

# ROLE OF CHAPLAINS

## IN HEALTHCARE ETHICS

Discussion Framework: Core Ethical Principals

Ethics Consultation in the US: A National Survey

Ethics Committees & Healthcare Chaplains

Advantages & Disadvantages of Chaplain Chairing



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# CLINICAL ETHICS

Approach to Medical Ethics consultation, that emphasizes the relevant clinical facts of the patient, while incorporating other factors, including, but not limited to prima facie principles, social, cultural, religious/spiritual, and legal. Purpose is to provide clinically relevant guidance, to a case of ethical uncertainty or moral distress.

ROLE OF CHAPLAINS

in healthcare ethics

# WHAT GUIDES HEALERS

The classic goals of medicine are: “The complete removal of the distress of the sick, the alleviation of the more violent diseases, and the refusal to undertake to cure cases in which disease has already won mastery, **knowing that everything is not possible to medicine.**” —Hippocrates, *The Science of Medicine*

# PRINCIPLES OF MEDICINE

## 1. AUTONOMY

Secular and predominately western value, placing the emphasis on the individual and their self-governance.

## 2. BENEFICENCE

To do good, to, for, or by another individual.

## 3. NON-MALEFICENCE

To avoid harm, to, for, or by another individual.

## 4. SOCIAL JUSTICE

Emphasizes the needs and health of the community, at large, over that of the individual.

## 5. FIDELITY

Covenant of trust between patient and physician, with the emphasis on placing the needs and interest of the patient, above all others, including family.





# THE SURVEY

In 2007, The American Journal of Bioethics published an article that shared light about ethics consultation in United States. The study was done on 600 hospitals randomly of all sizes nationwide and highlighted some of the ethical practices in these facilitates in efforts to facilitate a baseline data for future development.

Most “best informants” about ethics consultation (56%) were chairs of the ethics committee or Ethics Consultation Services (ECS). Their official titles most often related to medical staff (23%), hospital administration (16%), nursing (9%), quality improvement/utilization review (10%) **or chaplaincy (13%)**.

*The American Journal of Bioethics*

**Table 3. Reported Goals of Ethics Consultation**

<i>Explicit Goal</i>	<i>Primary Goal (%)</i>	<i>Secondary Goal (%)</i>	<i>Not an Explicit Goal (%)</i>
Intervening to protect patient rights	94	5	1
Resolving real or imagined conflicts	77	22	1
Changing patient care to improve quality	75	19	6
Increasing patient/family satisfaction	68	26	6
Educating staff about ethical issues	59	37	4
Preventing ethical problems in the future	59	36	5
Meeting a perceived need of staff	50	35	14
Providing moral support to staff	47	47	6
Suspending unwanted or wasteful treatments	41	40	19
Reducing the risk of legal liability	40	49	11

# INDIVIDUALS PERFORMING ETHICS CONSULTATION

Averaged across ECSs, the individuals who performed ethics consultation during the year prior to the survey were described as follows: **54% were female, 90% were white non-Hispanic**, 4% were black non-Hispanic, 3% were Hispanic, and the rest were from other ethnic backgrounds. Individuals performing ethics consultation were almost all physicians (34%), nurses (31%), social workers (11%), **chaplains (10%)**, or administrators (9%). Fewer than 4% were attorneys, other healthcare providers, laypersons, or “other” (e.g., philosophers, theologians).

Another way of characterizing the individuals who perform ethics consultation is by the percentage of hospitals whose ECSs included individuals from various backgrounds. In this regard, in 94% of hospitals, one or more physicians perform ethics consultation, 91% use nurses, 71% use social workers, **70% use chaplains**, 61% use administrators, 32% use attorneys, 25% use other healthcare providers, and 23% use lay people.

# CHAPLAINS & CLINICAL ETHICS

A core question for everyone working in a clinical setting is this: **How can the delivery and service systems I participate in be improved to enhance and improve quality of care for patients and families?** Chaplains, chaplaincy programs, clinical ethics consultants, and ethics committees all share this commitment.

