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Ethics and the Care of the Sick

An Overview for Professional Chaplains and Other Spiritual / Pastoral Care Providers

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Why Chaplains Must Be Present to Ethical Dilemmas

What is the difference between a dilemma and a problem? The short answer: problems can be solved, dilemmas cannot. What is an ethical dilemma, then? Another short answer: an ethical dilemma involves a set of moral choices in which no option is clearly right or clearly wrong. So, if ethical dilemmas arising in the care of the sick cannot be solved, and if they present themselves in such murky (and time-consuming) ways, can professional chaplains and other spiritual care providers just leave these dilemmas where they find them and go about doing whatever good they can?

No, they cannot. Complacency about ethical dilemmas in health care is hazardous to professionals and patients alike. Ethical dilemmas present choices about ways to respond to suffering. They may present themselves with urgency: something must be done, *now*, to prevent greater suffering or other avoidable burdens. For chaplains, complacency with respect to ethical dilemmas undermines their professional ethos of striving to be "present" in the face of suffering and with those who suffer. Being present to suffering involves being alive to moral complexity in health care and being prepared to address ethical dilemmas as they arise, whether at the bedside or as organizational challenges.

This chapter offers an overview of ethical issues arising in the care of the sick, with particular attention to the hospital setting and with some attention to other health care settings. It is written for professional chaplains, mindful of the special ethical responsibilities that chaplains bear as members of patient care teams and, often, as members of clinical ethics consultation teams, ethics committees, or institutional review boards (IRBs). It should also be helpful to other spiritual care providers and to local clergy who are involved in the care of the sick and need to be aware of the ethical dimensions of this work.

Cases can be useful ways to explore ethical dilemmas. At the outset of this discussion, it can be helpful to bring an ethical dilemma to mind by reflecting on one's own professional experience and recalling a situation marked by uncertainty and distress: someone was suffering, and someone else did not know what to do in response to suffering. Uncertainty and distress are characteristic of ethical dilemmas in the care of the sick. Any chaplain can recall situations like these, which can be haunting experiences for health care professionals and for other caregivers.

Three Ways of Thinking about Ethics

The word "ethics" can be used in various ways, whether in everyday speech or in different specialized contexts. Three ways (among others) in which "ethics" can be invoked in the health care setting are as the search for the good, as rules to live by, and as the critical analysis of morality.

Ethics as the Search for the Good

The questions of the ancient Greek philosophers—How ought we to live? What way of life best supports human flourishing? How can we avoid harm in the pursuit of the good? What are our reasons for pursuing one way of life over another?—are questions that are still alive today. They can assist our efforts to resolve ethical dilemmas, to teach and model ethical behavior, and to craft ethically sound policy that can support good practice. Being alive to these living questions keeps our thinking fresh and reminds us that these questions are likely to matter to patients, too. Taking patients seriously as persons means being attentive to the values that have shaped their lives and aiming to support their values and preferences concerning medical treatment, while recognizing

that wishes are not the same as choices. What a patient wants—or what a patient's surrogate thinks a patient would have wanted—may not be attainable through the actual choices available to this patient. However, sometimes an opportunity to support the patient's values and preferences has been overlooked. A chaplain who is skilled at listening is not an empty vessel or solely a witness to suffering. Rather, a chaplain should recognize that he or she has the potential to be a channel between a person's vision of the good, as expressed, in part, through values and preferences relevant to what is going on in this person's life right now, and the health care professionals and systems that can help support this vision under present circumstances. Human flourishing can continue even amid suffering, even when a person is near death.

Ethics as Rules to Live By

Being alive to ethics as the continuing search for the good also helps avoid reducing ethics to the application of rules and to rules compliance. However, various types of "rules"—including policies, processes, laws, regulations, forms, and so on—are important in ethics. When they represent consensus, rules can guide good practice and avoid hasty, ad hoc measures. Thus, ethics in health care settings typically includes various forms of consensus guidance concerning issues such as patients' rights and how to honor them; the protection of patients enrolled in research trials; how to discuss and document patients' wishes and preferences concerning medical treatment; or how to conduct a clinical ethics consultation or resolve a conflict. When such rules are (or seem) arbitrary, unfair, or unduly burdensome to one group, they are unlikely to be viewed as trustworthy guides to good practice; while the reason for a rule may have been a good one, that reason is no longer apparent.

Health care systems are complex systems in that they are always changing. The doing of ethics in a complex system requires ongoing attention to the usefulness of guidance intended to support ethical practice: Is this policy outdated, or does it still do its job of helping clinicians honor patients' rights and understand ethically challenging situations? How will clinical practice change in response to a new law or public policy development? Do we need to develop a new policy to respond to a frequently occurring dilemma, or would better clinician education be a more effective response?

