Are Health Professionals Ministry?

A Physician or Nurse May, *in the Performance of His or Her Work, Also Be Acting as a Minister of the Faith*

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Do those who practice in the health care professions minister to the people they serve? To answer this question, we must first define "health" and "ministry." One writer has defined the second word as follows: "Christian ministry is the public activity of a baptized follower of Jesus Christ flowing from the Spirit's charism and an individual personality on behalf of a Christian community to proclaim, serve, and realize the kingdom of God."[1] Not every positive act is necessarily ministry. People can do many good things without meeting these criteria. However, through baptism, every Christian is called to ministry. In this article, I will describe as ministry only those acts that meet the criteria mentioned above.

There are many definitions of "health." Today it is most commonly defined in physical terms. However, the word was derived from one signifying holiness or wholeness, completeness. Health exists when physiological, psychological, spiritual, and social functions act cooperatively and harmoniously.[2] "Health" will be understood here as a "dynamic process that embodies the spiritual, psychological, physical, and social dimensions of the person."[3]

Many Catholic religious communities have continued their commitments to health care ministry in hospitals. This care embraces not only the physical but also the psychological, social, and spiritual dimensions of the person. It incorporates both the medical and the pastoral aspects of care. "Pastoral care" includes a listening presence; help in dealing with powerlessness, pain, and alienation; and assistance in recognizing and responding to God's will with greater joy and peace. Pastoral care focuses on a patient's spiritual dimension, but it also affects psychological and social dimensions, particularly when the pastoral care comes from the patient's own church community. When it does not come directly from the church community, the pastoral caregiver may yet represent the community. As the U.S. bishops have put it, "Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death."[4] A Catholic health care institution should be a community that provides healing and compassion.

Lay Ministry

If one views the Catholic hospital as a whole team, it could fit the definition of ministry cited above. Catholic health care meets this definition only when those working for the institution approach their employment with the intention of performing ministry. Given today's dwindling numbers of women and men religious, it is more difficult than formerly to assume that employees have this intention. However, it is entirely possible that some laypeople working in Catholic health care do so with the full intention of ministering to those they serve. All laypeople are called by their baptism to serve in this way.

Professionals associated with Catholic health care facilities have a responsibility to understand the nature of human personhood and to care for the whole person. They are also to assume personal responsibility for continuance of the healing ministry and to exercise a prophetic voice in society. As Catholics come to realize that the role of the laity in the health care ministry is part of their right and responsibility as baptized Christians, it seems likely that those who work in various health care professions will begin to see themselves in a new light and also will seek to Christianize both their work and the health care institutions in which they perform this work. They will realize their opportunity to penetrate

society and "to serve as a leaven and a soul of society."[5]

Spiritual care is the work of every caregiver. The Second Vatican Council stated the importance of spiritual training in any aspect of the apostolate. This training certainly includes that of health care providers.[6] Chaplains can provide training to professionals, family members, and the community to help them minister in ways that will promote holistic health and provide spiritual care.[7] Not only do health care providers need their medical and technical skills, they also need catechesis and spiritual formation if they are to perform this ministry.

It is especially important for ecclesial lay ministers who are called to play an active role in building the reign of God to take time each day to talk to and listen to God. Increasingly, laypeople are working with spiritual directors and taking time for retreats. Regular participation in the sacraments is especially important for their spiritual nourishment, which is essential to the ministry. Attention to one's own spiritual health is essential to one's effectiveness as a minister and to prevent burnout.[8]

Ministry, Not Coercion

"Health care is not simply a response to illness or disease," as one writer notes. "It is a holistic, lifelong engagement with the meaning of life."[9] Patients are becoming more aware of their need for holistic care. Many patients no longer tolerate high-tech, no-touch health care. They want the best of both worlds—high-tech *and* high-touch care. According to one survey, 48 percent of hospitalized patients indicated that they want their physicians to pray with them, 98 percent of hospitalized patients believe in God, 96 percent pray before surgery, and 14 percent have experienced physical healing as a result of prayer or divine intervention.[10] Although the overall death rate for open-heart surgery patients six months after surgery was 9 percent, for those patients who attended church regularly the death rate was only 5 percent. Those patients who described themselves as obtaining significant strength and comfort from their beliefs all survived the six-month period. Dialysis patients who attended weekly religious services were more likely to be compliant with their medical regimens than nonreligious patients. They also experienced less isolation and fewer feelings of powerlessness and had more satisfying social interactions, which they said was the result of their religion helping them adjust to their illnesses. Positive benefits of prayer or religious involvement include patients finding purpose in their suffering.

