

# COMMUNITY ETHICS

VOL. 2

The Newsletter of the Consortium Ethics Program  
Addressing the Ethical Challenges Facing  
Community Health Care Providers of Western Pennsylvania

NO. 1

*The CEP is a cooperative effort of the University of Pittsburgh Center for Medical Ethics and the Hospital Council of Western Pennsylvania.*

## Special Issue: Medical Ethics and Religion

**In This Issue:** The theme of the current issue is medical ethics and religion. The motivations to inquire into the relationship of secular medical ethics to religion are obvious. Religion and medical ethics are both concerned with questions about death, suffering, respect for one's body, dignity, conflicts between one's duty to benefit others and the desire to avoid unnecessary suffering, etc. Contemporary medical ethics has religious roots and grew largely from the investigations of religious thinkers. However, these thinkers strove to create a basis and framework for resolving clinical ethical problems that does not require adherence to any particular religious doctrine. In one of our feature articles, Gary Fischer, M.D., gives his perspective on the relative roles of bioethics and religion.

Questions regarding the role of the clinical ethicist and his/her relationship to traditional roles in the ministry are also of particular importance. The ethics consultant is generally thought of as an educator of his or her colleagues and a facilitator of communication at the bedside. However, ethics consultants increasingly find themselves in situations where more than education and communication is sought. The consultant is sometimes

called upon to dispel a sense of uneasiness that hangs over a case. Those requesting the consultation may desire to be told that their actions are "OK" and to receive support of a more emotional or spiritual variety. The similarity of this role of the ethicist to that of a priest has not gone unnoticed. Thus, comparing not only the content of secular medical ethics to religious prescriptions, but also the role of the ethicist to that of clergyman is warranted. To address these and related issues, we present articles by three hospital chaplains, each of whom has substantial training in medical ethics.

The relationship of spirituality and medical ethics is a vast topic. The articles in this issue merely scratch the surface of a complex and largely unexplored area. As a consortium, the CEP strives to facilitate dialogue on important issues, not to promote particular viewpoints; these articles are valuable contributions toward that end. If you find important issues not raised and viewpoints not represented, we welcome your contribution to future issues of *Community Ethics*.

- Mark Kuczewski, Ph.D.  
Editor

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# Consortium to Expand in 1995

**Memberships Now Available !!!**



The Consortium Ethics Program (CEP) is taking applications for a new three-year module to begin in October 1995. The CEP is a collaborative continuing education program of the University of Pittsburgh Center for Medical Ethics and the Hospital Council of Western Pennsylvania and is designed to be a cost-effective way for local hospitals and health care institutions to meet their ethics needs. This is accomplished through a three-track program. Track one involves the in-depth training of two hospital representatives in the language and literature of medical ethics. Through annual retreats and monthly seminars, these health care professionals receive the education necessary to become ethics resource persons for their colleagues. Track two brings ethics education and support directly to the health care facility. CEP faculty conduct on-site staff and community education programs to meet the needs of the

particular hospital. Track three is the ethics network that has formed throughout Western Pennsylvania. Representatives of the CEP-member institutions form professional relationships that facilitate the sharing of experience regarding ethical issues.

The Consortium Ethics Program currently has 28 member institutions. The new three-year module will accept 12-28 institutions. Acute care hospitals, long-term care facilities, rehabilitation centers, and similar health care facilities are invited to join. Individual memberships are also available. A prospectus detailing membership in the CEP will be distributed to all members of HCWP after January 1, 1995. If your facility is not a member or you know of a health care professional interested in individual membership, call (412) 624-3481 to have your name added to our mailing list.

## CEP-2 Begins Second Year With Retreat

The Consortium Ethics Program began the second year of its current module (CEP-2) with an ethics retreat at Hidden Valley Resort from September 30 - October 2, 1994. This annual retreat previewed many of the topics that will be explored in greater depth at the monthly seminars held at the Education Center of the Hospital Council of Western Pennsylvania in Warrendale, PA. Representatives of the 28 member hospitals heard talks on a variety of topics including physician-assisted suicide, ethical and legal aspects of clinical decision making, and social justice in resource allocation. These seminars were conducted by the core faculty of the Consortium and a special guest -- K. Danner Clouser, Ph.D., Professor of Philosophy, of the Hershey Medical Center. Additionally, one session featured representatives from three member hospitals who shared their experiences on forming an ethics committee, performing ethics consultations, and establishing a hospital staff position in preventive ethics. Most didactic presentations were followed by a small group activity or discussion.