Making it a rule to maintain a vibrant forum to address ethics issues in an institution is its own challenge. In 1992, the Joint Commission mandated that hospitals have some means of addressing ethical issues in patient care. (The federally regulated IRB system for institutions that conduct research involving human subjects dates from the early 1980s.)

Nearly all American hospitals satisfy this accreditation requirement through an ethics committee that includes a consultation service. However, in too many institutions, the ethics committee lacks training and clear authority, consults on or reviews only a handful of cases each year, and meets too infrequently to sustain a practice of substantive and productive discussion. Chaplains, who frequently serve on ethics committees and may be assigned the difficult task of chairing an unproductive committee, should seek to contribute to this aspect of ethics by improving their own knowledge of the good-seeking goals of ethics as a clinical service, finding opportunities to participate in peer education networks of clinicians involved in ethics consultation, and sharing research and consensus concerning good practice with colleagues in their own institutions. These tasks should not be left to chaplains alone, but on occasion it will be up to the chaplain to promote change.

As a health care profession, chaplaincy has produced its own set of ethics rules. *The Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators and Students* was adopted in 2004 by the six organizations in the United States and Canada with authority to certify professionals and training programs. This code of ethics sets out principles that should inform relationships in professional practice, including relationships with clients, between supervisors and students, with faith communities, with other professionals and in the community, with colleagues in providing spiritual care, in advertising, and in research.

Members of any profession should be familiar with their profession's standards of conduct as articulated in a code of ethics, with the understanding that mere compliance with standards is insufficient as a guide to ethical practice. For supervisors and other mentors responsible for guiding the professional development of chaplains, the *Common Code* offers one way to encourage the practice of ethical reflection, including critical reflection on this code itself. For example, the *Common Code*'s reliance on the word "client" seems problematic. Clinicians in acute care settings usually do not view patients as "clients." Nor do clinicians who work in nursing homes, home care, or hospice. If this standard is

intended to suggest a chaplain and a client in a one-to-one therapeutic relationship, it may be useful with respect to professional conduct but inadequate with respect to situations in which a chaplain in an institution is simultaneously providing care to a patient, to members of that patient's family, and to colleagues on a team and is also functioning and being supervised as a member of that team.

As this example demonstrates, the limited scope of a professional code means that citing a code is not sufficient as ethics guidance. Because codes of conduct for community clergy may not address the health care context and the special duties of health care professionals and organizations to patients, chaplaincy organizations and health care institutions that involve community clergy should aim to offer some ethics education for community clergy involved in patient care.

Dilemmas can arise in ways not anticipated by a code of ethics. Some indispensable features of ethically sound practice are difficult to codify or do not apply to one profession in isolation. In health care, clarifying the medical facts relevant to a situation at hand is an example of indispensable information for any participant in a clinical ethics consultation, case discussion, or policy review. Dilemmas involve competing interests, and in health care, the best interests of patients often compete with powerful organizational and professional interests. Interpersonal conflict and the distress arising from experiencing or witnessing suffering can complicate efforts to resolve ethical dilemmas in health care. For these reasons, ethics education for chaplains cannot be limited to the context of chaplaincy. Indeed, it is possible that there is no such thing as "chaplaincy ethics," or "nursing ethics," or other professional ethics in isolation from other professions and disciplines and from the particular context of a unit, an institution, or a patient population. Chaplains must know their own rules, and they must also have some idea of the rules that others live by and what their colleagues may think of those rules.

Ethics as the Critical Analysis of Morality

Looking critically at rules brings us to another way of looking at ethics, as the difference between "is" and "ought." Looking uncritically at morality—for example, the moral norms of a department, a hospital, or a nation—means settling for "That's the way things are around here, they'll never change," and abandoning all hope (and all responsibility)

for social change. Looking critically at morality means asking, "Why are things like this, and what would need to change to make things better?" A philosophical commitment to social justice means looking critically at different levels of society, including systems of care for the sick, and asking whether these social systems are placing the best interests of the sick first. Those who benefit from these systems as employees or consultants have a special responsibility to think critically about them; health care is never just a business, a means to a paycheck, or a way to live out one's own vocation or values. It is difficult, even impossible, for patients to improve health care while they are seriously ill. They may see the flaws in the system, they may suffer as the result of these flaws, but they usually cannot correct these flaws on the spot and they lack the authority to repair broken systems even if they wish they could do so.

