THE HOSPITAL CHAPLAIN AS RELIGIOUS INTERPRETER IN BIOETHICAL DILEMMAS

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Abstract: Using a recent example of a highly publicized case in Canada in which a family's demands for life-sustaining treatment based on religious beliefs were pitted against a physician's refusal to provide "inappropriate" care, this article critiques the suggestion that chaplains function as "religious interpreters" in bioethics cases that seek to determine the medical validity of religious beliefs. It argues that the chaplain as interpreter of religious beliefs and values requires a full vision of the chaplain's unique and complex role in healthcare that (1) regards the patient not the chaplain as the "expert," (2) utilizes a variety of key images of pastoral care, and (3) engages a process of dialogical hermeneutics. It concludes that in its broadest understanding and fullest appreciation beyond judgmental interpretation of facts alone pastoral care provides a helpful resource to healthcare teams and an influential model in the art of ethics consultation that embraces uncertainty to build trust among stakeholders.

Key Words: bioethics; religious beliefs; validity; pastoral role; dialogue; ambiguity

Just as no historian worthy of the name is content to accept on authority the simplified statement of some other historian regarding the problem under investigation, so I have sought to begin not with the ready-made formulations contained in books but with the living human documents and with actual social conditions in all their complexity.
Anton Boisen, Exploration of the Inner World, 185

I too am not a bit tamed, I too am untranslatable. I sound my barbaric yawp over the roofs of the world.
Walt Whitman, *Song of Myself*

Introduction

Religious beliefs can be crucial for patients and their families in the trying process of bioethical decision-making, especially in regard to treatment options nearing the end of life. Yet religion is often a difficult topic to address adequately in healthcare. In extreme cases it can even become a flash point for open and emotionally charged conflicts between patients and their healthcare providers when religious beliefs clash with ethical principles and medical goals. Patient demands for so-called "inappropriate" or "futile" treatment options based on religious beliefs that violate established standards of care, for example, can pose seemingly irresolvable dilemmas to clinicians that call for evaluation against a backdrop of competing values, including the standard ethical principles of autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress 2009). And while bioethicists might be willing to recognize the importance of religious beliefs in a holistic approach to patient-centered care, some religious beliefs nonetheless offend general moral sensibilities and thus stubbornly defy conventional medical validity. Not all religious beliefs, therefore, obligate caregivers to respect them.

In an attempt to establish the validity of certain specific religious beliefs that arise in bioethics cases, Gregory L. Bock (2008) has proposed four conditions. He suggests that in order to be taken seriously by clinicians the religious belief in question must be (1) be shared by a community; (2) be deeply held; (3) pass the test of a religious interpreter; and (4) do no harm to others. These are not simply "pass" or "fail" conditions. Rather, they can be assessed on a fluid continuum that may include evaluations such as "mostly satisfies" or "mostly fails to satisfy" (Bock 2008: 438).

Bock's basic framework is compelling in its apparent simplicity that seeks to cut through much of the con-

fusion about religious beliefs to empower apprehensive clinicians with a proactive approach. This paper will explore how it applies to the details of a recent challenging case in Canada, and how it compares to the methodological nuances of pastoral care.

Religious Interpreters

In Bock's view "religious interpreters" may include hospital chaplains and social workers. They may also include community clergy members, including the patient's own religious leader, as long as they would be able and willing to communicate with hospital staff. And when none other is available religious interpreters might even include a professor of religious studies from a local college or university who happens to have studied the religion in question. A mythologist such as Joseph Campbell, for example, would be ideal. (Bock himself is a college professor of religion and philosophy).

It appears that the primary role of the religious interpreter is to provide objective data about the religious belief in question according to formal doctrines. Yet Bock also suggests that religious interpreters play a supportive role to patients in regard to their subjective understanding of their religion. Presumably, the religious interpreter would first seek to understand the personal religious beliefs in question held by the patient and/or family, then measure them against the formal definitions of the religion, and then finally attempt to facilitate communication in the role of liaison between patients, families, and the healthcare team. All told this is a daunting task.

Clinical experience appears to corroborate the value of Bock's recommendation to have a religious interpreter present when necessary, at least in part. For example, one Canadian intensive care physician, Hy Dwosh, who has cared for many religious Orthodox Jewish patients and their families, advocates a collaborative approach that includes recognition of the patient's values, wishes and beliefs by the medical team, as well as trust in the skill and expertise of the medical team by the patient and their family. In his experience inviting the patient's rabbi to sit in on family meetings has encouraged dialogue along with helping family members to keep an open mind (Dwosh 2008).

