ABSTRACT

PHYSICIANS' PERCEPTIONS OF THE CHAPLAIN'S ROLE IN CRITICAL CARE

by

Daniel Winiger

The purpose of this study was to investigate physicians' perceptions of the role of chaplains in the common goal of health care delivery in a critical care setting. Chaplains practice their ministry as a minority in a biologically and technologically driven environment. Some chaplains have found that their relationships with physicians are strained. In order for chaplains to function with more confidence, they need to understand their role in critical care better. Because physicians are the primary decision makers in hospitals and decide how closely they want to work with others, this project investigated how physicians perceive the chaplain's role.

The critical care setting was chosen because patients express a higher need and desire for spiritual care as acuity of their illness increases. During times of serious illness and end of life, the domains of medicine and faith start to overlap. Patients and, more often, families have to integrate medical facts with their faith. In those times physicians' perceptions of the chaplain's role become particularly relevant.

Due to the particularity and newness of research into the domain of the physician-chaplain relationship, I chose the qualitative research methodology, conducting semi-structured interviews. The qualitative format and semi-structured interviews proved valuable as physicians expressed their personal experience and opinion about the very chaplains with whom they rub shoulders during their daily work.

A surprising finding of the study was that critical care physicians perceive

chaplains are most important for providing ministry to patients' families, who are experiencing acute grief as their loved ones face critical illness and possible death. Congruent with previous research was that physicians appraise faith in psychological and not religious terms. In keeping with already reported studies, critical care physicians also did not attribute curative properties to faith activities, such as prayer or sacrament. Physicians clearly delineated between the domains of medicine and faith in keeping with a well-established distinction between science and religion.

Nevertheless, physicians in this study recognized the importance of faith as a means of coping with illness, dying and death, and appropriately recognized chaplains as trained professionals who are able to provide spiritual care. Physicians also expressed appreciation for chaplains' immediate availability and expertise in dealing with emotional and spiritual issues and verbalized a high level of trust toward them.

DISSERTATION APPROVAL

This is to certify that the dissertation entitled

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CHAPTER 1

PROBLEM

Faith, religion, and spirituality are very much a part of people's lives when they enter the care of a hospital, and religious factors play a considerable role in how patients and their families cope and make medical decisions while negotiating complex medical facts and personal faith values. While many patients and their families lean on their faith to cope and make medical decisions, physicians tend to focus on scientific medical facts as to how they present treatment options and prognosis.

Traditionally, the domains of faith and medicine are and have been kept separate, and, for the most part, they can be reasonably kept apart. However, when patients become severely ill medical treatment options are running out, or death may be inevitable, the two domains start to overlap. This overlap of domains peaks when families are asked to make the heart-wrenching decision to disconnect their loved one from life support or other life sustaining treatments. During times of end-of-life care and decision making is when patients and families need the most spiritual and emotional support.

Ironically, during these times of immense pressure, the domains of faith and medicine have the highest propensity to collide. Physicians tend to become uncomfortable, hesitant, and even suspicious toward patients' and families' ability to reason when they face arguments based on religious values.

In most cases, physicians' medical recommendations are reasonable and sound, and families who have to make an end-of-life decision may trust the physician. Nevertheless, how the decision is made and what values are used to support or guide the decision-making process is as important as the decision itself. Trained chaplains are able to provide guidance and support to the family as well as to the physician during medical

decision-making time. Just as medicine and faith have the propensity to collide during these critical situations, the functions of physicians and chaplains have the same proclivity. Instead of inviting chaplains to the decision-making process, physicians also often exhibit hesitation and suspicion toward chaplains, who they may perceive as taking the families' side, and, therefore, as working against physicians' opinions. Physicians and chaplains ought to understand each other's roles best and work more closely and proficiently together during the times when faith and medicine overlap in order to create an atmosphere conducive to holistic patient care.

The role of chaplains is a difficult one in these circumstances because they understand the medical facts but also empathize and understand reasons brought forth by faith. Chaplains are in danger to side with families to be empathetic and to soften some of the medical reality's harsh psychological and spiritual impact. Siding with families may be perceived by physicians as antagonism, and, as a result, they are hesitant to invite chaplains to the process. Therefore, role distinctions and role functions of chaplains have to be negotiated and defined within the interdisciplinary care team of which they are a part.

I am a chaplain to patients admitted to any of the four adult critical care units of a regional medical center in Louisiana guided by the Roman Catholic faith. As the chaplain, I am responsible for providing spiritual and religious care to patients, families, and staff. I am also part of the interdisciplinary care team, which consists of health care workers of various medical disciplines such as nurses, social workers, therapists, physicians, and chaplains. In the context of that team, each member has a specific function and teams up with others to work toward positive health outcomes for its patients and an overall encouraging hospital experience for its families.

In order to care effectively for critically ill patients, communication among the various disciplines is paramount. This communication occurs during interdisciplinary care rounds as well as individual conversations among various caregivers. Each morning the team meets as a group to discuss each patient in all adult intensive care units. During these rounds, team members report their concerns regarding each patient to the attending physicians as well as the rest of the team.

This project received its impetus from a conversation with one of the critical care physicians and took place after one of the interdisciplinary care rounds. This gentleman, whom I consider a friend, shared the following. "You know, we [the critical care group] do not invite chaplains to conversations with families regarding end-of-life issues because you all, not you personally, always make families decide against the removal of life support." Whatever past or present experiences triggered this physician's lament, it alarmed me to the extent that triggered the reflection process from which this project emerged. Teamwork requires knowledge of each other's functions as well as a degree of professional and personal relationship.

I understood this physician's relationship to chaplains was marred, which hindered him (as well as others in that medical group) from inviting chaplains to those very important end-of-life discussion meetings with patients' families—meetings where chaplains are needed and where their presence could make a significant difference. The presence of chaplains who are trained to understand and empathize with families who have to negotiate and reconcile complex medical facts with their faith could make a positive difference to the spiritual and emotional well-being of those involved in the process. Because of this conversation, I became interested in how to mend the breach of trust present in this group of critical care physicians.

The Chaplain-Physician Relationship

Chaplains are known to complain about being overlooked and about not being given the attention or respect by physicians they feel they deserve (VandeCreek, Chaplain-Physician Relationship 17). Some of these feelings are justified because physicians can come across as high and mighty and, at times, show signs of entitlement, which others, including chaplains, resent. As understandable as such behaviors may be, and physicians are responsible for them, chaplains profit when making efforts to understand how physicians came to be the persons and professionals they are (5-18).

Larry VandeCreek points to differing educational, professional, and personal characteristics. While physicians have exclusively focused on acquiring as much scientific knowledge as possible and have gone through the intense education rigors of medical school, internships, residencies, and fellowships, chaplains have concentrated on the humanities, taking courses in theology and pastoral psychology (Understanding Physicians 5-18).

Therefore, physicians and chaplains meet at work with educations and philosophical backgrounds that differ substantially enough to cause tension between them (VandeCreek, Physician-Chaplain Relationship 6, 13). Chaplains think, function, and work from philosophical paradigms opposite of those of physicians. While chaplains approach their tasks from psychological and theological viewpoints, physicians approach their tasks from a biologically driven model.

Chaplains may feel undervalued also because they are a minority profession in the hospital, providing a service very different from all other health care professionals. Besides being a minority, chaplains have to function in an environment driven by science and technology—fields that are foreign to them. Chaplains' unique function in itself may

contribute to their feeling alienated.

Chaplains tend to overlook that while they only have to be concerned for patients and families' spiritual well-being, physicians are solely responsible for all aspects of patient care and their recovery. As privileged physicians are to practice medicine, they are also the ones blamed if something goes wrong. In the context of critical care, families often have unrealistic expectations, asking physicians to perform medically impossible miracles. As a result, physicians are, more than anyone else, blamed and often sued. Due to those pressures and vulnerabilities, physicians may feel just as easily isolated as chaplains (Chaplain-Physician Relationship 14-16).

Another aspect that may create tensions for chaplains is that medicine is outcome-driven and measurable, whereas the effectiveness of religious and spiritual support is difficult to assess. What also complicates matters for chaplains is that hospitals are not counseling centers or churches. Even though spiritual issues emerged during hospital stays, people come to hospitals to be treated for their physical, and not spiritual, ailments.

Chaplains may attribute their relational difficulties with physicians to physicians too quickly without first examining their contribution to tensions between the two (Thiel and Robinson 96). According to Martha Thiel and Mary Redner Robinson, chaplains as clergy suffer the loss of theology as the "Queen of Sciences" and appear to be too easily intimidated by physicians. Chaplains may also harbor feelings of being undervalued when their conversations are interrupted by physicians (96). Thiel and Robinson note chaplains tend to relate to physicians solely from the vantage point of advocacy for patients or families who may be unhappy with their physicians and, at times, present themselves as morally superior (96-97).

On the other hand, amid some apparent tensions between physicians and

chaplains, physicians point to chaplains' helpfulness. Chaplains have been called to help negotiate with historical difficulties related to Jehovah's Witnesses regarding blood transfusion, Christian Scientists' problem with aggressive therapy, and Orthodox Jews regarding the removal of life support (Thiel and Robinson 97). Physicians also regard chaplains as trained and knowledgeable to assess and deal with people of a variety of religious traditions and viewpoints and as able to work in those patients' frame of reference (97).

Apart from anyone else's perception or limitations placed upon them, chaplains need to remain faithful to their historical role of providing pastoral support to the hurting. These roles are defined as healing, sustaining, guiding, and nurturing (Clinebell 43).

Religion, Faith, and Medical Care

Physicians' acceptance of chaplains depends on (1) if they see any value of religion and faith in health care, and (2) if they do so, their acceptance further depends on how they perceive to what extent and how faith interventions are used during patients' hospital stays. Furthermore, how physicians appraise the present and historical relationship among faith, health, and healing plays an important role. In addition, to gain a more complete picture, physicians' perception of faith in health care must also be compared to the general population's opinion about faith and health. In turn, chaplains must evaluate their role in respect to physicians' perceptions.

The inclusion of religion, faith, and spirituality in medical care follows along with Americans' religious characteristics. A Gallup Poll conducted in 1994 finds that 96 percent of persons aged eighteen years or older in the United States believe in God or a universal spirit. More than 40 percent of Americans attend church weekly, 90 percent pray, and 27 percent read the Bible or other religious literature at least several times per

week (Princeton Religion Research Center 29, 35, 37). Gowri Anandarajah and Ellen Hight came to a similar conclusion:

> Up to 77 percent of patients would like spiritual issues considered as part of their medical care and 37 percent of these patients wanted their physician to discuss religious beliefs more. However, only 10 to 20 percent of physicians discuss religious or spiritual matters with their patients. (81)

In agreement with these findings is another study reporting that 85 percent of those surveyed wanted to discuss spiritual beliefs and two-thirds wanted understanding from their physician (McCord et al. 360). For some patients, faith is such an important aspect of their lives they did not just want their physicians to know about their faith, but, conversely, they would also welcome to know more about their physicians' spiritual frame of reference (Oyama and Koenig 433).

Besides knowing more about the general population's spiritual characteristics, some American's religious convictions in connection with health care have been in the spotlight. The Terry Schiavo case is only one among several cases that brought religious issues and health care to the whole nation's attention (Shannon 17).

In addition, studies published by researchers and the medical community have already illuminated and asserted a positive impact of faith upon health in general, and health care outcomes in particular (Koenig, Healing Power of Faith; Siegel; Cousins). One such study concludes that frequent churchgoers, who also read the Bible and pray, are more likely to have better immune systems and less hypertension (Koenig, Healing Power of Faith 193, 209, 211-14).

Challenges in Critical Care

Because this study took place in the context of critical care, to discuss challenges physicians and chaplains encounter in that specialized medical field is particularly

important. With the rise and dependence on technology, medical care has become increasingly depersonalized. While in 1949 50 percent of the U. S. population died in hospitals, medical centers, and nursing homes, today the percentage has risen to above 80 percent (Humphry 50). The issue of depersonalization seems to be particularly relevant in the world of intensive care. The more serious the medical condition, the more technology dependent medical treatment becomes; however, with the complexity of modern health care, intricate moral and ethical dilemmas emerge. For many, religious faith plays a role in how these moral and ethical dilemmas are resolved (Mermann 337). One such dilemma is how to assess "quality of life" (337). Frequently, ethical and moral dilemmas are troublesome and challenging for all parties involved. Advances in medical technology also shifted the role of physicians from a compassionate presence in private settings to technology-dependent diagnosticians (Humphry 13-16).

In addition, changes in the practice of medicine altered the physician-patient relationship. One of these changes is that patients and families have increasing difficulty keeping up with the many specialists and the different diagnoses and prognoses given to them by physicians attending their patients. With so many physicians involved in the care of one patient, communication tends to become fragmented and, thus, inadequate. Fragmented communication causes confusion and insecurity with patients' families and lends itself to painting an unrealistic picture of medical possibilities (Twohig and Byock 27-28).

Religious needs often emerge during critical illness. Even though patients and families want their physicians to be sensitive to their spiritual needs, they likewise demand physicians to be technologically advanced providing accurate diagnosis, prognosis, and successful treatment. This twofold demand places an undue burden on

physicians, who are already weighed down by heavy time constraints.

Acuity and Spiritual Needs

When patients are admitted to intensive care units, their conditions are to various degrees critical. For many patients, their days in an intensive care unit are their last. Patients treated in intensive care units have had surgeries, were hurt by accidents, or have developed acute health problems that have led to temporary or permanent disabilities of various degrees. Often patients in intensive care units are noncommunicative, need permanent ventilation, have partial or total paralysis, suffer terminal illnesses (such as cancers), are in acute renal failure, as well as lie in various levels of comas.

Many of these patients' health have deteriorated to the point where families have to make difficult decisions on behalf of these patients. Chief among these decisions is to withdraw aggressive treatment, such as life support. The withdrawal of life support, (e.g., mechanical ventilation, dialysis, or any other life sustaining treatment) results in the demise of the patient.

Times of serious illness, dying, or death are immensely stressful for patients and families alike. Having to make decisions such as the withdrawal of life support weighs heavily on all parties involved. Patients' medical and spiritual needs culminate toward the end of life. Patients and families also become more interested in and verbal about having their spirituality and faith taken into account along with their medical care (Ehman et al. 1803-06). When families or patients have to make end-of-life decisions, they reach for their faith to support them. They start to rely increasingly on religion to cope with the difficulties placed upon them (Koenig, "Religious Attitudes" 216-19). Susan Strang and Peter Strang observe that existential questions increase with terminally ill patients (859). Other researchers observe that distress becomes more acute and visible during times when

people's lives are in the balance or when patients move toward their end on earth (Chibnall et al. 331-38).

Likewise, as patients approach their end of life, physicians also become more willing and find it more important to inquire about their patients' faith or even to get involved to some degree with their patients' religious needs. The more acute the prognosis the more likely physicians are interested in the spiritual care of their patients (Ellis et al. 252). As families make heart-wrenching decisions, they have to negotiate complex medical information with faith. Trained and experienced chaplains are able to support and guide families through the decision-making process. The challenges requiring the intervention of chaplains often involve cases where religious matters have become complicated to manage, and families poorly cope with the medical realities at hand.

In more cases than not, families and patients successfully cope with the physical reality of illness and death. Under these circumstances, they are able to apply their faith values in ways that makes sense and provide meaning. Nevertheless, grief is acutely present, and their faith helps patients and families grieve appropriately and come to terms with the medical situation.

Despite or because of strong faith values, patients and families' faith persuasions, at times, clash with medical recommendations to the extent that create barriers between them and the medical staff. In those circumstances, families' faith values interfere with medical assessments. In these cases, physicians try to value patients and families' faith but have difficulty comprehending how faith works in situations when no treatment options are available anymore and when decisions based on faith cause patients to go through prolonged suffering unnecessarily.

In these cases, physicians have to contend with and navigate through difficult

situations where matters of religion and faith have become the primary focus of the discussion in medical decision making. In addition, physicians face patients who express concerns regarding existential matters, such as questioning the meaning of life, posing "why" questions and asking about existential suffering, faith in God, suffering in eternity, and final separating from family (Strang and Strang 859). No easy answers to such questions exist, and to help patients or families move toward acceptance and resolution takes time, which physicians do not have. Chaplains do have the time and are able to be present to help patients and families get through the roughest period.

The following case reported by Bernard Lo et al. illustrates a common scenario in critical care units:

> Mrs. M is a 73-year-old woman with chronic obstructive pulmonary disease who has been receiving mechanical ventilation for 2 months because of acute respiratory failure. Believing that Mrs. M now has only 1% chance of being successfully extubated, her physicians begin to discuss limited life-sustaining interventions. Mrs. M is unable to participate in the discussions. She had previously indicated that her husband should act as the one making decisions for her but did not provide specific directives for her care. Mr. M and their 2 children insist that mechanical ventilation be continued. (752)

The family argues that God has stronger healing powers than medicine and that he will answer their prayers and work a miracle (752).

To avoid antagonism, physicians will navigate through a difficult decision-making process involving faith, an area that is foreign to their medical training. Physicians are placed under pressure and feel uncomfortable because, as in the case of Mrs. M, to continue aggressive treatment runs against their medical expertise and their understanding of standard of care. Physicians get frustrated or become irritated when they face religious arguments that challenge their medical assessments. The difficulties climax when families ask physicians to provide what they deem "futile care." Futile care is medical treatment

administered that will not cure the patient but only prolong the dying process. End-of-life scenarios, like that of Mrs. M. involving beliefs, are not infrequent and pose a challenge to integrating faith and spirituality into daily health care. Cases as illustrated above demonstrate the difficulty in negotiating the subjective value system of faith with the scientific objectivity practiced in health care.

In times of health care crises, tensions between matters of faith and medicine converge and potentially collide. On the one hand, at the crossroad of life and death, families need help from physicians regarding sound communication and help from chaplains to cope with the reality of illness and death. On the other hand, at the crossroad of life and death things escape people's control; and at that crossroad physicians and chaplains need to work closely together.

The Need for Pastoral Care and Teamwork with Physicians

The following realities accentuate the need for trained chaplains able to assist physicians in the care of intensive care patients: (1) patients and families' spiritual and religious needs increase with acuity of illness and culminate toward the end of life or death (Ellis et al. 252); (2) patients bring their faith values to the end-of-life decisions-making process, and matters of faith can cause tension in the relationship between families and medical personnel (Lo et al. 752); and, (3) physicians are often uncomfortable dealing with issues of faith because they are not religiously trained, may marginally value the function of religion in health care (Curlin and Moschovis 4-5), and feel constrained by perceived professional boundaries to deal with religious issues (Post, Puchalski, and Larson 578-83).

The quality of patient care stands and falls with the quality of teamwork among health care professionals (Barr 1005-10). Part of providing quality care requires taking

into account the various needs of patients and their families. Because both physiological and spiritual needs culminate during critical illness, they pose a challenge to the collaboration between physicians and chaplains. Physicians are the principal decision makers in critical care units; their willingness to involve others, such as chaplains, is important.

In respect to the physician-chaplain relationship, how physicians perceive the role of chaplains becomes an important factor. The role physicians attribute to their chaplains, as well as how they personally relate to them, determines how they will use pastoral care in the healing process.

Factors Influencing Physicians' Perception of the Role of Chaplains

Three factors emerge as important contributors to physicians' perceptions of chaplains' role in health care.

Education

Education is an important aspect, which contributes to how physicians perceive the role of chaplains in critical care. Both physicians and chaplains enter their relationship with preconceived ideas about the other's personal values and function in health care. Many of the ideas formed during the educational process will find an expression in their respective professional practice.

Physicians' extensive engagement with science and professional allegiances may have led them to indifference toward their patients' religious needs or perceptions that religion has no legitimate function in health care. Such indifference results in behaviors offensive to chaplains and end up in fewer referrals to clergy. Due to physicians' educationally acquired value system, they may assign chaplains roles that may or may not be appropriate or true.

While the road to becoming a certified chaplain entails focus on the humanities, theology, and psychology, which are all relationship related, physicians, from the beginning of their education (high school), have focused exclusively on science (VandeCreek, Chaplain-Physician Relationship 6, 13). VandeCreek points out that students with medical school in mind will seldom take courses such as English or history, nor do future clergy focus their class selection on physics, biology, or chemistry. The following statement captures the impact of educational differences between physicians and chaplains:

> This important contrast demonstrates not simply that humanity and science majors know different sets of facts, but that in the learning process they begin to draw different conclusions about what is important to know about life and its living. They begin to appreciate contrasting aspects of life and sometimes to devalue the aspects they neglect. (6)

Besides physicians having undergone a one-track science-oriented education (and rightly so), they have done so at great personal sacrifice, which often required them to choose study over relationship and socialization (7, 13).

Science

The second factor that influences physicians' perception of chaplains' role is the historical schism between science and religion. The relationship between religion and science has undergone tremendous changes since the discovery of the scientific method. None of these changes was as dramatic and had such a profound impact upon the relationship between the disciplines of science and theology as the ones experienced in this century.

After World War II, the United States experienced tremendous technological advances. These advances revolutionized health care and health care delivery. These health care improvements were very much advantageous as new surgical techniques

emerged and many illnesses such as infections that used to result in death became treatable with a growing number of antibiotics. As science and technology came to dominate health care, physicians' practice of medicine changed from a paradigm of care toward a paradigm of cure. Derek Humphry observes that in the past, physicians' role was to comfort at the bedside in times of grave illness and death, and when doctors did not have today's vast resources, the only intervention available to them was to remain present with the patient and alleviate pain (15). Before the emergence of penicillin and the current medical knowledge, faith and religion played a stronger role in health care and coexisted more peacefully with medicine (Cohen et al. 29-31). Therefore, technological advances in scientific medicine introduced a paradigm shift, which resulted in a reliance on biology to the exclusion of faith and religion as part of the healing process.

According to Mary Hroscikoski, the division between science and faith in health care is an outgrowth of the reliance on the biological model upon which medicine is built. The premise of the biological model is to accept only anything as real if it is measurable. In the biological model, medicine is cause-and-effect based and, according to Hroscikoski, is entirely materialistic (55). At one point during the twentieth century, science and faith in medicine grew apart to the point where physicians were warned to discuss religion with their patients was professionally unacceptable (Cohen et al. 31).

According to Christina Puchalski and Ann L. Romer, physicians tend to rely on what they are most comfortable with, which is their technical training. They write, "But in fact, patients are very dissatisfied with that sort of patient-doctor relationship because they want doctors to be caring, in addition to being technically skilled" (130). In addition, patients, when they are dying, desire warm and caring relationships with their physicians (130).

Observations about a gap between science and faith do not undermine the importance of science in medicine nor do they negatively evaluate science's achievements for the overall health of people. What they do say, however, is that science does not afford all the answers life seeks. If patient care is only concerned with the biological aspects of sickness, it overlooks the spiritual dimension of life. "The sole reliance upon biological materialism in medicine isolates disease and the sick from their social and cultural context. In other words, medicine is focused on *disease* [emphasis mine], rather than on *persons* [emphasis mine] living with the experience of disease" (Hroscikoski 55-56).

Against a somewhat bleak picture of health care and its relationship to faith and religion, the medical community has made efforts to mend the rift between the two domains. One beacon appeared when the Joint Commission on Accreditation of Healthcare Organizations responded to public request requiring health care institutions to assess and accommodate patients' spiritual beliefs and practices (Handzo and Koenig 1242).

