, as I understand it, the authors intend to say.

God will not go away because “the wiring of the human brain continues to provide believers with a range of unitary experiences that are often interpreted as

assurances that God exists.” Contrary to widespread prejudice, those experiences are not “delusions” or effects of stress or neuroses, or products of “any pathological state at all.” They are instead a result of “sound, healthy minds coherently reacting to perceptions that in neurobiological terms are absolutely *real*” (*italics added*). Indeed, the authors suggest that people who have regular experiences of transcendence may well be healthier, mentally and physically, than other people.

But that is not all. People who have transcendent experiences find that the experiences feel very real, and philosophy tells us, according to the authors, “that what’s real simply feels more real than what’s not. This may seem an unsatisfyingly soft standard, but it is the best guidance that the greatest minds and experts have produced. In most cases, it works quite well, and all other approaches to this problem are ultimately reduced to this assertion.”

Because people who have experienced advanced states of mystical unity insist that these states feel more vividly real, even, than everyday reality, this could mean that they really are real—that is, that they reveal something real about the universe. The fact that, from the perspective of material reality, these experiences seem to have their source

wholly in an unusual brain state does not affect the claim. “All perceptions exist in the mind . . . If you were to dismiss spiritual experience as ‘mere’ neurological activities, you would also have to distrust all of your own brain’s perceptions of the material world. On the other hand, if we do trust our perceptions of the physical world, we have no rational reason to declare that spiritual experience is a fiction that is ‘only’ in the mind.”

This is the argument. Leaving aside any questions we might have about its empirical details, it is important to notice that its logical structure as a whole depends on slippage between at least three meanings of the word “real.”

- Mystical experiences are “real” in the sense that they are not “delusions,” and they are not delusions because they are produced by a signature neurobiology. Our knowledge of this neurobiology can help us at least partly make sense of the experience itself.
- Mystical experiences are “real” in the sense that they feel very real to the people that have them.
- Mystical experiences are “real” in the sense that they tell us something about the “real” nature of the universe.

The assertions, taken together, just do not add up. To begin, we judge an experience “deluded,” not on the basis of whether or not we can understand it in terms of brain function, but by reference to some external benchmark we have of objective reality. Our ability to point to the “neurobiological realness” of an experience is no substitute for such a benchmark; the neurobiology underlying drug-induced hallucinations presumably is just as “real” as the neurobiology underlying mystical experience, but we would still likely judge such drug-induced hallucinations to be delusional.

Attempting to bootstrap ourselves out of this problem by distinguishing between “healthy” and “pathological” kinds of neurobiological functioning is no solution either, as William James pointed out a century ago in his *The Varieties of Religious Experience*:

Let us play fair in this whole matter, and be quite candid with ourselves and with the facts . . . When we speak disparagingly of “feverish fancies,” surely the fever-process as such is not the ground of our disesteem—for aught we know to the contrary, 103 degrees or 104 degrees Fahrenheit might be a much more favorable temperature for truths to germinate and sprout in, than the

more ordinary blood-heat of 97 or 98 degrees . . . In the natural sciences and industrial arts it never occurs to anyone to try to refute opinions by showing up their author’s neurotic constitution. Opinions here are invariably tested by logic and by experiment, no matter what may be their author’s neurological type. It should be no otherwise with religious opinions . . . Saint Teresa might have had the nervous system of the placidest cow, and it would not now save her theology, if the trial of the theology by these other tests should show it to be contemptible. And conversely if her theology can stand these other tests, it will make no difference how hysterical or nervously off her balance Saint Teresa may have been when she was with us here below.¹

Similarly, we can perhaps accept an argument for putting the vividness of mystical experience at the top of a subjective hierarchy of increasingly “real-feeling” immediate experiences. This does not mean, however—and I believe that the phenomenological philosophers referred to by the authors did not ever intend it to mean—that the higher up we go on such a subjective hierarchy, the closer we approach “real” knowledge of the universe, with “real” being used

now—again—as an external benchmark that scientists typically use interchangeably with words like “objective.” Dreams may seem real, especially while they are happening, but they are not necessarily accurate renderings of external events. An immediate everyday experience of a sunset may feel very real, but that does not mean that the other evidence suggesting the earth actually rotates is disproved thereby.

