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Hospital chaplains at the intersection between physicians and patients' families: crafting ethical response to conflicts of end-of-life care

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Project Thesis

**HOSPITAL CHAPLAINS AT THE INTERSECTION
BETWEEN PHYSICIANS AND PATIENTS' FAMILIES:
CRAFTING ETHICAL RESPONSE TO CONFLICTS OF END-OF-LIFE CARE**

By

IGNATIUS NWACHINEMERE CHIDI NZE

Dip. Journalism, Don Scotus School of Journalism, 1994
B.A., Bigard Memorial Seminary, Enugu 1995
B.A., Bigard Memorial Seminary, Enugu 2000
M.S.W., Boston College, 2015
M.A., Boston College, 2015

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Doctor of Ministry

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Approved by

Project Thesis Advisor _____
Joseph David Decosimo, Ph.D.
Associate Professor of Theology and Ethics

DEDICATION

I dedicate this thesis to my father, Anthony Onumaraekwu Nze, who often reminded me that “Life is a mystery to be lived and not a problem to be solved,” and to all physicians, patients/families, and chaplains who encounter conflicts during end-of-life care.

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Abstract

Catholic Chaplains face challenges of conflicts between families and physicians on issues of pulling off and keeping life support during end-of-life care. When conflict ensues between physicians and families in situations like this, chaplains are often called in. On the one hand, physicians recognize that chaplains have the ability to relate with families, have their trust, and so can persuade them to change their minds. On the other hand, families try to use chaplains to beat back their perceived pessimism of physicians and their suggestion to terminate life-support. While some chaplains tend to take sides with families as a way of showing religious solidarity, others tend to align with physicians as a needful collaboration with the hospital's interdisciplinary team.

This project repositions chaplains, so that instead of aligning to either side, they may maintain professional integrity and leverage their position to foster new and generative conversations by using the story telling techniques of Walter Fluker in an abbreviated Story Circle. Chaplains create new possibilities by building trust through ensuring ministry for both physicians and families, and establishing mutual respect, and good communication. This will mitigate the conflicts that occur at the intersections in health care service.

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LIST OF ABBREVIATIONS

AND	Allow Natural Death
CCC	Catechism of the Catholic Church
CPE	Clinical Pastoral Education
DNR	Do Not Resuscitate
DWD	Dying With Dignity
EOL	End-of-Life
ERDs	Ethical and Religious Directives
ICU	Intensive Care Unit
LST	Life Support Treatment
PVS	Persistent Vegetative Stage
PAS	Physician Assisted Suicide
USCCB	United States Conference of Catholic Bishops

Chapter One

1. Introduction and Overview

1.1 Introduction

At the very heart of Christianity is the person of Jesus of Nazareth, God, the Second Person of the Holy Trinity, who became man in the course of human history. Among the many realities brought to humanity and revealed through Jesus, is, of course, his deep compassion for every person, especially those he encountered who were sick and dying. As the mystical body of Christ, the Church continues his ministry to the sick and dying. . . . It is important for health-care practitioners to recognize the spiritual dimension of persons who are sick and dying, and to understand the complementary role that pastoral care shares with medical care.¹

In the above quote, Phillip G. Bochanski, a Catholic priest and a one-time chaplain of the Catholic Medical Association, Philadelphia, highlights Jesus Christ's deep compassion for all, especially the sick and dying. He calls to mind, the continuation of the Church's ministry to the sick and dying, notes the importance of the recognition of the spiritual dimension of the sick and dying by health-care practitioners, as well as understanding that pastoral and medical care share complementary roles. The spiritual care of the sick, especially in hospitals, is entrusted to hospital chaplains. In the hospitals, some chaplains are persons who provide pastoral and spiritual care to members of their faith traditions in the name of their religious affiliations, as with Catholic chaplains, and some are persons who provide pastoral and spiritual care on an inter-faith basis.

Chaplains provide pastoral and spiritual cares to patients, families and staff within the

¹ Philip G. Bochanski, "Pastoral Care of the Sick and Dying," in *Catholic Witness in Health Care: Practicing Medicine in Truth and Love*, ed. John M. Travaline and Louise A. Mitchell (Washington, DC: The Catholic University of America Press, 2017), 70.

hospital settings. Their ministries usher in the complementary roles they share with the medical team.