A challenge for both chaplains and ethics consultants is to articulate their unique roles, purposes, goals, and objectives so that they can establish adequate educational and training standards and programs, measure what they are doing against what they should be doing, and initiate, participate in, and maintain initiatives.



# CHAPLAINS & ETHICS CONSULTANTS

## ARE THESE ROLES DIFFERENT?

- Both meet with patients and their families one-on-one and during patient care conferences.
- Both serve on interdisciplinary teams and participate in multidisciplinary clinical rounds.
- Both document their interventions in patients' medical records.
- Both provide services to and routinely interact with clinical staff and other employees.
- Both participate as members of ethics committees and may lead ethics committees.
- Both participate as members of other organizational groups, such as institutional review boards and conflict of interest committees.
- Both can serve as patient advocates, assist with advance care planning, facilitate communication and reduce conflicts among various stakeholders.
- Both can refer patients, families and staff to other organizational resources after identifying their needs.
- As a result, both need similar skill sets, knowledge areas and character traits as well as excellent listeners, respectful, supportive and show empathy.
- Neither can claim a monopoly on expertise in their principle areas of services and focus—spirituality and ethical decision-making, respectively.

# CHAPLAINS ROLE ON ETHICS COMMITTEES

## AN AUSTRALIA STUDY

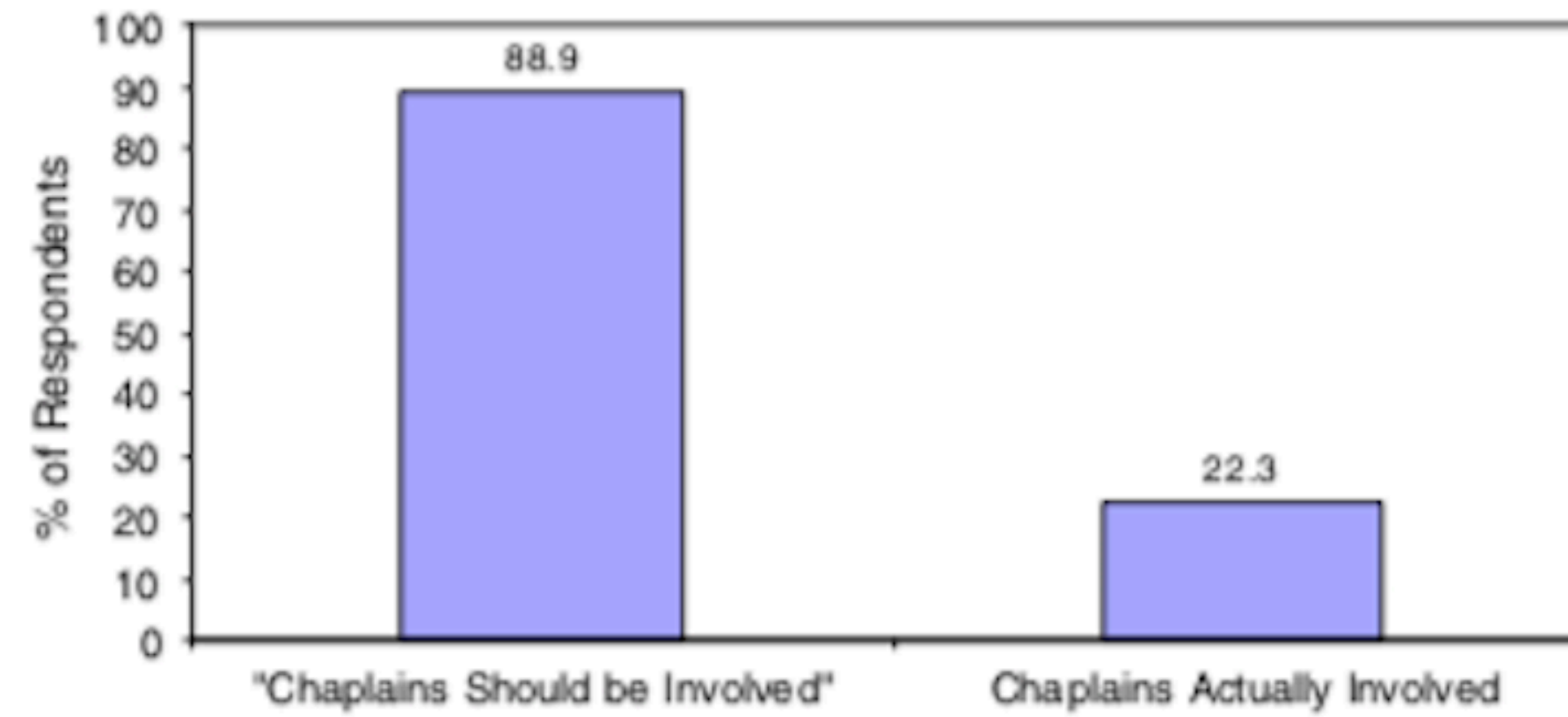
Survey results from over 300 Australian health care chaplains indicated that nearly 90% of chaplains believed there was merit in chaplains serving on hospital research ethics committees, yet only a minority (22.7%) had ever participated on such committees.