Some caution in considering faith and health care must be taken. Norman Cousins advocates realistic expectations. He cites Dr. Jerome D. Frank of the Johns Hopkins University School of Medicine, who told students at the university's graduating exercises in 1975 that any treatment of an illness that does not also minister to the human spirit is grossly deficient (Cousins 133-34). While advocating ministry to the human spirit, Dr. Frank also holds, "[A] 1974 British study showing that the survival rate of patients with heart disease being treated in an intensive-care unit was no higher than the survival rate of similar patients being treated at home" (133-34). Frank further believes, "[I]t is reasonable to expect the doctor to recognize that science may not have all the answers to

problems of health and healing. But it is not reasonable to expect him to give up the scientific method in treating his patients" (120-21). Frank voiced a balanced view that is not easily practiced but reflects this projects' aim to achieve.

Physicians' Views of Religion in Health Care

The third factor contributing to physicians' perceptions of chaplains' roles in health care is linked to how physicians view religion and faith as part of health care. In light of recent discoveries, patients wish their physicians to be more aware of their religious preference during critical illness (McCord et al. 360; Oyama and Koenig 43). According to Dana E. King et al., physicians acknowledge the trend of spirituality as a concern in the patient-physician relationship. Their study reports 85 percent to 93 percent of respondents agree they, the physicians, should be aware of, or consider, patients' religious and spiritual beliefs (158-62).

On the other hand, George Handzo and Harold G. Koenig have found many physicians are still reluctant to enter discussions with patients that relate to faith and religion (1242-44). Physicians' reluctance is justifiable as they are not trained in spiritual and religious matters and, therefore, feel uncomfortable discussing spiritual matters with patients. Reasons for this hesitance are related to professional boundaries, competency, and ethics (Post, Puchalski, and Larson 581-82).

Some researchers and commentators heavily criticize the scientific validity of studies reporting a positive relationship between faith and health (Sloan and Bagiella 14-21). To investigate the validity of claims made by a relatively new field of inquiry is important. Research methodologies for studies investigating faith and health have improved and are lending a high degree of credibility to these studies findings (Koenig et al., "Religion, Spirituality, and Medicine" 125-26).

Besides professional reasons, physicians' personal religious characteristics may also contribute to uneasiness among physicians as they try to negotiate faith as part of health care. Some limited studies have observed family physicians' religious characteristics are comparable to the general population (Daaleman and Frey, "Spiritual and Religious Beliefs" 98-104) and family physicians tend to be more religious than physicians practicing other specialties (Frank, Dell, and Chopp 17-22).

Physicians practicing in subspecialties that deal particularly with death, existential suffering, and moral complexity have similar religious characteristics as the general public (Curlin et al., "Religious Characteristics" 632). However, they differ substantially in that they less likely make a conscience effort to apply their religious beliefs to other areas of life, and they are less likely to rely on God to find strength, support, and guidance (Frank, Dell, and Chopp 17-22). What has not yet been determined is how these differences shape the clinical encounter (Curlin et al., "Religious Characteristics" 632).

The Purpose

As part of the interdisciplinary care team, chaplains engage physicians as care team partners. The need for physicians and chaplains to work together becomes the most pressing and has the potential to be of high impact when families face the severe illnesses or the end of life of one of their loved ones; however, their teamwork falters exactly under those circumstances.

In order to better the situation, chaplains need to understand their role from the perspective of physicians. Therefore, in the larger context of the chaplain-physician relationship, the purpose of this project was to investigate physicians' perceptions of the role of the chaplain in the common goal of health care delivery in a critical care setting.

Research Questions

The answers to the following two research questions led to the realization of the stated purpose.

Research Question #1

How do physicians view and appraise the chaplain's role in health care delivery in an intensive care setting?

Research Question #2

What were physicians' formative experiences that help form their perceptions of the chaplain's role?

Summary and Conclusion

Patients and families bring their religious values to the health care process, using their faith to cope with the stress that comes with hospitalization and to make medical decisions. During times of critical illness in general, and end of life in particular, patients and families' physiological and spiritual needs culminate, which requires the sensitive and collaborative presence of physicians and chaplains. In these times when the domains of faith and science need to interact intelligently, they tend to collide in the form of tensions between physicians and chaplains.

For chaplains to be more confident in their role in critical care, they need to understand how physicians, who are the principal decision makers, perceive their role. The main factors, which influence physicians' perceptions of the chaplain's role are (1) physicians' education, (2) their understanding of science, and (3) how they value faith as part of health and health care.

Definition of Terms

In this study, critical care units are adult intensive care units such as surgical intensive care, medical intensive care, cardiac care, and cardiac surgery care. These units predominantly serve patients having undergone serious surgery, patients who have acute medical problems, or those who have traumatic health crises due to accidents. Anthropology is not used in terms of social sciences but in terms of a biblical/theological description of human beings.

Context of Study

The hospital in which this project took place is a regional medical center serving a midsize city and its surrounding counties with medical care. It is located in the southern part of the United States and was founded by a Catholic order of sisters to serve the poor. At its present location, the hospital has 763 licensed beds and serves approximately 25,000 patients a year. Its mission statement asserts that the hospital exists to extend the healing ministry of Jesus as modeled by St. Francis and the Catholic Church. The core values are listed as "service," "reverence and love for all life," joyfulness of spirit," "humility," and "justice."

The medical specialties are too numerous to list, but among the standard medical specialties are oncology, thoracic and cardiovascular services, as well as general surgery and medical care. The hospital stands out as having the largest and most modernly equipped emergency room in the area where all the head traumas either resulting from accidents or medical reasons are admitted. This hospital is also unique in that it has its own separate pediatric emergency room and intensive care unit, and it also hosts the region's only children's hospital. The only service this hospital does not provide is gynecology and obstetrics; therefore, it does not deliver babies.

Relevant for this study is the fact that all head traumas resulting from accidents (adult and children) and all cases requiring neurological surgery in the region are exclusively performed in this hospital. Therefore, the four intensive care units I serve take care of patients with serious injuries that are frequently life threatening.

The four intensive care units are surgical intensive care, medical intensive care, cardiac care, and cardiac surgery care. These units total forty-four beds and are supervised and run by physicians specializing in critical and pulmonary care medicine. These physicians are called intensivists.

Besides mentioning critical care medicine as one of the pillars of medical care in this hospital, two years ago a trauma surgery program was established. These surgeons are responsible for all adult traumas admitted to the emergency room. Many of the patients treated in this hospital's intensive care units are admitted through the trauma surgery service. These patients are served by an interdisciplinary care team consisting of intensivists, nurses, physical therapists, nutritionists, respiratory therapists, social workers, and chaplains.

In addition to these acute medical specialties, this hospital has an inpatient psychiatric unit as well as a chemical detoxification, drug, and alcohol rehabilitation service. Overall, the hospital is committed to serving the many medical and psychiatric needs of the population in the city and its surrounding counties.

Pastoral care service has a long-standing tradition and is ultimately answerable to the local Catholic bishop. Only a few years ago, non-Roman Catholic clergy and chaplains were allowed to minister within the walls of this hospital. Since then, the pastoral care department has undergone substantial changes and now is staffed by eight full-time chaplains, a secretary, a part-time team leader serving in an administrative role,

and a director. The department is subordinated to a vice president of missions.

The staff is multicultural and multidenominational consisting of two Catholic priests, a Methodist, a Baptist, a Disciple of Christ, a former Catholic brother, a Catholic sister, and a nondenominational/Pentecostal minister. One of the ministers is from Africa, one from the Far East, and three are from European descent. The department's chaplains are predominantly male, whereas its leadership is female. All staff chaplains have masters degrees, are ordained and endorsed by their respective denominations, and have completed a minimum of four units of clinical pastoral education served in a residency program. This residency consisted of four hundred hours of supervised ministry in a hospital setting. All but one chaplain (who is in the process of certification) are certified by either the Association of Professional Chaplains (APC) or the National Association of Catholic Chaplains (NACC).

The department had its share of difficulties due to political haggling and leadership changes. Thus, today a nonreligiously educated person with no pastoral care experience or credentials directs the department. Her lack of training and knowledge of the inner workings of pastoral care has wide-ranging consequences for how the department is led, what is emphasized, and how the department is represented to the hospital's administration. Emphasis is generally given to hospital concerns such as patient safety and infection control (hand washing) as well as charting and other administrative tasks. These tasks are important but secondary to the calling and work of hospital chaplains. Little to no emphasis is given to real concerns of pastoral care work. Chaplains are left to their own devices and must find ways to cope with the stresses of their ministry outside of the department or among themselves. No pastoral or professional guidance is given or can be expected from the department's leadership.

Because the department's leadership is not familiar with the concerns of chaplains regarding their daily work nor the philosophical and theological foundation required to understand the ministry of chaplaincy, chaplains feel isolation and frustration. No intention or mechanism exists by which the department seeks deeper and more meaningful integration of spirituality into health care. The department does not initiate dialogue with physicians regarding spiritual matters in health care, which could potentially lead to better personal and professional relationships with physicians.

Nevertheless, in spite of these internal difficulties, chaplains are well respected, appropriately called upon for spiritual care, and were recently voted the best nonclinical department of the hospital.

Even though I maintained a ministry through the whole hospital and rubbed shoulders with a variety of medical specialties, this project was conducted with regard to physicians practicing in the four above-mentioned adult critical care units.

Methodology and Instrumentation

This was an exploratory study using a researcher-designed, semi-structured interview protocol. To seek answers to each research question, I posed open-ended, semi-structured questions that invited descriptive and experiential responses from the participants. This format enabled the interviewer to pose follow-up questions if necessary. The answers were taped, transcribed verbatim, and then evaluated. Evaluation of all responses resulted in significant themes. These themes were categorized according to their quantitative and thematic significance.

Subjects

The twenty-one interviewed subjects were approached from a pool of thirty physicians practicing a variety of medical specialties in all or any of the hospital's four

adult intensive care units and the emergency room. These physicians were of both genders but were predominantly male. Some were seasoned physicians while others were still in their fellowships and residencies. No variables were present, as this was not an interventional study.

Data Collection

I collected the data by interviewing physicians. The interview format was a semi-structured interview protocol. The interviews took place in the physicians' private offices and other places that provided for the needed confidentiality. Because the interview sample was small, extra caution was taken to ensure confidentiality. Therefore, no names or medical specialties were recorded.

Each interview was taped using a digital recorder. The recorder came with a software program that allowed the transfer of the interview data as voice files to a personal computer. The ability to play back interview data from a personal computer via this specialized software made transcription and evaluation easier and more efficient.

Reliability and Validity

Before data collection, I conducted two test interviews to verify if the interview questions and the semi-structured interview protocol were suited to answer the research questions. Validity was established through the coherency between the purpose of the project, the research methodology, and quality of the obtained data.

Delimitations and Generalizability

The outcome of this study was limited because it was conducted in one type of hospital with a particular faith affiliation located in the southern United States. In order for this project to be generalizable, it needed to have been conducted in various types of hospitals with other or no faith affiliation. The fact that the study was done in the narrow

field of critical care was not as much a limitation because the results may be compared to other critical care settings functioning under similar conditions. The results may be compared to previously published research investigating physicians' perceptions of chaplains' role in hospitals, as similar dynamics between physicians and chaplains may generally exist.

Overview

Chapter 2 discussed literary sources relevant to the project's purpose. Chapter 3 outlines the details of the study design. It includes a description of the project's subject samples, its instrumentation, reliability and generalizability, as well as the study's method of data collection and analysis. Chapter 4 then presents the findings gathered from twenty-one interviews with critical care and emergency physicians. The presentation of the findings is organized by themes, which are listed according to their importance given by physicians. Chapter 5 provides a summary and evaluation of the findings presented in Chapter 4. The evaluation includes interpretations of the results, comparisons with previously conducted research as presented in Chapter 2, as well as an evaluation of the findings in respect to the theology established in Chapter 1.

CHAPTER 2

LITERATURE

First, this chapter first examines the unity of personhood according to Scripture offering a theological perspective that provides a rational for chaplains and physicians to care for their patients spiritually and medically. Secondly, it reviews selected materials relevant to the purpose of the project, which was to investigate physicians' perceptions of the role of the chaplain in a critical care setting.

The Unity of Personhood: A Biblical Anthropology

This biblical anthropology has the purpose of establishing a scripturally based analysis of what comprises human beings and how a consequential view of personhood influences the range of hospital care. This theological inquiry discusses biblical texts and theological interpretations of texts concerned with biblical anthropology. Anthropology will not refer to the study of human behavior or culture but define the composition of human beings as explicated in Scripture. Expressions such as "view of" and "composition of human beings," "personhood," "persons," or "human beings" are included in, and interchangeable with, the term "anthropology."

The extent to which physicians understand persons' nonphysical and physical entities relate to and affect each other impacts how much they are willing to seek care for the nonphysical problems that arise during times of critical illness. Physicians' openness to acknowledge the necessity of caring for patients' and their families' spiritual struggles during hospital stays influences how they perceive the role of chaplains in health care and to what extent they will invite chaplains to be part of the overall health care process. The critical issue in anthropology and health care for the purpose of this project is how much weight physicians give spiritual aspects to achieve patients' well-being.

As resilient as human beings are, they are also vulnerable, physically and spiritually, to illness. Such vulnerability becomes evident during times of illness and hospitalization. Illness affects persons' bodies and spirits as described by the following thesis, which underlies the theological grounding of the project:

> Human persons are constituted as body and spirit, and illness grasps human beings as whole persons. In fact, whatever threatens the essential unity of the human body and the human spirit is what we mean when we say that a person is ill. (Sulmasy 40)

Daniel P. Sulmasy correctly defines illness as any threat against the fundamental unity of body and spirit. An interruption of health, in either the body or the spirit, constitutes sickness. If either part is ill, the other is affected also.

God designed people to be whole human beings. The Scriptures define wholeness with the word *shalom*, also translated as *peace*. Sin causes a break with God—the source of life, peace, and health. Sin breaks the unity between the body and the spirit. The fracture of the unity of body and spirit makes us vulnerable to sickness and causes human beings to die eventually. Human beings' wholeness (integrity) is modeled after the unity in God. God is fully integrated and whole—morally, spiritually, and physically.

In this theology, the terms persons, human beings, or personhood denote human beings as a complex fusion of body, intellect, emotions, and spirit. These components describe a "whole person." Furthermore, the thesis holds that spirit, emotions, and intellect cannot exist apart from the body. Neither the body nor the spirit can exist apart from each other.

In order for health care to attend to patients as whole persons, it must embrace the concept of a unity of body and spirit. If medical treatment fails to acknowledge that unity, it negates the impact of physical illness upon persons' spirits (nonphysical parts). To

separate human beings into loosely related and neatly separable entities fragments health care delivery in that it encourages health care givers either to overemphasize or to neglect one aspect of personhood over the other. Therefore, in order to care for the whole person, health care professionals must recognize the essential anthropological unity of human beings. If health care professionals were to accept this unity, they would more likely emphasize the necessity of holistic care. Holistic care aims at caring for the physical and the spiritual needs of patients as fully as possible.

The expression "unity of body and spirit" in this thesis means the fusion and interrelationship of the physical and nonphysical parts of human beings. Body is easily defined as persons' physical features. "Spirit" is harder to define because it contains multiple dimensions. "Spirit" includes all emotional, intellectual, and spiritual components. I believe that in the deepest sense "spirit" denotes the core of a person. The core is that which dominates, motivates, or moves persons—the heart. The core may also be defined as "the self." That self cannot be lived without a body.

Because illness is defined as any threat to the unity of body and spirit, and sin's detrimental impact upon the life-giving relationship with the source of life—God, medical care givers need to attend to the spiritual needs of hospital patients if wholeness of being is the goal. Because of the essential unity of body and spirit, persons relate to God through the totality of their existence. When God touches a person, he touches the total person.

Different Views and Challenges of Personhood

Christian theology over the past two thousand years has claimed different views of what comprises human beings. Some scholars have divided humans into consisting of two separate entities—a body and a spirit, or material and nonmaterial parts. Others have

claimed that persons are comprised of three distinguishable entities—a body, a soul, and a spirit. Proponents of either persuasion claim certain Scriptures but fail to connect the different parts of personhood in ways that define human beings as unified wholes (Grenz 156-58).

The challenge to establishing a scripturally based anthropology requires, first, to shed present theologies from their dualisms, second, to reexamine the biblical record, and third, to reformulate a new understanding. What has plagued Western anthropology is that it is infused with platonic dualism. Platonic dualism created a dichotomy that allows to treat spirit and body as two substantially different entities with little connection between them. The danger with dualism is that one treats the body and spirit as separate and detached entities. The best example of such a disconnect is found in Gnosticism, which treats spirit as superior to matter. Adherence to Gnostic dualism in anthropology leads either to neglect or to over emphasis on the body.

Dualism is inherent in Greek philosophy but is foreign to Jewish thought. Dualism has a long-standing tradition in Western anthropology as part of Gnostic thinking, which in turn influenced early Christian theology. Anthropological dualism appears to find expression in such Christian thinkers as Irenaeus (Alexander Roberts and James Donaldson 526-67), who asserted the human tripartite, namely body, soul, and spirit.

Presently, two schools of thought dominate the discussion regarding biblical anthropology—the trichotomist and dichotomist interpretation of personhood. The trichtomist view asserts that human beings consist of three distinguishable entities—the body, the soul, and the spirit. The tripartite view is predominantly held by conservative denominations such as the Southern Baptists or Pentecostal/Charismatics. This persuasion was popularized in the seventies by Watchman Nee, a prominent Chinese Christian who

constructed a theology of sanctification upon it (Grenz 156-57).

Classic theologians favor a dichotomist view. The dichotomist view treats spirit and soul as interchangeable but still views a person as consisting of two substantially different entities—the immaterial (or inner) self and the material (or outer) self (Grenz 157).

Contemporary theologians, on the other hand, reject either idea and believe that humans do not consist of multiple and substantially different parts. They reject these views for scientific, philosophical/biblical, and relational reasons. First, they argue that no empirical evidence supports the idea of the existence of materially different entities in human beings. Second, they reject the idea because of its origin in Plato's dualism, and third, they believe that such dualism is problematic because it is unknown how these entities interact with each other (Grenz 158-59). Contemporary thinkers also assert that Platonic dualism is disastrous: (1) because it leads to the elevation of one substance over the other and (2) because it nurtures the mistaken belief in the intrinsic immortality of the soul (159).

In medical care, anthropological dualism finds expression through the exclusive application of the biological model in diagnosis, prognosis, and treatment. The biological model fails to appreciate fully the unity of body and spirit as it tends only to marginally account for, or sometimes altogether neglect, the spiritual aspects of suffering. In order to help the medical profession to appreciate human beings more fully as a unity of body and spirit, chaplains themselves have to be clear about that unity, and they then must help physicians better understand the implication of that unity in medical care.

The Soul (ψυχη)

A major hurdle to overcoming anthropological dualism is the church's belief in the existence of a soul as an independent part in the body. The soul also is believed to contain the seat of persons' personalities and spirits. In addition, the soul is believed to be

the surviving essence at death going to heaven and then waiting to be rejoined by the body at the resurrection of the dead.

The problem with the existence of a soul is not that the New Testament talks about soul but that both trichotomists and dichotomists believe human beings have a soul distinct from the body and the spirit. To define the meaning of soul in the New Testament, therefore, is paramount to finding a solution. Trichotomists use 1 Thessalonians 5:23: "May God himself, the God of peace, sanctify you through and through. May your whole spirit, soul [ψυχη] and body kept blameless at the coming of our Lord Jesus Christ" (NIV) and Hebrews 4:12: "For the Word of God is living and active. Sharper then any double-edged sword, it penetrates even to dividing soul [ψυχη] and spirit, joints and marrow; it judges the thoughts and attitudes of the heart." On the other hand, dichotomists conflate "soul" and "spirit," saying they are used interchangeably (e.g., Gen. 35:18; Eccl. 12:7; Heb. 12:23; Rev. 6:9; Grenz 156-57).

Traditionally, Western Christians are still taught that at death the soul goes to heaven and then waits for a rejoining with the body at the resurrection of the dead. On the other hand, Jürgen Moltmann is convinced that the existence of a separate entity called "the soul" is untenable because such a belief amounts to the belief in the immortality of the soul (100). Moltmann writes, "The church still adheres to the continuance and subsistence after death of a spiritual element furnished with consciousness and will, so that the human self continues to exist, although in the intermediate period it lacks its full corporality" (100). Moltmann rejects the idea of an immortal soul not simply because it emanated from Plato but because it is inherently unbiblical, defying the principle of Christian hope. Unlike an immortal soul, which does not know birth or death, the human experience is captured by birth and death. Christian hope is not the immortality of the

soul but bodily resurrection (58-65). John Polkinghorne holds the same belief and states, "[O]ur hope is not survival but resurrection" (Serious Talk 106). The belief in the separate entity of a soul unnecessarily tears the human being apart and negates the unity inherent in human beings as being created in the image of God. The essential unity of being must be preserved beyond death; thus, eschatology should endeavor to account for unity also.

Ancient literature and the Bible write about soul. In ancient Greek literature, the concept of soul [ψυχη] has three basic meanings: (1) the term soul was thought to be an impersonal basis of life, (2) life itself, and (3) a person's inward part. The soul was also regarded as independent from the body. According to G. Harder, "[T]he soul was conceived as combined with the body. When it leaves the body, the body loses its life. A person's soul is snatched away, and with it his life" (677). Thus, physical life depends on the presence of the soul.

Soul can also stand for the inward part of people—their personality. In that case, the soul is equivalent to person and becomes the "I" (Harder 677). Soul according to Greek thought is the seat of perception, desire, pleasure, and enjoyment. Greek philosophers claim that the soul is incorporal, and without a soul, *sophia*, wisdom, and *nous*, understanding, could not develop (677-78). Plato took the concept of soul to the point that the soul must be separated from the body in order to come fully into its own.

On the other hand, the Septuagint translates *nepes* "soul, person, and being" (Gen. 2:7) with ψυχη. Soul in the context of the Old Testament stands for person or being, or that which makes a body (Gen. 1:20). It also denotes *leb* "heart" the inner being of a person, and the sensitive part of life, the ego (Cant. 1:7; Harder 680).

The New Testament likewise uses the concept of soul [ψυχη] in several ways.

Soul can denote life. “For whoever wants to save his soul [ψυχη] will lose it” (Mark 8:5). Soul in the New Testament also “embraces the whole natural being and life of man for which he concerns himself and of which he takes constant care” (Harder 682-83). John uses the word ψυχη when he says Jesus laid down his life for the sheep (10:11). In 2 Corinthians, ψυχη is used to mean the inner life of a person, equivalent to the ego or personality (Harder 683). On the other hand, in 1 Peter 2:11, the soul is the part that believes and is sanctified as well as destined to inherit the kingdom of God. In 1 Peter, soul is contrasted not with body and spirit but with the lust of the flesh (685).

In 1 Thessalonians 5:23, soul is distinguished from body [σωμα] and spirit [πνευμα]. According to Harder, spirit here may mean the higher side of people, that is, the spiritually enlightened, and soul as being alive in the sense of having a will and emotions (684).