In another study, two-thirds of the patients in an outpatient practice indicated that they would like a physician to inquire about their spiritual beliefs if they became seriously ill.[11] Family physicians involved in the survey strongly supported the notion that religious beliefs can promote healing; some argued for spiritual and religious interventions in medical practice. But others suggested that studies showing the benefits of religious practices were flawed. The researchers admit that many patients may receive comfort from their religion. However, they challenge the perspective that physicians can or should encourage religious activity. They argue that because patients accept physicians' authority, they may be too easily influenced by physicians' opinions on religious matters. In such cases, physicians' opinions might be coercive, creating ethical issues concerning patient autonomy regarding religion. These writers note that religious practices can be disruptive because of religious conflicts and disagreements about religious practice.

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Cultural and religious diversity are increasing in the United States. Physicians are usually not trained to address spiritual matters across diverse backgrounds and traditions. Although such issues are not the sole domain of any one profession, certified chaplains have training and clinical supervision that prepares them to discuss spiritual issues with patients. Chaplains are also prepared to address religious issues from an ecumenical perspective and to refer patients or clients to other appropriate clergy whenever necessary.

Sloan and his associates cite studies in which 47 percent of patients wanted no discussion of spiritual matters from their physician and only 37 percent desired such discussion.[12] The writers note that more positive results tend to occur in family practice settings in which physicians and patients are likely to have long-standing relationships. On the other hand, family practice physicians cite lack of time (71 percent), inadequate training (59 percent), and difficulty identifying which patients want to discuss spiritual issues (56 percent) as barriers to raising questions about religion. Sloan and his colleagues emphasize that the link between religion and health is controversial and that the physician's role in the patients' beliefs must be

approached extremely cautiously, if at all.

Interestingly, in a study conducted by Steven G. Post and two colleagues, 73 percent of inpatient rehabilitation patients indicated that no one from the health care staff ever spoke to them about spiritual concerns.[13] Only a small percentage of patients (16 percent) indicated that, if they were seriously ill, they would not welcome a carefully worded question regarding their spiritual beliefs. Assessment tools to address patients' spirituality do exist. These assessment tools can be used to guide referrals to chaplains. Post and his associates indicate that lack of appropriate clinical-spiritual referrals can in some cases even be described as negligence. However, these writers are more concerned about the actions of physicians who wish to act as pastoral caregivers. Their concern is that boundaries may appear somewhat artificial to the patients who believe that God is working through the physician. Some of the pressure comes from patients, about half of whom would like to have their physicians pray with them. Again, the concern is that some patients might attribute greater power to the physician than would occur without religious overtones. This is contrary to the modern biomedical-ethical approach of demystifying the authority of the sometimes paternalistic physician. Greater patient empowerment for autonomy and self-determination is the goal.[14]

Some patients say they would like to have their physicians pray with them.

A neurosurgeon and ethicist cited by Post and his colleagues suggests guidelines that would preclude physicians from praying openly with patients without the patient's explicit request. The neurosurgeon permits physicians, under certain conditions, to pray publicly if the patients so desire. However, he suggests that the prayer be led by an identified religious leader separate from the treating medical team, in order to avoid an appearance of coercion.[15] I would suggest that, if a fully integrated team includes an identified religious leader, this person should be its pastoral caregiver, particularly if no religious leader from the patient's congregation is available. Post and his colleagues state that physician-led prayer is acceptable only when pastoral care is not readily available, when the patient requests it, and when the physician can sincerely pray from his or her own faith without manipulating the patient. In most cases, the physician is encouraged to simply listen respectfully as a patient prays.[16]