Daniel Winiger describes the complementary roles between the medical team and chaplains in these words, “Chaplains and physicians take care of the same critically ill patients. Physicians are exclusively responsible for the physical well-being and recovery of their patients, while chaplains help patients and their families to cope with emotional and spiritual issues related to the medical crisis.”² Alongside working with physicians, chaplains also work with other members of the interdisciplinary team. These include nurses, social workers, psychiatrics, case managers, psychologists, interpreters, and others. While every other member of the interdisciplinary team provides services according to their designated roles, many believe that chaplains too provide their services with focus on care of souls. For instance, Karen Lebacqz and Joseph D. Driskill note the traditional Latin term for pastoral care as *cura animarum*, which means “care of souls.”³ These authors note that “care of souls distinguishes pastoral care from the interventions offered by the secular helping professions, for example, social workers, psychologists, or psychiatrics.”⁴

² Daniel Winiger, *Physicians’ Perceptions of the Chaplain’s Roles in Critical Care* (PhD diss., Asbury Theological Seminary, 2007), 84.

³ Karen Lebacqz and Joseph D. Driskill, *Ethics and Spiritual Care: A Guide for Pastors and Spiritual Directors* (Nashville, TN: Abingdon Press, 2000), 62.

⁴ Lebacqz and Driskill, *Ethics and Spiritual Care*, 62.

As pastoral care personnel, chaplains are trained to address the religious and spiritual care needs of patients. Their services help patients in coping with the challenges associated with their health issues. Harold G. Koenig, et al, made a presentation on debating on the positive and negative effects of religion on health. On a positive note, these authors argue that religion helps patients in coping with their physical health. Their conclusion was drawn from their report on the responses of patients on the question of what helps them in coping with physical health. According to them, “When patients themselves are asked how they cope with physical health problems and other major life stressors, they frequently mention religious beliefs and practices.”⁵ Koenig, et al, report that their research shows that patients’ religious and spiritual care needs affect their coping ability and the rate at which they recover. Given that chaplains are trained to attend to the religious and spiritual care needs of patients, they are often called in to assess these needs and provide support. These authors conclude that “Chaplains are uniquely positioned to meet the spiritual needs of the patients, and they are the only professional in the health care setting that is trained to do this.”⁶ As trained professionals who are uniquely positioned to meet the spiritual needs of patients, as Koenig, et al noted, chaplains stand the chance of leading in meaningful conversations between physicians, patients, and families, thereby providing desirable spiritual care support to patients and

⁵ Harold G. Koenig, Michael E. McCullough, and David B. Larson, *Handbook of Religion and Health* (New York: Oxford University, 2001), 94.

⁶ Koenig, McCullough, and Larson, *Handbook*, 460.

families, and fulfilling their complementary roles with the medical team in their care of patients.

Sometimes, the complementary roles of chaplains and the medical team raise ethical issues for chaplains when physicians and families face conflicts over end-of-life (EOL) decisions. These issues can pose challenges to chaplains in their ministerial roles. For example, during end-of-life care, physicians and families may have divergent opinions regarding withdrawing care and continuing treatment. In most cases, physicians recommend withdrawal of care when they have tried all available possible treatments and arrive at the conclusion that nothing else could be done to change the situation of the patient. Mostly at this time, they evoke their allegiance of not doing harm in the process of treating patients. Mohammed Nabhan, et al, describe this medical allegiance in these words, “As part of the Hippocratic Oath, “*Primum non nocere*,” the Latin phrase that means “First, do no harm” is a basis for ethics taught in medical school.”⁷ Citing Ludwig Edelstein (1943), Ryan T. Anderson, a former visiting fellow at DeVos Center in Grand Rapids, Michigan, and a writer on marriage, bioethics, religious liberty and political philosophy, notes that the Hippocratic Oath states: “I will keep [the sick] from harm and injustices. I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect.”⁸

⁷ Mohammed Nabhan et al., “What is preventable harm in healthcare? A systematic review of definitions,” *Bio Med Central Health Services Research* 12, no.1, article 128 (2012): 1, <http://www.biomedcentral.com/1472-6963/12/128>.

⁸ Ryan Anderson, “Always Care, Never Kill: How Physician-Assisted Suicide Endangers the Weak, Corrupts Medicine, Compromises the Family, and Violates Human Dignity and Equality,” *The Heritage Foundation*, 3004 (March 24, 2015): 1.