Scripture (the Old and the New Testaments) uses the terms body and soul in like manner. The writers of the New Testament did not propose a dualistic view of personhood, and the authors of the New and the Old Testaments likewise believed in the unity of body, soul, and spirit. In the Bible, the term or concept of soul is not a separate and distinguishable entity in the body. Even though Paul belabors the point of making a distinction between the mortal and the immortal body or personality (1 Cor. 15:44 ff.), he does not advocate that a separate entity called “soul” is going to be saved as opposed to the whole person. Therefore, Paul in 1 Thessalonians 5:23 and Hebrews 4:12 does not refer to soul as to a separate entity but to inward characteristics of a person, such as emotions and intellect. Therefore, soul [ψυχη] in the New and Old Testaments denotes both the nonphysical expressions of persons and life—that is, the total human being

including the body, itself. They do not describe soul as a separate redeemable entity apart from the body or a spirit.

The Unity of the Human Being in Creation and Eschatology

Customarily, scholars neatly separate theological disciplines such as creation and eschatology; however, in contemporary theology, the norm of separating the various theological disciplines is changing. A shift toward holistic theology is being expressed by scholars, such as Daniel W. Hardy who holds that creation and eschatology can be seen as different aspects of a single dynamic and that their significance is more likely seen when they are interrelated (106).

In the quest for a comprehensive view of personhood that will help bridge the gap between theology (faith) and science (medicine), students of theology must consider creation and eschatology as interrelated realities. In the past, theologians approached the connection between science and theology with caution as science dealt with the discovery of the special features of creation but neglected the larger (theological) issues at hand. Science still is, in some theological circles, perceived as a threat to the inner core of the Christian faith (Hardy 107). Hardy proposes the *eschaton* is the outcome of creation (111). The principles of creation must be consistent with the end and *vice versa*. Anthropology and the relationship between science and faith are congruent and linear just as creation and eschatology. Therefore, what is true at creation about human beings must also be true about them in the end (*eschaton*). The unity of body and spirit at creation must be preserved or maintained at and through death.

Creation and the Unity of Personhood

To be created in the image of God means to be a whole or holistic human being modeled after the wholeness and unity of God as displayed and experienced in and

through the Trinitarian relationship between the Father, the Son, and Holy Spirit. Genesis portrays Adam and Eve to be immortal beings (Gen. 3); therefore, according to Grenz, "[I]immortality is the goal of the entire human being as symbolized by the tree of life in the Genesis narrative of the fall" (159). Immortality is part of eternal life after the resurrection of the dead (Rev. 21:1-4). Revelation chapter 21 describes a state of being and quality of life that includes the absence of death; however, eternal life is not just immortality but the quality of life that God is and lives. Paul added to that notion in Romans 8:18-20, where he maintains the human race is eagerly awaiting to be freed from the bondage of decay.

Being created in the image of God is to be a parallel being to God, reflecting who God is. God is spirit and (has become) flesh (1 John 1:1-4; John 1:1-2, 14). God is invisible, yet in the beginning, he walked with the first pair in the garden. Walking with implies being with and refers to physical presence. Adam and Eve's garden experience must not be spiritualized; nevertheless, again God will be with them and will be their God (Rev. 21:3).

Being created in God's image makes humans spiritual beings because God is immanent spirit. However, humans are also body because God is also body, and humans exist as bodies. No one has ever existed without a body. God himself was and is able to be body (John 1; 1 John 1). Thus, human beings are spiritual beings as a body containing and functioning on an intellect, emotions, and a spirit. Humans connect to God not with their spirit (nonmaterial) but as a whole person as comprised of body, will, intellect, emotion, and spirit.

"In the beginning God created the heavens and the earth. Then God said, 'Let us make man in our image, in our likeness….' So God created man in his image, in the image of God he created him; male and female he created them" (Gen. 1:26-27) is the

principal text upon which concrete knowledge and descriptions of personhood stands.

Scholars argue over the precise meanings of the Hebrew prepositions b "in" and k "like." According to Gordon J. Wenham, they are not exact synonyms but early as well as most modern commentators agree that in the context of Genesis they are. b denotes "according to" or "in the pattern of" while k means "like" or "according to." Thus, "according to" explains the precise meaning of "in our image" (28-29).

Slx's "image" etymology is uncertain. Slx is used to describe idols as being made to be an image of the divine, which is considered the closest parallel. Genesis 5:3 also using the same words "in his image" (slx) and "according to his likeness" (jwmd) describes Adam begetting his first son Seth. Some hold the image of God in humans denotes God's physical appearance because slx is mostly used to describe a physical image. Others following Christian thinkers such as Iranaeus (ca. AD 180) make a distinction between image and likeness saying image refers to humans' natural abilities, such as reason or personality, whereas likeness refers to the supernatural graces such as ethics or what makes the redeemed godlike (Wenham 29). jwmd "likeness" is built upon and related to the verbs jmd "to be like" or "resemble" (29). "Likeness" and "to be like" form constructs that suggest human beings are very much like God in appearance and expression; however, because God is invisible, a difficulty exists obtaining the exact nature of the resemblance (29-30).

To gain a more complete picture of the resemblance, Karl Barth suggests being created in the image of God enables humans to enter into a personal relationship with him, speak to him, and make covenants with him (Wenham 31). Moltmann adds to understanding, equating life as the presence of God's spirit in the human being:

> [It] signifies a *relatedness that is* [original emphasis] immortal. By creating his image on earth, the Creator puts himself in a particular relationship to this being. *Imagio Dei*—the image of God—means first of all God's relationship to the human being, and then the relationship of human beings, women and men, to God. (72)

Therefore, in the context of medical care, relating to patients not just as medical personnel—that is in a technical manner, but also as fellow human beings who drive in the context of loving relationships, means to honor God who created people as relational beings.

The parallel use of slx "image" and jwmd "likeness" in connection with Adam begetting Seth suggests the same substances and processes as with the creation of Adam and Eve were in place in that begetting. Just as Seth was genetically derived from Adam his father, Adam and Eve reflected the same natural elements and attributes of God. To be able for God to relate to humans physically and spiritually, likeness is necessary. Dutch Sheets suggests Adam and Eve's likeness to God may have been so striking that when God walked with the pair in the cool of the evening one had to look twice to figure out who is who (10). Finally, in respect to unity of being, Wenham notes, "[t]he image of God must characterize man's whole being, not simply his mind or soul on the one hand or his body on the other" (30).

The fact that men and women are created in God's image and likeness does not allow to ascertain the various parts of human beings yet. Genesis provides some answers: "The Lord God formed the man from the dust of the ground and breathed into his nostrils the breath of life, and the man became a living being" (2:7). Being made of clay did not make Adam a human being. God's breadth was needed. Only after God breathed his breath into Adam did he became a living creature (Wenham 61).

Hpg denotes spirit or wind. The closest parallel to Hpg, "breath," is found in

Ezekiel (37:9), which illustrates the prophet blew on the re-created bodies to resuscitate them. Then, filled with wind/spirit (hor), they stood alive (Wenham 60). syyh jfcn, "breath of life," and hor, "spirit," are not the same, but they do occur in parallel (Job 27:3; Isa. 42:5) suggesting near synonymity (60). According to Wenham, "jfcn 'breath' is a narrower and rarer term than hor 'wind, spirit'" (60). jfcn denotes the ability to breathe (60). God's "breath of life" makes humans living beings. Thus, no life exists without breath (Ps. 104:30). Syyh, "breath," used to be translated with "soul," which may have contributed to support the Platonic notion that human beings are "souls" in bodies. However, the accurate translation for human beings is souls.

As creatures created in the image of God, persons reflect all aspects of God's existence—the physical, the intellectual, volitional, emotional, and the spiritual (Carter 198, 200). David also exclaimed, "You made him [man] little less than God and crowned him with glory and honor" (Ps. 8:5, CSB; for a parallel, see Heb. 2:6-8a).

Humanity's anthropological unity and diversity does not exist in isolation from the rest of creation. "Universe, the English equivalent of the Greek *kosmos* literally means all things turning in perfect harmony as *one* [original emphasis]—unity in diversity" (Carter 209). Therefore, when God exclaimed that "all that he had made was really very good" (trans. Wenham 3); the statement does not refer to the individual act of having created humans but to the completeness of the whole creation (34).

The conclusion is that human beings are like God in their physical and nonphysical attributes and, as such, they are unified wholes of multiple components such as body, spirit, will, intellect, and emotions. Either of these somewhat distinguishable parts cannot exist as God's creation without the other.

Eschatology and the Unity of Personhood

Reflection on personhood as anticipated in eschatology is further validation for the need to assert the unity in human beings. According to Moltmann, "The church still adheres to the continuance and subsistence after death of a spiritual element furnished with consciousness and will, so that the human self continues to exist, although in the intermediate period it lacks its full corporality" (100). To hold such a view amounts to believing in the immortality of the soul (100).

He rejects the idea of an immortal soul because it emanated from Plato but also because it is inherently unbiblical, defying the principle of Christian hope. Unlike an immortal soul, which does not know birth or death, the human experience is captured by birth and death. Hope is not the immortality of the soul but resurrection (Moltmann 58-65), or as Polkinghorne says, "[O]ur hope is not survival but resurrection" (Serious Talk 106). Again, contrasting the theory of an immortal soul, which is unable to experience true reality, Moltmann further holds that redemption can only be experienced in the body (75). Moltmann again helps to understand how eschatology influences anthropology:

> [T]he assumption of the soul's continuing bodiless existence is inconceivable. The unity of body and soul in human beings makes this thesis untenable. It is refuted by a person's death, the death of the consciousness, perception and will. The soul separated from the body is not a person. We can talk about a "continuing existence of the human person" only from a theocentric viewpoint, because all finite beings are eternally present before the eternal God, and hence God's history with human beings can continue after their death. (100-01)

In addition, just as Jesus died wholly, and rose wholly, people also will die wholly and be raised wholly (75). Death does not know a separation of components of personhood.

Another writer, Colin E. Gunton, also holds to the preservation of the unity of personhood in eschatology. He connects the presence of the spirit, resurrection, redemption,

and the new life:

> First, the resurrection establishes the representative status of Christ, because, as "the first-born among many,…" Rom 8:29, he becomes the means whereby, through the agency of the Spirit, the means of restoring to right relation those who had sought their own way and thus gone astray. (64)

Gunton also points to the agency of the Spirit to produce new life (64). This new life is complete only in resurrection and works toward the restoration of all things including the unity of personhood. As Christ for Christians is the hope of glory (Col. 1:27), and the Holy Spirit is given as the down payment for salvation (Eph. 1:13b-14), God's spirit works toward a complete restoration of God's image in humanity.

Jesus' resurrection provides the paradigm for a preservation of the unity of personhood at the resurrection of the dead. All of Jesus' attributes and faculties remained intact after his resurrection. Jesus' resurrection provides the paradigm for the resurrection and, therefore, of the restoration of the full humanity as a unified person of body and spirit.

Lastly, Revelation 21:3-4 shows God as being present with the redeemed in very real terms, even as a physical presence. The state described in Revelation 21:3-4 mirrors the description of the yet unbroken relationship between God and humans in Genesis 3:8. These reflections indicate the Bible affirms the unity of personhood in creation and in eschatological future.

The way anthropology in creation and eschatological informs the understanding of personhood is that the human composition of the present must mirror that of creation and eschatology. Because creation and eschatology present human beings as unities of bodies and spirits, people in general, and hospital patients in particular, must be honored as such.

Jesus and the Unity of Personhood

Jesus displays a healthy relationship to body and spirit. He honors people as holistic beings ministering to their physical and spiritual needs at the same time. Some passages record Jesus simply healed sick people: “Jesus went throughout Galilee, teaching in their synagogues, preaching the good news of the kingdom, and healing every disease and sickness among the people” (Matt. 4:23). Among those sick people were those suffering of severe pain, the demon possessed, some who had seizures, and the paralyzed (Matt. 4:24).

Jesus combined physical healing with social rectification and restoration when he called the woman with the bent back “a daughter of Abraham” (Luke 13:16). In addition, in the case of the woman with the issue of blood, Jesus restored her religious purity and standing in society by healing her instantaneously (Mark 5:25-34). In two cases, the healing of the paralytic at the pool and the man who was let down through the roof, Jesus mentioned sin (John 5:14; Mark 2:4).

In two other circumstances, as with the woman at the well (John 4:7-26) and the woman accused of adultery in the temple court (John 8:2-11), Jesus did not overlook their wrongdoing but was concerned with their forgiveness and restoration. Jesus was concerned about people being right with God and cautioned against sin (Matt. 5:29-30; Mark 9:43-47). The Scriptures demonstrate clearly to what extent Jesus connected personal sin with sickness, but many of his healings record his concern about the physical as well as spiritual healing and well-being.

Jesus healed and delivered many from demon possession like the dumb man (Matt. 9:32-33), the boy who threw himself into water or fire (Mark 9:20-27), or the man

in Gadarenes (Luke 8:26-39). Notwithstanding one's interpretation of the correlation of demon possession with mental illness, Jesus delivered many from their terrible psychological/emotional and physical chaos, destruction, and pain. Jesus went so far as to raise people from the dead (Mark 5:36-43; John 11:41-44). Jesus was aware of all manner of suffering—emotional, social, spiritual, and physical. He understood the reality of humans as a psychosomatic unity (Polkinghorne, Science and the Trinity 154-56, 161).

Jesus often referred to faith as the substance that enabled him to heal. Jesus is as much concerned about people's faith as he is about their physical healing. Jesus healed and restored on all levels of human existence. He had a balanced view of personhood, and one does not gain the impression that he divided persons into different and separate entities.

Conclusion

The Bible portrays the human being as a unity of body, emotions, intellect, will, and spirit. As this composite of various components, humans relate to each other and to God as that whole. Even though these components are distinguishable, they are interrelated to such an extent that they are not able to function properly without each other. Conversely, they affect each other. When God created humans, as his likeness on earth, he did so with all components being a unified whole. Human wholeness and interdependence is a reflection of God himself as *One* and as a *Trinity*.

The Fall impaired the spirit of humans as to damage the unity of all parts. The breakup of the unity of all part in persons caused and causes humans to die. The immortality intended for human beings at the onset of creation would have been maintained if sin were not have damaged the spirit of persons, leading to the breakup of the unity inherit in humans, which is necessary to remain immortality. Humans would

have remained immortal only if having remained a unity of all parts. At the resurrection of the dead, this wholeness as a unity will be restored and those in Christ will inherit eternal life. Even though eternal life is the quality of life lived by God and described in human terms in Revelation chapter 21, it is also a state of immortality again.

If humans suffer, they suffer as that unity of components. If one part suffers, all the others suffer likewise. Suffering that culminates in death causes spiritual, emotional, and social suffering. If patients suffer physical illness, they also suffer spiritually, emotionally, and socially. Therefore, biblical health care accounts for all human suffering including the spiritual, emotional, and social. Chaplains are responsible to attend to patients' nonphysical sufferings.

Critical care by necessity is especially science and biology driven. Nevertheless, this necessity to adhere to the principles of medical science does not mean that patients and their families' nonphysical sufferings should not be helped.

The conclusion of this theology, which asserts the necessity to attend to all components of human existence, if health care wants to be biblical, provides a foundation for chaplains to justify their legitimacy. It also serves as a tool to which physicians' views of personhood, as expressed in how physicians appraise chaplains' role in critical care, can be compared.

Physicians' Perceptions of the Chaplain's Role

Research addressing issues concerning the physician-chaplain relationship is scarce. One only source treats the chaplain-physician relationship—The Chaplain-Physician Relationship edited by Larry VandeCreek and Laurel Burton. It is a compilation of articles that first appeared separately in the Journal of the Health Care Chaplain. These essays are experiential accounts written from the viewpoint of several

chaplains. Another work, a Doctor of Ministry dissertation, presents a spiritual assessment-based model of collaboration between physicians and chaplains (Ledbetter).

Apart from these two works, only two studies specifically report on the role of chaplains in hospitals. No surveys concerning chaplains' roles in critical care settings such as Intensive Care Units or the emergency room are presently available. The most representative survey available was conducted by Kevin J. Flannelly et al. This group of researchers conducted a nation wide survey asking the directors of four hospital departments to rate their perceptions of the roles of hospital chaplains. The reason for their investigation was to seek better collaboration between the various disciplines participating in hospitals' interdisciplinary care teams (19-27).

According to Flannelly et al., interdisciplinary care teams fulfill their mission only if the various disciplines work together efficiently (19). Nevertheless, Flannelly et al. find, "[I]t is not uncommon for different disciplines to have difficulty collaborating with one another. Part of the problem may arise because of stereotyping of one discipline by another in terms of beliefs about the skills, abilities, and responsibilities" (19). Teamwork is essential if hospitals seek to provide holistic care for their patients (Barr 1005-10).

The study conducted by Flannelly et al. surveyed 1,514 medical, nursing, social work, and pastoral care directors. These directors were asked to rate nineteen different chaplain activities. These activities were then grouped into seven categories: (1) grief and death, (2) prayer, (3) emotional support, (4) religious services and rituals, (5) consultation and advocacy, (6) community liaison and outreach, as well as (7) directives and donations (19-20).

Overall, the first three roles, (grief and death, prayer, as well as emotional support) were rated significantly higher than the rest. Their ratings were between very

important to extremely important. The three chaplain's roles, religious services and rituals, consultation and advocacy, as well as community liaison and outreach were rated between moderately and important. Chaplains handling advance directives and organ donations were rated significantly less important than the others (Flannelly et al. 23-25).

The directors of all four departments rated chaplains' interventions in situations involving grief and death the highest. On the other hand, prayer and emotional support was least important to social workers and physicians, whereas nurses rate the traditional chaplain roles of prayer and emotional support high. Overall, physicians rated chaplains' roles lowest (Flannelly et al. 23-25).

The pastoral care directors (chaplains) agreed closest with nurses in how they rated the importance of grief and death support as well as prayer. With physicians, pastoral care directors only agreed in respect to chaplains in grief and death support. On the other hand, medical directors and pastoral care directors disagreed with the importance of providing prayer and emotional support (Flannelly et al. 22).

Flannelly et al. conclude that the high overall rating of chaplains' role with grief and death issues signifies that "[t]his is an area in which chaplains make a major contribution to the institution" (23). They also think prayer was overall rated high because it is still universally regarded as a traditional role of chaplains. Even though physicians rated prayer lowest, they still considered it as "helpful but not as essential activity for promoting health" (24). Flannelly et al. suggest that "physicians having been trained in the scientific method may see prayer as a nonscientific intervention that belongs to the realm of faith or even magic" (24).

A similar group of researchers also investigated chaplains' activities but related them to referral patterns. This study was conducted with the medical staff of Memorial

Sloan-Kettering, a cancer specialty hospital in New York (Flannelly, Weaver, and Handzo 760-68). That survey affirmed the various role importances given to chaplains reported by Flannelly et al. (23-25).

Most referrals (24.9 percent) came from nurses and the least (0.9 percent) from physicians. In this oncology setting, the most common reason for referrals to chaplains was a change of diagnosis or prognosis. The referral rate from nurses to attend patients' families and friends was perceived as unusually high (Flannelly, Weaver, and Handzo 763, 766).

In respect to activity (interventions), chaplains reported using prayer and Scripture readings before operations 82 percent of the time, at times of death 65 percent, during regular treatment visits 32.6 percent, at "code" situations 31.3 percent, and with dying patients 27.5 percent of the time. Chaplains affirmed patients during treatment visits 16.8 percent, at codes 46.9 percent, and when patients were dying 27.5 percent of the time. Emotional enabling was used 91.5 percent of the time during preoperative visits, 56.9 percent of the time in treatment visits, 45 percent of the time in situations of a new diagnosis or prognosis, 81.3 percent of the time at "code" situations, and 47.5 percent of the time with a dying patient. Performing religious rituals or blessings was only high at time of death (70 percent; Flannelly, Weaver, and Handzo 764). Need for prayer, which has been found to be a major coping tool by patients facing crises such as surgeries or poor prognosis, was met by these chaplains (Flannelly, Weaver, and Handzo 763, 766-68).

This study also stated that nurses, who tend to be more religious, are more aware and concerned about the spiritual welfare of their patients and rate prayer, Scripture

reading, and emotional support very high. The high rating of nurses valuing spiritual support for their patients may also be due to their awareness of their own need for spiritual and emotional support. In the case of Memorial Sloan-Kettering, the much higher referral rate from nurses may also be due the fact that they go through a pastoral care orientation at hiring (Flannelly, Weaver, and Handzo 766-68).

The low referral rate by physicians surprised the authors of the study because all physicians are staff and are well acquainted with the pastoral care staff. One possible reason suggested is that physicians may make referrals through nurses (Flannelly, Weaver, and Handzo 766). Such referrals are often not recorded in physicians' orders but given orally (766).

In the case of Memorial Sloan-Kettering hospital, chaplains meet the needs of their patients (768). This study being conducted in a single hospital limits its generalizability. Other studies have demonstrated that up to 30 percent of cancer patients think their spiritual and religious needs are not met (Jenkins and Paragment 51-74; Moadel et al. 378-85).

Studies about the need and role of chaplains specific to intensive care units are yet to be conducted, but one may surmise that the correlation between acuity of illness and the need for spiritual care affirms the need for pastoral care.

The Relationship between Science and Faith in Health Care

After reviewing available research into physicians' perceptions of the chaplain's role in hospitals, to discuss literature that deals with factors forming and influencing those perceptions is necessary. One such factor is the historical development leading to the present relationship between science and faith in health care.

The modern physician and the chaplain have to overcome a chasm that has started

to widen ever since the scientific revolution and the emergence of the scientific method in the 1500s (Kliewer 617). With the onset of this scientific inquiry, the relationship between faith and science gradually and substantially changed. Because this scientific method could not be readily applied to one's experience with and faith in God, religion over time became excluded from the world of science. The chasm widened also because the religious community tended to reject many of the discoveries generated by science (617). According to Stephen Kliewer, this chasm, however, may have reached its peak with the comments regarding spirituality in the glossary of technical terms in the Diagnostic and Statistical Manual of Mental Disorders, revised third edition (DSM-III-R). The DSM-III-R alluded to spirituality with illustrations of psychopathology (617).

The relative exclusion of faith from medicine by some is a recent phenomenon. During Plato and Aristotle's time, physicians would rehearse prevalent religious beliefs with incurable patients and rebuff them as rebels against a divine edict if they would demand treatment. During the pre-Constantine era also, physicians were called upon to offer spiritual guidance to the incurable. As Christianity became the predominant religion, medicine was considered to entail duties to God requiring caregivers (largely monks and priests) to direct patients' religious and spiritual beliefs (Cohen et al. 29-30).

In the later Middle Ages, laypeople of Jewish, Islamic, and Christian traditions maintained the ancient belief they were collaborators with God. The Christian physician was required to inquire of patients if they had received the sacrament of confession. If they had not received the sacrament of confession, patients were required to doing so. Jewish physicians also had a special obligation to their Jewish patients. During these times, the study of natural sciences including medicine was itself an activity of religious devotion (Cohen et al. 29-30).

Historians have found a strong connection between religious belief and the practice of medicine up to the first half of the eighteenth century, and inquiry into patients' religious beliefs was to various degrees still a practice until the mid-nineteenth century and part of official medical guidelines. As society was religiously more homogeneous, physicians up to the mid-nineteenth century were of a deeper Christian conviction and, therefore, were more apt to include their faith in medical practice. These physicians' faith mirrored largely the ones they served (Cohen et al. 29-30).

In the mid-nineteenth century, however, the professional climate changed. Medical scientists were told that religious commitments of physicians and patients had no place in medical discourse. Physicians were warned that discussing religion with patients was professionally unacceptable for them. Chaplains and pastoral counselors were seen as exclusively in charge of such matters. A clear line between medical care and religion had been drawn (Cohen et al. 29-31).