The Medical Professional as Minister

Certainly patients' rights and religious freedom should be respected. The issues of boundaries discussed in the medical literature are valid. Where, however, does this leave the physician who genuinely desires to treat the whole person as part of his or her mission/ministry as a baptized Christian? "All Christians in any state or walk of life are called to the fullness of Christian life into the perfection of love . . . following in [Christ's] footsteps . . . doing the will of God in everything, they may wholeheartedly devote themselves to the glory of God and to the service of their neighbor."[17] As this passage from *Lumen Gentium* suggests, a physician (or other health care provider) is clearly called to serve.

Margaret E. Mohrmann addresses the physician's role in her book, *Medicine as Ministry.* First, she points out that health includes mental and spiritual health in their own right, not just as promoters of physical health. She also notes that health is only a secondary good. God is the absolute good. Health is a subordinate good that enables us to be the whole person whom God has created us to be in order that we may perform service for neighbors, as we are called to do.

> Health [Mohrmann continues] is to be sought in and for God, not instead of God. . . . We must recognize the extent to which the idolatry of health represents a fear of death and often a denial of death's inevitability, both of which indicate a failure of hope. . . . We know that death is the natural end to our earthly stories. . . . Some of us in the ministry of medicine have the task of preventing untimely death. . . . . Others of us in the ministry of medicine have the task of preventing meaningless death . . . but none of us has the impossible task of preventing death. And all of us have the theological task of imparting hope—sometimes hope for an extension of earthly life, but always hope for life beyond death, and God. We may not always be able to transmit our hope to those to whom we minister, but at least we can refuse to be part of the lie, part of the denial of the fact of death.[18]

Mohrmann seeks to help medical professionals understand both their roles and the place of health in God's creation. She goes to great lengths to point out the individuality of the

patient and the need to treat him or her as a unique individual. Our service needs to demonstrate God's love. The beneficence of the physician is pictured in the role of the Good Samaritan. Mohrmann provides an interesting perspective when she discusses Jesus' answer to the question, "Who is my neighbor?" Her perspective is that of the Samaritan, the one who shows mercy.

Mohrmann suggests that the physician must be both the Samaritan *and* the injured one. We know that all people have needs. The physician, Mohrmann says, must be open to receiving as well as to giving, all at the same time, because a patient may have something important to give. Depriving patients of an opportunity to give deprives them also of their dignity and completeness; it constitutes a denial that physician and patient are in relationship. God is relational and so are we. Just because people are suffering does not mean they cannot give. Actually, when people are suffering their need to give may be as great as their need to receive. "We whose lives are bound up with the notion of giving must also receive—freely and openly and fearlessly—God's gifts of knowledge and healing offered to us by the very ones whom we're trying to know and to heal. Then, in turn, we may have within us the power to show God's mercy to them."[19]

Patients are not served in isolation. Each is in relationship with other people. Patients' lives must be put in the context of the relationships and their stories. These stories and relationships are interwoven with our identification as a Christian community, the community formed by the story of God's creation and the paschal mystery.[20] Nor is the minister in isolation: he or she is also in relationship with other people. In health care, the critical relationship is that between the patient and the provider. Neither the patient nor the provider should look on the other one as an instrument. Each must be seen as a whole person.

This brings us to an extremely important point: The provider must maintain his or her own wholeness in order to be able to carry out the ministry of healing. If the ministers do not attend to their own wholeness, they will not be able to assist others in achieving wholeness. We cannot give what we do not have. This places tremendous importance on the provider's spiritual development, if the provider wishes to minister in any way. Unless one pays attention to one's own personal spiritual development, one won't be able to minister. The story of God's love for us is transforming. "It has the power," Mohrmann writes, "to shape us into the sorts of persons who want and are able to discern what is good, and who then can and will act morally. [This] story also has the power to shape the Church into the sort of community that enables and encourages both the transformation and the empowered action of its members. . . . To be transformed is to live and love with open eyes."[21]

