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## *Professional Practice*

Rev. Dr. Emily Brault

### **Reflections from Prison**

I work as a Chaplain in prison. The story here is not much different than elsewhere – the prison industrial complex is growing and we continue to get more and more inmates everyday, filling up beyond capacity. As a side effect, the Department of Corrections takes a huge chunk of cash out of our state budget every year...which means less money for our schools and health care systems and infrastructure and other important things. And now we are in a position of increasing our numbers and having to cut our budget dramatically, too. This means fewer options for alcohol and drug treatment, mental health care, physical health care, dietary care, education, and more.

Unfortunately, I cannot change the system. I cannot make it better. I am witness to the struggles of life, of living in a broken and exhausted system, and it is easy to lose my cool. I am also witness to the struggles of living in a broken mind, a broken heart and body, a broken psyche that is not equipped to deal with the hardships of life, let alone the hardships associated with incarceration. And I can't change them, either. I can't fix their minds. I can't heal their hearts. I can't implant any magical coping skills or spiritual perspectives that will make their lives easier. I wish I could – but really, it's they who have to do the work. They have to make the change, to face the pain, to figure out what it takes to get through this impossible life with any sense of hope or dignity or illusion of control.

So what can I do? I witness their lives. I affirm their struggle. When I can, I try to offer different ways of seeing things – struggle as opportunity, pain as signs of growth, change as chance to revision priorities, to see things different, to re-imagine life, to experience God. And I try to foster some sense of hope and light in the darkness – some sense that we can make it, that maybe there is meaning to the chaos, maybe there are better ways to live – but sometimes I feel like my hope is bankrupt, that life is going to suck no matter what I do or say or hope or pray. And what is the spiritual import of "suck?" I know I sound despairing, but sometimes I think that is the most honest response to what is before me.

But I do hope. I am silly that way perhaps. I do dream. I do pray for change and help and healing, for the stubbornness to get through, for the courage to carry despair. To sit in the darkness with people – that is sometimes all I can do. Like Jonah in the belly of the

whale. Here we are – in the belly of the whale. It is stinky in here, and cold, and there are half-digested fish parts floating around, and it is dark. I have no idea how long we will be here – 3 days, 3 weeks, 30 years.... So what can I do? I sing. I pray. I cry. I sit in the belly of the whale. Sometimes I play with fish parts. I despair. I hope. And I think that someday I will get spit out – when it is time. Probably not when I want to be, or when I think I am ready to be, but when it is time. And I will land on the shore, and my clothes will be half-digested and I will be pale from the stench of the whale's belly, I will look and feel like poo, but I will be out. And I will begin again. But until then... here I am.

Life sucks. We get through. (Maybe, maybe not.) It hurts. It smells. It's hard. It's horrible. It's life. And somehow I don't feel so bleak for some reason...at least not today...

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*Rev. Dr. Emily Brault serves as a chaplain at Coffee Creek Correctional Facility outside of Portland, OR. She is ordained in the Unitarian Universalist tradition. Emily is currently preparing a manuscript for publication about sweat lodge ceremonies for Native Americans in prison. She has been in the field of prison chaplaincy for about eight years, and in her spare time she plays the banjo and chases her two-year-old around the house.*

Rev. Donald B. Stouder

### When People Think You Are An Expert

I have worked in health care long enough to know that when colleagues ask my opinion about something they usually think I am some sort of an expert. I currently serve as chaplain to an Organ Procurement Organization, and a typical day means either being on-call (when I am expected to respond to hospitals in our Southern California service area and approach families about organ donation) or being in the office, working on whatever current projects are on my desk.

On one such morning, an email appeared from my Director, having been forwarded to her by someone at our "mothership" (our affectionate term for the Medical Center we are a part of), seeking feedback on a document about religious and cultural differences that was to be added to a hospital policy and used to train clinicians. Billed as a "quick guide to cultures and spiritual traditions", she asked me to review the document's accuracy, since there are so many myths out there surrounding culture, religion, and organ donation.

The "quick guide" turned out to be twenty-six pages long, with quick snippets of information from twenty-eight different religions traditions, races, and cultures. As I gave it a careful read, I became concerned. While it covered many religions and cultures, nothing said about beliefs surrounding organ and tissue donation was up-to-date or accurate. By itself, this was not alarming to me. I often find that such myths need to be corrected through education. What did alarm me was the content of the other information provided. At best, it was largely outdated and inaccurate. At worst it struck me as racist, sexist, and exclusionary. I said so in my email reply, and the document was dropped from consideration.