Chaplains who view themselves as having a moral obligation to be truth tellers or justice seekers should ask, as part of their own critical reflection, *how* they are challenging systems that they observe to be harmful or unfair. For example, chaplains who work in nursing homes or in intensive care units are likely to observe long-standing practices of transferring frail elderly nursing home residents to the hospital when they are near the end of life. They may wonder why this practice exists and whose interests it serves. Is this really what this debilitated patient wants? Has anyone tried to find out what this patient wants or what the patient's surrogate thinks an incapacitated patient would have wanted? What are the economic factors that may drive "revolving-door" practices? Is there a different way to care for these patients? Would some of these patients prefer to be cared for in a different way? And what can the chaplain, in the nursing home or the intensive care unit (ICU), do from his or her position in a health care system to encourage colleagues, including leadership, to look critically at this situation and the ethical questions it raises?

This is not easy to do—the chaplain may not have much authority within the system. However, the chaplain has more power than the patient he or she is observing, and the chaplain has an obligation not only to be present to suffering but also to question conditions that appear to promote or add to suffering.

Doing ethics in complex and inherently imperfect health care systems usually requires working at all three of these levels: searching for the good, making good rules and questioning problematic ones, and thinking

critically about the morality of health care systems and acting to improve them. Time is a limited resource in health care. The opportunity to act to prevent or relieve a patient's suffering may not permit professionals to ascertain, definitively, what a good life consists of. The resolution of an ethical dilemma usually cannot wait for the drafting of policies and processes or for optimal social conditions. The resolution of an ethical dilemma in real time often involves the identification of the "least worst" option among available options, the one that does the least harm. Chaplains and their colleagues should not lose sight of opportunities to do better than the least worst, even if this cannot be done at the bedside but must be accomplished through consistent attention to education, to policy development—and even to the art of conducting a productive ethics consultation or ethics committee meeting—so as to spend available time well.

Doing Ethics in the Context of Science and Contemporary Society

Over the past fifty years, the consideration of ethical dilemmas raised by new and emerging medical treatments and technologies and by research into how health-related benefits and burdens are allocated within and across societies has become known as bioethics or biomedical ethics. While bioethics centers are often located in medical schools or academic medical centers, bioethics was initially conceived of neither as its own academic discipline nor as a profession, but as a mode of interdisciplinary inquiry. Questions that did not belong solely to the practice of medicine, to the sciences, to law, to philosophy, or to theology became the subject of deliberation and debate: What is the nature of suffering? What are the goals of medicine? What values and policy should guide the fair allocation of tragically scarce resources such as transplantable organs? How can death be determined if technology can sustain a body's vital functions? What does it mean to be a person? Is there a right to health care? Is there a right to health? What does it mean to make an informed choice about medical treatment or participation in research? Are we our genes? Are we our brains? The list of questions at the intersection of ethics, science, and society is endless. Some of these questions reflect ancient concerns—questions of medical ethics arose well before the advent of contemporary technological medicine—

while others take shape as a technology is introduced or is used in more than one way.

The working vocabulary of bioethics has long been informed by Western philosophy. Ethics education for chaplains and other clinicians should include some basic definitions of influential moral theories, with the reminder that bioethics, as a form of applied ethics, rarely functions along hard philosophical lines. It is useful to know what a "utilitarian" argument is and how it differs from a "deontological" argument. (Respectively, these refer to an argument in favor of an option whose consequences include the most good for the greatest number, and an argument that gives priority to moral obligations, such as truth telling.) It is usually less useful to try to make an ethical dilemma fit the requirements of a particular theory. Resolving the case at hand tends to involve looking at it from different perspectives, including different moral theories and the interests of different actual and imagined stakeholders.

Another important reminder concerning the doing of ethics in health care concerns the limits of what is sometimes termed the "principlist" approach. This term refers to the work of Thomas Beauchamp and James Childress, whose *Principles of Biomedical Ethics*, first published in 1971, has become immensely influential in the teaching of bioethics. Beauchamp and Childress proposed and have continued to refine an approach to bioethics that is grounded in four ethical principles. The principle of autonomy or self-determination refers to respect for patients as persons capable of "self-rule" and to practices that support the ability of patients to make informed choices. The principle of nonmaleficence refers to the duty to avoid harm to patients, while the principle of beneficence refers to the duty to do good and to act in patients' best interests. The principle of justice refers to considerations ranging from nondiscrimination in the treatment of patients, to the equitable allocation of resources and the use of fair processes, to respect for law.