If we are to see the suffering, we must have our eyes open; only then can we attempt to help relieve it. And we cannot see suffering without experiencing it, at least in some sense. We join in the suffering of the world as Jesus did, at least in some small way. To the one who is suffering, the disease may not be cancer or heart failure but rather, spiritually speaking, humiliation, fear, loneliness, or despair. Such patients are often diagnosed as having depression. Treatment with antidepressants alone does not make patients whole. True Christian realism calls us to name that which is. We cannot hide the spiritual and emotional pain of our physical diseases if we are to be whole. A clear vision and open acknowledgment of such suffering produces character, a character that is full of hope that neither suffering nor anything else will separate us from the love of God (Rom 8:35-39).[22]

Antidepressants alone can't relieve humiliation, loneliness, despair, and fear.

We experience the love of God in community. As we try to understand the communal nature of healing, we realize that human identity is best understood in the three dimensions of physical presence, community (or the relationships with each other), and the transcendent reality: a relationship with God.[23] The suffering that accompanies an illness is an assault on each of these levels. Therefore, healing must attend to each of them. This means that medicine is a ministry in which doctors are not the only healers. When ill, a patient suffers not just physical pain but also suffers isolation from the community and an assault on his or her relationship with God. God's power to protect us and God's love for us is thrown into question. For healing to occur, health care providers must address illness's physical dimension, the community must address the social dimension, and those in pastoral care must address the spiritual dimension. Patients need to be reassured that they have not lost the love of the community and that nothing can separate them from the love of God.[24]

A Ministry of Presence

We cannot minister to the suffering and seek to relieve their pain without suffering to some degree ourselves. We bear one another's burdens (Gal 6:2). Those who practice medicine need the continued healing support of the entire community to relieve the suffering in its midst. The community is defined not only by its role of healing but also by its primary identification as God's people. Mohrmann, in her book, describes the privilege of accompanying her patients through the risky journeys of illness. She felt compelled to be present during the silent suffering vigils to learn that which could never be learned by confining herself to the technical aspects of medicine. She noted the importance of rituals. Included in these rituals are hearing the story and being present to the suffering. In addition, medical rituals of laying on of hands and physical examination are added to the sacramental rituals of anointing, prayer, and reconciliation, and the ministering rituals of visitation and providing for the families. These have their roots in and derive their meaning from the primary ritual of the Christian community, the Eucharist.[25] The Eucharist is a sacrament of unity that certainly points to our relationships.

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What relationship should exist between the patient and the health care provider? "The fundamental relationship . . . is a mutually beneficial exchange in which the patient grants authority to the provider and the provider gives competence and commitment (accepts responsibility) to the patient."[26] This definition emphasizes the promise between the parties. It is a type of a covenantal relationship. The patient trusts the provider, and, in exchange, the provider is promising the best that he or she can give. Fr. Richard M. Gula, SS, PhD, describes a covenantal relationship as one that requires trustworthiness, accountability to the communal demands of a covenantal people, faithfulness in upholding the rights of the vulnerable, and using power in a liberating way.[27] The covenantal model resists accommodation to standards of individualism, self-glory, or greed. It favors service and generosity. The patient must be able to trust the provider, and the provider must be accountable to the patient and to the community of professionals as well as to the community at-large.

Fr. Gula describes five virtues that are expected in professional ministry: holiness, love, trustworthiness, altruism, and prudence.[28] Professionals must not only have virtues but also fulfill duties, which include maintaining specialized knowledge and skills, serving fundamental human needs, committing oneself to the best interest of others, and being accountable to those who are served and to the profession. These, Fr. Gula writes, are the duties of the professional pastoral minister.[29] They are also, I would add, the duties of the health care professional. I believe that we're starting to see similarities between health care professionals and ministers. The spiritual formation and ongoing development of health care providers is essential if they desire to minister. Clinical training alone is not enough.