Part of the reason was because of serious opposition by academia claiming that ministers of religion had no special training in philosophy or ethics.

## AN AUSTRALIAN STUDY: CLERGY QUALITIES

Research by Carey et al. (1997) identified a variety of reasons why some clinical staff (i.e., physicians, nurses, and allied health clinicians) affirmed the involvement of ministers of religion being employed as chaplains within the hospital context. These reasons included, that the chaplains”:

- (i) ethics role is important (e.g., “because the medical profession often ‘fails to initiate’ ethical discussion”);
- (ii) religious teaching is important (e.g., “because chaplains are a useful source of information” and that “staff should be taught about what different religions expect”);
- (iii) assistance to patients is valued (e.g., “people call upon religion to see if its the right thing to do”, that “...religion can change the way families react”);
- (iv) that assistance to staff is valued (e.g., “could have hospital program or ward based program to help staff”, could learn about “spiritual issues” and “staff can be advised about families’ religious beliefs and values”);
- (v) ethics role tempers science (e.g., “scientific process needs to be tempered by informed ethical discussion helped by chaplains”);
- (vi) role provides information/advises the hospital ethics committee (Carey et al. 1997).



**Fig. 1** Percentage of all chaplaincy respondents ( $n = 327$ ) who believe chaplains should be involved in the decision-making processes of hospital ethics committees (HEC) compared with the percentage of chaplains actually involved



**Table 2** Comparison between male/female, catholic/protestant, staff and volunteer respondents who believed chaplains “Should be involved on Hospital Ethics Committees” (HECS) and “Chaplains Actually Involved in HECS” (*n* = 327)