The CEP has already begun its educational series for representatives of the member hospitals. Advanced seminars, for participants enrolled since 1990, will cover topics involving law and health care, social justice and public health policy, AIDS and confidentiality, and case narratives in end-of-life decision making. The Basic Series, for new members, covers many of the same topics but stresses a core of fundamental issues as well, i.e., exploring the relationship between ethical theory and

clinical practice, examining legal and religious perspectives on health care, and the major aspects of forming and running institutional ethics committees, writing and reviewing basic clinical ethics policies, and conducting a medical ethics consultation service. Faculty for the combined seminars include:

ROSA LYNN PINKUS, PH.D.  
Director  
Consortium Ethics Program

MARK KUCZEWSKI, PH.D.  
Associate Director  
Consortium Ethics Program

ALAN STEINBERG, ESQ.  
Horty, Springer, & Mattem, P.C.  
Attorneys-at-Law

ANDREW THURMAN, J.D., M.P.H.  
Senior Vice President  
Forbes Health System

IRIS YOUNG, PH.D.  
Professor of Public Health  
University of Pittsburgh

JOHN COULEHAN, M.D.,  
Professor of Medicine and  
Preventive Medicine  
SUNY, Stony Brook

ROBERT M. ARNOLD, M.D.  
Associate Professor of Medicine  
University of Pittsburgh

DAVID KELLY, PH.D.  
Professor of Theology  
Duquesne University

MARYANNE FELLO, R.N., M.E.D.  
Assistant Executive Director  
Forbes Hospice

CHERYL FLINT-BUTCH, R.N.  
Head Nurse, Home Care  
Forbes Hospice

In addition, the Consortium will participate in Duquesne University's annual medical ethics conference on May 10, 1995. This year's topic will be physician-assisted suicide. (All seminars are held with the support of HCWP at their educational facilities in Warrendale, PA.)

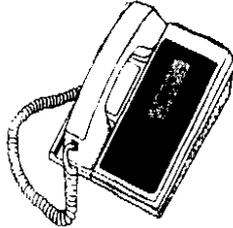
# CEP/Center for Medical Ethics Address Ethical Issues In Long-Term Care

**Teleconference Held November 16, 1994  
Day-Long Workshop Set for April 7, 1995**

While the CEP directs its programming primarily to its members, collaboration with the Center for Medical Ethics and the University's office of continuing education promotes educational programs that are available to a wider range of health care institutions. This year, the topic of ethics in long-term care is to be addressed at two forums; a teleconference and a day-long workshop at the Sheraton Warrendale. The topic itself was identified from within the membership of the CEP as one that is of major importance in Western Pennsylvania, whose overall elderly population ranks among the highest in the nation.

## (1) The Teleconference

On November 16, 1994, the teleconference "Ethics at the Interface: Hospitals, Nursing Homes, & End-of-Life Decisions" addressed ethical issues that arise in the transfer of patients from long-term care facilities to acute care hospitals. Sponsored by the CEP and the University of Pittsburgh Center for Continuing Education in the Health Sciences, it reached 36 hospitals and included on-site workshops at 16 locations. These workshops were conducted by CEP participants from the host or nearby hospitals.

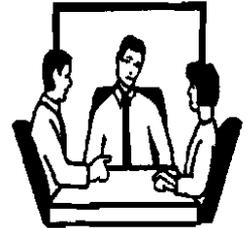


The main program featured presentations from three speakers: Robert M. Arnold, M.D., Associate Professor of Medicine at the University of Pittsburgh, who spoke on the concept of autonomy in long-term care; Alan Meisel, J.D., Professor of Law and Psychiatry and Director of the Center for Medical Ethics, who addressed legal issues surrounding end-of-life decisions; and CEP Director Rosa Lynn Pinkus, Ph.D., Associate Professor of Medicine and Neurosurgery at the University of Pittsburgh, who discussed strategies for dealing with ethical issues and end-of-life decision making during patient transfer. This last talk highlighted the ethical dilemmas that motivate prehospital DNR systems and Pinkus raised questions concerning how helpful such a system might be in Western Pennsylvania. CEP Associate

Director Mark Kuczewski, Ph.D., Research Assistant Professor of Medicine at the University of Pittsburgh, served as the moderator. This program attracted approximately 300 health care providers from both acute and long-term care facilities.

## (2) "Ethics In Long-Term Care" Conference: April 7, 1995

On April 7, 1995, the CEP, in conjunction with the Hospital Council of Western Pennsylvania Committee on Aging, the Pennsylvania Partnership for Aging, and the Health Policy Institute, will sponsor the day-long conference "Ethics in Long-Term Care" at the Sheraton Hotel in Warrendale. The conference will provide a basic introduction to ethical issues in long-term care and give an overview of relevant legal and ethical frameworks to address these issues. This one-day program is designed for health care professionals and administrators of nursing home facilities but is also ideal for professionals from acute care hospitals such as administrators, social workers, and discharge planners who frequently must address ethical issues in collaboration with nursing home representatives. The topics to be covered will include principles of end-of-life decision making -- including those covering the use of advance directives in the long-term care setting -- as well as related issues pertaining to patient autonomy/self-determination and the relationship of the nursing home to the acute care hospital and other providers.



The goal of this conference is to help long-term care providers to become aware of the ethics resources available in Western Pennsylvania and to help integrate long-term care providers into the burgeoning ethics network that the Consortium Ethics Program is fostering in Western Pennsylvania. Meeting announcements and registration materials for this workshop will be mailed to all members of HCWP and affiliated long-term care facilities. If you know of an individual or a facility with a specific interest in this topic, call (412) 624-3481 to be placed on a mailing list.