The pastoral psychotherapist has training that crosses the boundaries between spirituality and health care. "To the extent to which a therapist can stand before and within the ground and source of being, he or she is in a position to invite the client, also, to stand before and within the ground and source of being."[30] To the extent that the therapist is grounded in the ultimate source, he or she is free in a radical way to *be present.* According to the theologian Paul Tillich, all life actualizes itself according to three functions: self-integration, in which identity is constituted and maintained; self-creativity or growth; and self-transcendence, in which the finite moves beyond and outside itself.[31] This can be applied to other health care providers and patients as well. Self-integration, growth, and self-transcendence are necessary if we are to be present and show God's presence to another.

The ministry of presence is a form of servanthood, characterized by suffering alongside the patient. It means vulnerability to and participation in the world of those being served.[32] A health care provider who has paid adequate attention to his or her own spiritual development and nourishment is more likely to be able to be with the patient, *truly* to be with the patient. It is this being with and listening to the patient that helps us move from provider to minister.

Fr. Regis A. Duffy, OFM, asks some additional questions: "Does this ministry heal in the biblical sense? Does the care of the sick have an evangelization component that allows them to ask new questions about their lives and to clarify their intentions? Does the pastoral care of the sick permit a wider vision and a deeper commitment to the gospel and its mission?"[33] Although Duffy asks these questions of pastoral care, they would also apply to health care professions insofar as those professions are ministries. Duffy is trying to elucidate whether the care of the sick is uninten-

tionally privatized and limited. He also asks about the meaning of "sickness." Sickness reveals humankind's need for redemption. It is a symbol that exposes human vulnerability at all levels of experience. It can represent a change from unreflective living to questioning one's motives and meaning. The ritual of sprinkling of the sick with holy water calls to mind our sharing in the paschal mystery.[34] The rite of the pastoral care of the sick clearly states that those who visit the sick should be concerned about the whole person and offer both physical relief and spiritual comfort.[35] This is the ministry of the church to the sick.

Christians who are ill experience dependence on God and the freedom to choose whether they will participate in Christ's mission and ministry.[36] Their witness is a form of evangelization, a ministry of the sick to the church. If the care of the sick is privatized, these benefits may be lost.

Wondering whether contemporary health care professionals minister to patients, I recently conducted an informal survey of professionals whom I knew to be Christians. I asked them, "How do your faith and profession fit together?" Although the number of people involved was small and my approach was admittedly unscientific, the results were interesting. The responses ranged from "I never really thought about it before" to "It's an integral part of who I am."

One person, after thinking the question over, was able to identify how faith had contributed to his values. His faith, he said, had taught him the compassion that he lived and used to serve others. He recognized that he treated others in the manner he wished to be treated. One could argue that he was simply doing good, not ministering. On the other hand, one could also argue that this person was coming out of a position of significant faith and that his ministry is integrated into his life, although he had not reflected much on it. However, the strongest argument against his work being ministry is the fact that he had *not* reflected on it. Now that this person has been asked the question, and has spent time thinking about it, his work will perhaps become ministry.

Meanwhile other people, in responding to my question, *did* recognize their profession as intimately tied to their faith. They were able to articulate many of the virtues that Fr. Gula indicated professionals must have. They saw the importance of excellence and competence, as well as compassion, even in the form of tough love and facing conflict when necessary. Most of the time, when actually performing their professional duties, they were not, they said, consciously aware of ministering. There were occasions when some of them did consciously pray for the patient during the treatment. More often, these people said, their prayers for the patient occurred before or after treatment. They were, they said, conscious of their own need to grow, to maintain their competence, to maintain their faith, and to give generously in service of others and of God. (Several persons I approached said they would like to integrate their professions and their faith, but lacked an understanding of how to accomplish this.)

My survey certainly did not address all of the elements I've mentioned here regarding ministry and virtues. However, I believe that it showed that Christian health care professionals want to establish and maintain a covenantal relationship with patients. They displayed a commitment to share their expertise and, they reported, their patients did give them their trust. The professionals interviewed recognized that they came out of the Christian community and were not working alone.