Recent years have seen an accelerated scientific interest in the correlation between religion/spirituality and health as evidenced by an increase in articles published on this topic in academic journals. While fifty-two articles were published on this topic between 1960 and 1990, ninety articles can be found from 1991 to 1995, two hundred from 1996 to 1999, and a recent search produced 554 citations from 2000 to April 2003 (Kliewer 616).

This renewed interest in the relationship between faith and health urges the medical profession to reintegrate faith into medical practice. As the public and internal forces in the medical profession push toward further integration of faith into health care, physicians wrestle with how, when, and to what extent they should be involved in their patients' religious affairs. A transition toward a more holistic practice of medicine will

take time as physicians are raising valid questions in respect to professional boundaries, ethics, and competency (Post, Puchalski, and Larson 579, 281-82).

This renewed interest in faith as part of health care comes at the heels of a growing interest and desire among the general population for their faith to be taken seriously by the medical profession. Multiple studies on the view of patients and physicians in respect to their religious characteristics and involvement have been documented.

Faith as Part of Health and Health Care

Because physicians are the primary decision-makers in health care and because this project focused on how physicians perceive the chaplain's role, evaluating research exploring how faith relates to health in general and health care outcomes in particular, was important. To ascertain if and to what extent my interviewees were aware of existing research in this field and how such knowledge would have influenced their perceptions was not the scope of this study; nevertheless, the mounting literature published in medical journals on this topic merits an evaluation of the discussion.

Studies on Mortality and Longevity

Among the growing body of literature reporting on the merits of faith for health, studies on mortality are the most numerous and most sophisticated ones. These studies predominantly study the link by measuring peoples' attendance of religious services. A meta-analysis, which identified forty-two studies, concludes the odds of survival in favor of those who attend religious services weekly or more is 1.29 (McCullough et al. 211, 213-18).

One representative study conducted by Douglas Oman and Dwayne Reed found that after an average of 4.9 years of follow-up, of 2,025 residents fifty-five years and

older living in the affluent city of Marin, California, of those who attended religious services weekly, 21 percent had died, whereas of those who attended occasionally, 25.3 percent had died, and of those who never attended religious services, 32.1 percent had died. This study identified the co-variables as demographics, health status, physical functioning, health habits, social functioning and support, as well as psychological functioning. After adjusting for gender and age, weekly attenders had the lowest and nonattenders had the highest mortality. The difference amounted to 11.1 percent. The test for the trend was significant at <.01. The authors reported better social support as the main reason why frequent churchgoers lived longer. Social support not related to church attendance did not affect mortality for those who did not attend religious services.

Similarly, a six-year follow-up survey of 3,968 older adults in North Carolina shows a similar trend and confirms Oman and Reed's study reporting that 22.9 percent who died attended religious services whereas 37.4 who died attended services infrequently (Koenig et al., "Does Religious Attendance" M370-76). Similarly, H. Helm et al. also found that people who are healthy at baseline but do not engage in private religious activity are 47 percent more likely to die than persons who engage in such activities. On the other hand, Helm et al.'s study reported no survival difference between those who engage in private religious activity and those who do not if they are not healthy at baseline (400-05). Others, in contrast report no significant link between *private religious* practices and mortality (Hummer et al. 1225; McCullough et al. 211-22). General religious support and other yet-to-be-identified factors contribute positively to longevity, whereas the impact of private religious practices as a single contributing factor is still unclear.

The one well-designed study investigating racial differences found that the

mortality risk among African-Americans is twice as high for those who do not attend church compared to those who do. Socioeconomic status, general health, regional demographics, and social ties did not affect the results (Ellison et al. 630-67).

The fact that churchgoers refrained from smoking and excessive alcohol use, both of which are linked to greater health risks, are listed as a contributing factor for better health (Ellison et al. 630-67). Koenig likewise found that risky behavior affects longevity (Healing Power of Faith 72-103). Better social ties among churchgoers, consisting of personal, emotional, and even financial support, also contribute to church going African-Americans' higher longevity (Ellison et al. 630-67). Compared to Caucasian churches, African-American churches offer more help groups and social ministry to their members. This study confirmed the central role of the church in the African-American community (630-67). In addition, even the detrimental impact of living in dilapidated neighborhoods on changes in self-rated health over time is offset for those African-Americans who rely heavily on religious coping (Krause and Van Tran S4-S13).

While the above-discussed studies shed a positive light on faith's role in health, religion can also negatively affect people's mortality. Patients who felt alienated from or unloved by God and attributed their illness to the devil were associated with a 19 to 28 percent increase in risk of dying during the approximately two-year follow-up period (Pargament et al. 1883).

Faith and Specific Health Issues

In addition to focusing on longevity and faith, researchers have turned to extend their investigations to clinical areas such as stress reduction, recovery from illness, reduction of depression, substance abuse prevention and recovery, prevention of heart disease and high blood pressure, mitigation of pain, adjustment to disability, and recovery

from cardiac surgery in the elderly (Post, Puchalski, and Larson 579).

According to Harold G. Koenig, frequent churchgoers who also read the Bible and pray are more likely to have better immune systems and less hypertension (Healing Power of Faith 193, 209, 211-14). Another study reported that persons of faith recover faster from depression (Koenig, George, and Peterson 536-42). In the depression study, intrinsic faith was the main religious predictor, whereas faith practices had no impact on recovery (538-39). Confirming Harold G. Koenig, Linda K. George, and Bercedis L. Peterson's result, Kenneth S. Kendler, Charles O. Gardner, and Carol A. Prescott also report that a high level of personal devotion is related to lower levels of depressive symptoms and that personal devotion together with personal and institutional conservatism are inversely related to current levels of drinking and smoking as well as lifetime risk for alcoholism and nicotine dependence (322). The same study also concluded that personal religious devotion assists with coping with stress (322).

A survey using the Ironson-Woods Spirituality/Religiousness Index reported a strong association of spirituality and religiousness to long survival, health behaviors, less distress, and low Cortisol among patients with HIV/AIDS (Ironson et al. 34-48). The Ironson et al. study focused on measuring faith in relation to health outcomes in patients with HIV/AIDS.

Redford and Virginia Williams add to the discussion by affirming the psycho-spiritual behavior of anger has a detrimental effect upon physical health (25-60). In respect to end-of-life circumstances, Chibnall et al. state that lower spiritual well-being is part of significantly higher death distress (336).

Research appears more solid and accepted when claiming general benefits of faith for health. On the other hand, studies reporting benefits of faith (e.g., prayer) for specific

clinical outcomes are least persuasive and accepted. Research claiming faster recovery time and fewer complications after surgery because of prayer is rejected the most.

According to VandeCreek, new fields of research, like the study on faith and health, go through development cycles, one of which is developing hypotheses and exhibiting high levels of positivism. The process from positivism toward refined methods, methodologies, and designs is normal and necessary (Research Primer 17-27).

Physicians and Researchers' Perspectives

While the previous section reviewed literature reporting faith's impact upon longevity and health outcomes, the forthcoming discusses (1) how scholars and physicians perceive that research, and (2) how literature accounts for physicians' religious characteristics. How physicians view faith's influence on health, in general, and how they understand its role in health care, in particular, are crucial because they bear upon physicians' perception of chaplains' role in health care.

The Debate Concerning Faith and Health

The debate over the value, validity, and practical application of research into faith and health is multifaceted. Researchers and physicians alike are concerned about (1) the scientific validity of research a faith health connection and (2) about ethical and professional issues. The uncertainties regarding research validity are evoked by questions about methodology and possibility or impossibility of measuring faith with the scientific method. The second concerns are issues related to professional ethics, boundaries, and practical application. Both those who acknowledge and those who criticize the validity of studies' research designs and methods appear to be influenced by their preconditioned personal views about religion and science in medicine and by their personal religious convictions.

Aside from the scientific validity of the proposed positive impact of faith on health, physicians will have to respond to their patients' religious views in general, how these views affect their medical decision making and to what extent they should be involved with their patients' religion.

First, those researchers opposed to any physician involvement with patients' faith cite methodological flaws and poor research designs as well as professional boundary and ethical problems as their primary reasons for objecting to physicians' involvement with patients' faith (Sloan and Bagiella 14-21; Sloan et al. 1913-16). After reviewing abstracts of 266 articles published in 2002 about religion and health, Richard P. Sloan and Emilia Bagiella conclude that only seventeen of these articles actually made statements of a positive impact of faith upon health but none of the seventeen studies presented in these articles were valid due to poor research designs and flawed methodologies (17). They assert that present research tools do not account for confounders and variables and do not look for mechanisms though which faith impacts health (17). Added to their overall denunciation of present research validity, the above-mentioned authors also accuse primary researchers in the field of faith and health of misinterpreting the *evidence* because of an unfounded positivism and religious bias (16-19).

Responding to that criticism, Dr. Koenig (one of the leading researchers) and other experts and physicians maintain that such general skepticism is unfounded. They point to four newer studies that employ state-of-the-art methodology accounting for *true confounders*, such as age, gender, race, education, and baseline functioning. These studies also contain mediating variables that describe *the mechanisms* by which religion might affect health. Some of these variables are behavioral, like smoking or alcohol use, psychological, such as social support or depression, and biological, such as hypertension

or immune status (Koenig et al., "Religion, Spirituality, and Medicine" 125-26). In addition to citing studies with improved methodologies, Koenig et al. also point out that Sloan and Bagiella's article(s) omitted a large body of studies that link religion with mental health, arguing this link "is relevant because one of the strongest rationales for religions' effects on physical health lies in its connection with psychological and social functioning" (125).

Others in the field share some of Sloan and Bagiella's concerns but agree with Koenig et al. in that better measurements are being produced to account for more precise definitions of terms and measurements of causality (Berry 628-47; Mills 1-2). For example, the Ironson-Woods Spirituality/Religiousness Index (Ironson et al. 34-48) as well as the newly developed Santa Clara Strength of Religious Faith Questionnaire have shown promising and positive results in respect to measuring religious strength and its influence, both upon mental and physical health (Plante and Boccaccini 429-37). The Santa Clare Index has been successfully cross-validated by four different studies (Plante, et al., "Further Validation" 11-21; Sherman et al. 129-41; Plante, et al., "Association" 405-12; Plante, Saucedo, and Rice 291-300).

Because faith is a transcendental entity, to measure faith's impact upon health and healing and then to apply the findings scientifically is problematic if not impossible (Chibnall, Jeral, and Cerullo 2529). John T. Chibnall, Joseph M. Jeral, and Michael A. Cerullo, all medical doctors, take special issue with measuring of the effect of distant intercessory prayer on recovery from surgery and illness (2529-36):

> The very concept of prayer exists only in the context of human intercourse with the transcendent, not in nature. The epistemology that governs prayer (and all matters of faith) is separate from that which governs nature. Why, then, attempt to explicate it as if it were a controllable, natural phenomenon? (2530)

In light of the belief that God created the visible and invisible as well as the transcendent and nature, to distinguish between what is observable scientifically and what may be termed experiential or subjective amounts to fragmenting the holistic human experience.

Their argument is strengthened by the difficulty of quantifying prayer in terms of how many times a day and for how long intercessors pray for specific patients. The problem of measuring faith quantitatively is compounded by the difficulty to then relate it to effect. Because all prayers are directed to God seeking his intervention, trying to find causality between prayer and recovery is inappropriate because trying to find causality would amount to measuring God (Chibnall, Jeral, and Cerullo 2530-32).

Chibnall, Jeral, and Cerullo are *not* against prayer with patients but against asserting scientific proof of prayer's positive effects, especially distant prayer (2529-36). Arguments against rational predictable researching prayer in connection with health outcomes are based on the scientific assumption of explanation; however, science has not yet been able to explain such predictability (Stein). On the other hand, Stein quotes John A. Astin saying, "Yesterday's science fiction often becomes tomorrow's science."

While research reporting positive correlations between faith and health, in general, and faith and health outcomes, in particular, have been questioned extensively, none have been as heavily scrutinized as those studies asserting that distant intercessory prayer affects recovery time from surgeries and improved health (Stein; Chibnall, Jeral, and Cerullo 2529-36; McCaffrey et al. 858-62).

On the other hand, despite little scientific evidence of intercessory prayers' effects on clinical outcomes, 35 percent of respondents in a national survey prayed for health concerns (McCaffrey et al. 858-62). Of the 35 percent, 77 percent prayed for general wellness, 22 percent for specific conditions, and 69 percent found prayer for health

helpful (858). People mostly prayed for "illnesses associated by painful or aggravating symptoms, nonspecific diagnosis, and limited treatment options such as depression, headaches, back and/or neck pain, digestive problems, and allergies" (860-61). The study reported only small sociodemographic differences. Respondents not affiliated with a Christian faith prayed almost as much for health concerns as those confessing to be Christians. On the other hand, 12 percent more Protestants prayed more for health concerns than Catholics (859).

When compared to the rules of science, skeptics' arguments are well taken, as measuring an intervention by something or someone, who is invisible—God, is problematic at the least, if not possible at best. From the viewpoint of testimony, however, my personal, as well as those of others, prayer has significantly altered patients' health status—even though sometimes only for a season. Nevertheless, to measure scientifically the effects of prayer, especially with quantification of outcome in mind, is dabbling in a domain far too uncertain to be ascertained scientifically.

According to Farr A. Curlin et al., "[e]mperical evidence for a faith-health connection may have little influence on physicians' conceptions of and approaches to religion in the patient encounter" ("How Are Religion" 761). Therefore, to what degree physicians' individual assessment of debate concerning a scientifically proven benefit of prayer upon health influences how they are responding to their patients' religious sentiments and practices is uncertain. Yet, physicians who are more positively inclined to validate the positive impact of faith upon their patients' overall health and well-being, would pay more attention to their patients' spiritual inclinations and wishes.

Second, whereas the dispute about validity is fought on scientific and philosophical grounds, the debate about practical and professional issues is guided by

reasons related to patient care. Again, Sloan and Bagiella appear to be the leading voices. In an article written together with noted and published chaplains, they list the following concerns as part of their opposition to physicians' involvement with their patients' faith:

1. Physicians involvement in spiritual care would be an abuse of power as physicians have considerable influence over their patients.

2. Physicians participating in their patients' faith would be a serious invasion of privacy as patients regard their faith even more personal than their health.

3. Physicians are not trained to engage in matters of faith, which can become complicated.

4. Physicians' involvement would trivialize religion.

5. Not enough evidence is present that patients truly want their physicians to inquire about their spiritual preferences (Sloan et al. 1913-16).

In a follow-up article to their initial article, Richard P. Sloan, Emilia Bagiella, and T. Powell state, "Health professionals, even in these days of consumer advocacy, influence patients by virtue of their medical expertise. When doctors depart from areas of established expertise to promote a *non-medical* [emphasis mine] agenda, they abuse their status as professionals" (666). On the other hand, the same authors in the same article postulate the following:

> There is no ethical objection to co-worshippers discussing medical issues in the context of a shared faith. Indeed, a thorough understanding of a patient's religious values can be extremely important in discussing critical medical issues, such as care at the end of life. Irrespective of the practitioner's religion, respectful attention must be paid to the impact of religion on the patient's decisions about health care. (666)

Sloan, Bagiella, and Powell insight does both honor physicians' commitment to their professional office and patients' need to have their religious convictions heard.

Therefore, skeptics are not against physicians being respectful of their patients' faith but seek to put clear boundaries or guidelines for the manner in which physicians should be involved. In respect to the nature of religion in general, Sloan, Bagiella, and Powell advocate that religion be used for nonutilitarian purposes—that is, not to promote it for better health but used it to account for all aspects of the patient's experience (666).

Sloan and others are not against religion per se nor are they against physicians' being sensitive toward their patients' religious values; however, they are strongly opposed to physicians prescribing religious activity as interventions alongside scientific medical treatment. Skeptics of more religious involvement by physicians are afraid physicians, especially religious ones, will start providing spiritual care. On account of all their arguments, Sloan, Bagiella, and Powell hold to advocate religious activity as adjunct medicine due to a weak attestation of validity, unresolved ethical issues, and the lack of practical guidelines is premature (667).

The flaw in some of the critics' reasoning is that they themselves do not rely on scientific argumentation alone but infuse their writings with their own view of the nature and purpose of religion. They assert physicians are not qualified in regards to religious matters but then make themselves the experts by defining the nature of faith. Sloan and those who have cowritten the above-mentioned articles are not physicians; nevertheless, their arguments and objections are important and must be taken seriously by those who favor physicians' involvement with patients' faith.

After having examined in some detail how social researchers such as Sloan et al. approach the subject of physician involvement with matters of faith, Curlin et al. studied what practicing physicians think of faith as part of health care and healing. In their 2005 survey, all physicians in the sample believed religion influenced health, but they "did not

talk about the instrumental or biomedical effects of religion on health, and only indirectly discussed influences on specific health outcomes" ("How Are Religion" 763). They were skeptical, stating science may never be able to prove such a connection (763).

On the other hand, the same physicians validated the role of faith noting that (1) religion forms the paradigm out of which many patients understand, cope with, and respond to illness; (2) many patients are members of, and are, therefore, shaped by, religious communities; and, (3) religious paradigms and religious communities at times lead patients to make decisions that conflict with medical recommendations (Curlin et al., "How Are Religion" 763).

Those physicians who advocate the need for physicians paying more attention to their patients' spiritual needs, and who believe that physicians should take a proactive role in respect to their patients' spiritual well-being (e.g., by adding a spiritual assessment to their regular medical assessments; Anandarajah and Hight 85-86; Puchalski and Romer 129-37) have good reasons for their advocacy.

Proponents of physicians' increased involvement with their patients' faith hold present professional standards discourage physicians to be involved with religion in their medical practice (Post, Puchalski, and Larson 581-82), but, at the same time, they believe research shows patients wish for their physicians to be attentive to their spiritual needs. Proponents, who tend to be personally religious, hold patients' wishes, together with the renewed scientific interest in the relationship between faith and health, merits for the medical profession to reintegrate faith into medical practice (579, 281-82).

As an important voice for those who favor increased physicians' involvement with patients spirituality, Stephen G. Post, Christina M. Puchalski, and David B. Larson are

not blindsided by their zeal but demonstrate an acute awareness of the professional and ethical concerns raised by Sloan, Bagiella, and others (578-83).

While seeking practical solutions to the when, how, and extent of physician involvement, Post, Puchalski, and Larson understand physicians' reluctance with matters of faith (579, 281-82). Physicians' hesitation is justifiable as they are not trained in spiritual and religious matters and, therefore, feel uncomfortable discussing spiritual matters with patients. Reasons for this hesitance are related to professional boundaries, competency, and ethics (581-82). Even though physicians verbalize discomfort discussing their patients' faith, they tend to move toward the understanding that limited inquiry and religious involvement is a matter of patient care, and that such involvement is relevant to the physician-patient relationship.

Post, Puchalski, and Larson encourage conducting a spiritual assessment at the time of initial screening but hold that it must be done with the patients' overall care in mind. Agreeing with Sloan et al., they regard physicians acting as pastoral caregivers (chaplains), which they also denote as spiritual activism, as professionally unethical (581). On the other hand, they believe physicians can and should pray with their patients as long as such action is desired by their patients. Nevertheless, prayer with patients should only be conducted under limited circumstances, (e.g., when no pastoral care givers such as chaplains or other clergy are available; 581-82).

Cynthia Cohen et al. add to discussion on ethical boundaries that medicine is not a form of religion and physicians are not priests. "Deliberately undertaking 'spiritual assessments' of patients in order to counsel them falls outside the proper scope of medical care" (36). Even though Cohen et al. advocate active involvement if necessary, they caution that spiritual dialogue is not possible from a theologically neutral position (36).

Dealing with spiritual matters requires a good deal of awareness of one's own religious understanding (Anandarajah and Hight 84).

Nevertheless, professional boundaries should not stifle physicians taking a more active role because "[p]rofessional boundaries may appear somewhat artificial to the patient who believes that God is working through the physician" (Post, Puchalski, and Larson 581). In addition, physicians may not intrude upon patients' privacy as much as they think because studies report patients are open and desire (under some circumstance more than others) that their physicians show interest in their faith (581).

Following those critical of physicians' involvement, Post, Puchalski, and Larson do not propose for practitioners to prescribe prayer as conventional or even adjunct medical therapy; however, they do encourage physicians to pay attention to the fact that patients often regard prayer as an alternative or even substitute treatment (581). In addition, they assert that responding to patients' request for prayer strengthens their relationship with them (582).

The same group of doctors tries to mend the apparent rift of opinion between science and faith as played out in the physician-patient relationship by pointing to the fact that those professional organizations, which regulate the medical profession, regulate under the premise that medicine has been largely secularized. At the same time, even in societies where medicine is secularized, "most religious traditions (and, therefore, many patients) still regard the physician as both the skilled agent of scientifically informed clinical interventions and as an instrument of a higher healing power" (581).

Lastly, Post, Puchalski, and Larson acknowledge chaplains as the primary professional responsible for the spiritual care of patients and advocate them as the appropriate source for referral. For practical purposes, Post, Puchalski, and Larson hold

that physicians should include a spiritual assessment in their initial medical assessment, followed by, and only if necessary, a limited spiritual intervention and participation with patients' faith, if (1) pastoral care is not readily available, or (2) if patients request it. Otherwise, they promote adhering to the given professional boundaries that validate chaplains as the trained professionals providing spiritual care (581-82).

Physicians' Spiritual Characteristics

Even though physicians and social researchers debate the value and application of faith as part of health care in terms of validity, philosophy, and professional ethics, the difference of opinion discussing those issues are also influenced by personal religious or nonreligiousness. More pious physicians are positively inclined whereas less or nonreligious physicians (also termed as secular physicians) tend to be more skeptical or reserved.

According to Myles N. Sheehan, the self-professed atheists among physicians may not pay adequate attention to their patients' spiritual concerns (430). He fears that the significant percentage of patients who profess faith and want it considered during medical care will not receive the needed empathy or may not benefit from the ministry of a trained chaplain, if they are attended by physicians who are atheists (430). Sheehan holds, "[T]he discomfort for some doctors and other caregivers at things religious or spiritual does not mean it is appropriate to neglect the suffering and needs of others in the spiritual domain" (431). To attend to the spiritual needs of patients is part of patient care (429-31). He was alerted to this problem during his lectures when around half of his hearers approached him saying they were atheists (430).

Neil Scheurich, an assistant professor of psychiatry, counters Sheehan's view by asserting that irreligious or atheistic physicians are able to care as much as believing ones

but do so out of a respect for the full humanity of their patients (360). In order to accommodate what he terms "secular physicians" and to maintain appropriate professional boundaries, such as respecting patient privacy, Scheurich advocates the separation of church and medicine like the separation of church and state (356). He is afraid of a spiritualized medicine and laments that overly religious physicians may push a theistic worldview (e.g., by proselytizing; 357).

He acknowledges, "[U]ntil modern times, healing, religion, and the supernatural went hand in hand (and this is often still the case in non-Western cultures); however, such unity works only when there is a near universality of belief shared by patients and healers" (Scheurich 357). In view of the large percentage of secular physicians and physicians of minority religions, such a unity is absent (357). At the same time, he recognizes that in the United States, Christianity is the majority religion and, therefore, pressure arises for those who do not belong to this category (359).