What to do when our colleagues in health care think we are experts? I have no doubt that the document was the product of a great deal of work, passion, and commitment on the part of its authors. But a lot has changed in our world, and in my practice, since it was written. I have learned that giving a list of cultural and religious "dos and don'ts" to clinical staff only reinforces the practice of stereotyping. I have learned that patients and families are more complex than their cultural or religious heritage. Finally, I have learned to let patients and families tell me how I can best be a chaplain to them, in the always changing and unique circumstances that we find ourselves in.

I am no expert in cultural and religious differences, although I like it that my institution thinks I am. The real experts are the patients and families we serve.

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Kevin J. Flannelly, Ph.D.

### Chaplains and End-of-Life Research

A study published in the March 18th issue of JAMA created quite a stir in some chaplain circles, probably because it found that advanced cancer patients who were more likely to use religious coping were also more likely than other patients to want and receive life-prolonging care during their last week of life.[1] The first finding is not new. Previous research has found that more religious patients are more likely to want measures that prolong life than other patients.[2,3] What was new was the finding that they actually do receive life-prolonging care. Apparently, this finding was also considered quite newsworthy, and the newspaper stories about the study that actually caused the stir. Like most studies on religion and health, the effects were modest and it probably would not have gotten the press coverage it received if it had been published in a different journal. Nevertheless, the authors are correct in saying their results should be given “consideration from those providing pastoral counseling to terminally ill patients with cancer.”

My point of view, as some may know, is not just that pastoral care providers should consider the findings of others, but that they should conduct studies to produce their own results. If chaplains wait to be asked to collaborate on a study, they may never be asked. There were eleven authors on that religious coping article and not one of them had a theological or divinity degree. So, chaplains have to be proactive in order to ensure their perspective is heard in research on religion and health.

Many chaplains are reluctant to do research, and some may be especially reluctant to become involved in end-of-life research, because they feel it too burdensome or potentially harmful to terminally ill patients. A study conducted at a palliative care hospital in New York City provides evidence that should help allay these concerns.[4] The study participants, who were admitted for end-of-life care, were interviewed for 1-2 hours (over 1-3 sessions) and administered “an extensive battery of tests” about depression, hopelessness, suicide, pain, etc.

After the interview and tests were completely they were asked how they felt about doing them. Surprisingly, perhaps, 75% of the participants said they did not find it burdensome at all, and only 6% said it was very burdensome. Over 75% said that they would participate in another study if asked. And most said they benefited from it. “The most commonly reported benefits were enjoying the social interaction (75%), feeling a sense of contribution to society (57%), [and] helping to keep busy (47%)” [4, p. 628]. “Over 40% said that being interviewed about their symptoms and death and dying was helpful.” [4, p. 628]

I hope chaplains reflect upon these findings when they consider the possibility of conducting research. The burden on the patient may be far less than you imagine, and they may directly benefit from it. As the Editor-in-Chief of the *Journal of Health Care Chaplaincy*, I strongly encourage chaplains to do research and I welcome the

submission of studies by chaplains to the journal.

**Footnotes:**

[1] Phelps AC, Maciejewski PK, Nilsson M, Balboni TA, Wright AA, Paulk EM, Trice E, Schrag D, Peteet JR, Block SD, Prigerson HG. "Religious coping and use of intensive life-prolonging care near death in patients with advanced cancer." *Journal of the American Medical Association* (March 18, 2009), 301(11): 1140-1147.

[2] Balboni TA, Vanderwerker LC, Block SD, Paulk ME, Lathan CS, Peteet JR, Prigerson HG. "Religiousness and spiritual support among advanced cancer patients and associations with end-of-life treatment preferences and quality of life." *Journal of Clinical Oncology* (2007), 25(5): 555-560.

[3] Van Ness PH, Towle VR, O'Leary JR, and Fried TR. "Religion, risk, and medical decision making at the end of life." *Journal of Aging and Health* (2008), 20(5): 545-559.