On the other hand, most families, especially Catholic families, insist that physicians should continue treatment and not withdraw care. This insistence is primarily rooted in their religious beliefs. Some of these are the prohibitions of not enabling or participating in euthanasia and physician assisted suicide (PAS). An example of these prohibitions is presented in the discussion of the United States Conference of Catholic Bishops on issues in care for the seriously ill and dying: “We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.”⁹

Chaplains’ integrity and their professional identity could be at stake when physicians attempt to talk them into using their vantage point. The case is not different when families of dying patients who often refuse treatment withdrawal for religious reasons look up to the chaplain for intervention. The questions arise: in end-of-life situations, how could the chaplain mediate between hospital physicians and patient’s family? How could families of patients be reassured that their loved one is dying with dignity (DWD)? Being a part of the hospital staff, how may the chaplain offer families pastoral care while honoring the principles, mission and vision of the hospital? Given the fact that some patients put premium on their religious ethical tenets, how does the chaplain as a spiritual and pastoral guide, support patients and families in matters of end-

⁹ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB Publishing, 2009), 25.

of-life treatment plan that conflict with their belief? This project is set to engage the above questions to demonstrate how the hospital catholic chaplain can respond ethically to conflicts often associated with end-of-life in hospitals. It challenges chaplains to be authentic ethical leaders at the critical intersection of medical and spiritual care where professional, cultural and religious interests collide.

There are not many researches on this subject matter from pastoral theology and chaplaincy. We have a bunch of literatures from physicians expressing their challenges during end-of-life surrounding euthanasia, Hippocratic Oath and the process of dying. From the pastoral point of view, a few theologians and chaplains have lamented the tension chaplains have faced as hospital employees ministering to patients and their families and maintaining the ethical and religious teachings of the Christian faith they represent. Therefore, from authors of books that addressed aspects of this thesis, reviewed articles, relevant oral communications, writer's personal experiences and reflections, this thesis offers the reader insights into the challenges, which chaplains encounter in their ministries during end of life conflicts between physicians and families. While crafting ethical responses for chaplains in these situations, this work opens up curiosity and imaginations of the reader who may wish to engage in further research on the subject matter.

We have divided this work into five chapters for an ordered articulation. Chapter 1 consists of an introduction and an overview of the role of the Catholic hospital chaplain during end-of-life issues. It discusses the history, meaning and evolution of hospital chaplaincy, the role and professional integrity of the chaplain. Given that most end-of-life

conflicts occur in the Intensive Care Units (ICUs), this chapter presents a discussion on the ICU and issues of end-of-life conflicts therein. It presents the challenge of end-of-life as a critical point where the interests of physicians and families collide and raises critical questions about navigating at this intersection. The chapter gives a capitulation of the rest of the chapters, addressing the problem of conflicts in end-of-life situations and my vision for chaplains' interventions. We argue that hospital chaplains ought to maintain their integrity and professional identity in order to mediate in critical and conflictual chaplaincy cases. The chapter ends by highlighting Walter Fluker's narrative-based ethics and Circle Process as a praxis for ministerial approach.

Chapter 2 expounds the problem of end-of-life in the hospital setting as often constituting a tremendous ministerial challenge for the hospital chaplain. Presenting a case scenario, it highlights the nitty-gritty of the conflicts that arise between patient's physicians and their families, as well as the various values in contention during end-of-life care. Based on this, discussion is focused on how chaplains are caught in-between this conflict, and further addresses the problem of the pressure on chaplains by physicians and patients' families during end-of-life care. While physicians try to use the chaplains to get what they want, pulling life-support, families also try to use chaplains to get what they want, prolonging life. Some chaplains mistake yielding to physicians as a way to keep peace with the hospital's interdisciplinary team; others yield unduly to patients' families as a way of showing solidarity. This project notes that both responses are out of joint. This chapter discusses the concepts of brain death, natural death, compassionate extubation, and how the chaplain is put in triangulation by both physicians and families

of patients. It contends that the chaplain in the midst of pressure should be able to mediate dispassionately in the conflict and uphold a sound ethical response. This chapter leads us to a discussion on our vision for mediation in an end-of-life case by the hospital chaplain.

Chapter 3 recommends that it is ideal for chaplains to stay at the intersection between physicians' and families' conflicts during end-of-life care. At this intersection, chaplains can create new possibilities. Discussions on this chapter focus on possible ways and means that the chaplain could create new opportunities for resolution of conflicts in end-of-life situations in his ministry. This includes maintaining ethical identity, whereby chaplains remain professional in their roles, and not allow power dynamics to outweigh the empathetic care of patients, a deep understanding of the end-of-life dynamics and the honoring of human dignity. This chapter recommends that chaplains should be firm and enduring in the heat of ordeals that challenge their perspectives, and not take sides with either parties. It makes the submission that the appreciation of the idea of dignified death, which might give common ground for both parties, promotes understanding and resolution of conflictual issues between physicians and families of dying patients in end-of-life issues. This leads us to an ethical, pastoral model for concrete action.