Particularly today, most professionals recognize that they are part of a larger team. These teams typically include physicians, nurses, allied health professionals, and pastoral caregivers. No profession is isolated from the other, nor are there absolute distinctions among them. Although their fields of expertise clearly overlap to some degree, each has a depth of knowledge and skills that distinguishes it from the others. Each relies on the other so that total care for the patient can be achieved. Far more than in the recent past, everyone involved acknowledges the need for holistic care.

Working together, a team of health care professionals—including pastoral caregivers—is better equipped today to achieve holistic care. Nursing and pastoral care, for example, depend on one another for expertise, skill, and knowledge in providing high-quality holistic care for patients. Nurses can do the simple spiritual assessment after some training from the pastoral care department. They can make appropriate referrals to the pastoral care team, thus allowing pastoral caregivers to spend more time with the patients who are in greatest need. At the same time, nurses are enabled to feel a sense of accomplishment regarding their role in pastoral care and the spiritual health of patients.[37]

With training, nurses can perform simple spiritual assessments.

When we talk about the members of the health care team, we can't leave out the patient and his or her family and friends. Family and friends may

represent the Christian community and, in any case, are very important aspects of the care for the patient. The patient should be the central member of the team. Patients need to be empowered to accept the services needed and to take responsibility for their own health, to the extent possible, and to carry out the treatment plan that they have, one hopes, participated in developing.

The late Cardinal Joseph Bernardin wrote, from his own personal perspective, that he wished to receive high-quality health care in an institution that recognized patients as human beings with spiritual needs. The Catholic health care ministry belongs to the whole church, he wrote. Unfortunately, the church has "not yet developed ecclesiological categories adequate to reflect the new realities of expanded identity, health care as a ministry of the entire Church and new structures that are necessary to support this ministry."[38] However, despite this lack of structures and ecclesiological categories, it has been noted, "patients who feel God is absent in their dying discover him in the compassionate presence of the hospital chaplain, the caring medical team, and their family and friends."[39] A vast opportunity exists for greater support for this ministry in our current understanding and structures.

Responding to the Baptismal Call

A health care provider can be a minister when he or she is carrying out his or her baptismal call. Carrying out the call includes coming from and participating in the Christian community. The provider brings his or her individual gifts and presence to patients, listening actively to their story and caring lovingly about their health and whole being. On the other hand, a health care professional may not be a minister if his or her primary goal is to obtain a profit or seek self-gratification. Health care providers minister when the needs of the other are of greater importance than their own needs. Those who consciously seek to be present to serve each and every patient and meet their individual needs proclaim God's kingdom through their actions.

Are health professions ministries? The answer is, sometimes yes and sometimes no. It depends on the provider's consciousness, his or her awareness of God's presence, and his or her willingness to try to make God's presence known. Although the provider may not be able to concentrate on providing health care while thinking about that presence, the intention of making God's presence known and providing excellent care is, in my opinion, adequate to meet the criteria for ministry. The provider who ministers will serve with compassion and accountability to the best of his her or her ability. A provider who does not meet these criteria does not minister. It is not the health profession that defines the ministry; it is the manner in which the health care provider acts, thinks, and prays that determines whether ministry is being performed.

It is not necessary for a provider to be performing pastoral care in order for the service to be ministry. Pastoral care is a particular ministry. Each profession may be a ministry in its own right, when it is provided by a baptized Christian who is using his or her gifts in the service of others to proclaim God's kingdom through his or her actions. "We are many parts, but we are all one body, one body in Christ" (1 Cor 12:12). Although we are different parts, we are to work together to accomplish the ministry of Christ: health and salvation for all. All members of the health care team need to work together to help the patient become healthy and whole. We must attend to God's presence within us and allow it to show through us as we provide excellent health care. In this way we can be ministers at the same time that we deliver care. □