However, in addition to serving as a guide, the rabbi or other religious leader in a family meeting is also a potent symbol of the faith in question. Thus, he or she functions beyond the role of a religious interpreter. In other words, by embodying a unique kind of what sociologist Pierre Bourdieu calls "cultural capital" (Moore 2008: 111) rabbis, priests, imams and other religious leaders thus function differently from other religious interpreters drawn from social workers, professors, and multifaith hospital chaplains.

Each of Bock's religious interpreters embodies a different kind of cultural capital. The social worker brings clinical credibility to the table along with expertise in family systems and dynamics, but lacks religious cultural capital. The professor of religion brings intellectual cultural capital to the table but lacks clinical pastoral experience. And the religious leader from the community brings religious cultural capital to the table but lacks detailed medical knowledge along with religious objectivity. The hospital chaplain, however, appears to embody aspects of the cultural capital of each of the religious leader, social worker, and professor, and transforms them all into a unique pastoral role. The potency of each kind of cultural capital is diminished in the chaplain's role, however, in order to accommodate them all. For example, the chaplain compromises religious capital and symbolic potency in order to encompass "religious" care within the broader contexts of interfaith pluralism and "spiritual" care.

On the surface multifaith hospital chaplains appear to be well qualified to serve as religious interpreters in Bock's schema. They have clinical pastoral training and experience. They are knowledgeable about the potential complexity of family dynamics. They are also no doubt knowledgeable about their own particular faith traditions as well as being presumably familiar with a wide variety of religions in general based upon their everyday encounters in multifaith healthcare environments. And while a chaplain's own religious beliefs may appear to challenge his or her objectivity in the role of religious interpreter, this does not necessarily disqualify the chaplain. Even though Bock calls for religious interpreters to be objective third-party mediators, he states that it is desirable for the religious interpreter to be not *too* objective so as to fail to understand the point of view of religious believers. In other words, it is helpful if

the religious interpreter knows what it feels like to hold religious beliefs, whatever they may be.

Chaplains might even appreciate the rare opportunities that Bock's framework affords them to be recognized as key "experts" on interdisciplinary healthcare teams. More likely, however, they would resist its implications of authority (Stouder 2009), and here is where Bock's schema loses some traction in regard to co-opting chaplains as religious interpreters.

Hospital chaplains cannot be expected to know with any real depth and accuracy all the details of specific beliefs and practices of multiple religious traditions, and a summary rehearsal of basic fundamental points risks stereotyping otherwise complex belief systems. The real "experts" after all are the patients and their families themselves, not the chaplain (Stouder 2009). Indeed chaplains can invite patients and their families to provide accurate information about their religious beliefs, yet they cannot entirely bridge the boundary between "self" and "other." A fundamental alterity sustains, and a chaplain's interpretation of the highly personal beliefs of an "other" is fallible.

Regarding chaplains as able interpreters of both religious beliefs and believers is therefore problematic. Looking to chaplains as authoritative multi-faith experts to validate the religious beliefs of others in Bock's ethical framework does not fit comfortably with their pastoral sensibilities. Moreover, it can place them in awkward if not impossible situations where expectations for decisive interpretations of religious data are heightened, yet none may be forthcoming at all.

The Golubchuck Case

Hospital chaplains often encounter members of a variety of religions, including Orthodox Judaism, fundamentalist Protestantism, fundamentalist Islam and conservative Catholicism, who believe that the sanctity of human life implies a religious obligation to seek out and obtain life-prolonging medical treatment. Such a "vitalist" position was illustrated recently in Canada in the highly publicized case of Samuel Golubchuck.

Mr. Golubchuck was an elderly Orthodox Jewish man admitted to hospital with pneumonia and hypertension with a pre-existing brain injury that left him with minimal brain function. His illness was so severe that he was soon transferred to the ICU and intubated. There were few if any positive signs that he would recover. In horrifying terms Mr. Golubchuck's physicians argued that to keep him on life support was "torture" due to his increasingly complicated care, whereas his family argued that to take him off life support was tantamount to "murder" according to their Orthodox Jewish beliefs. (Attaran et al 2008).