He favors the concept of spirituality but because spirituality is so closely viewed as an integral part of religion, Scheurich proposes to subordinate faith under the concept of values. He feels such a move to be important as spirituality and faith are biased toward the supernatural (356-57). Science and medicine are strictly in the realm of the natural, faith must not become a part of the biology of medicine (356).

On the other hand, maintaining values is essential for Scheurich as their "collapse—that is, a withdrawal of attachment to reality—may be said to underlie experiences such as substance abuse, depression, and suicide" (358). He asserts the importance for the neutral physicians to acknowledge their patients values, including the religious ones, but states that "to inquire about patients' spiritual concerns is very different from encouraging or even validating belief (e.g., through prayer with patients)"

(359).

Because "patients bring to the clinical encounter the conviction that their faith ought to be central to their treatment" and physicians are ethically obliged to respect and respond to their patients values, Scheurich proposes to refer patients with religious concerns to the appropriate religious authority (359).

Scheurich believes physicians' personal religious values do not affect their medical practice. Nevertheless, studies investigating physicians' religious characteristic show that religious variables are associated with different practices regarding physicians handling euthanasia, physician-assisted suicide, and abortion (Curlin et al., "Religious Characteristics" 632). In addition, substantial differences exist between religious and nonreligious physicians in respect to writing do not resuscitate orders (Wenger and Carmel 341-43). At the same time, Curlin et al. state, "[A]part from these areas of overt moral controversy, little is known about the ways in which physicians' religious commitments affect the ways they relate to, and provide care to patients" ("Religious Characteristics" 632).

Daaleman and Frey observe differences of religious views among physicians of diverse medical specialties. Family physicians, pediatricians, and obstetricians tend to be more religious and religiously more comparable to the general population then physicians of other specialties ("Spiritual and Religious Beliefs" 98-104; Frank, Dell, and Chopp 1717-22).

A nationwide survey of two thousand physicians, which paid particular attention to physicians dealing with death, existential suffering, and issues related to moral complexity found that physicians of subspecialties as pulmonary critical care, geriatrics, and oncology are less religious than family physicians or pediatricians and less religiously

comparable with the general population (Curlin et al., "Religious Characteristics" 629-30).

On the other hand, as a whole, physicians attend religious services more frequently than the general population, but they are less likely to make a conscience effort to apply their religious beliefs to other areas of life. They are also less likely to rely on God to find strength, support, and guidance (Curlin et al., "Religious Characteristics" 632).

The following study conducted by Ross P. Scherer will lend further help in understanding of how critical care physicians' religious mind-set influences their view of the psychosocial input into the healing process. The study sought to inquire about allied caregivers:

> Consciousness of any connection between the healing process and the patient's mental outlook and social relations,… as well as between healing and spirituality and religion … [and] [t]o what extent they are open to complementing their practice of biomedicine ... with elements of psychosocial/mind-body medicine, which introduces a more holistic and rounded conception of the patient as a feeling, trusting, and believing whole human being. (302-03)

Scherer's study also considered allied caregivers' own religious concepts and how they bear upon their perception of the psychosocial well-being of their patients. Because Scherer's study was conducted with caregivers working in an acute care setting (302), its findings are especially relevant to my project, which sought physicians' perceptions working in critical care units and the emergency room.

The five psychosocial entities studied were holism, positive mindedness, social support, religious support, and patient equality. They were then evaluated with a scale, developed by Martin E. Marty, which measures religious attitude and God's involvement in healing in terms of sympathy, synergy, monergism, and autogenesis (Scherer 305,

315).

The plurality of caregivers reported a medium level of 40 percent of religious practice. Physicians in general, and anesthesiologists, emergency doctors, pathologists, and respiratory therapists in particular professed the lowest level of religious practice. Those caregivers who scored high on the religious practice intensity index also scored higher toward a positive appraisal of the psychosocial. In addition, the study found a positive correlation between the level of religious practice and the index of religious support and positive mindedness (Scherer 314-15).

Those caregivers who placed themselves under "not religious" who also had the lowest religious practice scores, showed the least agreement with all indices—holism, positive mind, social and religious support, and patient equality. Because the religious-psychosocial correlation was weak, Scherer concluded that occupational socialization and function might be a greater determinant of openness to psychosocial factors than religious background (Scherer 314-15).

On the continuum of sympathy (God suffering with), synergism (more a new age concept), monergism (the belief in modern-day miracles,) and autogenesis (self-reliance), physicians (emergency medicine and anesthesiologists, in particular) scored highest on the autogenesis. The rest of the physicians were grouped with a sympathetic understanding (Scherer 314-15). As a large proportion of physicians in this study were Catholics, and Catholic caregiver scored highest on the sympathy view, Scherer was not surprised that Catholic physician would score high in respect to the sympathetic view of suffering as well. Physicians who did not profess a faith affiliation as well as Jewish physicians scored high on sympathy. Monergism (the belief in modern-day miracles) only scored high among protestant evangelicals (mostly nurses). Synergism scored low in

general (315).

Scherer‘s study also found that physicians who are less in contact with patients scored lower on the psychosocial scale then those with frequent patient contact. The study reported a weak correlation between religious affiliation and religious practice but a stronger link between religious practice and positive appraisal of the psychosocial impact on healing (309-15).

When allied caregivers believe their patients showed signs of negative religious coping, 53 percent felt it was important to refer those patients to the care of chaplains. In respect to referrals, physicians scored at 39 percent and chaplains only at 29 percent. Chaplains saw themselves as a poorer source of referral then physicians (Scherer 317-18).

Summary

- Physicians and researchers are equally divided on the scientific validity of studies connecting faith to health and issues concerning professional ethics, boundaries, and physicians’ involvement with patients’ faith.
- Religious physicians appear more positively inclined toward the validity of research and the possibility to be sensitively involved with their patients’ faith.
- Both proponents and opponents make use of their personal faith values and understanding of science.
- Physicians acknowledge that many of their patients cope with faith during illness and hospitalization and use religious convictions to make medical decisions.
- Physicians are more apt to engage with their patients’ faith when medical conditions are terminal or their death is approaching.
- They all agree that religious inquire and facilitation must be patient centered and sensitive.

- The majority of physicians is skeptical about clinical benefits of faith and favor its psychological over the biological impact.
- They are hesitant to engage in religious activities such as prayer.
- The more clinically demanding the medical environment, the less likely do physicians practicing in these environments look favorably on faith as part of health care.

The most significant findings in respect to physicians' perspectives are that they recognize the existence of spiritual needs in critically ill patients, that faith's impact is psychological rather than biological, and that acute care physicians tend to be less empathetic and willing to engage with their patients' faith than physicians of other subspecialties.

The Patient Perspective

The last section investigated physicians' perspectives. The following literature discusses patients' perspectives. To know about how patients value and use faith as part of their health and health care is important as those physicians who advocate being concerned about and getting more involved with their patients faith, do so in part because they believe a formidable percentage of their patients wish such involvement.

Literature on prevalence of religion and religious practices of patients in health care focus on (1) how many patients want physicians to be aware of their religious preferences, (2) what kind of religious characteristics these patients exhibit, and (3) under what circumstances, how, and to what extent their physicians are involved with their faith.

Princeton's Religion Research Center found 96 percent of Americans believe in God or a "higher power," 90 percent pray, and 43 percent attend church weekly or more. Others have observed that Americans engage deeply with spiritual issues and carry these

values to the clinical encounter (Cohen et al. 30).

Cohen et al.'s statement is confirmed by Koenig's study, which found that medically ill and hospitalized patients predominantly cope with their situations by using their religious resources ("Religious Attitudes" 213). Despite multiple medical problems, 53.4 percent of these patients attended religious services weekly (20.9 percent more than once) and 58.7 percent engaged in daily Scripture reading and prayer. Among these elderly patients (mean age 72), intrinsic religion was high, as 91.2 reported experiencing the presence of the Divine. Of all persons surveyed in Koenig's study, 87 percent said that nothing is as important as serving God, 89.6 percent reported that seeking God's guidance when making important decisions is imperative, and 87.1 percent held that religious beliefs lie behind their whole approach to life (216-19). In respect to religious coping with illness and other stressors, 42.3 percent spontaneously gave religious responses, such as, "the Lord," "God," "Jesus," "prayer," or "my religious faith." On a scale of zero to ten, 40.1 percent circled ten indicating to what degree they use faith to cope with illness (216-19).

In a family clinic setting 30 percent of 135 patients believed religion in general affected health but attributed religion a much higher priority in specific situations such as terminal illness, death, birth, and major surgery and illness (Maugans and Wadland 211-12). While these patients would appreciate physicians asking, the majority of them did not recall their physicians inquiring about religion. Physicians did not even ask in situations of death (19), major surgery (10 percent), or major and terminal illness (86 percent; 212).

Similarly, 77 percent of 203 Kentucky families wanted spiritual issues considered

as part of their medical care, 37 percent would like their physician to discuss religious beliefs more frequently, and 48 percent of these families would like their physician to pray with them if they could. On the other hand, 68 percent reported their physicians had never discussed beliefs with them (King and Bushwick 349-52).

Patients surveyed in six different academic medical clinics shared a similar view. Two-thirds thought physicians should be aware of their religious or spiritual beliefs and one-third of respondents wanted their physicians to ask about their faith during a regular office visit. On the other hand, only 10 percent of these patients were willing to trade medical talk time for spiritual discussion. The mean age of these patients was 52.4 for women and fifty-five for men (MacLean et al. 39-40).

A survey conducted in a subspecialty outpatient setting sought to inquire if and how severity of illness would affect patients' wishes regarding physicians' involvement with their religion (Ehman et al. 1803-04). Of these outpatients, 51 percent considered themselves very religious, 77 percent reported to believe in "life after death," and 90 percent believed prayer might sometimes influence recovery from an illness (1803).

Of the 177 respondents, 66 percent agreed or strongly agreed they would like their physicians to ask whether they have spiritual or religious beliefs that would influence their medical decisions during grave illness, and 45 percent of respondents agreed with the question that spiritual or religious beliefs would influence their medical decisions if they were to become gravely ill. Another 66 percent were of the opinion their physician's knowing about their faith would strengthen their relationship with them. The 45 percent who did not report spiritual beliefs would nevertheless welcome their physician to ask about them (Ehman et al. 1803-04).

Ehman et al.'s study also revealed that patients selectively chose what to share

with their physicians. Patients share intimate details of their lives that they may not share with anyone else. Details patients share with their physician includes disclosure of sexual practices if they affect their health. Likewise, patients want their physicians at least to be aware of their faith if they believed their faith might have an impact on their medical decisions and outcomes (1805).

Another interview sample of 456 participants revealed that 33 percent desired physicians to inquire into their spiritual lives during a regular office visit; however, the percentage increased to 40 percent during hospitalization and to 70 percent if patients were near death (MacLean et al. 40).

Of the same 456 interviewees, 28 percent wanted physicians to pray silently for them during an office visit, 39 percent during hospitalization, and 55 percent if they were near death (MacLean et al. 40). The scores were similar concerning open prayer. Of all respondents, 19 percent of respondents would welcome open prayer during an office visit, 29 percent during hospitalization, and 50 percent at near death (40).

The results reported in the literature are confirmed by a Gallup survey, which captured peoples' wishes in case they were dying:

> [T]hey, would want human contact (54 percent), especially with someone with whom they could share their fears and concerns (55 percent). Many expressed a desire for holding hands or touch (47 percent). Fifty percent indicated that prayer would be very important, as would having a person to help them become spiritually at peace (44 percent). (Norris, Strohmaier, and Byock 1)

The same respondents also reported that physicians lack in this kind of relational skill (Puchalski and Romer 130).

Summary of Patients' Perceptions

- About a third of all patients consider themselves very religious. Their faith

compels them to want to share their faith with their physicians and physicians to pray with them regardless of the acuity of their medical condition.

- Another third does not consider themselves as religious but still want their physicians to be aware of their religious sentiments. Their desire for their physicians to be practically involved with their faith increases proportionally to the severity of their illness.

- Those who do not consider themselves religious still want their physicians to ask about their faith but only desire spiritual care if death is approaching.

The most important finding that can be extracted from the literature for the purpose of this project is that patients want their physicians to be aware of their faith in general, and toward their possible end of life, in particular. The emerging consensus is that patients use faith to cope with illness and to make medical decisions. The desire of patients for their physicians to engage in prayer is also directly related to the severity of the medical condition.

Physicians' Response to Patients' Perceptions

Some expert physicians hold that patients desire to be cared for relationally and are comforted and develop trust when physicians show concern for their spiritual sentiments and practices (Puchalski and Romer 130). Patients' willingness to receive comfort is not based on physicians' expertise in spiritual matters but stems from relational factors that are part of any human encounter. The main factor opening the way to comfort is the concern physicians show (130). "Patients want to be cared for beyond medical expertise and technology" (Post, Puchalski, and Larson 578-81). Koenig, adding to the discussion, states the following:

> The primary task of a physician is "to cure sometimes, to relieve often, *to comfort always*" [original emphasis]. If some proportion of patients utilize religious beliefs and practices as their primary way of coping with medial illness and the stresses associated with it, then "to comfort always" must include the support and recognition of what the patients find comforting. ("Religion, Spirituality, and Medicine" 129)

To include giving attention to comfort as being more than medical care is necessary if physicians want to honor their patients as holistic and by God created beings.

Primary care physicians' attitude toward their obligation to their patients' spiritual needs depends on medical acuity and institutional setting in which they find their patients (Monroe et al. 2753-55). Physicians believed they should only be involved with their patients' spiritual lives when their patients are dying. Physicians believe in the importance of them being aware and sensitive to their patients' religious beliefs and practices, but they are still reluctant to become involved with their patients' religion. These physicians were especially hesitant to engage in the spiritual practice of prayer. The more intensely patients expressed spiritual behavior, the less physicians agreed to its appropriateness (2753-55).

Another survey found 89 percent of physicians held that they have the right to address religion with their patients but were split on the issue of responsibility (Maugans and Wadland 211). Of the 89 percent, 64 percent believed in the existence of God, whereas 25 percent were uncertain (210). This study reported no difference of frequency of inquiry about their patients' faith between those who believe in God and those who do not (211). On the other hand, those physicians who believe in God and also attend religious services frequently ask their patients more often about their faith than those who physicians who attend religious services infrequently (211). Those physicians who believe it to be right to inquire about their patients' faith also felt it was their

responsibility to initiate the topic. Even though these physicians felt to initiate a conversation about faith was their responsibility still inquire about their patients' faith only infrequently (211). Confirming patients' preference, physicians in this survey thought religious inquiry is most necessary in times of major illness, in times of terminal illness, and at near death. Religious issues were also considered important when discussing abortion (212). Striking in this survey was that physicians found religious inquiry more to be their responsibility than their patients'.

Timothy P. Daaleman and Bruce Frey's survey also compared (1) patients with physicians' religious characteristics and (2) religious characteristics between physicians of various medical specialties ("Prevalence and Patterns" 548-53). The comparison revealed that other than family physicians or obstetricians, clinical specialists as those practicing in an acute hospital settings like ICUs are least likely to engage their patients in matters of faith (548-53). The same study found family physicians referred their patients to chaplains only when end of life was coming in sight (553).

Some physicians (especially family physicians) address spiritual issues with their patients because spirituality is primary in their own lives and because they are convinced of the evidence linking spirituality and positive health outcomes. As one physician states, "Every physician ought to be dealing with [patients'] spiritual issues…. [For example,] how can you justify not talking about spirituality to a patient with depression when you can prove scientifically that strengthening faith commitment helps them?" (Ellis et al. 251). The severity of illness also was the major reason why these physicians wanted to be engaged with their patients religiously (252-53).

Even though physicians in this survey were very willing to address spiritual issues with their patients, they still felt "that in most circumstances, patients should initiate

spiritual discussion. [As] [o]ne said, It's one of these areas where you need a small amount of the patient's permission to get started and lot more of the patients' permission to finish" (Ellis et al. 252).

In respect to taking spiritual assessments, respondents were divided in their opinion. On the other hand, they likened talking about matters of faith to talking about sexual matters. Obviously, physicians believe that faith is a very private and sensitive issue (Ellis et al. 253). My encounters with physicians confirm Ellis et al. observation as I have found that physicians are reluctant to talk about their faith convictions. Likely, physicians' reluctance to share their faith with patients and others, such as chaplains, stems from a fear of crossing professional boundaries and a role understanding, which stipulates to remain objective and unbiased. On the other hand, Puchalski and Romer as well as Anandarajah and Hight are of the opinion that taking spiritual assessments are an excellent tool for physicians to connect more deeply with their patients and to strengthen the relationship (Puchalski and Romer 129-37; Anandarajah and Hight 81-87).

In addition, Farr A. Curlin and Peter P. Moschovis believe that acknowledging patients' faith enhances the clinical encounter and hold that not engaging with patients' value systems leads to an impoverishment of the clinical encounter. They believe that physicians and patients finding a common language to address existential issues is important. If that language is religious in the case of patients, the physicians cannot respond from a neutral position but must be able to empathize with their patients' sentiments (4).

Curlin et al. interpret the findings of their survey as follows:

> Physicians describe religion as providing a paradigm for interpretation and decision making related to illness and a community in which illness is experienced and endured. They further believe that religion enables

> patients to cope with suffering and adhere to difficult medical regimens but consider it as harmful when faith generates psychological conflict or when it leads patients to decline medial recommendations. ("How Are Religion" 761)

Physicians regard religion as important and believe it influences health but tend to avoid matters of faith during clinical outcomes and become skeptical toward patients' faith if it contradicts their own opinion about the nature and function of faith in health care.

Conclusion

Physicians and social researchers are becoming increasingly aware of how important intrinsic faith and religious practices are to help patients and their families come to terms with illness and death. Research reporting proof of a beneficial connection between intrinsic faith, church attendance, faith activities such as prayer with better health and longevity is making progress. Better and more valid research methods are being produced and a positive connection between faith and health and health outcomes is becoming evident, but researchers and physicians are still divided as to how faith exactly mediates health.

Those in favor of physicians getting involved with patients' faith tend to acknowledge the research's positive reports, while opponents are very skeptical of its scientific, religious, and ethical validity. On the other hand, both camps agree that professional and ethical boundaries and protocols are needed to ensure physicians' appropriately handling of spiritual matters with patients. They further agree that spiritual interventions such as prayer or sacrament are not adjunct or equal to the practice of medicine and should not be prescribed as medical interventions. Both also concur that physicians must acknowledge and be sensitive to their patients' faith and spirituality to provide good patient care. Both camps acknowledge faith as part of their patients' frame

of reference and this frame of reference influences how they cope and make medical decisions. Nevertheless, as to how and to what extent physicians should explore faith with their patients is unclear.

Both opponents and those in favor of physicians' participation with patients' faith, tend to view faith and activities related to faith in terms of psychology rather than religion—that is, they believe faith is a means of coping and not a means of cure. Therefore, even those in favor of more faith as part of health care make a clear distinction between the roles of medical science and religion. Proponents, however, are more aware of the unity and the interrelationship of the various components in humans and, therefore, are more willing to acknowledge the role of faith as part of the overall well-being and care of their patients This awareness leads them to seeking ways of becoming reasonably engaged with their patients' faith. These physicians also still struggle as to the appropriateness of place, time, and extent of their involvement. Many still appropriately favor referring their patients to chaplains and clergy.

Even proponents have not yet been able or willing to establish clear guidelines. One thing on which everyone seems to agree is that physicians ought not to become spiritual caregivers, which would be a serious infraction of professional boundaries. Physicians should only approach faith in a strictly patient-centered manner. Professional and ethical boundaries are to be taken seriously and must be observed in order to avoid a conflict of interest on the part of physicians.

Because those in favor of increased physician involvement tend to be religious, those opposed to it are afraid of a renewed spiritualization of medicine. They are fearful established professional boundaries are being unnecessarily challenged or erased. From a chaplain's viewpoint, these concerns are very appropriate. Physicians tend to be confident

and pragmatic and have a considerable influence on patients. Therefore, they may be tempted (even unconsciously) to take over patients' spiritual care and, with that, use their professional and educational power to influence their patients' medical decision making to their favor. A mingling and conflation of medicine and faith, in that case, is likely and should be avoided.

I believe physicians need to limit themselves to their expertise, which is the scientific practice of medicine as they (1) do not have the required time to delve into their patients' religious issues and, (2) as they are probably lack the awareness of how easily they might transfers their own religious perspectives to their patients. (3) Physicians are also not knowledgeable enough about the complexity of issues involved when faith and medicine collide and how time sensitive and intensive spiritual care can become.

At this point, I believe physicians ought to be aware of, sensitive to, and considerate of their patients' faith values but should appropriately seek out and refer patients to trained chaplains or clergy. I also hold that a low profile spiritual assessment such as the HOPE questionnaire (Anadrarajah and Hight 85-86) is appropriate for physicians to use. I recommend they first seek their patients' permission to do so.

In addition, I hold that physicians who consider faith as critical to patient care look for clues and overt patient invitations to approach matters of faith. I firmly believe patients' faith, and faith in general, needs to be part of health care, if health care professionals want to care for the whole person. On the other hand, the domains of faith and medicine need to be kept separate especially regarding specific religious interventions, such as prayer or rituals. Specific religious interventions, such as prayer and rituals, need to be provided if all possible by chaplains or other trained spiritual caregivers. Therefore, professional boundaries need to be observed. Nevertheless, both

physicians and chaplains ought to have some elementary knowledge of each other's professions to value and work with each other more productively. The separation of the two domains of faith and science is not a matter of isolating them; however, for the sake of providing optimal medical as well as spiritual care, the respective professionals—physicians and chaplains need to work within their professional boundaries and according patients' needs and desires.

Qualitative Research and Semi-Structured Interviews

Little research has been done to assess physicians' perceptions of chaplains in general, and no studies have been found that investigate those perceptions in a critical care setting. Thus, no rounded theory or hypothesis has yet emerged in this field of research. In keeping with original investigations, I have chosen to use the qualitative research method to investigate physicians' perceptions of the role of chaplains in critical care.

According to William Wiersma, "[q]ualitative research does not emphasize a theoretical base for whatever it is being studied at the beginning of research. A theory may develop as research is conducted. [I]f a theory develops based on the data, we have a grounded theory" (12). Qualitative research lends itself to original research.

In contrast to quantitative research, qualitative research expresses its data not in numbers but in words and is, therefore, descriptive (Wiersma 12). It is context specific and emphasizes holistic interpretations (12-13). Since this project investigates a relationship of two professionals in a narrowly defined clinical care context, the qualitative research methodology is best suited for it.

I sought to elicit content information from physicians concerning their view and appraisal of the chaplain's role in critical care and, therefore, data collection needed to

emphasize their viewpoint. In qualitative interviewing, the viewpoint of the interviewee is of primary concern, yet the outcome is that the interview addresses the researcher's concern. Qualitative interviewing is flexible, and the researcher wants rich, detailed answers (”Interviewing in Qualitative Research” 313).

Qualitative research uses two primary interviewing methods—the unstructured and the semi-structured interview protocol. In an unstructured interview, the interviewer may ask just one question and then responds to points that seem worthy of being pursued. In a semi-structured interview, the interviewer has a list of questions specific to the research topic but the interviewee has leeway to reply (”Interviewing in Qualitative Research” 314). The semi-structured interview is best used if the researcher starts with a clear focus rather than a general notion of wanting to do research on a topic (315). Because of the focus of this project and the nature of qualitative research, I have chosen to use a semi-structured interview protocol to obtain the needed data.