Principles are tools. We do not simply "have" principles; we use them to help us sort out what to value and how to act. Using them to help us think through the ethics of a situation requires us also to think about how this approach shapes our perspective. In clinical settings, Beauchamp and Childress's principle-based approach can be a starting place for discussion, with the understanding that there can be more than one reasonable way to look at an ethical dilemma and that reducing this approach to a formula (or to four bullet points on a slide) is unlikely to

be sufficient as a guide to using these tools or to being alive to moral complexity in the care of the sick.

Even when only one patient is involved, getting a grasp on the ethical issues at stake in a particular case can be difficult. A patient with a psychiatric condition affecting thought may have the capacity to make some decisions under some conditions. Can this patient make an informed choice concerning medical treatment for a life-threatening condition if this patient is incapable of making an informed choice concerning psychiatric treatment? Or is this patient's underlying psychiatric diagnosis impairing the patient's capacity to make the medical decision? If so, is it in the patient's best interests to receive medical treatment over objection? And how would this work, as a practical matter? Or, consider a case in which a patient wishes to receive a medical treatment that is likely to create economic or other burdens for family caregivers: to what extent do their interests matter? Certain dilemmas, such as how to care for patients under conditions of extreme resource scarcity and rapidly changing conditions, as would occur during a public health emergency, are likely to require special tools for ethical deliberation under abnormal rather than normal clinical conditions.

Chaplains should also keep in mind that there are dimensions of their own practice that can aid in interdisciplinary moral reasoning concerning the ethics of a clinical or an organizational situation. For example, chaplains and other clergy tend to value hospitality—the reception of guests and of strangers—as part of good spiritual care and a practice that is historically associated with the care of the sick: "hospitality," "hospital," and "hospice" share Latin roots. Hospitality can be expressed in ways that are not ethically problematic, such as by offering family caregivers a place to rest or to have private discussions. It can also be a useful way of looking at an ethical challenge within an organization. What does a hospital owe the "stranger" at its gate, whether this stranger is a person who lacks health insurance, an undocumented community resident, a newly arrived group whose interests are competing with those of a long-established group, or a previously uninvolved family member who is now seeking to become involved in a patient's care? And how can a chaplain, as a participant in clinical ethics consultation or in organizational policy development, work from hospitality as moral practice to develop a reasonable argument for a moral theory of hospitality that acknowledges the gray areas of dilemmas and constraints?

Toward Ethically Competent Spiritual Care: Integrating Ethics into Chaplaincy Education and Practice

Ethics education should be part of professional formation and clinician education. Professionals responsible for the care of the sick should be prepared for the moral, psychological, and social issues they will encounter in this work and should be equipped to address ethical dilemmas and interpersonal conflicts as they arise amid the organizational complexity of a particular health care setting: the emergency department, the ICU, the neonatal ICU, the psychiatric unit, the room on the medical floor where a "difficult conversation" is about to take place.

Clinical pastoral education (CPE) supervisors, in their capacity as clinician educators, should take responsibility for integrating bioethics into the CPE curriculum, as the ethical dilemmas chaplains will confront will rarely be limited to the practice of chaplaincy in isolation from other professions. To this end, CPE supervisors should have a vision for bioethics education in the context of CPE residency programs and the needs of residents. What are the fundamentals that any CPE resident should learn and incorporate into practice, even if this resident does not plan to become a professional chaplain? What skills and areas of knowledge must a resident master in preparation for a career in chaplaincy? What opportunities for cross-training in ethics exist or can be created within an institution, at the residency level and also for staff chaplains? (For example, are residents and staff encouraged to attend ethics grand rounds offered by medical departments and by interdisciplinary services?) How valued is bioethics education at an institution, and how can CPE supervisors participate in strengthening this area of the institution? How are CPE supervisors improving their own knowledge and skills concerning bioethics education for clinicians and concerning bioethics as a clinical service in which they and their residents are likely to participate?

Chaplaincy directors—and, indeed, all professional chaplains and other spiritual care providers—should recognize continuing education in bioethics as integral to clinical excellence. Whether or not they also function as CPE supervisors, chaplaincy directors should seek out opportunities to learn from other professions and to share knowledge and skills with other professions, with the common goal of supporting ethically sound practice.

Getting Better at Doing Good: What Chaplains Should Master

Chaplains, other spiritual care providers, and those responsible for their education have a special obligation to master the areas of clinical and organizational ethics in which the involvement of a chaplain is foreseeable or desired by patients and loved ones or in which a chaplain's skills may be helpful in promoting a patient's best interests. With respect to the care of seriously ill patients, and often chronically ill patients, these areas include the following:

Palliative Care

Palliative care is part of good care. It is ethically mandatory with all treatment plans for seriously ill patients, including but not limited to plans to forgo medical treatment.