In a striking move, Mr. Golubchuck's attending physician resigned his position at the hospital over the case, followed by two other intensivists who refused shifts in the ICU, arguing that to continue to treat Mr. Golubchuck was a violation of their medical ethics and their prima facie duty to "do no harm." The physician graphically described that keeping Mr. Golubchuck from his natural death required surgical "hacking away" at his infected bedsores at the bedside in order to keep his infection at bay. Without reasonable hope of benefit the physician characterized this kind of treatment as "assault" and a "grotesque abomination" (quoted in Smith 2008). Instead, Mr. Golubchuck was cared for by substitute physicians and remained on life support for a total of seven and a half months. All the while his family never stopped pleading the medical duty to act according to his Orthodox Jewish beliefs. Mr. Golubchuck died while expert neurologists representing both sides continued to debate the status of his brain function and prognosis. His court case was still pending.

In his initial assessment the judge appointed to the Golubchuck case noted that no mediation was made available early on to address the communication break down between the family and the physicians (*Golubchuck* 2008). This unfortunate lack of mediation in the case now allows chaplains and other potential religious interpreters a window through which to imagine how they would have acted in the case themselves if they had been invited to participate in the case according to Bock's schema.

Religious Interpretation of the Golubchuck Case

Community consensus?

Following Bock's schema, the religious interpreter would review the vitalist position expressed by Mr.

Golubchuck's family and attempt to assess whether or not the Orthodox Jewish community supported their view. Instead of consensus, however, the religious interpreter would soon discover a plurality of views.

On the one hand, a leading expert in Jewish medical ethics—Rabbi Dr. Edward Reichman—stated that the "overwhelming majority" of rabbinic authorities would prohibit removal of Mr. Golubchuck's ventilator, if doing so would have led to his death (quoted in Micoli 2008). On the other hand, Rabbi Chaim David Halevi, the late Sefardi Orthodox Chief Rabbi of Tel Aviv, once stated that it is prohibited to prolong life artificially when there is no longer any hope for the patient. He said that in such cases it is not only permissible to disconnect the machine, but it is mandatory to do so, in that ventilators can cause the soul to suffer rather than the body by preventing it from departing and going to its rest and peace (quoted in Micoli 2008). And side-stepping the religious-medical debate altogether, yet another rabbi argued that the Golubchuk case was not really a "Jewish" issue at all, but that its scope transcended religious bounds to become a human rights issue (Bulka 2008).

Consensus within religious communities is surely elusive if not illusory. Is not the decisive factor in religious traditions the existential confession rather than doctrinal interpretation? (Panikkar 1995: 174). Therefore, while the "religious interpreter" can effectively engage in meaningful dialogue about specific beliefs, he or she can neither confirm nor deny community consensus.

Furthermore, religious interpretation might seek comparison with views from other mainline faiths. A Roman Catholic analysis of the case, for example, concluded that the most appropriate option for Mr. Golubchuck would have been palliative care (Micoli 2008). If the religious interpreter in such a case were a Roman Catholic chaplain, or if the hospital was a Roman Catholic one, to what extent, if any, might Roman Catholic bioethics stand to influence interpretation of the case?

Belief deeply held?

Next the religious interpreter would attempt to assess whether the Golubchucks' religious beliefs were deeply held on religious grounds, or if they were perhaps masking other issues. While there is no doubt that the Golubchucks voiced their religious beliefs clearly and strongly, it is unclear what emotions and dynamics might have been fuelling their position. From a family systems perspective, for example, the death of a family leader can disrupt a family system and throw it into chaos. A spiritual assessment in end-of-life cases could utilize a genogram to focus on how much a "vitalist" position might actually be driven by fear of a father's death and how that would disorient the family in its wake. Was it fear of their father's death that gripped Mr. Golubchuck's adult children? Or denial? Or long-standing guilt? Was it the burden of uncertainty about what to do that paralyzed their decision-making capacity? Or was it a lack of trust in the medical team? Or was it perhaps something else? If religion was indeed the main issue in the Golubchuck case, as the family argued, then it must be acknowledged at face value.

Physicians are encouraged to explore with their patients the wider questions and deeper issues pertaining to their religious concerns (Weijer et al 1998: 820). Yet such an approach is a special contribution that pastoral care can make to bioethics (Hart 2002).