Different types of questions are asked in a semi-structured interview. Researchers use open-ended questions to introduce a topic and then tries to arrive at more depth with follow-up questions (“Interviewing in Qualitative Research” 318). Nevertheless, leading questions ought to be avoided and single item questions should be asked (Wiersma 169).

If interviewers ask for quantity, which is permissible, they must ask for specifics, not averages or estimations (Wiersma 169). In addition, interviewers may also engage the interviewee with probing and direct questions (“Interviewing in Qualitative Research” 318). I used all four discussed question types to elicit depth and establish possible correlations between personal religious characteristics, general view of the interaction between religion and health care, as well as to investigate possible links between these

items and relationship components defining physicians' perception of the role of chaplains.

Thus, information is organized and then coded according to categories suited specific to the study. "Qualitative data analysis requires organization of information and data reduction … [and] is a process of successive approximation toward an accurate description and interpretation of the phenomenon" (Wiersma 202-03). Most of the time, categories emerge and are established after data collection (203).

Literature bears out that with proper consent, interviews may be taped and then transcribed verbatim. Computer programs are available to analyze qualitative data, which support the task of coding. Some programs have the limited capabilities to transform data to arrive at and develop a grounded theory (Wiersma 214). No computer help was needed and used for competing this project's data analysis.

CHAPTER 3

METHODOLOGY

Introduction

Chaplains and physicians take care of the same critically ill patients. Physicians are exclusively responsible for the physical well-being and recovery of their patients, while chaplains help patients and their families to cope with emotional and spiritual issues related to the medical crisis. In a critical care setting, where this project took place, end-of-life issues prominently emerge. During such difficult circumstances, the domains of medicine and faith overlap and patients, or more often families, have to negotiate medical facts and faith. During these intense times of decision making, physicians and chaplains have to work together most closely, and physicians' perception of the role of chaplains gains importance.

Nevertheless, during a discussion, a critical care physician revealed they (the critical care doctors) hesitate inviting chaplains to end-of-life meetings with families because chaplains, in the past, encouraged families to continue medical treatment, which did not improve patients' condition but only prolonged their suffering.

Research Questions

In order to gain as full a picture as possible, I designed the following research questions to help ascertain (1) how physicians view the chaplains' role, and (2) what experiences led to their perceptions.

Research Question #1

How do physicians view and appraise the chaplains' role in health care delivery in an intensive care setting?

Physicians may not be well acquainted with some aspects of chaplains' roles and,

therefore, relate to chaplains based on some misconceptions. They, like any other health care professional, relate to other team members according to their job description and assigned roles. Job descriptions of nurses, physical therapists, or social workers are clearly defined and physicians will relate to them information and orders accordingly. With the exception of chaplains, all other team members, apart from social workers, care for the physical well-being of patients. Chaplains, on the other hand, constitute a foreign element in the mix in that they are concerned about the spiritual and religious aspects of patient care.

For chaplains to function more confidently and more efficiently as care team partners, for them to understand their role beyond their own perception is important. Because physicians need to collaborate with chaplains in crucial circumstances such as end-of-life care investigating physicians' viewpoint was imperative.

Therefore, the first research question aimed at finding information on how physicians perceive the content and value of chaplains' ministry. As physicians' perceptions may differ from those of chaplains, I specifically wanted to know to whom they perceive chaplains provide ministry, when physicians perceive chaplains are most needed, and what kind of services physicians perceive chaplains as providing. Lastly, finding out why or why not physicians value or appreciate chaplains as part of the health care team also was crucial for this project.

I posed three interview questions specifically aimed at answering this research questions: (1) "Please, think back to one of your first experiences with a chaplain and describe that experience as fully as possible"; (2) "What in your perception do chaplains try to accomplish when visiting with patients in your intensive care units?"; and, (3) "Have you had the opportunity to work with chaplains side by side in such situations? If

yes, what was that specific experience like for you?"

All three interview questions, which followed a semi-structured interview protocol, probed for concrete experiences these physicians may have had with chaplains during their medical practice. The questions were specific to physicians' actual work place and to the persons they were asked to evaluate.

Research Question #2

What were physicians' formative experiences that help form their perceptions of the chaplain's role?

Perceptions of others are not fashioned in isolation but are formed in an experiential context. Because negative experiences led a critical care physicians to mistrust chaplains to be part of end-of-life discussions with families, this research question aimed at eliciting information as to what experiences helped shape critical care physicians' perceptions of the chaplain's role.

Two interview questions were specifically aimed at answering this research question: (1) "Have you had the opportunity to work with chaplains side by side? If yes, what was that experience like?"; and, (2) "Would you recall and then describe encounters with chaplains that stand out in your memory?" Both interview questions, which followed a semi-structured interview protocol, probed for concrete experiences these physicians may have had with chaplains during their medical practice. The questions were specific to physicians' actual work place and to the persons they were asked to evaluate.

Research Participants

I selected the pool of possible interviewees from physicians practicing medicine in at least one of the hospital's four adult critical care units or the emergency room and then narrowed it further by the criteria that these physicians were not just consulted on a

sporadic basis to attend to patients in intensive care units but that they had to admit and treat patients routinely in any of the four critical care units and the emergency room. My interviewees emerged from (1) physicians admitting and treating intensive care unit patients on a regular basis, (2) physicians supervising the operation of those intensive care units, and (3) surgeons of different subspecialties admitting, following, and treating intensive care unit patients. The pool of possible participants amounted to fifteen.

The actual interview participants of the pool were predominantly male (only two female), which is congruent with the medical subspecialties. Physicians who participated in the interview included both seasoned (fourteen), newly practicing physicians (five), completing their fellowships (one), and still in their residency program (one). Physicians interviewed practice in the following six different subspecialties: pulmonary disease and critical care (nine), trauma surgery (four), emergency medicine (three), neurological surgery (three), cardiovascular surgery (one), and nephrology (one).

Instrumentation

This was an exploratory study using a researcher-designed, semi-structured interview protocol. To seek answers to each research question, I interviewed physicians practicing medicine in adult critical care units. The interview questions were open-ended and intended to aid physicians in expressing their views and experiences of chaplains working in critical care units and the emergency room. I chose the open-ended question format in hopes of ascertaining a broad range of information, that I could evaluate and then group according to emerging themes. I posed four grand tour questions, which I then followed up with questions probing for more detail and depth.

The Interview

The following are the interview questions posed to participating physicians.

1. “Please think back to one of your first experiences with a chaplain and describe that experience as fully as possible?”

The possible follow-up questions were

- “How would you describe that chaplain?”
- “Did you have opportunity to observe his/her in relationship with a patient?”

2. “What in your perception do chaplains try to accomplish when visiting with patients in your ICUs?”

The possible follow-up questions were

- “Do you think the chaplain accomplished his/her goal?”
- “Did the chaplain do certain things that impressed or displeased you?”
- “Is there anything in the chaplain’s interventions that stands out?”

“Like in your own medical practice, chaplains do many routine visits marked by simple interventions such as gestures of empathy, reading Scriptures, praying, or just being with patients and families. But, there are critical moments in a patient’s stay in an intensive care unit requiring wisdom and sensitivity. How these situations are handled by the medical staff and chaplains may determine further medical interventions or lead to families giving consents to terminate medical treatment. Such moments are (e.g., when end-of-life decisions have to be made or when doctors are trying to convey to families the difficulty of their loved one’s medical situation.

3. In light of these above-mentioned circumstances, “Have you had the opportunity to work with chaplains side by side in such situations? If yes, what was that precise experience like for you?”

The possible follow-up question was

- “How could the chaplain have worked better with you in this situation?”

The next questions assumes you had multiple encounters with chaplains under different kinds of circumstances while treating patients in an intensive care unit.

4. "Would you recall and then describe those encounters with chaplains that stand out in your memory?"

The possible follow-up questions were

- "Would you be able to tell me how this experience impacted you as a person?"
- "How did this experience impact your personal or professional relationship with that chaplain, or with chaplains in general?"

5. "Have you ever talked with a chaplain about his/her work?"

Data Collection

The possible interviewee pool amounted to thirty physicians of which I was able to interview twenty-one. I contacted the thirty physicians, either in advance by letter of invitation or as I encountered them in their respective areas of practice while conducting the interviews.

In the manner consistent with my theme of relationship, I paved the way for participation early on in the project. Several months before actually issuing an official invitation of participation and conducting interviews, I mentioned my project during regular dialogues with a variety of prospective participants. Using a relational and gradual approach, I was able to secure early verbal acceptance of physicians' participation. Closer to the data collection phase of the project, I inquired of physicians how best to secure their definite participation and with whom to arrange dates, times, and places where the interviews could take place.

Once the project entered the field research phase, I contacted the prospective participants' personal assistants as well as the head physician of each medical specialty.

Each physician's personal assistant agreed to hand a package to each prospective participant containing both an official letter of invitation to join in the research project and the consent form. When the time for the interviews came, only two interviews were prearranged by physicians' personal assistants. The rest took place after personally consulting with and finding physicians at their various workplaces. One of the difficulties I encountered was to get past personal assistants and secretaries who control the flow of communication with physicians. Had I been able to speak personally with some of the prospective interviewees who had previously verbalized interest and willingness to participate, I would have been able to obtain more interviews.

Because of physicians' heavy work load, the intense time pressure, and their having to move frequently to attend to patients in different areas of the hospital, as well as, seeing patients in their respective clinics, I had to be very flexible and willing to conduct interviews whenever and wherever they were convenient to the interviewees. Therefore, I needed persistence and patience to obtain the twenty-one interviews.

Interviews took place in locations of participants' choice as long as they offered adequate privacy and confidentiality. Nevertheless, five physicians asked me to interview them while they were either charting (three) or sitting at their workstations in the emergency room (one) or at the center table in the intensive care unit (one). All other interviews took place in physicians' personal offices (fifteen) or over the phone (one). I designed interviews not to exceed thirty minutes. Before the start of the interview, each physician read and signed the consent form, and I explained the recording of the interview and placed the digital recorder in a prominent position in order to ensure good quality.

Privacy and Confidentiality

Each profession and institution is governed by ethical protocols. Hospitals' confidentiality, privacy, and research ethics are governed by the Health Insurance Portability & Accountability Act (HIPAA) and internal review boards. HIPAA mandates strict patient confidentiality. HIPAA's confidentiality and privacy clauses require each medical care professional only acquire, dispense, or share the amount of knowledge of patients necessary to provide optimal health care.

This project did not require research participants to disclose any patient information or professional medical practices. Because of financial considerations, and the research participants' employment status as contracted employees, I did not go through the hospital's internal review board. I disclosed the avoidance of going before an internal review board in the consent form (see Appendix C).

Research participants' privacy was guarded, as they were not asked to reveal their name, medical specialty, or place of work. Participants were not asked to disclose any patient information or personal data, and no data was made public at any time during or after the completion of the project. All interviews were held in places of physicians' choice and convenience ensuring adequate privacy and confidentiality. The consent form stipulated that the researcher and research participants would, at all times, adhere to HIPAA's privacy and confidentiality regulations. The project was conducted under Asbury Theological Seminary's ethical guidelines for research projects.

Consent Form

The consent form (see Appendix C) contained the title of the project and information about the researcher, stated the precise purpose of the study, elaborated on procedures, risks, and benefits, as well as informed participants of the right to withdraw

from the study. It also stated participants' right to privacy and confidentiality and that the researcher would try to publish an evaluated form of the data as an article in a professional journal.

Data Safety

The interviews were stored on a digital tape recorder. The transcription of the interviews were stored as data files on my password-protected personal computer. If the tape recorder was not in use, it was stored in my personal safe. Access to the data was limited to my mentor and myself. After successful completion of the project and the doctoral program, all interview data on the tape recorder were discarded.

Data Analysis

The aid of a computer analysis was not necessary. Following principles inherent in qualitative and exploratory research, I did not pre-establish categories of evaluation. The purpose of using open-ended and grand tour questions was to identify emerging themes, which then may have led to establishing a working hypothesis regarding physicians' perceptions of chaplains' role in critical care.

I refrained from placing unnecessary constraints on the evaluation process by preestablishing categories of evaluation; however, I expected participants to answer along the lines of positive and negative experiences, notions of preconceived ideas, and perceptions based on professional considerations and personal ideas. I also hoped to find clues as to why physicians may trust and mistrust chaplains and clues as to experiences that lead physicians to misconceive or stereotype the chaplain's role.

Validity

Virginia Cano writes, "On the broadest sense reliability and validity address issues about the quality of the data and appropriateness of the methods used in carrying a

research project." Because this project was an exploratory study, the qualitative research method was best suited for it. The data gathering protocol of using semi-structured interviews posing open-ended questions was the most appropriate data-gathering method for this study. The quality of data was best assured by using open-ended questions, which provided me opportunity to explore with the interviewee their whole realm of experience related to the purpose of the project.

In gathering data from physicians, professional, personal, as well as issues of confidentiality and privacy are at stake. In order to test the appropriateness of the content of my interview questions, I conducted two test interviews with two physicians posing one open-ended question each, asking for information regarding end-of-life care. Both interviews stalled at the very beginning. Searching for reasons for their hesitation to answer these questions, the two physicians though such medically oriented questions reminded them of specific patient encounters, which made them feel vulnerable and uncomfortable.

The failure of the two test interviews confirmed that all questions ought be devoid of seeking medical details and should not lead physicians to suspect anything concerning patient encounters was requested. Further, I concluded that in order to decrease barriers to answering questions regarding matters of faith, I informed each interviewee of the purpose of the project. The validity of the project depended on the quality of my interviewees' experiential accounts of their encounters with chaplains.

Delimitations and Generalizability

The findings of this study are difficult to generalize because the project was conducted in only one hospital located in a particularly religious area of the country and in a hospital that is operated by the Roman Catholic Church. The sisters who founded and

own the hospital understand its mission in spiritual terms and want pastoral care to be central to its operation. Therefore, the pastoral care department is well funded and its chaplains are integral to the hospital's operation. In order for the findings of this project to be generalizable, it needs to be replicated in other areas of the United States and in hospitals with other or no faith affiliation.

The fact the study was conducted with physicians practicing in intensive care units and the emergency room was not a limitation because other intensive care and emergency room physicians may encounter similar condition in their respective hospitals. The results may also be compared to previously published research investigating physicians' perceptions of chaplains' role in hospitals, as similar dynamics between physicians and chaplains may generally exist.

CHAPTER 4

FINDINGS

Physicians' Perceptions of the Role of Chaplains

This chapter presents the findings obtained from interviews with twenty-one of thirty possible physicians practicing medicine in critical care units or the emergency room. Interview participants were predominantly male (two female). I interviewed fourteen seasoned and five newly practicing physicians, as well as one physician who was completing his fellowship and one physician who is still in her residency.

Interviewed physicians represented the following six subspecialties: pulmonary disease and critical care (nine), trauma surgery (four), emergency medicine (three), neurological surgery (three), cardiovascular surgery (one), and nephrology (one). The interviews lasted between three minutes and eight seconds and sixteen minutes and seven seconds. For privacy reasons, I did not ascertain individual physicians' religious affiliation; however, interviewees adhere to the Roman Catholic and several Protestant faiths, as well as to no Christian religions.

The mean interview time was ten minutes and ten seconds. Even though these physicians were under time constraints, they approached the interviews seriously, recounting their experiences in depth while sharing details about their perceptions of the role of chaplains. The short length of some interviews had no bearing on the quality of the content as interviewees under time constraints simply spoke faster. Physicians are used to dictating notes at record speeds.

The purpose of my research questions was to discover how these physicians perceived the role of chaplains and how these perceptions were formed experientially. The two research questions aimed at gaining insight into physicians' perspectives as to

what they see chaplains are doing and as to the *value* physicians attached to chaplains' services.

I arranged the findings of physicians' perception of chaplains' role in the following categories:

- **Whom** do chaplains provide ministry?
- **When** are chaplains most needed?
- **What** kind of services do chaplains provide?
- **Why** do physicians' value chaplains' services?

Within this framework of categories, I further arranged the findings consistent with their importance. Importance is defined as how often physicians mentioned certain themes. In addition, I listed answers in keeping with specific follow-up questions.

Ministry to Families

All twenty-one physicians insisted that taking care of the families of ill patients is chaplains' **single most important** contribution. Not one physician perceived ministry to patients to be the primary focus of chaplains' ministry. Fourteen physicians mentioned patients as part of chaplains' concerns, but every interviewee referred to patients in connection to their families. According to all twenty-one interviewees, families need pastoral care support because of the stress caused by the seriousness of their loved ones' condition. Two physicians stated that patients are not chaplains' primary focus.

The need for family support emerged as the principal concern among physicians as evidenced in the following statement. I think chaplains provide support for the family. They are especially great at providing comfort to families who are going through the trauma of an acute illness of a loved one. To comfort families is especially important when the illness is life threatening or when it takes the life of their loved one. Families

need support because there is a big need to get through the acceptance phase. Chaplains help families to get through this initial acceptance phase [paraphrased].

Death, Dying, and Critical Illness

The circumstance of dying, death, or critical illness is the overwhelming occasion when physicians perceive patients' families need pastoral care. All twenty-one physicians discussed patients' critical conditions, their death, or their dying as the reason why families need pastoral help. Thirteen interviewees thought that families need chaplains if their loved one has died, eight if their patient is dying, and six if a person has a serious or life-threatening condition. In respect to dying, fourteen physicians emphasized that chaplains are needed to help families come to terms with the death or dying of their patients or to help families sort out issues related to end-of-life care.

Comfort and Support during Times of Loss and Grief

Twelve interviewees perceived that chaplains provide families with assurance, stability, and constancy in times of death, dying, or critical illness. According to ten physicians, chaplains lend general spiritual and religious support and another ten interviewees described the ministry of chaplains to families with the words "consoling," "comforting," and "calming." Part of chaplains' interventions, according to seven physicians, is also providing help with the grieving process and grief counseling.

Communication

Physicians also perceive chaplains as skilled communicators. Fourteen physicians mentioned that chaplains are needed for providing communication between physicians and the family. In this role, chaplains are perceived as giving families general information "about what was going on with their patient" or "communicating medical data in layman's terms." All four trauma surgeons beleive chaplains are very beneficial to

providing families with information when physicians are intensely occupied treating their patients and, therefore, do not have time to talk to families.

Prayer and Sacrament

Five physicians mentioned prayer. Two of them considered prayer as a distinctly important component of chaplains' ministries, whereas one talked about prayer as a part of his personal encouragement. The remaining two respondents did not place a specific value on chaplains praying with patients or families.

Only two physicians talked about the sacrament of the sick (last rite) as a standard intervention. One stated, "Obviously, sacraments of life and things like that, when patients are not going to make it, would be a standard, but that is not where I see them [chaplains] as most beneficial. I see them as most beneficial with family dynamics." The other was appreciative of such a religious service to his patients.

Physicians' Validation of Chaplains' Services

Several reasons emerged as to why physicians are so overwhelmingly interested in chaplains' ministry to families.

First, all twenty-one physicians expressed a high level of awareness of families needing empathetic support by someone during health crisis. All interviewees also verbalized that chaplains are the competent professionals to do the job. Nine interviewees believe chaplains are needed in crises because they recognized the spiritual nature of the situation. The same persons also verbalized that chaplains are spiritual caregivers; however, only five mentioned prayer as an important pastoral care intervention. Three individuals perceived religion or religious needs as part of health crisis requiring the presence of chaplains.

Second, physicians are aware of and concerned about the traumatic impact of

sudden health crises on patients' families. As one physician stated, "I think you serve as a great liaison between us and the family, especially because a lot of families suffer as much a spiritual trauma as a physical trauma that happens when they lose a loved one."

Third, fourteen physicians mentioned chaplains as important communicators. Nine interviewees described the role of chaplains as liaisons between them and the families. As one physician said, "You guys have always acted as a great liaison between us and them and also between them and their own clergy, to make them more comfortable." On the other hand, only seven of the twenty-one actually admitted having worked side-by-side with a chaplain, and even fewer (two) have ever been present when chaplains ministered to a family or patient.

In respect to communication, one interviewee described his situation as follows: "I like to do my medical communication part, but then I am glad to leave and commit the family to the care of the chaplain." Each interviewee highly valued chaplains for being there for and dealing with families on their behalf. One physician described chaplains as "physician extenders."

Fourth, eight physicians perceived that chaplains made up for lack of empathy on their part or their unwillingness to get emotionally involved with families' grieves and issues. Four physicians explicitly mentioned their desire not to get involved with families. One interviewee commented, "I am not cut out for the emotional stuff." He also said he was grateful chaplains take care of emotional issues. One other physician bluntly verbalized, "I have problems dealing with family and individuals with emotional needs."

Fifth, many (twelve interviewees) mentioned not having the time to spend with families because "another twenty patients are waiting for their services."

Sixth, two interviewees also discussed they needed to make a clean distinction

between scientific functioning and emotional functioning. Scientific functioning requires objectivity while emotional functioning requires getting involved with families' emotional and spiritual issues. Physicians think getting involved with families' issues either drains or distracts them, as well as undermines their objectivity. One physician expressly mentioned that if he would get emotionally involved he would lose focus. The following quote made by one of my interviewees captures a generally perceived sentiment:

> Sometimes, I think physicians come across as being uncaring, when they are really just trying to stay at a level they can function. If you get emotionally involved, I know, because I personally have had experience with my own family members being in a situation. And you're the physician, you cannot function under that. You have to be objective. You have to be scientific, have to make the right decision. If you get emotional you can't do it.

Therefore, the hesitation of physicians getting emotionally involved with families stems from physicians' need to remain as scientifically objective as possible, which may be then perceived by others as being uncaring.

Seventh, ready accessibility was highly valued, as eleven physicians expressed appreciation for the immediate availability of a chaplain. One interviewee recognized that chaplain services are available twenty-four hours a day for seven days a week, and another was impressed that chaplains are one of the first to respond to trauma calls. Two physicians who previously worked in hospitals with very limited resources expressed being pleasantly surprised by the strong presence of pastoral care.

Physicians' Relationship to Chaplains

I posed three questions aimed at discovering how physicians want chaplains to relate to them. The three questions were (1) "How do you want chaplains to relate to you as a person and as a physician?" (2) "Who in your opinion is more responsible to initiate

and maintain the relationship between physicians and chaplains, physicians or chaplains?" and, (3) "Do chaplains have an impact on you personally or professionally?" The majority, sixteen out of the twenty-one physicians, want chaplains to relate to them as members of the interdisciplinary team. Eight physicians believe chaplains are more responsible for the relationship while five held that both chaplains and the physicians are equally responsible, and four interviewees believed physicians should be the responsible party. Fourteen physicians communicated that chaplains had some impact on them, whereas six thought they were not impacted by chaplains at all. Four physicians who felt impacted by chaplains made the following statements:

- "They bring out the best in us."
- "They remind me of the bigger picture."
- "It is just good to know that they are around."
- "They make me softer."

Chaplains' Effectiveness

Four interviewees thought chaplains were definitely effective, and three held that chaplains accomplish their goals partially. The three, who think chaplains are only partially effective, believe either limited time or the spiritual condition and receptivity of those they serve are cause for the partial accomplishment of the task. The other fourteen answered the question with descriptions of what they see chaplains do. Two physicians mentioned chaplains are more effective than they in helping families come to terms with the loss a loved one. Overall, fourteen physicians perceived chaplains are very beneficial in dealing with families, whereas five expressed that chaplains are a "huge benefit" and asset to them, to the hospital, and to the families.