[4] Pessin H, Galietta M, Nelson CJ, Brescia R, Rosenfeld B, and Breitbart W. "Burden and benefit of psychosocial research at the end of life." *Journal of Palliative Medicine* (2008), 11(4): 627-632.

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## *Spiritual Development*

Rev. Regan Doyle Saoirse

### *The Scent Memory of a Chaplain*

One of the strange side effects of being a chaplain resident at a level one trauma center that I did not expect is my new library of scent memories. I recall somebody somewhere saying that our scent memory is the most accurate form of memory we have and triggers subconscious responses based on past experiences connected to that smell. Sounds pretty nifty – if you're a pastry chef or a florist.

But I now have these smells burned into my memory with images and emotions that are disturbing and – very surreal. I have the almost sweet, metallic smell of blood dried and caked and flowing freely mixing with images of disfigured bodies and trauma room chaos, exposed body parts, and frantic and crying family members. With the smell of vomit, I see images of bereft patients and families talking close to my face while I try not to gag from the stench of each breath, each word coming out of their mouths. When I smell stale urine, I remember rummaging through the urine soaked clothes on a dead man, looking for something that might tell me who he is or who might want to know he's died. The smell of poop recalls images of patients soiling their beds as they talk to me.

If there is a body fluid smell out there, I've got a memory to match it. I don't have nightmares about my scent memories. But I do have these flashes of memory that interrupt my thoughts when I pass by or catch a whiff of something similar. It reminds me that I am human. Underneath the logical analysis, mountaintop mystical experiences, and amazing sentience, I am still literally flesh and blood. Nothing more humbling than the reminder that I am a sack of fluids held up on a frame of bones, working on electrical impulses.

It also reminds me that despite my calmer demeanor and more efficient manner regarding suffering, trauma and death, I am still affected. My heart is not stone, my soul is not numb. I've smelled suffering, I've smelled death.

At one point in my life – not long ago – I somehow bought into the idea that these smells are embarrassing, shameful and scary. The irony is that everybody poops and pees, throws up and bleeds. Life is not antiseptically clean, so why should death be any different? Again, the irony is that everybody dies. Our mortal bodies smell and our mortal bodies die. I will die. It may not be pretty and it will most likely smell, but I will die. The point worth remembering, however, is that today I live.

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*Rev. Dr. Emily Brault serves as a chaplain at Coffee Creek Correctional Facility outside of Portland, OR. She is ordained in the Unitarian Universalist tradition. Emily is currently preparing a manuscript for publication about sweat lodge ceremonies for Native Americans in prison. She has been in the field of prison chaplaincy for about eight years, and in her spare time she plays the banjo and chases her two-year-old around the house.*

*BioethicsWalk* addresses bioethical issues that chaplains face in their day-to-day work. *PlainViews* invites our readers to share their responses to each *BioethicsWalk* column, which will be published in the following issue. We also invite our readers to submit areas of concern/interest about which they would like Nancy to write.

If you'd like to respond to *BioethicsWalk*, please send a comment of no more than 100 words. You can use the e-form below (click on "hearing from you," link) or submit your commentary to the editors in the body of an e-mail (or as a Microsoft Word attachment) sent to [Info@PlainViews.org](mailto:Info@PlainViews.org). Please put the phrase "*BioethicsWalk*" in your subject line. Comments that are too late for the previous issue can be viewed in TalkBack.

We look forward to [hearing from you.](#)

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### The Complex Ethics of Moral Distress

Last month, I participated in a meeting hosted by Yale University's Interdisciplinary Bioethics Center to discuss "moral distress": those situations in health care in which a health care professional perceives that there is a systemic barrier to ethically appropriate action, and experiences psychological distress as the result of this perception. The phenomenon of moral distress, which was first described in the nursing literature twenty-five years ago, continues to be studied among nurses, but may also be experienced by physicians and other health care professionals, if they perceive that they are powerless to alter an ethically wrong situation.

