

BIOETHICAL ISSUES AND HEALTH CARE CHAPLAINCY IN AUSTRALIA

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Abstract: Using personal insight and interpretation the authors summarise the results and discussion of the largest cross sectional empirical study of Australian Health Care Chaplains concerning their involvement in multiple bioethical issues encountered by patients, families and clinical staff within the health care context. The implications of this study concerning, health care chaplaincy, ecclesiastical institutions, health care institutions and government responsibilities are discussed and interpreted.

Key Words: Bioethics, chaplaincy, pastoral care.

Introduction

In Australia, similar to other Western countries, bioethics has become a specialist arena of tremendous personal and social significance. Given the developments in bio and nanotechnologies, it is likely that bioethical issues will be an integral and vital part of medical, social, theological and political discussion throughout the 21st century. Thus far, however, there has been little empirical research or discussion about the involvement of health care chaplains in bioethical issues.

Research focus & method

Given various anecdotal accounts and previous literature (e.g., Carey, Aroni & Edwards, 1997; Carey, et al 1996) that suggests the potential input of chaplains with regard to bioethical issues, it seemed timely to empirically explore several pertinent questions: 'Are Chaplains involved in bioethical issues?' and, 'If chaplains do have involvement in bioethical issues, with whom do they engage about such issues?' Finally, 'If chaplains are involved in bioethical issues with patients, their families and staff, what is the nature of that involvement?'

As part of an international comparative research project (Australia *cf* New Zealand: Carey, et al, 1998) chaplains from the Australian Health and Welfare Chaplains Association (AHWCA) over a two year period (1998-2000) were asked to volunteer information about their pastoral care provided to patients, families and clinical staff involved in ten critical bioethical issues: abortion, euthanasia, gender reassignment, genetics, invitro-fertilization, not for resuscitation or do not resuscitate orders, organ harvesting / transplant, pain control, surrogacy and withdrawal of life support,.

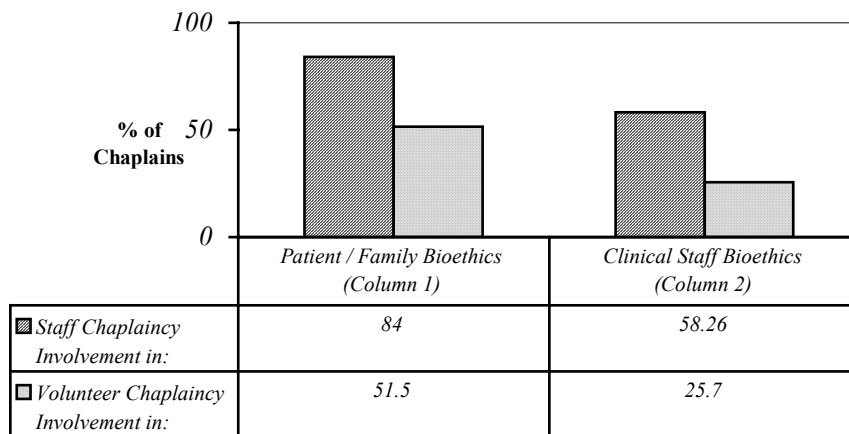
Of the 327 respondents returning a survey 218 indicated being 'staff' employed chaplains and 109 respondents indicated being 'volunteer chaplains' (Fig 1: Col. 1). The qualitative component of the research involved chaplain informants being interviewed using the in-depth semi-structured model of interviewing (Minichiello, et al, 1996). A total of 100 chaplains volunteered as interview informants (Fig 1, Col.2).

Figure 1: Australian Chaplaincy Survey Respondents & Interview Informants

	Column 1 Survey Respondents	Column 2 Interview Informants
Staff Chaplain:	218	79
Volunteer Chaplain:	109	21
Total:	327	100

Figure 2:

Combined results showing percentage of ‘Staff Chaplaincy Involvement’ (n = 218) and ‘Volunteer Chaplaincy Involvement’ (n = 109) in: ‘Patient / Family Bioethical Issues’ (Col. 1) and ‘Staff Bioethical Issues’ (Col. 2) (Total n = 327).



Results

The results presented herein are grouped into three areas:

- Overall chaplaincy involvement in patient / family and staff bioethical issues;
- Chaplaincy involvement in specific bioethical issues;
- Chaplaincy pastoral intervention in bioethical issues.