Physicians' Formative Experiences with Chaplains

Physicians were not able to pinpoint explicitly formative experiences that shaped their perceptions of the role of chaplains. Nevertheless, their answers pointed to an experiential context in which their perceptions started to take shape.

Eight physicians recounted situations where their patients suffered a life-threatening illness, had a traumatic health crisis such as an accident with brain injury, or had a patient dying or a patient had died. Three physicians described an encounter where a chaplain was present in a generally difficult situation, and four interviewees remembered meetings and interactions with chaplains as interdisciplinary team members.

Only four physicians remembered any problem or possible difficulties with chaplains. Two of them were able to recount an incident they perceived as negative. Both were concerned with situations regarding the end-of-life decision-making process for a patient. One physician said on one occasion, after the chaplain visited the family, the family re-decided to continue aggressive treatment against all odds and medical advice. This physician complained that the chaplain obviously did not understand the condition of the patient and gave the family false hope. The second negative comment made by one of the four physicians centered on a chaplain who was more interested in bringing his point across to the family instead of comforting them in their time of grief.

The third of the four physicians had initial encounters with hospital chaplains where chaplains were asked to take on roles uncommon to them. These chaplains had to fill out death certificates and communicate medical facts to families of the deceased, making the physician uncomfortable. The fourth physician mentioned issues concerning boundaries. The three physicians who encountered difficulties with chaplains in the hospital within which this project was undertaken held that such difficulties were in the

past and had not recurred recently.

Summary

The following statements summarize physicians' answers given in the interviews.

- Chaplains are most important providing family support.
- Chaplains are most needed and effective during times when patients are dying or have died.
- Chaplains provide the most valuable support during times of grief and loss.
- Chaplains are liaisons between physicians and patients' families and provide necessary communication to families.
- Chaplains are important to the ministry of the interdisciplinary care team.
- Chaplains are perceived as effective.
- Chaplains are available and present in crises.

CHAPTER 5

DISCUSSION

This project began with an interest in finding clues to the chaplain-physician relationship. For that reason, I sought to investigate how physicians perceive chaplains' role in critical care. While the findings are discussed in light of the study's distinct critical care setting, they are also compared to previous studies and literature as well as evaluated considering my proposed anthropology. The postscript links the project's results to the discussion that triggered the project in the first place.

Ministry to Families

Physicians in this study verbalized that chaplains play an important role in critical health care and the interdisciplinary care team. They perceived chaplains as most important and helpful when taking care of patients' families who are often confronted with a loved one's unexpected or troubling medical circumstances. Acute care physicians insisted on chaplains being most beneficial to them when ministering to families. This role perception was the single most striking and unforeseen finding. It also has not yet been reported as a specific chaplain role by previously published studies or literature (Flannelly et al.; Flannelly, Weaver, and Handzo) and may be unique to the critical care setting in which this study took place.

While physicians emphasized the chaplain's role in family care, they perceived that chaplains' spiritual ministry to patients is only marginally important. On the other hand, their responses implied that patients profit from the support of spiritually healthy and well-adjusted families. Physicians, therefore, perceived chaplains' ministry to families as indirectly benefiting their patients. Physicians' responses indicated that chaplains taking care of families lessens their workload and takes an otherwise

burdensome responsibility off their shoulders. In addition to being relieved of an added responsibility, physicians also considered personal and professional reasons. Interviewees' consensus to delegate family care to chaplains to such a high degree came as a surprise, but after considering the particular circumstances as present in a critical care setting and considering personal experience as a critical care chaplain, physicians needing support for their patients' families is evident and, therefore, makes sense.

Helping families sort out those conflicting and troubling emotions and helping them cope with medical issues is a ministry in its own right but certainly benefits patients as well as physicians who are glad when chaplains are able to work with families and can reasonably comprehend and discuss the medical and spiritual issues at hand. In that respect chaplains indeed provide an invaluable service to families, patients, physicians, and to the overall operation of the hospital.

Part of family care is being present during times of grief and death. Physicians joined those surveyed by Flannelly et al., ascertaining that chaplains are the vital source of comfort and stability during families' initial periods of grief as patients die.

Interviewees rightly recognized the importance of the family system for the benefit of their patients. They expressed an awareness that families' spiritual condition proves pivotal in cases where complex medical decisions have to be made and personally and religiously based wishes of patients and families play a role in the decision-making process. To work with families who are reasonably well-adjusted and prepared is much easier and time saving for physicians. Unresolved family issues are known to have negative impacts upon patients' sense of resolve and peace. They also can complicate medical care (Lo et al.). Physicians in this study trust chaplains to have the skills to help families sort out personal issues and with that help decrease an otherwise high level of

anxiety.

Suffering and illness is lived in and affects patients' social framework. By placing their patients' spiritual well-being in the sphere of a family system, physicians show awareness of the theological concept of holism even though they did not express this awareness in theological but sociological terms. Physicians indirectly agree with the biblical anthropology as proposed in chapter 2, expressing understanding of the need of embracing patients as part of a family system; however, they do so only partially because their concern does not extend to patients as individual spiritual beings in need of spiritual care also. Like ministry to families, religious ministry to patients is a task in its own right.

The lack of physicians' awareness that not attending to patients' spiritual needs may affect (1) patients' sense of hope and peace and (2) their recovery is evidenced by interviewees' willingness to direct chaplains' ministry away from direct patient care. They agree with an opinion very commonly held by physicians that spiritual interventions such as prayer, Scripture reading, and religious rituals have little if no impact at all upon the physical health of patients or their recovery from illness (Curlin et al.; Chibnall, Jeral, and Cerullo; MacLean et al.; Stein; McCaffrey et al.).

Aside from pragmatic reasons, which include getting families off their backs, physicians' concern for the welfare of families are also motivated by their personal aversion to getting involved with the emotional and spiritual issues of others, their concerns about professional ethics and boundaries, and a true interest in the spiritual well-being of patients as well as their families.

Physicians correctly recognized that families come under serious pressure when faced with the critical illness, death, or dying of a loved one (Ellis et al.; Daaleman and Frey, "Prevalence and Patterns"; Lo et al.). However, by assigning chaplains to focus so

exclusively on families, physicians knowingly are willing to divert chaplains' attention away from patients. In doing so, interviewees disagreed with experts and patients that the more serious the illness and the closer patients approach the inevitable—death—the more patients need and seek spiritual support, cope with their situations with intrinsic faith and religious practices, as well as are interested for their physicians to be at least aware of, and sensitive to their faith, or in limited and acute circumstances want their physicians to engage in the religious activity of prayer (Curlin et al.; Maugans and Wadland; King and Bushwick; Koenig "Religious Attitudes"; Ehman et al.; MacLean et al.).

Critical care physicians agree with patients that faith is one of the most commonly used and important means of coping and sense making during a medical crisis (Koenig, "Religious Attitudes"; Ehman et al.). Nevertheless, they disagree with patients, families, and chaplains alike, regarding to attaching value to the effectiveness and importance of religious activities, such as prayer, reading of sacred texts, and rituals (Flannelly et al.). According to Flannelly et al. and Flannelly, Weaver, and Handzo, chaplains use prayer, Scripture reading, and rituals very frequently and in a variety of circumstances.

On the other hand, physicians agree (first) with other studies' assessments that acute care physicians are religious but less prone to use faith as a means of personal support. They hesitate letting their faith affect their professional functioning (Curlin et al.) and, like other physicians, more closely associate their opinion about the function of faith in respect to patient care with their professional role than with their personal faith (Scherer). Second, physicians in this study also agreed with a host of commentators and other physicians that prayer, even though universally used by patients for the purpose of health (McCaffrey et al.), and also importantly used by chaplains (Flannelly et al.), is not to be used as adjunct medical intervention and that has little or no effect upon physical

recovery (Post, Puchalski, and Larson; Scheurich; Sloan, Bagiella, and Powell; Sloan et al.; Chibnall, Jeral, and Cerullo).

In agreement with social researchers and physicians such as Sloan et al. and Scheurich, but disregarding physicians who propose increased physician involvement with patients' faith (Post, Puchalski, and Larson; Cohen et al.; Anandarajah and Hight), they keep with established professional boundaries, which call for physicians to remain neutral (Scheurich), refer to chaplains (Post, Puchalski, and Larson), or stay away from getting involved with patients' faith (Sloan et al.; Sloan, Bagiella, and Powell). By doing so, they hold to historically developed distinctions between science and faith (Cohen et al.) and confirm a still-remaining chasm between the two domains. More work has to be done to integrate faith better into the health care process.

Interviewees also expressed an already reported sentiment (Post, Puchalski, and Larson) that physicians hesitate to get involved with their patients' faith because they are not trained in spiritual and religious matters. They further agree (with VandeCreek, Chaplain-Physician Relationship) that a personal affinity for and education in the sciences, necessitated and all important for practicing medicine, contributes to how they interact with and view the roles of chaplains.

Even though these physicians are making a clear distinction between the domains of medicine and faith, they do so, except in one particular circumstance (end-of-life care), out of necessity and appropriately. They show their positive affirmation of faith as valuable in health care by inviting chaplains to the health care process (family care in particular). In the hospital where this project was conducted, I have never been barred access to a patient, been disregarded or avoided, or held back by physicians from ministering to patients.

The medical profession left without the presence of chaplains who are a constant reminder of the necessity to honor patients as holistic beings, would neglect the spiritual care of their patients for the already-discussed personal and professional reasons. However, inviting chaplains to the overall health care process, which includes honoring chaplains as integral and important members of the interdisciplinary care team, physicians compensate for the necessary apprehension of getting involved with matters of faith.

I concur that physicians are not called to provide pastoral care for the very reasons postulated by some physicians and social researchers (Scheurich; Sloan et al.; and Sloan, Weaver, and Handzo); however, I am in full agreement with those who urge physicians to pay attention and respond to patients' and families' spiritual concerns and opinions (Koenig, "Healing Power of Faith; Post, Puchalski, and Larson; Sheehan), and caution physicians not to let their personal belief system (devout or not) influence their response to patients' religious requests by denying them appropriate and necessary referrals to professional chaplains.

God gives physicians an inclination toward science and the gift to comprehend the complexity of human biology in greater measure than anyone else; however, in order for patients to be honored as holistic beings—that is to be ministered to spiritually also, chaplains are needed to complement what physicians are not able to provide.

Agreeing with the thought of holistic care practiced through the work of the interdisciplinary care team, physicians assigned chaplains a more important role in the interdisciplinary care team than I would have expected. What stood out, and where physicians appear to differ with chaplains, is in that they relate to chaplains primarily for professional, pragmatic, and not personal reasons (cf. VandeCreek, Chaplain-Physician Relationship). Previous studies have not commented on physicians' appraisal of chaplains

as team members. Also the extent to which physicians' perceived chaplains as important liaisons and communicators was also a surprise finding. Being liaisons and communicators are chaplains' roles not reported in previous literature. Therefore, physicians' perceptions of the chaplain's role in family care as important interdisciplinary team members, liaisons, and communicators extend roles previously assigned to chaplains (Flannelly et al.; Flannelly, Weaver, and Handzo; Post, Puchalski, and Larson). Whether these newly assigned roles only apply to a critical care context could not be established by this study.

This study bore out that chaplains in this hospital are encouraged to continue to serve physicians, families, and patients by actively and carefully ministering to patients' families but because patients express a need and desire to be spiritually attended to, chaplains must continue to minister to them with all their skills and time.

This hospital expresses its vision of applying holistic care by placing chaplains into the interdisciplinary care team, which makes them visible and accessible to physicians practicing in all four critical care units and the emergency room. Being part of that team puts chaplains, by their very presence, in the favorable position of promoting the scriptural value of patients being a unity of body and spirit. They are, therefore, with their ministry a visible exposition of God's image in humans.

As part of the interdisciplinary care team and in lieu of some physician responses, chaplains must continue to strengthen their knowledge of the health care process and acquire elementary knowledge of health care without verbalizing it. Chaplains are validated as important team members but could strengthen their relationship to physicians by demonstrating they understand their place in critical care and the interdisciplinary team, serve them in the best interest of patient care, while not neglecting their

responsibility to patients' spiritual well-being.

This study confirmed that physicians separate the domains of religion and science and they adhere to traditional and appropriate role distinctions as present in the professions of clergy and physicians; however, it also demonstrated that physicians are positively inclined toward faith as part of health care. In the context of this study, I believe the overall spiritually defined mission of the hospital combined with a competent and around-the-clock presence and availability of chaplains contributes to physicians' appreciation of the pastoral care staff.

On the other hand, this project also established that the closer faith, in general, and religious activities, in particular, come to be regarded as influencing medical decision making and specific health outcomes (e.g., faster recovery from illness or healing) the more physicians become skeptical toward faith's value and function in health care. This attitude spills over in how they appraise chaplains' roles in critical care in general and in their hesitation to involve chaplains with end-of-life care in particular.

Whenever the possibility exists of faith starting to interfere or mingle with medicine proper, the concept of holism, as expressed in an influencing relationship between body and spirit, the implementation of scriptural anthropology is prone to collapse.

Because physicians unanimously perceived the chaplain's role in critical care as ministering to patients' families, their hesitation to involve chaplains in the end-of-life decision-making process remains an enigma. On the one hand, physicians insisted chaplains are most important and valuable in family care, but they are hesitant on the other hand, to involve chaplains in the very time when families need their spiritual assistance most. If physicians are impressed with how the chaplains are taking care of

their patients' families, they should invite chaplains to this most important phase of medical treatment. Physicians' actions contradict their responses.

Two possible reasons emerged: (1) physicians practicing critical care medicine in this hospital are still too marred by negative experiences of the past and are, therefore, not yet willing to make a fresh start even though no recent difficulties have been reported, and (2) more likely, physicians are not yet comfortable in inviting chaplains to the end-of-life care process. At that crucial point of decision making, the domains of medicine and religion start to overlap; therefore, physicians may be prone to overemphasize the function of medicine over and against faith, while experiencing discomfort as they see medicine and faith so intertwined. As reasons related to faith may have an influence on families wanting to continue treatment physicians deem unethical, physicians may perceive they are losing power over the process. In addition, because chaplains are spiritual caregivers, physicians may still perceive chaplains as a threat to their authority or do not want to take a chance of a possible mishap. Physicians may still be afraid of acknowledging that faith is more intertwined with medicine than they would like to believe.

Recommendations

This study's findings underlined the importance of the chaplain's role from the viewpoint of critical care physicians practicing in a religiously affiliated regional medical center. Physicians' responses encourage chaplains (1) to seek and maintain professional and personal relationships with physicians, (2) to define and practice their roles as professionals and contributors to the work of the interdisciplinary care team, (3) to acquire basic knowledge of medicine and medical care, and (4) to continue to provide the whole range of pastoral care to patients, families, and hospital staff.

Due to their education, understanding of their professional roles, and personal religious characteristics, physicians in this study do not understand the comprehensive character of pastoral care and chaplains' roles and exhibit a deficient understanding and lack of appreciation for the unity of body and spirit. Nevertheless, their appreciation of chaplains working with families and their willingness to incorporate chaplains into the overall health care process as team members somewhat compensates for that deficiency and affords chaplains the opportunity to practice pastoral care. Being part of the team gives chaplains the opportunity to advocate holistic care and to help shift medical care toward holism.

The fact that critical care physicians in this hospital assign chaplains primarily to care for patients' families shows a lack of understanding of chaplains' roles, but this fact must not discourage chaplains from fulfilling their obligation to provide pastoral care to patients. Taking care of patients' spiritual needs is the chaplain's primary responsibility, regardless of physicians' perceptions. Chaplains must continue to serve all parties involved in the care process without neglecting to attend to the many issues concerning patients' families, as, indirectly, patients and the care process benefit from well-adjusted family networks.

While being sensitive to their patients' medical needs and to physicians' primacy in providing and coordinating patient care while also adhering to appropriate professional boundaries, chaplains need to take a stand for their professional role as religious experts and spiritual caregivers and minister indiscriminately. In order to further their own ministry and to reach the goal of improved spiritual care, chaplains can initiate and maintain excellent personal, professional, and pastoral relationships with physicians.

This study confirmed an existing gap between medical science and faith as well as

between physicians' perceptions of chaplains' roles—chaplains' roles as defined by patients' needs and professional pastoral care standards. Nevertheless, an attempt to narrow the gap should and can be made. The following recommendations could contribute to close the gap. First, the director of pastoral care services should give a detailed explanation and description of chaplains' roles and pastoral care ministries during the new physician orientation. Second, the hospital can provide regular inservice training to physicians to educate them about the necessity and practical application of spiritual care to patients and families. Such measures are not designed to force or encourage physicians toward a spiritualized medicine but to promote better teamwork, which results in improved and more holistic patient care.

Third, just as physicians want chaplains to have some elementary knowledge of medicine and medical care, they, likewise, should be given the opportunity to or be required to acquire some basic knowledge of theology and matters of faith such as the function of sacraments, prayer, and the reading of sacred texts as well as pastoral care practices such as active listening. Hospitals, in general, and this hospital, in particular because it has a religious basis and the resources, could offer a limited clinical pastoral care rotation for each incoming physician (especially residents and fellows), which could consist of some required reading and entail spending a day with a chaplain. Further, the pastoral care department may nurture dialogue between chaplains and physicians by offering discussion groups and seminars dealing with topics related to spirituality and medicine.

While such endeavors are recommended, chaplains in this hospital should not at all feel hindered from continuing to provide pastoral care to patients or anyone else who needs it. On the contrary, chaplains may now be aware that physicians value them overall

and consider their ministry to families as an important contribution. The widespread appreciation and acceptance of chaplains in this hospital by physicians can further serve as a platform to initiate these changes and foster a fruitful dialogue from which chaplains may venture to enhance their pastoral care ministry for the benefit of patients receiving end-of-life care.

For chaplains working in hospitals that do not afford them high visibility or range of ministry opportunities, whose departments are underfunded, and whose ministries are marginally recognized, the findings of this study may provide an impetus and encouragement either to remain involved or to become more involved in interdisciplinary care. In addition, they may seek to intensify their ministry to families hoping physicians will begin to appreciate their ministry more.

Weakness of Study

The weakness of this study is that it was conducted in one type of hospital, located in one particular part of the United States, while also belonging to a particular religious faith. The combination of locality, religious characteristics of the hospital, and limited interview sample comprised the greatest limitations. These limitations place restrictions on the generalizability of the results.

The hospital is in a region where religion is still openly practiced and very much part of people's lives. In addition, the hospital was founded on religious principle and, therefore, emphasizes spiritual care. Religious directives are basic to hospital policies; therefore, physicians who practice in this hospital may be more frequently challenged to reflect upon the value of faith in health care than their counterparts in other hospitals with no religious backing. Such reflection, and the possibility that this hospital's particular religious orientation may present an incentive for physicians of like faith to practice there,

may also cloud the generalizability of the study.

In order for the study to gain greater strength and generalizability, it needs to be replicated in hospitals with different religious orientations or no religious backgrounds at all. It also needs to be conducted in different regions of the country and in various types of hospitals such as community and university hospitals.

Postscript

The findings of this study provided insight as to physicians' preferences regarding chaplains' value and effectiveness in critical care medicine, how they perceive faith as part of health care, and how this perception came to be. The fact that physicians practicing critical care medicine in this hospital verbalized their hesitation to invite chaplains to the end-of-life care process due to negative past experiences is only half of the story. The other half is that educational, scientific, and personal reasons influence their appraisal of the extent of chaplains' roles in critical care. The factors of education, science, and personal views of the value and function of faith in health care are strong determinants.

When physicians face patients standing at the crossroad of life and death and where their role as healers comes to an end, when the domains of medicine and faith merge and science ceases to provide the answers, physicians experience discomfort and tend to withdraw to work in isolation. At that point, chaplains' presence is needed to bring comfort to all parties involved and they feel obligated to continue to seek a place in the end-of-life care process.

I feel strengthened in striving to build productive and harmonious professional and personal relationships with physicians who are part of the same interdisciplinary care team in order to find ways to a more comprehensive involvement in patients' end-of-life

care. The opportunity afforded obligates me to represent God's intention to honor patients as holistic and human beings created in God's image. As I continue to endeavor to minister holistically and in God's will, I must include all parties involved in health care delivery—patients, families, general medical staff, and physicians.

APPENDIX A

Semi-Structured Interview Questions

1. "Please think back to one of your first experiences with a chaplain and describe that experience as fully as possible?"

The possible follow-up questions were:

- "How would you describe that chaplain?"
- "Did you have opportunity to observe his/her in relationship with a patient?"

2. "What in your perception do chaplains try to accomplish when visiting with patients in your ICUs?"

The possible follow-up questions were:

- "Do you think the chaplain accomplished his/her goal?"
- "Did the chaplain do certain things that impressed or displeased you?"
- "Is there anything in the chaplain's interventions that stands out?"

"Like in your own medical practice, chaplains do many routine visits marked by simple interventions such as gestures of empathy, reading Scriptures, praying, or just being with patients and families. But, there are critical moments in a patient's stay in an intensive care unit requiring wisdom and sensitivity. How these situations are handled by the medical staff and chaplains may determine further medical interventions or lead to families giving consents to terminate medical treatment. Such moments are for example when end-of-life decisions have to be made or when doctors are trying to convey to families the difficulty of their loved one's medical situation.

3. In light of these above-mentioned circumstances, "Have you had the opportunity to work with chaplains side by side in such situations? If yes, what was that

precise experience like for you?"

The possible follow-up question was:

- "How could the chaplain have worked better with you in this situation?"

The next questions assume you had multiple encounters with chaplains under different kinds of circumstances while treating patients in an intensive care unit.

4. "Would you recall and then describe those encounters with chaplains that stand out in your memory?"

The possible follow-up questions:

- "Would you be able to tell me how this experience impacted you as a person?"
- "How did this experience impact your personal or professional relationship with that chaplain, or with chaplains in general?"

5. "Have you ever talked with a chaplain about his/her work?"

APPENDIX B

Invitation Letter to Physicians and Consent Form

Dear Dr. ,

I would like to invite you to participate in a research project that investigates the **chaplain-physician relationship** as it relates to critical care. I am doing this research in partial fulfillment for completing a Doctor of Ministry degree at Asbury Theological Seminary located in Wilmore, KY. The idea for researching this topic arose from the observation that spiritual and religious issues arise when patients become seriously and life-threateningly ill and that the chaplain-physician relationship is vital to assessing and meeting these needs if the most holistic care wants to be provided.

This project aims at discovering possible dynamics that either hinder or foster a good professional working relationship between chaplains and physicians with the goal to educate myself and other chaplains to this relationship. Therefore, I wanted to ask you for your time to pose some interview questions. Below, you find the research questions for your information and the interview questions that I would like to pose to you.

The findings and evaluation of the data will be used personally, and I will try to publish an evaluation of the data in an article (if accepted for publication) by a professional medical or pastoral care journal. In order to secure confidentiality and privacy, the interview will be conducted in a quarter of your choice at your convenience. The interview will be taped and then transcribed verbatim. After the project is accepted and finished, all taped and transcribed data will be destroyed. At no time will your identity be noted or released. The interviews will have individual numbers only.

Sincerely,

Rev. Daniel Winiger
Chaplain

APPENDIX C

Consent Form

Consent to Participate in a Research Study
Asbury Theological Seminary, Wilmore, Kentucky

TITLE OF STUDY: The physician's perception of the chaplain's role in critical care.