## Special Section: Religion and Medical Ethics

### The Limitations of Secular Medical Ethics

by Gary S. Fischer, M.D.

General Internal Medicine Fellow, University of Pittsburgh

As I approach the end of fellowship training in medical ethics, I am sadly coming to the conclusion that conventional, secular medical ethics is incapable of providing us answers to some crucial moral problems in health care. Contemporary "medical ethics," as it is taught in the university and written about in journals, emphasizes patients' rights and provides important rules of conduct for health care providers – but necessarily fails to help patients determine what course of action they are morally bound to pursue.

The courts, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, and major textbooks on medical ethics agree that patients have a right to determine what is done for and to them. We are told that ethical decision making regarding the medical treatment of patients must reflect patients' interests, desires, and wishes. As a result, we have established a number of formal procedures to aid in ethical decision making: informed consent, written advance directives, and substituted judgment. This framework makes very clear the answer to the question concerning who should be making the decisions. Its limitation is that it is necessarily silent about what the decision ought to be.

This approach may be adequate to provide direction for health care providers who are ethically bound to respect patients' wishes regarding their medical care, but it gives no guidance to the primary decision maker, the patient. If anything, we trivialize that task of the patient. We speak of patient "preferences," as if the decision whether to suffer through another intubation to fight for a few months of life or to forgo that treatment is merely a matter of taste. We forget that to many patients and their families, these questions have profound moral and religious significance. The patient may reflect on questions such as what is one's responsibility to oneself as a steward of his or her body, what is one's obligation to intimates who may bear the emotional and financial burden of caring for the patient during a prolonged illness, and what are the reciprocal responsibilities of the individual and society regarding

the appropriate use of societal resources?

The answers to questions like these depend upon beliefs regarding what gives life value, and what are the mutual obligations of people to each other either to preserve life or to forgo a slim chance at continued life to preserve resources for others. Attempts to answer questions like these have been made by secular moral philosophers, such as utilitarians, but for many patients, the answers are sought from religion. Patients for whom religion is important will have to turn to their religious counselors and to their own understanding of their religion. An ethical philosophy which is intended to prescribe behavior for all members of a liberal, pluralistic society is incapable of answering these questions, because in so doing, it would force upon all a particular vision of what is "good" in life. As an orthodox Jew, I am aware of the content that religion can bring to moral life and the importance of answering such questions; as a member of a religious minority, I understand the dangers of the majority trying to enforce a particular view of the answers to these questions upon all.

We must recognize the limitation that this places on clinical and ethical consultation based upon the principles of a secular medical ethic. Ethics consultants perform many important services. They can aid in patient or surrogate decision making by facilitating communication and clearing up misunderstandings. They can educate health care providers regarding the need to respect the patient's wishes and values. They can inform patients and surrogates about the options which they are at liberty to choose regarding end-of-life care. What they cannot do is tell patients which of these options is the moral choice.

This is the crucial point. The ethical and legal principles that govern the practice of medicine in a liberal democratic society can only describe the liberties which patients have regarding their medical care. They give patients "the right to be wrong," as philosopher Tris Englehardt puts it. Unfortunately, when patients themselves need to decide what is actually right, they need to look elsewhere for their answers.

# THREE VIEWS OF THE HOSPITAL CHAPLAIN

## "What's My Line?"

#1

by Philip Williams, MDiv, STM, Coordinator of Pastoral Care, The Western Pennsylvania Hospital



"You do this full time?" "What do you do?" "How do you get to be a chaplain?" Some people have difficulty understanding that we chaplains work full time in institutions which are, in essence, our parishes. Some think we

chaplains must not have been able to hack it in the parish or synagogue. For a minority that could be true, but not generally. This is an article on the care and feeding of a hospital chaplain or, as Mark, the editor, requested, "The training and education of a hospital chaplain." I'll share bits of my story which is somewhat typical, allowing for a few additional wrinkles.

Today's hospital chaplain has, like myself, an undergraduate college degree and 3-4 years of seminary education leading to a Master of Divinity degree (M.Div.). With Roman Catholic Sisters and Brothers in chaplaincy who aren't ordained priests, the M.Div. may have a degree or comparable course equivalency. An influx of lay persons interested in chaplaincy, but without theological education and degrees, has caused serious evaluation of chaplaincy requirements. Nevertheless, the story of the usual education process remains, but doesn't end here.