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

In overall terms perhaps one of the most significant findings of this research was that, the majority of

surveyed chaplains (70.9%) had been involved in one or more of the patient / family bioethical issues explored in this study. As might be expected significantly more staff chaplains (84%) indicated being involved in patient family bioethical issues than volunteer chaplains (51.5%). (Figure 2: Col. 1).

On the other hand, and again in overall terms, less than half of the surveyed chaplains (47.4%) had been involved with clinical staff concerning one or more of the same bioethical issues, but staff chaplains (58.2%) were, again, significantly more in-

volved than volunteer chaplains (25.7%) (Fig 2: Col. 2).

Chaplaincy involvement in individual bioethical issues is identified in Figure 3.

Figure 3:
Percentage of ‘Total Chaplaincy Involvement’, ‘Staff Chaplaincy Involvement’ and ‘Volunteer Chaplaincy Involvement’ in assisting Patients / Families (P/F) and Clinical Staff (CS) according to specific bioethical issues by rank order.

Bioethical Issue (Column 1)	Total Chaplaincy Involvement N = 327 (Column 2)		Staff Chaplaincy Involvement n = 218 (Column 3)		Volunteer Chaplaincy Involvement n = 109 (Column 4)	
	P/F %	CS %	P/F %	CS %	P/F %	CS %
Pain Control	57.2	36.7	66.0	44.0	39.4	22.9
Withdrawal of Life Support	47.0	29.9	56.8	37.1	27.5	15.6
Organ Donation /Transplantation	31.8	18.6	38.0	24.3	19.2	12.8
Euthanasia	26.3	18.3	33.0	22.9	17.4	10.0
NFR / DNR Orders *	24.1	16.8	31.2	18.8	12.8	7.3
Abortion	21.1	9.7	22.9	11.0	10.1	6.4
Invitro Fertilization	12.2	6.1	14.6	7.3	7.3	3.6
Gender Reassignment	2.7	1.5	3.6	2.3	1.8	1.8
Surrogacy	2.7	1.0	3.2	0.9	1.8	0.9
Genetics	2.1	1.0	2.3	0.5	1.0	0.0

* NFR / DNR Orders = Not For Resuscitation / Do Not Resuscitate;

Chaplaincy Pastoral Intervention in Bio-ethical Issues

The substantial interview data was transcribed and compiled thematically according to the World Health Organization’s ‘Pastoral Intervention’ codings (WHO, 2002). The WHO-PI codings have proven useful as a research tool in previous pastoral care research (e.g., Carey, Cobb & Equeall, 2005; Carey & Meece, 2005; Carey, et al, 2004; McFarlin & Carey, 2004) and were instrumental within this project for identifying thematic issues relevant to

particular stake holders – namely, ‘Health Care Chaplains’, ‘Ecclesiastical Institutions’, ‘Health Care Institutions’ and ‘Government Authorities’.

Health Care Chaplaincy

In answer to the initial research questions ‘*Are Chaplains involved in bioethical issues?*’ and ‘*If chaplains do have involvement in bioethical issues, with whom do they engage about such issues?*’, the results clearly indicated that, the majority of chaplaincy respondents were involved in bioethical issues of one kind or another – but predominantly

with patients and / or their families. Secondly, staff chaplains were more involved in both patient / family and clinical staff bioethical issues, than were volunteer chaplains.

In answer to the final question '*...what is the nature of that involvement?*', a thematic analysis of interview data highlighted numerous strategies which chaplains used to help patients, family and staff address and /or cope with bioethical issues. These ranged from the more traditional cleric roles such as providing counselling about religious, theological and moral concerns, conducting prayers, dedications, last rites and funerals, to the more specific and contemporary involvement such as helping patients, families and staff to assess / clarify bioethical issues and treatment options, providing advocacy, facilitating reciprocity between family members and clinical staff concerning professional practice, providing an independent 'non-medical' perspective about bioethical procedures, addressing issues of identity and providing staff debriefing and instruction concerning specific bioethical dilemmas.