None of this is to deny that mystical experience has been part of larger human experience from time immemorial, and is worthy of more serious attention than it generally has been given. Newberg and D’Aquili clearly have been serious students of this phenomenon, and, with their SPECT work, have made an imaginative and potentially important contribution to its elucidation. Neither am I denying here the possibility of a fruitful conversation between scientists and mystics about the truth status of mystically derived understandings of the universe, and their relationship to the truth-claims of the objectivist sciences—one that proceeded, perhaps, on some basis other than subjective vividness or the health-enhancing effects associated with exercising one’s “machinery of transcendence.” All I am saying is that there are dangers in tying

together these different projects and possibilities with a single cord that one calls “the real.” Almost inevitably, some people are going to find themselves getting tangled up in the logic.

—Anne Harrington

NOTE

1. William James, *The Varieties of Religious Experience* (Reprint, New York: Penguin, 1982), 15.

■ ■

Pushing God Around the Globe

God and Globalization. Vol. 1: Religion and the Powers of the Common Life.

Max Stackhouse with Peter Paris, eds.
Harrisburg, Pa.: Trinity Press
International, 2000. 288 pp. \$40
(Hardcover).

God and Globalization. Vol. 2: The Spirit and the Modern Authorities.

Harrisburg, Pa.: Trinity Press
International, 2001. 244 pp. \$35
(Hardcover).

In its very title, *God and Globalization* suggests that it will fill an important gap in the literature and debates about globalization. This four-volume series (three volumes of which are now in print) argues that globalization cannot be left to the economists and that theological ethics has something to offer those who wish to make descriptive and normative sense of globalization. The series provides its target audience—"churches, seminaries, colleges and universities, other communities of faith, and . . . the morally and spiritually committed leaders of the emerging international civil society"—with an intricate and biblically evocative framework—including powers, principalities, authorities, dominions, spheres, and regencies—for thinking through the

ethics and structural interrelationships of globalization. The essays that comprise the first two volumes are from luminary thinkers writing out of a diversity of disciplines and perspectives, though regrettably only one of thirteen is female. While all of the essayists believe that "public theology" has something important to contribute to the development of ethical globalization, their analyses imply a range of understandings, even of this key term.

In *Religion and the Powers of the Common Life* (vol. 1) contributors consider those "principalities" deemed most germane to globalization (Mammon, Mars, Eros, and the Muses), translating this consideration into theological ethical analyses of modern arenas, such as transnational corporations, violence, the family, traditional religion, and the media. *The Spirit and the Modern Authorities* (vol. 2), in turn, analyzes the classic professions, technology, "nature," and moral exemplars or heroes as bearers of moral frameworks and therefore sources of authority in the present age.

The essays stand on their own as critical reflections from key thinkers in each area, such as Roland Robertson on sociology of religion and John Witte Jr. on religion and human rights, but they lack real interaction with Max Stackhouse's

framing introductions to each volume and to the series. And yet this lack of interaction is a strength, saving the essays from collusion with an oppressive vision of posturing among the religions (Christianity not least) for dominance over an emerging global “super-ethos.”

To be sure, many of Stackhouse’s questions about globalization are vitally important ones and some of his descriptions of the present moment are on point as well. For example, the Seattle protests are for him a kind of parable, revealing the lack not only of consensus, but of a teleology to frame the normative issues of right and good. “What ought we support and what ought we protest?” he asks. And, he queries further, given the violent and inarticulate nature of protests against supranational structures like the World Trade Organization (WTO), how are we to envision authority? For Stackhouse, new power structures are asserting themselves, and we need tools with which to evaluate them.

What is problematic in Stackhouse’s framework is not his application of a theological ethical analysis to the issues of globalization. Ethically and theologically thoughtful considerations of globalization are rare in a field drenched in the language, assumptions, and worldview of free-trade economics.

Rather, Stackhouse adopts a near-Hegelian vision of global integration on the one hand, and optimistically propounds a “God-based framework” (indeed, Christ-based) for “discernment, evaluation, and transformation” of the new global civilization on the other. In other words, his framework for globalization involves both descriptive and normative errors.

Stackhouse’s vision is “near-Hegelian” insofar as he describes globalization as a process that is laying the groundwork not just for integrations and compressions but for a “new super-ethos, a worldwide set of operating values and norms that will influence most, if not all peoples, cultures, and societies.” This eschatological intensification of more mildly formulated optimisms about the “international community” or “international civil society” is made more problematic by being left underdeveloped: How will such norms and values be institutionalized? How contested? What mechanisms will be in place for their implementation (or will they require none)? Despite many positive post-Cold War signs of cross-cultural dialogue and consensus-building—including significant multilateral consensus on matters of governance, environment, and population—we are astronomically far

from any meaningful sense of global participation or citizenship or any concrete notion of global public goods. To characterize globalization as a process moving toward a single global civilization is to flatten globalization's complexities, fragmentations, and inequalities profoundly.