Physicians are also encouraged to explore the depth of their own religious beliefs that bears upon their choice of actions. Research shows, for example, how the medical care patients receive in morally contested interventions at the end of life will vary based on their physicians' religious characteristics, ethnicity, and experience caring for dying patients (Curlin et al 2008).

Pass the test?

To "pass the test" of a religious interpreter seems like a clear criterion, yet for non-judgmental chaplains as religious interpreters it poses a conflict of interest. A dialogical approach to religious pluralism, however, appropriately facilitates open communication among equal partners, while it rejects the claim of superiority assumed by the role of the religious interpreter as evaluator and judge of religious validity for others. Besides, as pluralist theologian Raimon Panikkar argues, the study of religion is not like the approaching physical phenomena and data scientifically—supposing objective facts even existed we are not dealing with them when it comes to religion (Panikkar 1995: 174).

Moreover, given the extreme dynamics of the Golubchuck case it is doubtful whether a religious interpreter himself or herself could pass the test of the case, let alone the other way around. While the case clearly calls for mediation, without formal training in dispute resolution it is questionable how helpful an interpreter's role could be, at least at the point when the conflict had escalated so far that the physicians walked off the case.

Do no harm?

Harm in the Golubchuck case is not easy to assess. It could be perceived as either physical or spiritual pain inflicted in various ways upon a variety of individuals. By continuing to treat Mr. Golubchuck his physicians argued that they were inflicting physical harm upon him, yet it also could be argued that he did not experience any physical pain due to his minimal brain function. More surely, the treatment did appear to inflict spiritual harm upon the clinicians themselves in carrying it out. Also, some Jewish authorities would argue that the Golubchuck family was inflicting spiritual pain upon their father by not allowing him to die with dignity and to set his soul free. And other interpreters might argue that the physicians were inflicting spiritual pain upon the Golubchucks by not acknowledging their religious beliefs, by seeking to withdraw treatment, and especially by quitting the case so abruptly.

Chaplain's Role

It is only in cases when a lack of respect and trust develops, intensivist Hy Dwosh observes, that conflicts such as those resulting in the Golubchuk case arise. And unfortunately, conflict in such cases only leads to the further polarization and entrenchment of views (Dwosh 2008). The chaplain's role in bioethics is to attempt to bridge polarization and ease entrenchment of views by cultivating respect and trust.

Chaplains can help build trust between patients, families and medical teams in the deadlock of ethical dilemmas in ways that correspond to the main tools of pastoral practice (Simmonds 1994: 7). For example, chaplains provide a ministry of "presence" to patients and to families that enables them to tell their stories freely, ask all their questions without haste and fear of judgment, and contemplate their decisions thoroughly with an attentive and reflective listener. Thus chaplains approach first with an offer of companionship rather than with ready-made answers and certainly not with an air of judgment (Simmonds 1994: 7-8). By their intimate relationships with patients and families chaplains are also able to acknowledge feelings of grief and sadness over the prospective loss of a loved one. And they can assist families by obtaining and reviewing with them clear and current communication from the medical staff about prognoses and any additional options for treatment. The hope is that when family members voice religious concerns about the necessity of doing everything possible to sustain life, chaplains can listen attentively and respond respectfully. They may also be able to affirm for families that it can be morally permissible to provide support and comfort while not necessarily extending life beyond natural limits and at all costs (Hart 2002). Finally, chaplaincy is a reflexive practice and chaplains know that no matter the outcome many potentially useful insights derive from all kinds of experience.

Instead of "religious interpreters" chaplains can be understood more widely as "values interpreters" who engage the treasury of images and symbols in which religious beliefs among other values are expressed (Fichtner & McKenny 1991). Chaplains steeped in theological reflection make excellent interpreters of values that are expressed in symbolic language. Thus they offer a most helpful albeit underutilized resource to healthcare teams and their patients. Yet the term "values interpreter" also fails to capture the full range of chaplains whose extensive professional training draws them paradoxically "beyond the skillful response" (Nouwen 1978: 41-65).