Proactive Chaplaincy

Many chaplains had the potential to assess and assist patients and families at a very early stage in their bioethical decision-making. Some chaplains however were reluctant or were unable to be pro-active concerning patient / family bioethical issues. Some chaplains, within this study, also expressed a reluctance to pursue certain clinical staff, particularly medical staff, even though advocacy on behalf of a patient was obviously needed.

While it is not possible for chaplains to be pro-active at all times, or in all circumstances, nevertheless being more willing and readily available (e.g., particularly specialist units - abortion clinics, organ transplant units, etc), so as to assist families and staff with any critical pre-decision dilemmas, may help relieve patients and/or families of significant emotional stress. To be this pro-active however may require chaplains (particularly volunteer chaplains) to undertake specific post-graduate tertiary training to better equip them to be more knowledgeable, skilled and confident in their interaction and expression of bioethical issues with patients, families and clinical staff.

Teamwork and professional development

One option for developing proactive chaplaincy and achieving regular contact with clinical staff is to ensure that, whenever possible, a chaplain is present at clinical staff meetings. This increases the likelihood of the chaplain being viewed as part of the clinical team and optimizes the opportunities of being consulted as to their professional opinion concerning bioethical matters effecting patients, their families and staff. Another possible method is for chaplains to be more pro-active in terms of their input into the educational training of clinical staff. This can be achieved, for example, by chaplains explaining the pastoral intervention function of chaplains during staff induction training days and by discussing the role of chaplains at bioethical forums.

Ritual and Worship

Ritual and worship activities tend to be an intervention predominantly used with regard to the finalization of life. There was no reference by any chaplain concerning the use of ritual or worship activities that celebrated a healing process or a successful 'return to life'. Further, due to the limited involvement of chaplains with regard to some medical procedures, there appeared no evidence concerning the use of ritual or worship activities with regard to some bioethical issues (e.g., 'genetic engineering', 'gender reassignment', 'surrogacy').

Ecclesiastical Institutions

There are several areas of priority raised by this research that can be addressed by sponsoring religious bodies. These include, professional equality, contemporary bioethical theology, chaplaincy resources and chaplaincy research.

Professional Equality

It is arguable that many chaplains, particularly health care chaplains, can be at the forefront of regularly addressing contemporary bioethical issues that only occasionally confront parish ministers, parish priests or academics instructing within ecclesiastical colleges. We would suggest that ecclesiastical institutions, and their respective educational colleges, should recognize the important contribution that chaplains can make to the education of future clergy by employing among their teaching staff, those who can educate future and current chaplains regarding bioethical practice. Ecclesiastical institutions should also consider it mandatory for ordination candidates

to undertake some practical instruction under the supervision of a chaplain within a health care context that will maximize the educational and experiential opportunities to engage in bioethical issues. Such instruction would also benefit pastoral carers with existing skills in pastoral care (Newell, 1999).

Further, in terms of professional equity, it seems timely, given the bioethical complexities of the 21st Century, that ecclesiastical institutions should give greater acknowledgment to the ministry of health care chaplains within institutions at the forefront of technological development.

Contemporary Bioethical Theology

Over the centuries the religious paradigm, particularly within the post-Enlightenment Western world, has increasingly given way to the scientific approach and the rise of bioethics is inherently related to this approach. The largely secular language of bioethics does not provide adequate tools for chaplains and indeed, it could be argued that there needs to be a reclaiming of some of the insights of theology to ensure a holistic approach to patient and staff care. Contemporary bioethical issues however, such as those listed in this paper (e.g., IVF, euthanasia, abortion), have proven to be extremely controversial producing substantial disagreement between Church and society and within the various ecclesiastical denominations.

One could argue that it is ecclesiastical disagreement, combined with ignorance and fear of contemporary bioethical controversy, that has caused uncertainty, reluctance, and even timidity among some Church denominations to provide contemporary, timely and specific guidance and training about various bioethical issues. To put it simply, it would seem that ecclesiastical institutions and their respective theological colleagues, have often failed to provide a connection between the religious and biomedical paradigms. This may explain why some chaplains (particularly volunteer chaplains) are reluctant to be involved in bioethical issues. Some chaplains simply do not have the language or concepts to practice or cope with a paradigm and related discourses associated with bioethics in secular health care. In terms of maintaining relevance, one could argue that, for the benefit of the church, patients, staff and particularly health care chaplains, there is a need for future pastoral theological endeavors to explore and reflect

deavors to explore and reflect greater pragmatic awareness of the contemporary bioethical and theological issues affecting chaplains and the community.