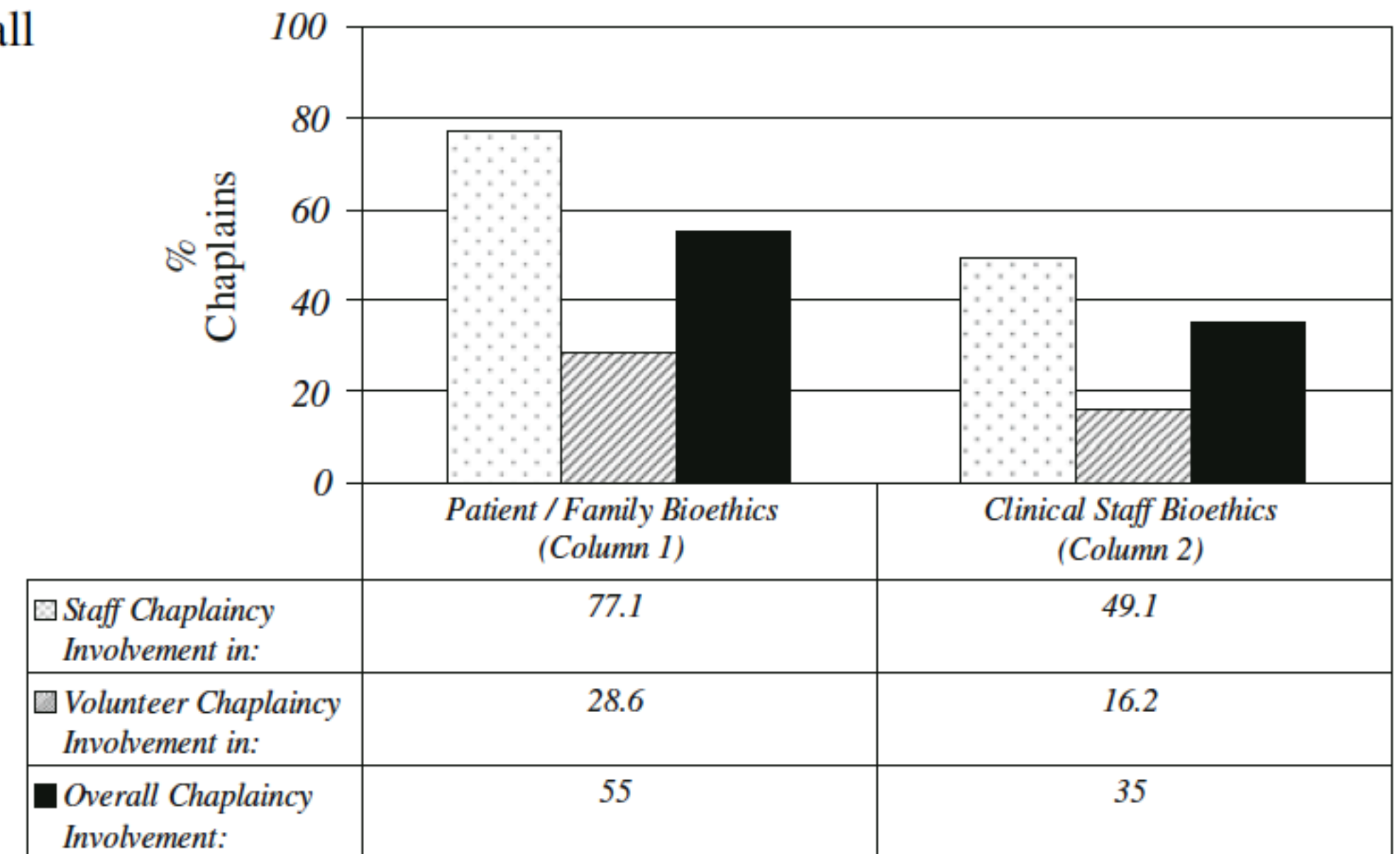
	Column 1 Chaplains should be involved in HECS	Column 2 Chaplains actually involved in HECS
Male	128 (88.9%)	48 (33.3%)
Female	163 (89.0%)	25 (13.6%)
Catholic	110 (85.9%)	28 (21.8%)
Protestant	178 (90.8%)	45 (22.9%)
Staff chaplain	199 (91.2%)	63 (28.9%)
Volunteer chaplain	92 (84.4%)	10 (9.1%)

### Overall Chaplaincy involvement in Patient/Family and Staff bioethical issues

In response to the first research question, regarding whether chaplains in New Zealand were involved in bioethical issues within their health care context, the answer is—‘Yes’ and ‘No’. That is to say, in overall terms, just over half of the respondents (55%) indicated that they had, in one way or another, been involved in one or more *patient/family* bioethical issues, while approximately 45% gave no indication of being involved in any of the ten bioethical issues explored (Fig. 1, Col. 1). Concerning *clinical staff*, and again in overall

### A NEW ZEALAND STUDY

**Fig. 1** Combined results showing percentage (%) of New Zealand ‘Overall Chaplaincy Involvement’ (N = 100), ‘Hospital/Staff Chaplaincy Involvement’ (n = 57) and ‘Chaplaincy Assistant’ Involvement’ (n = 43) in: ‘Patient/Family Bioethical Issues’ (Col. 1) and ‘Staff Bioethical Issues’ (Col. 2)