Moral distress is of importance to ethicists for at least three reasons. Those who experience it describe the source of their distress in moral terms: not simply, "I'm under stress," but also, "I'm under stress because I perceive that my ethical integrity is being undermined." Clinicians experiencing moral distress may resort to work-arounds for relief – avoiding the distressing situation, rationalizing rule-breaking as civil disobedience – rather than trying to solve the perceived problem. And they may appeal to "ethics" for relief. One member of our group at Yale was a clinical ethicist who has studied the difference between requests for ethics consultations that arise from clinicians' moral distress, and requests that arise from dilemmas over ethical courses of action. These cases can be hard to resolve, as they turn on clinicians' perceptions, may have been brewing for a long time, and may be associated with a history of poor relations or inadequate communications among different professions. According to this ethicist, understanding what's going on in these cases, and whether perceptions concerning ethical action are accurate, requires a commitment to "presence" as well as the ability to make clear recommendations.

If a chaplain reading this column hasn't yet figured out what moral distress has to do with chaplaincy, that word "presence" brings it home. Moral distress cases may overlap with the types of cases chaplains encounter among clinicians in highly stressful situations, when a clinician is witnessing suffering and questioning whether his actions

are contributing to it. Several of the physicians and nurses in our Yale group acknowledged that, in the practice of medicine, they do plenty of things that result in pain and suffering – starting an IV on a neonate, giving chemotherapy – with goal of saving or prolonging a patient’s life. These situations can be distressing; where moral distress arises is when the clinician is unsure whether she is contributing to needless suffering, or when she perceives this to be the case but feels powerless to alter the situation. I suspect that most chaplains have heard from clinicians in these situations; some chaplains may recognize the experience of moral distress from their own work. So let’s open up the conversation:

- What are some examples of moral distress that may be observed by chaplains in particular?
- What are some examples of moral distress that may be experienced by chaplains in particular?
- Have you been involved in addressing moral distress in a health care institution, whether as a participant in an ethics consultation or through the provision of spiritual care to clinicians? What insights can you offer?

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*Nancy Berlinger is Deputy Director and Research Scholar at The Hastings Center, an independent, nonprofit, nonpartisan bioethics research institute located in Garrison, New York. Her research interests focus on clinical ethics and include end of life care; ethics in health care chaplaincy; ethics in cancer care; conscientious objection and moral distress in health care; patient safety and the resolution of medical harm; and ethics education for pandemic planners. Broader interests include narrative ethics and medical humanities. Currently, she directs a research project that is revising the influential Hastings Center guidelines on end of life care. This project is funded by the Patrick and Catherine Weldon Donaghue Medical Research Foundation and the Albert Sussman Charitable Remainder Annuity Trust. She recently completed a research project, funded by the Arthur Vining Davis Foundations, which examined how professional chaplains define “quality” within their own practice and profession, and how these definitions correspond to how chaplaincy is represented in the health care “QI” movement and in efforts to advance patient-centered care. As Deputy Director, she manages the Center’s organizational capacity-building initiative, Bioethics and the Public Interest, which has received major support from the Ford Foundation. Berlinger is the author of After Harm: Medical Error and the Ethics of Forgiveness (Johns Hopkins, 2005, paperback 2007) and is currently developing a book project on cancer “survivorship” and the future of cancer care. She serves on the ethics research group of the Joint Commission; the ethics faculty of the American Society of Healthcare Risk Managers (ASHRM); the bioethics committees at Montefiore Medical Center, Bronx, New York and at Richmond of New York, a longterm care facility; and the editorial board of Medical Ethics Advisor. She teaches health care ethics at the Yale School of Nursing, and is a frequent presenter at grand rounds and other ethics education programs for health care professionals. She volunteers on the Chaplaincy Service at Memorial Sloan-Kettering Cancer Center in New York City. She is a graduate of Smith College and holds the Ph.D. in English Literature from the University of Glasgow and the M.Div. in Christian Ethics from Union Theological Seminary.*

Rev. Gordon W. Burton

## The Ministry of the Yellow Phone

When the *Heart Attack One* program was started at Methodist Hospital, it was seen as a way to more quickly get patients into the life-saving procedures of the Cardiac Catherization (Cath) Lab. When it comes to the heart, time is muscle; the sooner treatment is started to open blocked blood vessels, the less likely valuable heart muscle will be lost. The goal for the program was for there to be ninety minutes from presentation in an Emergency Room in one of our smaller facilities to the first balloon inflation or open artery in the Cath Lab at Methodist.