Unlike the global ethic developed by Hans Küng, in which teachings shared by the world's religions are abstracted for a universal, elementary ethical consensus, Stackhouse's vision appears to be one of a super-ethos and global civilization dominated by one religion which will rise above the others. The real question for him then becomes: Which one?

Since no enduring civilization . . . has developed without a dominant religion at its core, and it is unlikely that a globalized civilization . . . can develop creative directions without one either, it makes a great difference which religion becomes dominant, how it does so, and how it treats other traditions.

Stackhouse concedes that his theological ethical framework must be questioned within the context of interreligious dialogue, but his point of departure suggests which religion he favors for global dominion and perhaps also for the

terms of consensus: "Our question [to the followers of Krishna, Confucius, Buddha, and the Prophet Muhammad]" he avers, "will be whether Christ is, and can be, and should become Lord over all the powers, principalities, authorities, and regencies in a global civilization." In other words, well beyond an inquiry into Christianity's distinctive historical role in global processes, Stackhouse queries whether Christ himself will have an exclusive normative role in the new global order. While a Christian believer might reflect theologically on such a question, one might well wonder how successful an interreligious dialogue about global civilization would be with such a Constantinian opening.

Beyond the tensions Stackhouse's approach seems to imply for interreligious dialogue, I question equally the basic metaphors of his framework. As biblically evocative as the metaphors may be, why describe globalization in terms of powers, regencies, or dominions for the victor to lord over—imagery which, beyond the biblical, may well evoke the colonial conquests of the bipolar Cold War era, perhaps especially for those entering the dialogue on globalization from the developing world. Wouldn't friendship, good neighborliness, the golden rule, and partnership

be equally evocative of Christian and other scriptures, as well as useful hermeneutically in evaluating globalization from a theological ethical approach? Indeed, why not relate religions to globalization using a tenet they all seem to share, namely, that earthly power is an illusion. Rather than vying for lordship, perhaps religions can contribute to ethical globalization to the degree that they eschew earthly power games and witness to the power of inclusion, access, and participation.

Stackhouse's optimism is not limited to the emergence of a global super-ethos; he is equally sanguine about religion's ability to discern and ultimately offer prescriptive guidance for such a global ethos and the civilization it is supposed to rudder. Because not every religious insight is equally valid, Stackhouse explains, theological ethics must engage in comparative analyses and must consider "the relative validity of various religious claims about how we should live." But what criteria are used in evaluating the "validity" of these claims? And how will theological ethics stand far enough apart from each particular religious insight to judge its respective validity? Finally, why are the religions set apart as the source of normative prescription?

Stackhouse reasons that religious leaders, missionaries, and reformers are specially oriented toward reform—and, presumably, normative prescription—because they have the "discerning ethical framework" that reveals those things in need of reform. "A sense of holiness illuminates the depths of corruption," Stackhouse explains. And because of this, he continues, religious actors have more often been opponents of imperial impulses of domination than supporters. While holiness itself does indeed illuminate, our human sense of holiness often only collides with humility and clouds the truth, and that is the real danger of a "God-based framework" for globalization. As a Christian I am indeed thoughtful about what sense God makes of our world and where we are taking it. But when I think of a framework that prescribes on those grounds (WWGD?), my thoughts turn to at least two other God-based frameworks: the theological and scriptural justifications of South Africa's apartheid regime and the religiously patrolling Taliban regime.

—*Mieke Holkeboer*

■ ■

CIRCLING THE DRAIN

BY AVIS CLENDENEN

That's what they told me today:
"In short, she's circling the drain."
Dwindling
before my eyes.

I'm her daughter,
the middle child of her three.
The only one who lived to hear
"she's circling the drain."

That's the image the doctor used
on 6 June 2001.
Crass, but painfully apt.
I wasn't offended
because I felt myself
swirling with her
around some new edge.
She's dropping off
from the edge of life,
spiraling downward
(into God, I want to believe,
although her cries of pain
prompt a rush of doubt in me).

She got old fast
without my permission.

I look at her now
so fragile.
Hanging on
but not really.

"She's circling the drain."
So succinctly stated;
but they don't know her
her life beyond those four words.