After the usual 7-8 years of higher education, there are requirements for specialized education in pastoral care and counseling. In my case, I have another Master's Degree in Psychology and Pastoral Counseling, but that isn't required. What has become the norm is specialized training in Clinical Pastoral Education. This is a non-degree educational program for both parish clergy and persons wanting to specialize in chaplaincy. I am one of approximately 700 who are certified as Clinical Pastoral Education Supervisors by the Association of Clinical Pastoral Education, Inc. (ACPE, Inc.). This is a professional certification process which can take 2-4 years to complete, post-college and M.Div. degrees. Obtaining this certification enables me to conduct a self-study process of an institution, such as the Western Pennsylvania Hospital, leading to accreditation as a training/education Center. The Western Pennsylvania Hospital is the only accredited tertiary-care facility in Pittsburgh and one of two in Western Pennsylvania; there are about 400 centers nationally. It should be noted that Roman Catholics have a parallel association called the National Association of Catholic Chaplains (NACC) which educates Catholic chaplains. There is growing cooperation between the ACPE, Inc. and NACC. Pretty dry stuff so far, right? Oh, for a good story!

Anyway, clergy need to be trained by these organizations to qualify for most chaplaincy positions. What

is unique about this training is that it uses an experiential process methodology. This places an intense and focused emphasis on the knowledge and use of the potential chaplain's "self" in learning to minister in more depth. For example, a standard practice in CPE training is for a student to visit a patient and write this visit as a verbatim (case). This write-up includes the actual conversation and an in-depth reflection/evaluation about the patient's and chaplain's thoughts, feelings, personal history, and religious perspective on her/his ministry. Both the external interchange and the internal world of the chaplain are evaluated. The chaplain student meets with a peer group of five to six students, and is, as it is said, on the "hot seat" for an hour to an hour and a half engaging, defending and processing his- or herself and this ministry. It helps to have a streak of sadomasochism!

This seminar, however, is only one part of the training of a chaplain. Other aspects include typical lecture/discussions, an interpersonal relations group process, and individual supervision. A unit of training is 10-12 weeks (if it is done on a five-days-per-week basis) for a required standard of 400 hours. Usually two to four of these units are needed as part of the qualifying portfolio for chaplaincy positions.

Having just completed our JCAHO hospital accreditation at West Penn and with the synchronic appearance of a New York Times article on the importance of chaplaincy in hospitals and in the healing process, the rhetoric of meeting "psychosocial and spiritual" needs has been in the air. More and more research, as currently popularized by such persons as Dr. Larry Dossey, former chief of staff at Dallas Hospital, has been showing that attending to the psychosocial and spiritual needs of patients contributes to the healing process, and to the delight of some administrators, shortens the length of stay and promotes cost containment!

I now want to turn to our favorite topic -- medical ethics. Within chaplaincy training there has traditionally been little to no education in medical ethics. This has begun to change, and is now primarily incorporated into a lecture or discussion format for one to three sessions. A few colleagues have been creatively experimenting with incorporating more medical ethics curricula into our process model of education. I intend to integrate more of this into my program. A colleague says "The purpose of incorporating bioethics into CPE is not to train little 'bioethicists,' but to develop bioethically knowledgeable and aware pastors and chaplains." This is accomplished through acquaintance with the theoretical frameworks of medical

ethics as well as case analysis and processing.

In this process curriculum, multiple foci need to be kept in mind, such as teaching the application of didactic material, recognizing and analyzing ethical issues, looking at pastoral options to address the ethical, emotional, and spiritual issues, and addressing the student's own personal and pastoral issues which come out of and influence specific ethical issues. This is, of course, a large and challenging task; but it also has the potential to be valuable in a chaplain's process of learning more about self and ministry.

I borrow an example from a colleague and one of his students. One of his chaplaincy students had related the principle of respect for patient autonomy to her previous experience with her dying father. She said that she and her family couldn't bear to "allow him to die" even though it was his wish. Some old pain in her relationship with her father was partially resolved as she gave him hands-on-care as his terminal condition ran its course. Hers was a painful

story of grief and grace. She gave permission to further talk about her experience in terms of the ethical conflict between autonomy and paternalism. In the actual peer group learning experience, a number of things were processed helpfully -- her pain and grief, experiencing peer group support, and some medical ethical principles came alive in personal and unforgettable ways.

I hope this gives you a picture of what goes into the general care and feeding of a chaplain. It is by no means the only way in which clergy become chaplains, but it has become the primary means for specialized chaplaincy. I need to note that most chaplains are not CPE supervisors. By far, the majority are clergy and religious order people who as staff chaplains bring themselves and their ministry to the support, healing, and caring of people in hospitals, mental health centers, correctional institutions, extended-care facilities, hospice programs, and other specialized centers and programs.

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## The Catholic Chaplain in a Catholic Hospital

# #2

by Patrick J. McCruden, Chaplain, Marian Health Center, Sioux City, Iowa



The hospital chaplain, for better or worse, is frequently perceived by patients and family members as an authority in the area of medical ethics. This should not be surprising. The role of a religious authority as an ethical authority is an ancient one. Whether shaman or witch doctor, prophet or priest, rabbi or pastor, those who have held authority in religious matters have simultaneously been seen by their congregations and religious bodies as having authority in ethical matters. Of course, whether this faith in the hospital chaplain as ethicist has merit is another issue. Although it is often the case that the chaplain has received formal education in the area of philosophy and ethics -- perhaps more so than other health care professionals attending the patient -- it is not always clear that this training has adequately prepared him or her to provide ethical counsel in the complex world of modern medicine.