Palliative care includes continuous pain and symptom management and continuous access to other palliative care services, including mental health services, social services, and chaplaincy services.

Collaborative Decision Making

The involvement of professionals with expertise in communications can support the practice of collaborative decision making involving parents, physicians, and pediatric patients, aimed at identifying a child's best interests. Collaborative decision making may also be appropriate for some adult patients who lack decision making capacity but are capable of expressing preferences and who wish to participate in decision making with physicians and surrogates. Social workers, chaplains, mental health specialists, and nurses can assist the collaborative process as discussion facilitators, as continuity between discussions, and by offering support to participants.

Advance Care Planning

Asking patients about their values and preferences and documenting and using patient preferences are integral to good care. A professional responsible for the care of a seriously ill patient should know how to initiate advance care planning and to use documents resulting from this process. Nurses, chaplains, and social workers may share responsibility with physicians for advance care planning.

Decisions about Food and Feeding When a Patient Is Near the End of Life

Including a chaplain or another member of the health care team with strong communications skills may be helpful in clarifying the nutritional needs of the dying person in the context of good end-of-life care, with appropriate reference to social values concerning food, feeding, and caregiving. The chaplain, in particular, should be well informed about religious teachings concerning feeding near the end of life, as these teachings may be unfamiliar to or misunderstood by other participants in the discussion.

Discussing "Hope" in the Context of Treatment Decision Making

The language of hope can be prominent (and confusing) in decision making near the end of life. Because this language may be associated with religious beliefs and practices, the involvement of a chaplain may be helpful in facilitating communication during treatment decision making.

Objections to a Determination of Death

Acknowledging objections to the declaration of death, including objections to the neurological criteria for making a determination of death, does not alter the physiological state of the deceased patient. However, some religious groups acknowledge only cardiopulmonary death. Sometimes a family will express a nonspecific religious or moral objection to the determination of brain death or will use religious language ("we're praying for a miracle") that may indicate a belief that the patient is still alive or reflect an inability to acknowledge that death has already occurred. The involvement of a chaplain with experience caring for bereaved families and who is familiar with how grief and other emotions may be expressed in religious terms may be helpful in such situations.

Religious Objections to Treatment Decisions

Involving a chaplain as soon as any religious objection to a treatment decision is expressed is more productive than paging the chaplain to intervene in a standoff. If a religious objection is an effort to halt a decision-making process, the chaplain may be able to elicit the underlying source of distress or serve as a nonconfrontational presence.

If the objection reflects a religious struggle or an unmet religious need, the chaplain can collaborate with others to provide appropriate care to loved ones while protecting the patient's best interests and supporting the decision maker. A chaplain may also be able to collaborate with outside clergy trusted by a patient or loved ones but who is unfamiliar with clinical settings.

Policy Supporting Good Practice

Because chaplains are responsible for meeting any specific religious and related cultural needs of a patient or family, including rituals associated with the care of the sick or the dying, institutional policies and processes should ensure that chaplaincy, mental health services, and social services are routinely alerted to cases identified by medical and nursing staff as situations in which end-of-life decisions are being made.

Final Words

Good chaplaincy does not exist in a bubble. It is connected to other professions, to teams, to units, and to organizations, as well as to patients and their loved ones. The maturation of chaplaincy as a health care profession will include the expectation that chaplains are well informed about the ethical dimensions of the care of the sick and are prepared to participate in ethics consultation, ethics education, and the analysis and development of ethically sound policy.

Further Reading

These readings and web-based collections of resources reflect the interdisciplinary nature of bioethics. While professionals in all disciplines, including medicine, should read beyond their own disciplines, much of the professional literature in bioethics is written by physician-ethicists or concerns research conducted by physicians, so chaplains should expect to read medical journal articles. All of the books, articles, and websites listed here include extensive bibliographies for those interested in pursuing specific topics.

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Resources

Center to Advance Palliative Care (research and education in palliative care): www.capc.org

The Hastings Center: www.thehastingscenter.org

Kennedy Institute for Ethics (bioethics library): http://bioethics.georgetown.edu

Public Responsibility in Medicine and Research (research ethics): www.primr.org

PubMed, U.S. National Library of Medicine, National Institutes of Health: www.ncbi.nlm.nih.gov/pubmed

Spiritual Care Collaborative, Council on Collaboration, *Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and Students* (2004), www.spiritualcarecollaborative.org/docs/common-code-ethics.pdf

About the Contributor

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