Her diminishing body
holds the story of the young widow
left hanging on the edge in 1954
with three tiny ones.
The woman who "could do more
than fifteen-women-in-one-day,"

She would say to us three
As she wiped our butts
Washed the floor
Made our meals
Wiped our faces
Donned her nurses cap
And worked all night
To return home
To start *our* day
Of many more hours after the night before.

Did I say her own mother suffered
from depression and could never help
when her husband died
six years into the marriage?

We three
fatherless
with a mother striving to do more
than fifteen-women-in-any-one-day.

Did I mention that seven years
after burying her husband
her eight-year old baby died
in the "accident" of which
we never spoke?

She named him Jude
as she promised

the saint of hopeless cases
after a miscarriage
after me
threatened the large family
she hoped to bear.

She told me then
she would give me a
backbone of steel.
But whatever I have in me from her
will not stop my mother's
circling the drain right now.

The woman who did more than fifteen
lies on the fallow ground of life's journey
exposed
literally and figuratively
(so many "healthcare professionals" with
so many titles all miss the moment to
pull her gown above her breast
or cover her raw bottom from public view).

Why is that?

She's dwindling
before my eyes
Ebbing
Circling
Swirling
Caught in a current
Taking her away.

She's the mother at the foot of the cross
whose firstborn son
died from AIDS in 1993.
Get the picture, people,
she's lived a life beyond the pale
of many to imagine.

As this June of 2001 dawns
I ask myself
Why don't those who know
and tell me with assurance
that she is circling the drain

CARE?

What's the point of jumbling
all her fresh clothes together
so that everything smells of urine?

Hey, pay attention to me when I'm
standing at the nurses' station!
You seem to want to be called
a personal care assistant, a CNA,
or something important, so
what's the point of degrading
my mother
and soiling her dignity
by your tired indifference?

Don't you see who she really is:
A strong woman
who always smelled of tigress cologne
And deserves the small respect
of smelling nice
and simply hanging up her clothes neatly.

How could you people not tend
her raw butt
after she wiped and tended
so many in 34 years of nursing,
not even counting baby butts?

How dare you degrade
the profession you share
And she so loved?

By not bothering to read the chart
you miss that she missed having
a bowel movement in 6 days.

Oh, the bleeding
from her raw, worn butt.
When I call you at 1:30 A.M.
from yet another emergency room
you are dismissive, saying
"these things happen."

Yet you were so sure to taunt her
to move her neuropathetic feet
to your satisfaction.

Shame on you.

I watch her lie fallow
Sapped of all energy
Circling the goddamn drain
Because, at least it seems to me,
that day after day
shift after shift
caregivers (and I use this term loosely)
coming and going
fail to notice
bowel movements or lack thereof
because you are too busy
too tired
too
too
too

To care.

Did you know that the biblical Greek word
for compassion
literally means
to be moved at the level of one's bowels?

When Jesus looks with compassion
he is moved at the center of his being,
stirred within his bowels
with feeling
that leads to healing.

Because you fail to notice
To listen to her
To really see her

Margaret Ann Clendenen

You missed the graced opportunity
to tend one of God's beloved daughters.

Come to think of it
I think

that you are the ones with the bowel
obstruction.

It is your compassion that is impacted,
blocking the flow of healing
in the guise of health care.

It is you—the system
Who is so impacted
as to remain unmoved

Unmovable
Unable to see
that it is you who is circling the drain.

As we keep moving through your system
please don't hand me
another brochure
describing your team holistic approach to
caring
of which you must know you have so little
clue.

And if you are offended by this
judgment of mine,
if you even bother to read these words,
you just might feel moved inside your
bowels
to do something about the mindlessness
of your own circling the drain.

That's all folks.
No graceful
poetic closure.

No way out.

We're all circling the drain.

Postscript:

She didn't clog your system for too long.
She died on 17 June 2001.

SECOND O P I N I O N

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Spiritual Care at the End of Life: A Special Report

Challenges for Hospital, Hospice, and Congregational Clergy

Edwin R. DuBose

Books

Faith and Health

Patricia Murphy

Being Human on Earth

Cynthia D. Moe-Lobeda

Poetry

Circling the Drain

Avis Clendenen



THE PARK RIDGE CENTER
FOR THE STUDY OF HEALTH, FAITH, AND ETHICS

211 E. Ontario St., Suite 800
Chicago, IL 60611-3215

Ms. Burns
Lutheran General Hospital
1775 Dempster St. - 9 West
Health Sciences Library
Park Ridge IL 60068

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