In my own ministry as a non-ordained Catholic chaplain in a community hospital of Catholic sponsorship, I have found that the perception that the chaplain is an ethical counselor is strong. This role is part of a hospital ministry that cannot and should not, be avoided. In general, I have found this to be an extremely positive experience. Ethical questions may be posed in straightforward yes or no terms, e.g., "Chaplain, is it right to: discontinue this treatment? not place this feeding tube? refuse this surgery?" etc. However, a caring pastoral relationship also provides an opportunity to explore the deeper issues at stake in these ethical decisions. Values can be examined, options explored, and religious and ethical language used to clarify questions that appear at face value to be technical medical questions. Finally, support can

be given to those who are making difficult and painful decisions.

However, I have found that providing this ethical guidance is no easy task. In my own experience, I have identified two major issues that the chaplain needs to explore for him- or herself before entering into ethical counseling. One is cognitive in nature, the other concerns the pastor-patient relationship. The first issue is a theological/philosophical one: What ethical framework should the chaplain use when discussing ethical questions? Like most seminary-trained chaplains, I received instruction in the moral theology of my own particular religion. How helpful or applicable is this training when counseling persons of other faiths or denominations? Furthermore, what is the relationship of my training to the frameworks and principles of contemporary secular medical ethics?

In a Catholic institution there exists the reality of ethical norms that are based upon traditional Catholic moral teaching. The language of this form of ethical discourse uses terms such as "object of the will," "intention," "doctrine of double effect," "intrinsically evil acts," etc. This traditional ethical framework is codified in the *Ethical and Religious Directives for Catholic Health Care Facilities*. As a Catholic chaplain in a Catholic hospital, I am expected to understand these directives and be able to apply them in addressing ethical issues. I am supposed to succinctly answer questions that begin, "Chaplain, is it right to . . ." At the same time, I am a member of a multidisciplinary ethics committee that provides education, policy development, and case consultation. As a member of this ethics committee, I have attended educational programs at the bioethics center

of Creighton University in Omaha, Nebraska and become acquainted with the language of contemporary medical ethics, e.g., "patient self-determination," "best interests," "substituted judgment," and, of course, "autonomy, beneficence, nonmaleficence, and justice." Although there are clearly some terms and values common to both frameworks, at times, it seems these two languages have little to say to one another.

When I am providing ethical guidance to patients or family members, it is often difficult to know which of these two ethical languages, some combination of both, or perhaps, some other with which I am currently unfamiliar, would be most helpful in examining the ethical issues at hand. It would be a gross oversimplification to state that the "Catholic" language should be used with Catholics and the "contemporary" language with all others. For instance, I minister to people of many different faiths and cultures, and the contemporary language of medical ethics is by no means universally helpful to all non-Catholics when discussing ethical questions.

The second major issue with which I struggle is whether the role of chaplain as medical ethicist obstructs the primary role of the chaplain as pastoral care giver. There is a small but real danger that the chaplain can come to be seen as a judge or arbiter. To avoid this, the chaplain must resist the temptation to replace compassionate listening and counseling with sterile analysis or moral pronouncements. I have experienced situations where I believed families were asking ethical guidance of me but, in reality, were seeking affirmation for a decision they had already made with great difficulty. When my perspective ran contrary to their

decision, I found the pastoral relationship strained. Even though I do not believe that there is a need for us to agree, the tension that resulted from disagreement was difficult to overcome.

There have been few occasions when I encountered serious personal dilemmas, but some have occurred when I strongly disagreed with the ethics of a decision that had been made. Like all persons, I have my own beliefs and convictions. As a chaplain I can set these aside, for a period of time, in order to provide counseling. However, if my ethical advice is sought, ultimately, I must be faithful to who I am as a person, pastoral minister, and member of the Church. As a Catholic Chaplain, *I undoubtedly have the responsibility of accurately reflecting the moral precepts that are expected to be upheld in a Catholic facility.* It would be dishonest of me to simply reflect back to all who ask my counsel, what I think they wish to hear. There seems to be no easy reconciliation of the enigma of wearing these different hats. It is definitely not the chaplain's role to be the "ethics police" nor should the chaplain feel that his or her ethical counsel must always be accepted. Nevertheless, it is part of the very nature of pastoral care that it has a normative dimension. *The task is to express these ethical norms and still maintain a supportive pastoral presence in the face of any outcome.*

In sum, the hospital chaplain can play a key role in providing ethical counsel to patients and families but must be vigilant to recognize his or her own religious and ethical perspective and the limits of its usefulness. Most importantly, the chaplain must avoid *losing the role of minister* in acquiring that of *ethicist*.