Further, it would seem that in order for pastoral theology to have some effect upon bioethical matters of the future, the theological exploration of, and response to, contemporary clinical and bioethical issues, needs to be continuously undertaken with expediency. Chaplains can be at the forefront of bioethical procedures well before formal bioethical protocols have been established. Yet as formal protocols become determined, the pastoral assessment role of the chaplain alters and the chaplain's potential input and influence upon ethical decision-making can diminish. Consequently, one could argue that, during the period when chaplains are being consulted, prior to bioethical protocols being formalized, pastoral theologians (and their respective religious institutions) have a 'window of opportunity' to maximize their input and response to newly developing bioethical procedures.

Pastoral Resources

Perhaps one of the most obvious findings from the literature search for this study was the inadequate pastoral care literature concerning the practice of chaplains involved in the pragmatic issues of bioethical procedures. An obvious reason for the lack of pastoral resources is the rapid development in biosciences and the clinical applications of these, making it difficult for academics of 'practical theology' to keep pace. This in turn affects the production of resources, literature and the instructional guidance for future clergy and chaplaincy training.

It is important to note however, that the range of issues explored within this research included bioethical procedures that have been ongoing for many years (i.e., organ transplants). The lack of available pastoral care literature, particularly concerning bioethical issues and chaplaincy ministry, cannot solely be explained by the rapid expansion of technology. A more likely explanation for the lack of bioethical material, is that the traditional and primary focus of ecclesiastical institutions (and their associated theological colleges) has not been specifically upon bioethics but predominantly upon other disciplines and paradigms (e.g., 'Biblical Studies', 'Church History', 'Christology').

The combination of the churches traditional primary foci, allocation of resources, and the rapid expansion of biotechnology have caused the church to be in a period of pastoral-technological lag, where Australian pastoral research, publication and training, are significantly behind in terms of the pragmatics of pastoral practice involved with bio-technology. There is clearly a need to develop greater literature and resources for chaplains and for the wider church concerning pastoral care practice and bioethical issues. It could also be argued that the training of clergy in medical and bioethical paradigms needs to be given higher credence within theological institutions as does post-graduate training for chaplains (e.g., clinical pastoral education), ensuring the link between pastoral care paradigms and research (Carey & Newell, 2003).

Pastoral care research

Until the current study there has been no examination within Australia of what has actually been happening at the 'ward level' in terms of pastoral care practice engaging with multiple bioethical issues. Predominantly the focus of ecclesiastical institutions has not been towards funding of pastoral care research to explore pastoral practice concerning life and death issues. Hence this research raises ethical questions about the churches funding allocation. In order to address the current bioethical questions being faced by chaplains and the wider church, there needs to be greater support given to pastoral care research, particularly that within health care institutions.

Health Care Institutions

This research raised several issues that should be addressed by health care institutions. These concern, professional equality, chaplaincy provision, hospital ethics committees, clinical pastoral education and pastoral care research.

This research empirically recorded a contribution that chaplains make to the health care environment which has been given little attention within either the pastoral care or bioethics literature. One potentially important contribution for health care institutions is to give due recognition to the work and role of chaplains. Such recognition can be shown by ensuring that health care chaplains are treated with the same professional status as other clinical staff

working within the clinical context. This is particularly important given contemporary aspirations of 'professionalism' that equates to some professionals professing to be holistic but covertly seeking to maintain their status as "superior" and consequently retaining a concept of teamwork which, in actual fact, does not mean that other contributing team members (e.g. clergy / chaplains) are fully or equally valued. It is also important to note that, in an age of rapidly progressing science and technology, it is easy to discriminate on the grounds of religious belief (Carey, et al, 1997). Thus it can be argued that it is not only possible for patients and their families to be discriminated against but also chaplains.

Chaplaincy provision

The benefits of having a chaplain working within specialized areas has already been indicated elsewhere (Elliot & Carey, 1996; Ireland, et al, 1999). This study gives further support to such developments. Given the involvement of chaplains in bioethical issues, indicated by this study, the concept of having chaplains to deal exclusively with bioethical issues unique to a particularly medical condition may enable chaplains to be more effective and efficient in caring for patients with specialist needs.