NOTES

1. Thomas O'Meara, *Theology of Ministry,* rev. ed., Paulist Press, New York City, 1999, p. 150.
2. Kevin D. O'Rourke, *Reasons for Hope: Laity in Catholic Health Care Facilities,* Catholic Health Association, St. Louis, 1983, p. 66.
3. Phyllis Ann Solari-Twadell, "The Emerging Practice of Parish Nursing," in Phyllis Ann Solari-Twadell and Mary Ann McDermott, eds., *Parish Nursing: Promoting Whole Person Health within Faith Communities,* Sage Publications, London, England, 1999, p. 5.
4. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* Washington, DC, 2001, p. 8.
5. O'Rourke, pp. 66-67.
6. "Apostolicam Actuositatem," in Austin Flannery, ed., *Vatican Council II: The Conciliar and Post-Conciliar Documents,* study ed., Costello Publishing, Northport, NY, 1986, p. 29.
7. Emily Phelen and Rosaleen Simpleman, "Pastoral Care's Role in a Reformed System," *Health Progress,* July-August 1994, pp. 64-66.
8. Robert W. Evans, "Strengthening the Spirituality of Lay Ministers," *New Theology Review,* November 2000, pp. 49-51.
9. Robert L. Kinast, "Heath Care and the Catholic Parish," *Chicago Studies,* December 1996, p. 278.
10. Tom Sofio, "Faith and Your Health," *Heart Beat,* vol. 36, no. 4, 1998 (also available at www.chausa.org/PUBS/PUBSART.ASP? ISSUE=XP9903&ARTICLE=C).
11. Richard P. Sloan, Emilia Bagiella, Larry VandeCreek, et al., "Should Physicians Prescribe Religious Activities," *New England Journal of Medicine,* June 22, 2000, p. 1,915.
12. Sloan, pp. 1,914-1,916.

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GIVING PATIENTS A "GOOD DEATH"

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gram? "Enlist a champion who's dynamic, gung-ho, passionate, and respected in the community and the hospital," urges Dr. McDonah. "Also, get a very good administrative person, since passion and organizational skills don't often go together. And look at care for the caregiving team, to prevent burnout."

"Identify key people to serve on the team who represent various disciplines but share the same philosophy of care," advises Lammers. "They must be comfortable discussing end-of-life issues and have no agenda. The level of support from the top down must be generated and sustained. And education is key—you must engage the community. End-of-life issues aren't black-and-white, and it's not cookbook medicine. There's no algorithm for end-of-life care; you have to work with patients and their families on an individual basis. And meet them where they are.

"It's tough work," Lammers says. "I go home emotionally exhausted. But I wake up the next day and I want to be here." □

NOTES

1. Mitch Albom, *Tuesdays with Morrie: An Old Man, a Young Man, and Life's Greatest Lesson*, Doubleday, New York City, 1997; the PBS program, *On Our Own Terms: Moyers on Dying*, was broadcast in four parts in September 2000; a website about the program can be found at www.thirteen.org/onourownterms/about/.
2. See Daniel R. Tobin, *Peaceful Dying: The Step-by-Step Guide to Preserving Your Dignity, Your Choice, and Your Inner Peace at the End of Life*, Perseus Books, Boulder, CO, 1998.
3. Center to Advance Palliative Care, *The Case for Hospital-Based Palliative Care*, New York City, no date, p. 1; the document can be found at www.capc.org/site_root/documents/files/tmp_133221135.pdf.