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## Religion and Spirituality In Modern Medical Practice

# #3

by Reverend Dr. Bruce Bryce, D.T. Watson Rehabilitation Services



The general public perceives a hospital to be a "temple of science" in which wondrous miracles are performed by technically proficient professionals. Health care, however, is not all physical medicine. It involves a wholistic approach which has uncovered a broader set of issues not treated with serum or a scalpel. These are issues delineated by lines of lesser definition. They are emotional, ethical, and spiritual in nature. They involve generations of cultural, philosophical, provincial, ethical and religious tradition, as well as medically scientific fact.

The caregiver who takes this seriously faces questions like: What is the value of a human life? How long should it last? When does it begin? Should some lives be prohibited from beginning? On the other hand, should some lives be ended because they show no sign of productivity or quality? Such questions have, for centuries spawned even more queries like: Who should receive the limited and

expensive treatment that is available? What is the role of faith? Is there a Power/Intelligence/Being in the universe that could possibly be the source of answers? Is religion significant, or is it, as Marx claimed, a mere "opiate"?

When health care disciplines are challenged by these questions, there can be conflicting answers. Practitioners have strong feelings about their particular specialty. There needs to be a common ground on which they can meet. Cooperation and mutual respect are essential among consumers, Hippocratically motivated physicians, Nightingalean inspired nurses, technically proficient ancillaries, resourceful social workers, profit- and loss-conscious administrators, idealistic religionists, justice conscious lawyers and dozens of other essential laborers. The need for high ethical standards throughout the health care industry is more important now than ever before. As a result, there is a need for an arena in which this multi-faceted collection of professionals can confront each

other. The Institutional Ethics Committee can be that arena.

Good modern pastoral care practitioners have a role and a way of being that narrows the distance among the sciences, the humanities, and religion. They accept the influence of the humanistic disciplines. Their methods are steeped in psychology, philosophy, science, sociology, and ethics; yet they maintain the integrity and authority of theology. This renews the possibility of establishing clergy as viable participants and leaders for Institutional Ethics Committees. Chaplains experience people in their most vulnerable times and find them reaching beyond medicine and other humanistic sciences to a spiritual power, one they may not or cannot understand, but one they instinctively trust to help them differentiate between right and wrong.

The importance of religion comes from the human being's natural desire for answers that are not able to be rationalized or measured scientifically. Medicine and the humanities are based on the findings of human experience and scientific research. Spirituality appears to have grown from an overwhelming need for answers they can't give. As members of the health care team, clergy are accustomed to the precarious position of being in the middle of these two points of view. Within the hospital he or she stands

between patient and physician, patient and family, or patient and God. It is the chaplain's job to provide perspective and to support the patient spiritually at his or her particular level of need, being mindful of the professional principles of his or her health care colleagues as well.

The chaplain is in the "faith business." He or she is a promoter of the ultimate health care team and encourages faith in God, faith in the care givers of choice, and faith in the self. *Since no one discipline has any greater importance than another on this intricately woven team, the chaplain can be a significant facilitator in the face of questions that have long exceeded the capabilities of science.* Because the goal of the Institutional Ethics Committee is to resolve differences between opposing opinions, the spiritual science could be the one to lead the others in this exploration. Religion, by itself, cannot provide the answers; but it *can* have a significant role to play on a team that is committed to finding them. *While ethics is complicated by the opinions of academic, scientific, sociological, philosophical, psychological, cultural, legal and theological disciplines, it respects them all and strives to find a balance that meets the greatest need for the greatest number of people.*

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## A Preview of Dena Davis' "It Ain't Necessarily So: Clinicians, Bioethics, and Religious Studies"

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by Rosa Lynn Pinkus, Ph.D., Director, Consortium Ethics Program

"The identification and interrelationship of [religious and philosophical ethics]...goes back thousands of years," comments K. Danner Clouser, philosopher at Hershey Medical School. Sketching a practical approach to understanding their differences and similarities, Clouser defines religious ethics as "an attempt to look at moral problems from a religious perspective." While this seems straightforward, the moral implications of various religious beliefs are not easily interpreted -- especially as they relate to ethical/medical dilemmas.

Clouser's definition of secular ethics echoes those suggested by our contributors. Secular, philosophical ethics, he explains, aims to construct a theoretical framework of moral beliefs that "all rational people would accept." Morality, according to this definition, would not be tied to a particular religious belief system but would be shared by all persons.

It is precisely this minimalist approach, however, that this issue's contributors find troublesome! Their feeling is that specific religious/ethics perspectives *can* be valuable to an ethics consultant. Patrick McCruden says it convincingly: "The chaplain must avoid losing the role of minister in acquiring the role of ethicist." Gary Fischer, MD, implies that the doctor must, likewise, avoid losing the role of

physician when he is acting as an ethics consultant. Using secular ethics in the clinical setting, it seems, lacks the richness one needs when specific ethics dilemmas occur.