Clinical education

In order for pastoral care to be conducted at the best level, all health care institutions need to encourage the development of both initial and continuing education in pastoral education. Health care institutions should also encourage and provide support for the conduct of pastoral care research to both evaluate the conduct of pastoral care and to provide data to guide the practice of pastoral care education (Carey & Newell, 2003).

Government

There are two important issues raised by this study that involve Government application: ethics committee membership and the benefits of ritual and worship activities.

Previous research concerning the perceptions of clinical staff, about the role of chaplains, indicated that clinical staff deemed it appropriate for chaplains to be involved in decisions relating to ethics both within the clinical context and on hospital ethics committees (Carey, 1997; Carey, et al, 1997). This

current research suggests that the majority of chaplains (particularly staff chaplains) were involved, in one way or another, with facilitating 'local' ward decisions and management issues with regard to bioethical issues effecting patients, their families and clinical staff. This allows chaplains the privilege of being '...privy to the thoughts and concerns of many people from different backgrounds' (NH&RMC, 1983; 1985) who have struggled with moral, theological, ethical, social and psychological issues. Chaplains thus acquire a tacit knowledge that could be invaluable to ethics committees.

It is a requirement within Australia that Human Research Ethics Committees registered with the Australian Health Ethics Committee have a minister of religion or equivalent on their institution's research and ethics committee. The effectiveness of having a minister of religion on such committees however, has been questioned by those who tend to advocate for 'ethics without religion' (Khuse & Singer, 1985; Muschamp, 1988; McNeil, et al, 1994). Yet given the everyday clinical experience of staff chaplains, gained from their involvement of dealing with bioethical issues at the ward / unit level, it can be argued that hospital ethics committees gain invaluable insights from the contribution of chaplains with regard to religious, cultural and pragmatic factors that effect individual patients, families and clinical staff.

Finally while some hospital and government 'economic rationalists' may try to argue that the chaplain's conduct of ritual and/ or worship activities fail to provide any direct financial benefit to the health care institution and thus the Government of the day, this research supports previous research (e.g., Newell & Carey, 2000) that chaplaincy services, such as liturgical practices, can help appropriately expedite patient / family decisions and thus save time, costs and resources (both human and clinical).

Future Considerations

This study was concerned with the overall involvement of chaplains engaged in various bioethical issues. More in-depth research should be undertaken exploring chaplaincy involvement with specific bioethical issues Further research could also be undertaken with regard to chaplaincy involvement in other bioethical areas not discussed within this study (e.g., areas of disability involving, for example, artificial

prostheses and various implants such as cochlear implants).

Health care institutions and governments could benefit from such research given due acknowledgement that Chaplaincy assistance with bioethical issues can help to reduce the time taken for patients, families and staff to address complex bioethical issues and finalize critical decisions. Such an outcome is not only cost saving to health care facilities, and hence the Government's health-budget, but also leads to better outcome for the well-being of patients, families and staff. To maximize any such potential benefits from the contribution of chaplaincy, there is a need for further research to be conducted and supported to explore and encourage the best practice with respect to pastoral care and bioethics.

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References:

- CAREY, L.B. (1998) *The sacralization of identity*, The Journal of Health Care Chaplaincy, Cambridge, February, p. 15 - 24.
- CAREY, L.B. (1997) *'The role of hospital chaplains: A research overview'*, The Journal of Health Care Chaplaincy, Cambridge, May, 1997, p. 3 - 11.