RESEARCHER INFORMATION: The person conducting this study is Reverend Daniel Winiger, a Doctor of Ministry candidate of the doctor of ministry department at Asbury Theological Seminary in Wilmore, Kentucky. He is mentored during this research project by Dr. Leslie Andrews, Dean of the program.

PURPOSE: The purpose of this study is to investigate the physician's perception of the role of the chaplain in the common goal of health care delivery in a critical care setting. The study is conducted within the broader goal of understanding the dynamics and components that frame the chaplain-physician relationship.

PROCEDURES: You will be interviewed by the researcher, who will tape, transcribe, and then evaluate the data. The interview questions will consist of open-ended questions and the interview should not exceed 30 minutes. You will not be asked to reveal any names or other specifics that could lead to an identification of a particular individual, yourself or particular circumstance known to others. Your interview date will be combined with interview data of other participants. Evaluation and/or publication of the data is based on general observations and evaluation of all data received.

RISK/DISCOMFORT: To the best of my knowledge, your participation will not carry any physical or psychological risks.

BENEFITS: You may benefit from your participation through the need to personally reflect upon your perception and interaction with a member of the health care team. Further, this study may result in an enhanced knowledge of the chaplain-physician relationship, which may improve professional relationship between the two, and possibly the care provided to patients in critical care units.

RIGHT TO WITHDRAW: Your participation in this study is entirely voluntary and you may withdraw at any time during the interview process.

PRIVACY AND CONFIDENTIALITY: Your personal privacy will be guarded as you will not be asked to reveal your name, medical specialty, or place of work. No personal or medical data will be revealed or made public at any time during and after completion of the project. You will not be asked to reveal any patient information or medical practices. However, this consent stipulates that the researcher and the research participant will, at all times, adhere to HIPPA regulations. The interview will be held in a place of your choice at your convenience providing necessary privacy and confidentiality.

Your interview will be numbered, and no name, medical specialty, or place of work will be attached to it. Your interview will be stored together with others on a digital tape recorder, and as voice and transcribed data files on the researcher's password protected personal computer. If the tape recorder is not in use, it will be stored in the researcher's personal safe. Access to the data is limited to the researcher and his mentor. After successful completion of the project and the doctoral program, your interview data on the tape recorder will be discarded.

This research project is conducted under Asbury Theological Seminary's ethical guidelines for research projects.

Due to financial consideration, the researcher did not ask for permission of the hospital's internal review board.

PUBLICATION: Your interview data will, in evaluated form, be printed as part of the doctor of ministry thesis, and stored, as well as be accessible from Asbury Theological Seminary's library. If accepted by a journal, the researcher plans to publish an evaluation of the data in the form of an article in a professional journal of his choice. He further asks permission to be allowed to use the evaluated form of the data for personal, professional, and educational purposes.

OFFER TO ANSWER ANY QUESTIONS: If you have any questions about this study, you may call or e-mail Daniel Winiger, at (423) 926-0944, (423) 431-8208, or djwiniger@comcast.net. You may also contact Dr. Leslie Andrews, mentor and dean of the doctor of ministry program, at Asbury Theological Seminary at 1-877-776-3646.

SIGNATURES: I understand and give consent to participate voluntarily in this research project. I understand the nature and scope of the study, and that a copy of this consent form will be provided to me if I request one.

_____

Signature of research participant Date

_____

Name of research participant

WORKS CITED

Anandarajah, Gowri, and Ellen Hight. "Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment." American Family Physician 63.1 (2001): 81-88.

Barr, O. "Interdisciplinary Teamwork: Consideration of the Challenges." British Journal of Nursing 6.17 (1997): 1005-10.

Berry, Devon. "Methodological Pitfalls in the Study of Religiosity and Spirituality." Western Journal of Nursing Research 27.5 (2005): 628-47.

Cano, Virginia. Reliability & Validity in Qualitative Research. 2 Nov. 2006 <http://www.qmuc.ac.uk/psych/RTrek/study_notes/web/sn5.htm>.

Carter, Charles W., ed. "Anthropology: Man, the Crown of Divine Creation." A Contemporary Wesleyan Theology. Grand Rapids: Francis Asbury-Zondervan, 1983. 1: 195-32.

Chibnall, John T., Joseph M. Jeral, and Michael A. Cerullo. "Experiments on Distant Intercessory Prayer." Archives of Internal Medicine 161 (2001): 2529-35.

Chibnall, et al. "Psychosocial-Spiritual Correlates of Death Distress in Patients with Life-Threatening Medical Conditions." Palliative Medicine 16 (2002): 331-38.

Clinebell, Howard. Basic Types of Pastoral Care & Counseling. Nashville: Abingdon, 1984. . .

Cohen, Cynthia, et al. "Walking a Fine Line." Hastings Center Report 31.5 (Sept.-Oct. 2001): 29-39.

Cousins, Norman. Anatomy of an Illness. New York: Bantam, 1981.

Curlin, Farr A., et al. "How Are Religion and Spirituality Related to Health? A Study of

Physicians' Perspectives." Southern Medical Journal 98.8 (Aug. 2005): 761-66.

---. "Religious Characteristics of U. S. Physicians: A National Survey." Journal of General Internal Medicine 20 (2005): 629-34.

Curlin, Farr A. and Peter P. Moschovis. "Is Religious Devotion Relevant to the Doctor-Patients Relationship?" Journal of Family Practice 53.8 (Aug. 2004): 1-6.

Daaleman, Timothy P. and Bruce Frey. "Prevalence and Patterns of Physician Referral to Clergy and Pastoral Care Providers." Archives of Family Medicine 7 (1998): 548-53.

---. "Spiritual and Religious Beliefs and Practices of Family Physicians." Journal of Family Practice 48 (1999): 98-104.

Ehman, John W., et al. "Do Patients Want Physicians to Inquire about Their Spiritual or Religious Beliefs If They Become Gravely Ill?" Archives of Internal Medicine 159.23 (Aug. 1999): 1803-06.

Ellis, Mark R., et al. "What Do Family Physicians Think about Spirituality in Clinical Practice?" The Journal of Family Practice 51.3 (Mar. 2002): 249-54.

Ellison, Christopher G., et al. "Religious Involvement and Mortality Risk among African American Adults." Research on Aging 22 (2000): 630-67.

Flannelly, Kevin J., et al. "Department Directors' Perceptions of the Roles and Functions of Hospital Chaplains: A National Survey." Hospital Topics 83.4 (Fall 2005): 19-27.

Flannelly, Kevin J., Andrew J. Weaver, and George F. Handzo. "A Three-Year Study of Chaplains' Professional Activities at Memorial Sloan-Kettering Cancer Center in New York City." Psycho-Oncology 12 (2003): 760-68.

Frank, Erica, Mary Lynn Dell, and R. Chopp. "Religious Characteristics of US Women Physicians." Social Science & Medicine 49.12 (Dec. 1999): 17-22.

Grenz, Stanley J. Theology for the Community of God. Grand Rapids: Eerdmans, 2000.

Gunton, Collin E. Christ and Creation. Grand Rapids: Eerdmans, 1992.

Handzo, George, and Harold G. Koenig. "Spiritual Care: Whose Job Is It Anyway?" Southern Medical Journal 97.12 (Dec. 2004): 1242-44.

Harder, G. "ψυχη." New International Dictionary of New Testament Theology. Ed. C. Brown. Grand Rapids: Zondervan, 1986. 3: 676-86.

Hardy, Daniel W. "Creation and Eschatology." The Doctrine of Creation. Ed. Colin Gunton. Edinburgh: T & T Clark, 1997. 105-33.

Helm, H., et al. "Does Private Religious Activity Prolong Survival?" Journal of Gerontological Medical Science 55a (2000): 400-05.

Hroscikoski, Mary. "The Patient and the Disease as 'Other.'" Franciscans and Healthcare: Facing the Future. Ed. Elise Saggau. St. Bonaventure, NY: Franciscan Institute, 2001. 53-62.

Hummer, Roger A., et al. "Religious Involvement and Adult Mortality in the United States: Review and Perspective." Southern Medical Journal 97.12 (Dec. 2004): 1223-30.

Humphry, Derek. Freedom to Die. New York: St. Martin, 1998.

"Interviewing in Qualitative Research" pp. 311-33. 10 Oct. 2006 <http//www.oup.co.uk/pdf/0-19-874204-5chap15.pdf>.

Ironson, Gail, et al. "The Ironson-Woods Spirituality/Religiousness Index Is Associated with Long Survival, Health Behavior, Less Distress, and Low Cortisol in People with HIV/AIDS." Annals of Behavioral Medicine 24.1 (2002): 34-48.

Jenkins, R., and K. Pargament. "Religion and Spirituality as Resources for Coping with Cancer." Journal for Psycho-Oncology 13.1/2 (1995): 51-74.

Kendler, Kenneth S., Charles O. Gardner, and Carol A. Prescott. "Religion, Psychopathology, and Substance Use and Abuse: A Multimeasure, Genetic-Epidemiologic Study." American Journal of Psychiatry 154.3 (1997): 322-29.

King, Dana E., and Bruce Bushwick. "Beliefs and Attitudes of Hospital Inpatients about Faith Healing and Prayer." Journal of Family Practice 39.4 (Oct. 1994): 349-52.

King, Dana E., et al. "Experiences and Attitudes about Faith Healing among Family Physicians." Journal of Family Practice 35 (1992): 158-62.

Kliewer, Stephen. "Allowing Spirituality into the Healing Process." The Journal of Family Practice 53.8 (2004): 616-24.

Koenig, Harold G. The Healing Power of Faith. New York: Simon, 1999.

---. "Religious Attitudes and Practices of Hospitalized Medically Ill Older Adults." International Journal of Geriatric Psychiatry 13 (1998): 213-24.

Koenig, Herald G., et al. "Does Religious Attendance Prolong Survival? A Six-Year Follow-Up Study of 3,968 Older Adults." Journals of Gerontology Series: Biological Sciences and Medical Sciences 54.7 (1999): M370-76.

---. "Religion, Spirituality, and Medicine: A Rebuttal to Skeptics." International Journal of Psychiatry in Medicine 29.2 (1999): 123-31.

Koenig, Harold G., Linda K. George, and Bercedis L. Peterson. "Religiosity and Remission of Depression in Medically Ill Older Patients." American Journal of Psychiatry 155.4 (1998): 536-42.

Krause, N., and T. Van Tran. "Stress and Religious Involvement among Older Blacks." Journal of Gerontology 44 (1989): S4-S13.

Ledbetter, Timothy James. "Physician-Chaplain Collaboration: A Suggested Approach in the Care of Critically Ill Patients, Utilizing Relevant Spiritual Resources in the Healing Process." Diss. San Francisco Theological Seminary, 2001.

Lo, Bernard, et al. "Discussing Religious and Spiritual Issues at the End of Life." Journal of the American Medical Association 28.5 (Feb. 2002): 749-54.

MacLean, C. D., et al. "Patient Preference for Physician Discussion and Practice of Spirituality." Journal of General Internal Medicine 38 (2003): 38-43.

Maugans, Todd A., and William C. Wadland. "Religion and Family Medicine: A Survey of Physicians and Patients." The Journal of Family Practice 32.2 (1991): 210-13.

McCaffrey, Ann M., et al. "Prayer for Health Concerns." Archives of Internal Medicine 164 (2004): 858-62.

McCord, Gary, et al. "Discussing Spirituality with Patients: A Rational and Ethical Approach." Annals of Family Medicine 2.4 (July-Aug. 2004): 356-61.

McCullough, et al. "Religious Involvement and Mortality: A Meta-Analysis Review." Health Psychology 19.3 (2000): 211-22.

Mermann, Alan C. "Faith at the End of Life." Journal of Pastoral Care 46.4 (1992): 337-39.

Mills, Paul J. "Spirituality, Religiousness, and Health: From Research to Clinical Practice." Annals of Behavioral Medicine 24.1 (2002): 1-2.

Moadel, Andrew D., et al. "Seeking Meaning and Hope: Self-Reported Spiritual and Existential Needs Among an Ethnically Diverse Cancer Patient Population." Journal of Psycho-Oncology 8 (1999): 378-85.

Moltmann, Jürgen. The Coming of God: Christian Eschatology. Minneapolis: Fortress,

1996.

Monroe, Michael H., et al. "Primary Care Physicians' Preferences Regarding Spiritual Behavior in Medical Practice." Archives of Internal Medicine (2003): 2751-56.

Norris, Kaye, Gretchen Strohmaier, and Ira Byock. "Spiritual Care at the End of Life." Health Progress July-Aug. (2004): 1-11.

Oman, Douglas, and Dwayne Reed. "Religion and Mortality among the Community-Dwelling Elderly." American Journal of Public Health 88.10 (1998): 1469-75.

Oyama, Oliver, and Harold G. Koenig. "Religious Beliefs and Practices in Family Medicine." Archives of Family Medicine 7 (Sept.-Oct. 1998): 431-35.

Pargament, Kenneth I., et al. "Religious Struggle as a Predictor of Mortality among Medically Ill Elderly Patients." Archives of Internal Medicine 161 (Aug. 2001): 1881-85.

Plante, Thomas G., and Marcus T. Boccaccini. "Reliability and Validity of the Santa Clara Strength of Religious Faith Questionnaire." Pastoral Psychology 45 (1997): 429-37.

Plante, Thomas G., et al. "The Association between Strength of Religious Faith and Psychological Functioning." Pastoral Psychology 45.5 (2000): 405-12.

---. "Further Validation of the Santa Clara Strength of Religious Faith Questionnaire." Pastoral Psychology 48.1 (1999): 11-21.

Plante, Thomas G., Beatriz Saucedo, and Chelsea Rice. "The Association between Strength of Religious Faith and Coping with Daily Stress." Pastoral Psychology 49.4 (2001): 291-300.

Polkinghorne, John. Science and The Trinity: The Christian Encounter with Reality. New Haven, CT: Yale UP, 2004.

---. Serious Talk: Science and Religion in Dialogue. Harrisburg, PA: Trinity, 1995.

Post, Stephen G., Christina M. Puchalski, and David B. Larson. "Physicians and Patient Spirituality: Professional Boundaries, Competence, and Ethics." Annals of Internal Medicine 132.7 (2000): 578-83.

Princeton Religion Research Center. Religion in America. Princeton, NJ: Gallup Poll, 1996.

Puchalski, Christina, and Ann L. Romer. "Taking a Spiritual History Allows Clinicians to Understand Patients More Fully." Journal of Palliative Medicine 3.1 (2000): 129-37.

Roberts, Alexander, and James Donaldson, eds. "Adversus Haereses 5.6.1 and 5.9.1." The Writings of the Fathers Down to 325 A.D.: The Ante-Nicene Fathers, Justin Martyr, Irenaeus. Peabody, MA: Hendrickson, 1995. 1:526-67.

Scherer, Ross P. "Hospital Caregivers' Own Religion in Relation to Their Perception of Psychosocial Inputs into Health and Healing." Review of Religious Research 37.4 (1996): 302-24.

Scheurich, Neil. "Reconsidering Spirituality and Medicine." Academic Medicine 78.4 (Apr. 2003): 356-60.

Shannon, Thomas. "The Legacy of the Schiavo Case." America (June 2005): 17-19.

Sheehan, Myles N. "Spirituality and Medicine." Journal of Palliative Medicine 6.3 (2003): 329-31.

Sheets, Dutch. Intercessory Prayer: How God Can Use Your Prayers to Move Heaven & Earth. Ventura, CA: Regal, 1997.

Sherman, Allen C., et al. "Assessing Religious Faith in Medical Patients: Cross-Validation of the Santa Clara Strength of Religious Faith Questionnaire." Pastoral

Psychology 48.2 (1999): 129-41.

Siegel, Bernie. Love, Medicine and Miracles. New York: HarperPerennial, 2002.

Sloan, Richard P., and Emilia Bagiella. "Claims about Religious Involvement and Health Outcomes." Annals of Behavioral Medicine 24.1 (2002): 14-21.

Sloan, Richard P., Emilia Bagiella, and T. Powell. "Religion, Spirituality, and Medicine." The Lancet 353 (Feb. 1999): 664-67.

Sloan Richard P., et al. "Should Physicians Prescribe Religious Activities." New England Journal of Medicine 342.25 (June 2000): 1913-16.

Stein, Rob. "Researchers Study Prayer's Influence on Healing." 20 Jan. 2007 <http://www.msnbc.msn.com/id/11986926/did/11986926/?GT1=7850&print=1&displaymo>.

Strang, Susan, and Peter Strang. "Questions Posed to Hospital Chaplains by Palliative Care Patients." Journal of Palliative Medicine 5.6 (2002): 857-64.

Sulmasy, Daniel P. "The Blood of Christ: Towards a Franciscan Spirituality of Healthcare." Franciscans and Healthcare: Facing the Future. Ed. Elise Saggau. St. Bonaventure, NY: Franciscan Institute, 2001. 29-43.

Thiel, Martha, and Mary Redner Robinson. "Physicians' Collaboration with Chaplains: Difficulties and Benefits." Journal of Clinical Ethics 8.1 (1997): 94-103.

Twohig, Jeanne S., and Ira Byock. "Aligning Values with Practice." Health Progress (July-Aug. 2004): 27-33.

VandeCreek, Larry. Research Primer for Pastoral Care and Counseling. Decatur, GA: Journal of Pastoral Care, 1988.

VandeCreek, Larry, and Laurel Burton, eds. The Chaplain-Physician Relationship. New

York: Haworth, 1991.

Wenger, Neil, and Sara Carmel. "Physicians' Religiosity and End of Life Care Attitudes and Behaviors." The Mount Sinai Journal of Medicine 71.5 (Oct. 2004): 335-43.

Wenham, Gordon J. Genesis 1-15. Waco, TX: Word, 1987.

Wiersma, William. Research Methods in Education: An Introduction. 7th ed. Boston: Allyn, 2000.

Williams, Redford, and Virginia Williams. Anger Kills: Seventeen Strategies for Controlling the Hostility That Can Harm Your Health. New York: Random, 1993.

WORKS CONSULTED

Association of American Medical Colleges. "Contemporary Issues in Medicine: Communication in Medicine." Medical School Objectives Project, Report III. 1999. 15 May 2006 <http://www.aamc.org/ newsroom/pressrel/ 1999/ 991026.htm>.

Breitbart, William, et al. "Psychotherapeutic Intervention at the End of Life: A Focus on Meaning and Spirituality." Canadian Journal of Psychiatry 49.6 (June 2004): 366-72.

Cacchione, P. "What's Another Word for Euphenism?" American Journal of Hospice and Palliative Care 17 (2000): 6-7.

Center for Spirituality, Theology and Health. Home page. Duke. 10 June 2006 <http://www.dukespiritualityandhealth.org/index.html>.

Curlin Farr A., et al. "When Patients Choose Faith over Medicine." Archives of Internal Medicine 165 (Jan. 2005): 88-91.

Cutler, S. J. "Membership in Different Types of Voluntary Associations and Psychological Well-Being." Gerontologist 16 (1976): 335-39.

Daaleman, Timothy P., and Donald E. Nease, Jr. "Patient Attitudes Regarding Physician Inquiry into Spiritual and Religious Issues." The Journal of Family Practice 39.6 (Dec. 1994): 564-68.

Daaleman, Timothy P., and Larry VandeCreek. "Placing Religion and Spirituality in End of life Care." Journal of the American Medical Association 284.9 (Nov. 2000): 2514-17.

Dodd, C. H. The Apostolic Preaching and Its Development. Grand Rapids: Baker, 1980.

Dunne, Tad. "Spiritual Care at the End of Life." Hastings Center Report 31.2 (2001): 22-26.

Friccione, G. L. "Illness and the Origin of Caring." Journal of Medical Humanity 14 (1993): 15-21.

Gunton, Collin E., ed. The Doctrine of Creation. Edinburgh: T & T Clark, 1997.

Hill, Peter C., and R. W. Hood, eds. Measures of Religiosity. Birmingham, AL: Religious Education, 1999.

Johnson, Luke T. Religious Experience in Early Christianity: A Missing Dimension in New Testament Study. Minneapolis: Fortress, 1998.

Journal of the Health Care Chaplain 3.2 (1991).

Kagawa-Singer, Marjorie, and Leslie J. Blackhall. "Negotiating Cross-Cultural Issues at the End of Life." Journal of the American Medical Association 286.23 (Dec. 2001): 2993-3001.

Kedem, Roee, and James Krinsley. "Does Having a Religious Affiliation Affect the Outcome of ICU Patients?" Critical Care Medicine 32.12 (2004): 260.

Kelly, Gerald. "Notes: The Duty to Preserve Life." Theological Studies 12 (1951): 550-56.

King, Dana E., and Brian Wells. "End of life Issues and Spiritual Histories." Southern Medical Journal 96.4 (2003): 391-93.

Koenig, Harold G. Spirituality in Patient Care: Why, How, When, and What. Philadelphia: Templeton, 2002.

Koenig, Harold, Michael McCullough, and David B. Larson. Handbook of Religion and Health. Oxford, England: Oxford, 2001.

Koenig, Harold G., D. O. Moberg, and J. N. Kvale. "Religious Activities and Attitudes of

Older Adults in a Geriatric Assessment Clinic." Journal of the American Geriatric Society 36 (1988): 362-74.

Koenig, Harold G., M. Smiley, and J. A. P. Gonzales. "Religion, Health and Aging: a Review and Theoretical Integration." Contributions to the Study of Aging 10 (1988): 129-40.

Kübler-Ross, Elisabeth. On Death and Dying. New York: Collier, 1970.

Larson, D. G., and D. R. Tobin. "End of Life Conversations: Evolving Practice and Theory." Journal of the American Medical Association 284 (2000): 1573-78.

Lo, Bernard, et al. "Responding to Requests Regarding Prayer and Religious Ceremonies by Patients Near the End of Life and Their Families." Journal of Palliative Medicine 6.3 (2003): 409-15.

Malony, H. Newton. "The Demise and Rebirth of the Chaplaincy." Journal of Pastoral Care 29.2 (1975): 129-34.

Nelson, Robert M. "The Compassionate Clinician: Attending to the Spiritual Needs of Self and Others." Critical Care Medicine 33.12 (2005): 2841-42.

Polkinghorne, John. Science and the Trinity: The Christian Encounter with Reality. New Haven, CT: Yale UP, 2004.

Propp, Douglas A. "Is Spirituality an Emergency Physician's Competency?" Academic Emergency Medicine 10.10 (2003): 1098-99.

PubMed. Home page. 15 May 2006 <http://Pubmed.gov>.

Searight, Russell, and Jennifer Gafford. "Cultural Diversity at the End of Life: Issues and Guidelines for Family Physicians." American Family Physician 71.3 (Feb. 2005): 515-22.

Spohn, Gustav. "Chaplains Can Help with Ultimate Issues." National Catholic Reporter 19 Jan. 1996: 20-21.

Todres, David I., Elisabeth Catlin, and Mary Martha Thiel. "The Intensivist in a Spiritual Care Training Program Adapted for Clinicians." Critical Care Medicine 33.12 (2005): 2733-36.

Waite, Linda J., and Evelyn L. Lehrer. "The Benefits from Marriage and Religion in the United States: A Comparative Analysis." Population & Development Review 29.2 (June 2003): 255-75.

Wright, N. T. The Resurrection of the Son of God: Christian Origins and the Question of God. Vol. 3. Minneapolis: Fortress, 2003.