The question we may ask, then, is, "Does the religious/ethics literature fill this void?" According to Dena Davis, Ph.D., L.L.B., "It Ain't Necessarily So." Dr. Davis has written an article, primarily for religious ethics scholars, to highlight four perspectives that she feels would be most helpful for clinicians. These are perspectives which, according to Davis, the most oft-quoted religiously based bioethics literature by and large ignores. I have rephrased the four perspectives as questions one could keep in mind when (and if) this literature is consulted:

1. Is the goal of this article to explain in general the role and function of religious beliefs in the lives of individuals in the culture as a whole?
2. Does it explain, with respect to a certain religion, how a tradition wrestles with a moral issue and does it explain that tradition's current thinking?
3. Does it describe how people actually believe and act?

4. Does it present expert points in an honest manner? Or is only one view identified with (to the exclusion of others)? Is it the official set of behavior and beliefs that religious authorities would like their constituents to have?

Davis' use of empirical evidence to point out that many of the generalizations cited in the religious ethics literature "don't actually reflect how people in a given faith tradition behave" is highly instructive. She also echoes a point made by Clouser that both philosophers and religious ethicists should focus on explaining how and why religion "fits in" to a particular dilemma, identify issues, explicate concepts, and

develop lines of reasoning. Professor Davis' article is a valuable contribution to an ever-more-complex area of ethics. For her convincingly critical view of entries in the Encyclopedia of Bioethics and specific articles by leading religious/ethics scholars, be sure to read her article in the upcoming issue of *The Journal of Clinical Ethics* (Vol. 5, no. 4).

Quotations from:

K. Danner Clouser, *Teaching Bioethics: Strategies, Problems, and Resources*, Hastings-on-Hudson, NY: Institute of Society, Ethics, and the Life Sciences, 1980. (Chapter 6, section D: "Religious vs. Philosophical Ethics")

Dena Davis, "It Ain't Necessarily So: Clinicians, Bioethics, and Religious Studies," *The Journal of Clinical Ethics*, 5(4).



## Truly Useful Literature

by Alan Joyce, Editorial Assistant



*"Guidelines for the Chaplain's Role in Bioethics," The Bioethics Committee of the College of Chaplains, Inc.; J. Vincent Guss, Jr., FCOC, Chairperson.*

*"The Chaplain's Role in Bioethics Consultation: The Chaplain and the Ethics Committee," Lawrence E. Holst, FCOC, and Clyde Shallenberger, FCOC, contributors and members of the Bioethics Committee of the College of Chaplains, Inc.*

**Review:** These two papers delineate and suggest means of implementing general guidelines for the role of pastors and chaplains in a hospital's bioethics process. Both documents stress the importance of a "pastoral presence" in all parts of the hospital's bioethics structure and in every step of the consultation process. In addition to the obvious role of spiritual counselor/caregiver to patients, family, and staff, it is recommended that the pastor or chaplain take an active role in the review and recommendation of hospital policy. Chaplains should first serve "as resource persons for understanding and interpreting faith communities and belief systems as they might relate to or be affected by proposed policies and procedures;" following this, they are to provide standard counseling to those who must implement policies with bioethical implications. It is also urged that chaplains seek out continuing education for themselves and, when able, provide it to others. In all steps of the bioethical process -- particularly consultation -- the pastor or chaplain is to identify and interpret the spiritual or religious concerns of the parties involved (while

withholding any of his or her own rigid theological biases), and provide a final analysis of the process from a spiritual perspective.

\* \* \*

*Ralph L. Carnes, Ph.D., FCOC, "Bioethical Principles and Guidelines: Links Between Theory and Practice."*

**Review:** Carnes' central argument in this article is that "a [bioethical] principle alone is not always sufficient to tell us what to do" in the clinical setting, and that it is important to interpret and apply principles to individual events. Carnes breaks this process into several steps -- from discovery or invention of a principle, to implementation of guidelines derived from the principle, to evaluation of the results of acting on these guidelines. However, says Carnes, even with these steps in mind, the use of bioethical guidelines is no guarantee that the final decision will be ethical. He dismisses the idea that ethical decisions can be based strictly on personal feelings or "gut decisions" and suggests, instead, a combination of thorough knowledge of the operative principles in a case, a balanced view of the needs and concerns of everyone involved in the case, and the patience and compassion necessary to bring a case to its best possible conclusion. Carnes concludes with a criticism of current ethics certification programs that are primarily concerned with legal and financial matters, and calls for pastors and chaplains to lead the other professions touched by bioethics back to "the philosophical, theological, and spiritual principles on which bioethical decisions are made."

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David B. McCurdy, D.Min., "Clinical Bioethics Education in Clinical Pastoral Education," *Journal of Supervision and Training in Ministry*, Vol. 14, 1992-1993.

**Review:** In discussing the place of bioethics education in Clinical Pastoral Education (CPE), McCurdy contends that ethical training is a natural complement to CPE, and that the real question is not, "Should bioethics be a component of Pastoral Education?" but is rather, "How should the two be integrated?" McCurdy presents a modified version of a plan proposed by Scott Hinrichs and Bill Nelson in 1985 for including bioethics education in Clinical Pastoral Education. He praises the strengths of the original program, such as clear presentation of bioethical ideas and the use of an ethics case study, but asserts that many aspects of Hinrichs' and Nelsons' model

need to be modified. McCurdy places special importance on the need to "articulate pastoral responses to persons struggling with common ethical problems" and on the production of "bioethically knowledgeable and aware pastors and chaplains."