## A NEW ZEALAND STUDY

### Chaplaincy Involvement in Specific Bioethical Issues

A systematic breakdown by rank order of all the investigated bioethical issues (Table 2, Col. 4) indicated that the majority of chaplaincy personnel surveyed (HCs and CAs) had been involved in ‘pain control’ issues with *patients/families* (P/F: 39%) and with *clinical staff* (CS 28%) (Table 2, Col. 4), and that HCs were more actively involved in bioethical issues than their CA colleagues (Table 2, Col. 2 and 3). Likewise, the next largest percentage of chaplaincy involvement (by rank order) concerned ‘withdrawal of life support’ (P/F 38%; CS 24%), organ transplantation (P/F 29%; CS 16%), abortion (P/F 21%; CS 12%), not for resuscitation (P/F 17%; CS 13%) and euthanasia (P/F 15%; CS 10%) (Table 2, Col. 4). All other bioethical issues explored (e.g., IVF, gender reassignment, surrogacy, genetic engineering) gained less than 10% chaplaincy involvement (refer Table 2, Col. 4).

**Table 2** Percentage (%) of New Zealand ‘Hospital Chaplaincy (HC) Involvement’ ( $n = 57$ ) and ‘Chaplaincy Assistant (CA) Involvement’ ( $n = 43$ ) and ‘Overall Chaplaincy Involvement’ ( $N = 100$ ) in assisting Patients/Families (P/F) and Clinical Staff (CS) according to specific bioethical issues

Bioethical issues (Column 1)	HC involvement $n = 57$ (column 2)		CA involvement $n = 43$ (column 3)		Overall involvement $N = 100$ (column 4) [Rank Order]	
	P/F (%)	CS (%)	P/F (%)	CS (%)	P/F (%)	CS (%)
Pain control	52.6	31.8	20.9	11.7	<b>39</b>	<b>28</b>
Withdrawal of life support (WLS)	57.9	31.8	11.6	5.8	<b>38</b>	<b>24</b>
Organ Donation/Transplantation	29.0	22.7	4.6	2.9	<b>29</b>	<b>16</b>
Abortion	29.8	17.6	9.3	2.9	<b>21</b>	<b>12</b>
NFR/DNR orders	26.3	22.7	4.6	2.9	<b>17</b>	<b>13</b>
Euthanasia	19.3	15.1	9.3	0	<b>15</b>	<b>10</b>
In-vitro fertilization (IVF)	8.7	3.0	4.6	0	<b>7</b>	<b>2</b>
Gender reassignment	5.2	1.5	4.6	0	<b>5</b>	<b>0</b>
Surrogacy	7.0	1.5	2.3	0	<b>5</b>	<b>1</b>
Genetics	1.7	0	2.3	0	<b>2</b>	<b>0</b>

HC Hospital Chaplain, CA Chaplaincy Assistant, P/F, Patient/Family, CS Clinical Staff

NFR/DNR Orders Not For Resuscitation/Do Not Resuscitate

# CHAPLAINS AS CHAIRS: MY EXPERIENCE

## ADVANTAGES

- Be able to run a meeting and promote a neutral setting for all disciplines to come together.
- Mature relationships among the committee can promote trust and therefore more sincere feedback when discussing a case as members will feel safe in sharing their expertise.
- Able to have a 360 degree spiritual view when discussing each case and consider culture, faith systems and traditions (i.e. coining).
- Can add a spiritual dimension to the ongoing conversations, education, case reviews and deliberation.

## DISADVANTAGES

- Deliberation can be challenging as chaplain may have already established a relationship with patient, family or staff.
- High level of dependency on others for the writing of the recommendation as medical terminology may be limited to the chaplain.
- Cases may take you away from chaplaincy duties and put you behind on patient visitation.
- If recommendation is not favorable, patient, families, staff can look down on chaplain and rapport may be lost.



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