- CAREY, L.B. (1993) *'Religiosity and health: A review and synthesis'*, New Doctor, Sydney, Vol. 60, p. 26 - 32.
- CAREY, L.B., COBB, M., EQUEALL, D. (2005) *From pastoral contacts to pastoral interventions*, Scottish Journal of Health Care Chaplaincy, 8. (1), p. 14 - 20.
- CAREY, L.B. & MEECE, C. (2005) *Do pastoral care and spirituality services make a positive difference?*, Ministry, Society & Theology, Vol. 19, No. 1, p. 114 - 127.
- CAREY, L.B., HOLMES, C., & NEVEN, E. (2004) *Chaplaincy and pastoral care services Pilot program process: A case study*. Ministry, Society & Theology, 18 (1), 109-126.
- CAREY, L.B. & NEWELL, C. (2003) *Clinical Pastoral Education and the Value of Empirical Research: Examples from Australian and New Zealand Datum*. In: VandeCreek, L. [ed] *Professional Chaplaincy and Clinical Pastoral Education*, Haworth Press, New York, p. 143 - 15.
- CAREY, L.B., ARONI, R.A., & GRONLUND, M. (1998) *Biomedical ethics, clinical decision making and hospital chaplaincy in New Zealand: A research progress report*, Ministry, Society & Theology, Melbourne, Vol. 12, No. 2, p. 136-155.
- CAREY, L.B., ARONI, R.A. & EDWARDS, A. (1997) *Health & Well being: Hospital chaplaincy*. In: Gardner, H. (1997) *Health Policy in Australia*, Melbourne: Oxford University Press, p. 190 - 210.
- CAREY, L.B., ARONI, R.A., EDWARDS, A. (1996) *'Medical ethics & the role of hospital chaplains: A case study research report'*, Ministry, Society & Theology, Melbourne, Vol. 10, No. 2, p.66 - 79.
- ELLIOT, H., CAREY, L.B. (1996) *'The hospital chaplains role in an organ transplant unit'*, Ministry, Society & Theology, Melbourne, p. 66 - 77.
- IRELAND, B., CAREY, L.B., BAGULEY, I., MAURIZI, R., CROOKS, J., GRONLUND, M. (1999) *The Westmead Hospital Brain Injury Rehabilitation Unit & Pastoral Care Department Pilot Research: A joint research endeavour*. Ministry, Society & Theology, Vol. 13, No. 1, p. 46 - 60.
- KHUSE, H., SINGER, P. (1985) *Should the baby live? The problem of handicapped infants*. Oxford: Oxford University Press.
- KOENIG, H.G., MCCULLOUGH, M.E., LARSON, D.B. (2001) *Handbook of religion and health*. Philadelphia: Oxford University Press.
- MCFARLIN, P. & CAREY, L.B. (2004) *'I'm not religious but please pray': The coding of pastoral visits by Anglican chaplains at the Royal Adelaide Hospital'*. Ministry, Society & Theology, 18 (2), p. 211 - 225.
- MCNEILL, P. M., BERGLUND, C.A., WEBSTER, I.W. (1994). *Ethics at the borders of medical research: How much influence do various members have within research ethics committees ?* *Cambridge Quarterly of Health Care Ethics*, 3, 522 - 532.
- MINICHELLO, V, ARONI, R., TIMEWELL, E., ALEXANDER, L. (1990) *In-depth Interviewing: Researching People*, Longman Cheshire, Melbourne.
- MOL, H. (1983). *Meaning and place: An introduction to the social scientific study of religion*. New York: The Pilgrim Press.
- MUSCHAMP, D. (1988) *Who should sit on an institutional research ethics committee?*. Paper presented at the proceedings of the conference. Can ethics be done by committee? A conference on the role, methods and nature of institutional ethics committees, Royal Australasian College of Surgeons, 15 November 1988.
- NEWELL, C. (1999) *Reflective Learning on Pastoral Care and Ethics: A Pilot Course*, Ministry Society & Theology, Vol 13, No 1, p. 61-75.
- NEWELL, C., CAREY, L.B. (2000) *Economic rationalism and the cost efficiency of hospital chaplaincy*. *Journal of Health Care Chaplaincy*, New York, Vol. 10, No. 1, p. 37 - 52.
- NEWELL, C. & CAREY, L.B. (1998), *'The euthanasia debate and Hospital Chaplaincy in Australia'*, *Journal of Health Care Chaplaincy*, Cambridge, June, p. 8 - 16.
- NH&MRC. (1983). *Ethics in Medical Research: Report of the National Health & Medical Research Council Working Party on Ethics in Medical Research*. Canberra: Government Publishing Service.
- NH&MRC. (1985). *Report on Workshops on the Constitution and Functions of Institutional Ethics Committees in Australia 1984-1985*. (Vol. November). Canberra: National Health & Research Medical Council.
- WHO (2002) 'Pastoral Intervention Codings', *International Classification of Diseases*, Vol. 10, Australian Modification. Geneva, World Health Organization.