SPIRITUAL CARE AT THE END OF LIFE

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6. E. B. Clarke, J. R. Curtis, J. M. Luce, et al., "Quality Indicators for End-of-Life Care in the Intensive Care Unit," *Critical Care Medicine*, vol. 31, no. 9, 2003, pp. 2,255-2,262; T. A. Rummans, J. M. Bostwick, and M. M. Clark, "Maintaining Quality of Life at the End of Life," *Mayo Clinic Procedures*, vol. 75, no. 12, 2000, pp. 1,305-1,310; K. E. Steinhauser, E. C. Clipp, N. McNeilly, et al., "In Search of a Good Death: Observations of Patients, Families, and Providers," *Annals of Internal Medicine*, vol. 132, no. 10, 2000, pp. 825-832; M. W. Rabow, K. Schanche, J. Petersen, et al., "Patient Perceptions of an Outpatient Palliative Care Intervention," *Journal of Pain Symptom Management*, vol. 26, no. 5, 2003, pp. 1,010-1,015; A. Stepnick and T. Perry, "Preventing Spiritual Distress in the Dying Client," *Journal of Psychosocial Nursing and Mental Health Services*, vol. 30, no. 1, 1992, pp. 17-24; C. M. Puchalski and D. B. Larson, "Developing Curricula in Spirituality and Medicine," *Academic Medicine*, vol. 73, no. 9, 1998, pp. 970-974; and J. R. Staton, R. Shuy, and I. Byock, *A Few Months to Live*, Georgetown University Press, Washington, DC, 2001.
7. J. R. Curtis, D. L. Patrick, R. A. Engelberg, et al., "A Measure of the Quality of Dying and Death: Initial Validation Using After-Death Interviews with Family Members," *Journal of Pain Symptom Management*, vol. 24, no. 1, 2002, pp. 17-31.
8. Curtis.
9. Gallup Institute.
10. Garloch.
11. M. J. Field and C. K. Cassel, eds., *Approaching Death: Improving Care at the End of Life*, National Academies Press, Washington, DC, 1997.
12. K. J. Doka and M. Jenreski, "Clergy Understanding of Grief, Bereavement and Mourning," *Research Record*, vol. 2, no. 4, 1985, pp. 105-112.
13. I. Byock, K. Norris, J. R. Curtis, et al., "Improving End-of-Life Experience and Care in the Community: A Conceptual Framework," *Journal of Pain Symptom Management*, vol. 22, no. 3, 2001, pp. 759-772.
14. For the survey data, see www.lifes-end.org/faith_community_leader.phtml
15. Field and Cassel.

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13. Stephen G. Post, Christina M. Puchalsky, and David B. Larson, "Physicians and Patient Spirituality: Professional Boundaries, Competency, and Ethics," *Annals of Internal Medicine*, April 4, 2000, p. 580.
14. Post, p. 581.
15. Post, pp. 581-582.
16. Post, p. 582.
17. "Lumen Gentium," in Austin Flannery, ed., *Vatican Council II: The Conciliar and Post-Conciliar Documents*, study ed., Costello Publishing, Northport, NY, 1986, p. 40.
18. Margaret E. Mohrmann, *Medicine as Ministry: Reflections of Suffering, Ethics and Hope*, Pilgrim Press, Cleveland, 1995, pp. 16-20.
19. Mohrmann, p. 50.
20. Mohrmann, p. 54.
21. Mohrmann, pp. 63-64.
22. Mohrmann, pp. 69-74.
23. Mohrmann, p. 81.
24. Mohrmann, pp. 82-88.
25. Mohrmann, pp. 111-115.
26. Charles D. Hepler and Linda M. Strand, "Opportunities and Responsibilities in Pharmaceutical Care," *American Journal of Hospital Pharmacy*, March 1990, pp. 533-543.
27. Richard M. Gula, *Ethics and Pastoral Ministry*, Paulist Press, New York City, 1996, p. 21.
28. Gula, pp. 46-50.
29. Gula, p. 51.
30. John Rutland-Wallis, "A Theology of Psychotherapy," *Journal of Pastoral Care*, Fall 1996, p. 264.
31. Rutland-Wallis, p. 258.
32. Janet Stokes, "Ministry of Presence and Presence of Spirit in Pastoral Visitation," *Journal of Pastoral Care*, Summer 1999, p. 192.
33. Regis A. Duffy, *A Roman Catholic Theology of Pastoral Care*, Fortress Press, Philadelphia, 1983, p. 95.
34. Duffy, pp. 95-102.
35. Kinast, p. 278.
36. Duffy, p. 102.
37. Carol A. Griswold, "Pastoral Partners," *Health Progress*, March 1990, p. 72.
38. Joseph Bernardin, "What Makes a Hospital Catholic? A Response," *America*, May 4, 1996, pp. 9-11.
39. Helen Hayes and Cornelius J. van Der Poel, *Health Care Ministry: The Handbook for Chaplains*, Paulist Press, New York City, 1990, p. 126.