But time and muscle are not the only factors in a positive outcome for the STEMI [1] patient. Their emotional and spiritual well-being play a role as well. Having a patient calm and relaxed is important. However, it soon became apparent to the planning team that a side-effect of a speedy trip to the Cath Lab for the patient was increased anxiety. First, the patients were worried about their families finding them, and, second, about their family getting the medical information.

Enter the yellow phone, or rather the innovation that the chaplain would carry a yellow phone.

When the patient is whisked away from their admitting ER and taken to Methodist Hospital, their families are often far behind. So, the families are given a folder of information at the initiating hospital, which includes a phone number. Upon arrival at Methodist Hospital, families are instructed to go to the main lobby and ask the receptionist to call this phone number. At the other end is a chaplain, who then comes and escorts the family to the Cath Lab waiting area. It matters not the time of day or night, the chaplain is available, and helps the family get settled and comfortable, even providing blankets and refreshments from the kitchen, if needed.

The care does not stop there. After getting the family settled, the chaplain goes back into the Cath Lab and informs the physician of the arrival of the family. At that point the physician either comes and gives them an update, or gives the chaplain an update for them, with an approximate time when the procedure will be finished and when the physician will come speak with the family.

By use of a yellow phone, ministry has been made possible. Anxious patients are reassured that family are met and cared for. The family, having been met and given information, have their own anxiety calmed.

The love of God through the care for others is made possible by the exemplary interdisciplinary teamwork of the *Heart Attack One* team, and by a simple yellow phone.

**Footnote:**

[1] STEMI stands for S-T Elevated Myocardial Infarction. S and T stand for types of electrocardiogram waves that indicate blockages in blood vessels going to the heart.

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*Rev. Gordon W. Burton, M. Div, BCC, LCSW, CMP, is the staff chaplain at Methodist Hospital of Indiana, Clarian Health Partners. He is ordained in the United Methodist Church. His colleagues, Michelle Hare, RN, BSN and Holly Cook, RN, BSN, contributed to this article.*

## Review

Sarah Masters reviews

### *The Dhamma Brothers*

*The Dhamma Brothers* is a moving story of transformation. Men held in an overcrowded maximum security prison in Bessemer, Alabama, are forever changed by a meditation program. The *Dhamma Brothers* has been described as a film where “East meets West in the Deep South,” an apt portrait of what happens to a number of hardened criminals who volunteer for a ten-day Vipassana retreat.

The film’s directors are a cultural anthropologist and psychotherapist, a documentary filmmaker, and a film-school administrator. They focus their narrative on four inmates, all convicted murderers, who volunteer for and participate in the program of silent meditation with 32 other inmates.

Donaldson Correctional Facility, southwest of Birmingham in Bessemer, seems an unlikely place for such a prison program. The facility holds 1,500 of Alabama’s hardened criminals. The retreats were actually suspended at Donaldson for a period of time when the prison chaplain complained that he was losing inmates to the Buddhist program.

The prisoners who participate in the retreat speak of having to face at a very deep level during prolonged silent meditation the evil of the crimes that they committed and the suffering that they themselves are experiencing as inmates. Some also talk about self-improvement while acknowledging that they face lifelong incarceration.

Prison officials speak of the profound changes in some prisoners’ behaviors. Many inmates, according to prison administrators, became less aggressive after participating in the retreat, and some even disassociated from their gangs after an introduction to Vipassana.

In addition to interviews with guards and prison officials, the directors interview local residents of Bessemer, which is near Birmingham. The local residents are very vocal about the Vipassana retreat, some viewing it as anti-Christian.

The Vipassana retreat is both psychologically and physically taxing, and the directors indirectly target through the long and arduous days of silent meditation the issue of prison rehabilitation versus punishment.

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Completed: 2008

Running Time: 77 Minutes

Directors: Jenny Phillips, Anne Marie Stein, Andrew Kukura

If you are interested in purchasing *The Dhamma Brothers*, you can do so at.

<http://www.neoflix.com/store/fre86>. Click on “Home Use.” The cost is \$19.99 for a DVD.

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*Sarah Masters is the Managing Director of the Hartley Film Foundation, a non-profit organization dedicated to production, cultivation, support and distribution of the best documentaries on world religions and spirituality.*

Do you have thoughts about this issue you'd like to share with your colleagues? Send an e-mail to [info@PlainViews.org](mailto:info@PlainViews.org).