McCurdy provides examples of and suggestions for implementing each of the components of his ideal CPE model: seminars covering basic bioethical knowledge and relevant material from various religious perspectives; case reports from students, submitted to a supervisor or presented to the CPE group; and two or more clinical ethical seminars, also involving group case presentations. In all cases, McCurdy stresses the need for balance between bioethics and pastoral issues, noting the humanizing effect of CPE on some otherwise "dry" ethics material, and the utility of a solid base of ethical knowledge in providing pastoral support.

### Note from the editor's desk:



In the brief space available, we obviously cannot do justice to the vast literature on medical ethics and religion that is available. However, I would like to call your attention to a superb two-part bibliography on this subject. The *Kennedy Institute of Ethics Journal* has recently published this bibliography as part of its bibliographic feature known as "Scope Notes." See the *Kennedy Institute of Ethics Journal*, Vol. 4, nos. 2 & 4, 1994. This two-part bibliography contains citations and abstracts for articles and books dealing with religious perspectives on particular ethical issues as well as sub-sections highlighting literature relevant to specific major religions and denominations.

## Upcoming Events

### CEP Series One Classes\*

March 16, 1995

8:30 a.m. - 12:00 p.m.

"Ethics Committees I: Policy, Consultation & Education"

ROBERT M. ARNOLD, M.D. -

Associate Professor of Medicine, University of Pittsburgh

April 18, 1995

1:00 p.m. - 5:00 p.m.

"Religious Perspectives on Ethical Dilemmas"

DAVID KELLY, PH.D.

Professor of Theology, Duquesne University

### CEP Series Two Classes\*

March 16, 1995

1:00 p.m. - 5:00 p.m.

"Decision Making in Health Policy:

Democratic Process and Social Justice"

IRIS YOUNG, PH.D.

Professor of Public and International Affairs, University of Pittsburgh

\* All CEP classes are held at the Education Center of the Hospital Council of Western Pennsylvania, Warrendale, PA.

### CONSORTIUM ETHICS PROGRAM

Rosa Lynn B. Pinkus, Ph.D., Director

Mark Kuczewski, Ph.D., Associate Director & Editor of  
*Community Ethics*

Anne Medsger, R.N., M.S., Evaluation Consultant

Connie Johnston, Administrative Assistant

Alan Joyce, Editorial Assistant

Connie Rakela, Intern

As always, we extend special words of thanks to the Vira I. Heinz Endowment for its continued support of the Consortium Ethics Program. We are also deeply indebted to the Ethics Task Force of the Hospital Council of Western Pennsylvania for the continued encouragement and guidance that it lends to the CEP.

If you have suggestions or questions regarding the Consortium Ethics Program, wish to submit information for an upcoming edition of *Community Ethics*, or wish to receive this newsletter, contact Mark Kuczewski, Ph.D., University of Pittsburgh Center for Medical Ethics, 3400 Forbes Avenue, Suite 110, Pittsburgh, PA 15213, phone (412) 624-3486 or fax (412) 681-1261.

The University of Pittsburgh  
Center for Medical Ethics  
and the  
Center for Continuing Education in the Health Sciences  
Present

## **Ethics for Lunch Spring 1995 Schedule**

A series of lunch-hour presentations dealing with ethical problems in medical practice.

ALL SESSIONS TAKE PLACE IN AUDITORIUM 5, SCAIFE HALL  
NOON - 1:00 P.M.

Presentations begin *promptly* at noon.

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**January 19, 1995**

Conceptualizing Genetic Identity: Of Being and Bondage

**Rhonda Hartman, J.D.**

Visiting Assistant Professor of Law  
University of Pittsburgh

**February 9, 1995**

Public Health's Images of Women:  
Madonnas and Whores, Victims, Vessels and Vectors

**Lisa S. Parker, Ph.D.**

Assistant Professor of Human Genetics  
University of Pittsburgh

**March 9, 1995**

National Health Care Policy Making:  
Oxymoron or Just Plain Moronic?

**Mark A. Peterson, Ph.D.**

Associate Professor of Public and International Affairs  
University of Pittsburgh

**March 23, 1995**

Approving New Drugs at the FDA:  
What's Changed as a Result of AIDS Activism?

**John Mendeloff, Ph.D.**

Professor of Public and International Affairs  
University of Pittsburgh

**April 13, 1995**

Newborns' Mothers and the Ethics of Screening for HIV

**Ronald Bayer, Ph.D.**

Professor of Public Health  
Columbia University

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The Center for Continuing Education in the Health Sciences, University of Pittsburgh, is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The Center for Continuing Education in the Health Sciences designates this continuing medical education activity for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association. Nurses and other health care professionals are awarded 0.1 continuing education units (CEUs).