Images of Pastoral Care

Pastoral care has traditionally defied singular characterizations. Like no other profession it has inspired a multitude of images and metaphors. Images of pastoral care run the gamut from Paul Pruyser's professionally affirming metaphor of the "minister as diagnostician" (Pruyser 1976, Dykstra 2005), to James Dittes' daring model of the chaplain as "ascetic witness" who risks giving up professional diagnostic agendas, expectations, demands and checklists to elicit the other's "uncalculated, unmeasured, even reckless trust" (Dittes 1999, Dykstra 2005). Chaplains may also understand their role according to other inherently paradoxical metaphors, including Robert Dykstra's "intimate stranger" (Dykstra 1990, 2005) by which they become necessarily familiar

with patients and families who are strangers in situations of sudden loss. In turn, chaplains come to appreciate how in such situations they are strangers even unto themselves who must open themselves to the God-bearing power of strangeness itself.

Pastoral images of "diagnostician," "ascetic witness" and "intimate stranger," among many other classic and contemporary metaphors for pastoral care, all trace their heritage back to Anton Boisen's founding imagery of the patient as "living human document" (Boisen 1936, Dykstra 2005). In reclaiming Boisen's metaphor Charles Gerkin (1984) argues that in their pastoral relationships with others, chaplains require a process of dialogical hermeneutics that begins with a position of uncertainty and even vulnerability, and here it is worth quoting him at length.

He writes, "To listen to stories with an effort to understand means to listen first as a stranger who does not yet fully know the language, the nuanced meanings of the other as his or her story is being told. Needless to say, one of the first lessons of life on the boundary is that it is important to avoid, at all costs, the temptation to stereotype or take for granted.…Pastoral counseling may thus be understood as a dialogical hermeneutical process involving the counselor and counselee in communication across the boundaries of language worlds. The dialogue takes place at many levels, some between the counselor and counselee, still more within the counselor as he or she sorts through the images, themes, and symbols of the various disciplines that have been appropriated in a search for those that seem apropos or make sense out of what is being heard.…The pastoral counselor as interpreter, like the reader of the New Testament, does not come empty-handed. He or she comes bearing a history and a language world. More accurately, he or she comes embedded in a personal and social history and immersed in one or more language worlds from which the images, symbols, and meanings are drawn with which to make an interpretation." (Gerkin 1984; Dykstra 2005: 31-32, 36).

Conclusion

Hospital chaplains value their role in the process of bioethical decision-making and believe that they make a significant contribution to the discussion and resolution of bioethical dilemmas (Simmonds 1994). Moreover such participation proves to have a positive influence upon cost containment and risk management in healthcare (Simmonds 1994).

The value of pastoral care for bioethics lies not in any external evaluative judgment of religious beliefs—long ago Anton Boisen himself dismissed "ready-made formulations contained in books." Rather, it lies in its modeling of intimate engagement with real people who are "living human documents" worthy of interpretation themselves with actual social conditions in all their extraordinary complexity (Boisen 1936: 185). In this way pastoral care offers not only a helpful resource to bioethics when it comes to understanding some of the details of specific religions, but a creative dialogical and reflexive methodology that bears upon the art of clinical ethics consultation itself.

Nonetheless, it is doubtful that even the best pastoral care could have helped ease the tremendous conflict in the Golubchuck case. The Golubchucks failed to meet one of Bock's other potentially relevant criteria that he appends to his schema—that patients and families show a willingness to reason or discuss their beliefs with the caregivers of whom they are making the request for treatment (Bock 2008: 440).

Chaplains might be able to encourage patients and families to be more open and willing to discuss their beliefs with clinicians. Moreover, they might also be able to encourage physicians to reflect on their own religious or non-religious perspectives and biases and even to discuss their own beliefs with their patients and their families.

Conflict can escalate in extreme cases to the point of chaos, such as when Mr. Golubchuck's physicians walked off the case. Yet chaplains can also prophetically bear witness to the ethical imperative for greater tolerance for attending to chaos as part of a life story (Frank 1995: 110-111). And pastoral tolerance for chaos and lack of resolution in ethical dilemmas stems no doubt from chaplains' tolerance for the sustaining creative tension in their own professional profiles that resist categorization.

The perennial challenge is for chaplains to explain their role to others, especially bioethicists with whom they are so closely aligned. This is surely a daunting task when their role is characterized by "split professional identities" (Zock 2008) and the "essential in-

security" (Dykstra 2005: 3-4) that runs through the entire tradition of healthcare chaplaincy, and which thus challenge chaplains continuously to understand and articulate their roles even for themselves. No doubt chaplains are effective "religious interpreters" in Bock's framework, but only in the widest sense possible, and distinguished from other kinds religious interpreters, including social workers, religious leaders, and professors of religion.

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