In crafting an ethical response to the problem addressed in this work, chapter 4 argues that chaplains should be ethical leaders in order to stand at the intersection between physicians and families during end-of-life care. This section explores the resources of conflict transformation. We consider Walter Fluker's Storytelling ethics,

which is targeted to transform the dynamics among physicians, families, and chaplains, and the Circle Process as viable tools for practical engagement with end-of-life conflicts resolution. The chapter serves as a bridge between chapters 2 and 3, that is, the project's problem and ideal. It discusses, Fluker's notion of ethical leadership and narrative-based ethics as an approach to resolve conflicts as encountered by the chaplain in his ministry. It presents the Circle Process as a praxis-oriented model and a peacemaking tool for the chaplain during conflictual end-of-life conversations. We submit that the Circle Process provides a dialogical praxis for staff-families support and meaningful understanding.

The last chapter (chapter 5) explains the method of assessing the project's results. It discusses the evaluation of the activity carried out in chapter four, the transformative potential of Storytelling and Circle Process, and determines what amounts to success or failure. We submit that navigating the end-of-life conflict is a difficult task but worth the time and resources put into it. The hospital chaplain saves the institution, its staff and patients' families a whole lot when an end-of-life conflict is resolved peacefully.

1.2 Chaplains and Chaplaincy

Lindsay B. Carey, et al, "present the results of a scoping review exploring moral injury and the perspective, experiences and current role of chaplains."¹⁰ In their presentation, these authors note the derivative meaning of chaplain. According to them, "The term 'chaplain' originates from the Latin '*cappa*' - meaning a hooded cloak or cape

¹⁰ Lindsay B. Carey et al., "Moral Injury, Spiritual Care and the Role of Chaplains: An Exploratory Scoping Review of Literatures," *Journal of Religion and Health* 55, no. 4 (August 2016): 1222. <https://www.jstor.org/stable/24735912>.

– which was extended to ‘*capallanis*’ (chaplains), meaning ‘keepers of the cloak’ to attribute the role of clergy caring for people and important items or relics of sacred status maintained within a ‘*cappela*’ (*chapel*).”¹¹ This derivative definition of chaplain highlights the role of the clergy (chaplains: ‘keepers of the flock’) in caring for people. Human beings are composites of body, mind and soul. When the body or mind is sick, people seek medical attention usually in health care facilities. The Church who has the care of souls provides pastoral and spiritual care to her sick and hospitalized members. This implies hospital visitation by the clergy and women religious and includes administration of the sacraments especially the “Extreme Unction”¹² by the priests as it is believed to prepare the dying for meeting their maker. Sometimes, patients themselves request for the visit of their clergy. Hence the arrangement of community clergy who visits hospitals to provide the sacraments, especially last rites to dying believers in the hospital. The history of hospital chaplaincy therefore began with priests and religious visiting the church members to provide them pastoral and spiritual support. Thus, clergy and chaplain appeared to be interchangeable at a time in the history of health care. Writing on this understanding, John Swinton, a Scottish theologian, professor of practical theology and pastoral care, and Presbyterian minister notes, “Historically, chaplains have been ordained Christian ministers who have specific training within the fields of biblical

¹¹ Carey et al., “Moral Injury, Spiritual Care and the Role of Chaplains,” 1222.

¹² Extreme Unction also called sacrament of the sick is a sacrament administered to sick Roman Catholics especially those in danger of death. Catholics believe that it helps them prepare for the life hereafter and desire to receive it before dying.

studies and Christian theology, in order to attain their status as ordained ministers of the word and sacrament.”¹³ These chaplains, by virtue of their training, are authorities in the field of theology and faith that their church members uphold. Little wonder most Catholic patients and families prefer to have ordained ministers or religious leaders of their faith traditions to provide pastoral/spiritual care for them when admitted in hospitals.

However, the role of hospital chaplains have changed radically in the past several decades. This is due largely to the decline in the number of clergy and the expanded ministerial opportunities that Vatican II has given to the laity. The Sacred Council (Vatican II) in a radical shift from the previous council, emphasized the common priesthood shared by all the faithful via baptism and how the laity participate in the three-fold offices of Christ namely, priestly, prophetic and kingly offices or ministries.¹⁴ These promoted lay ministries as lay people now perform some of the duties that priests did hitherto, including hospital chaplaincy. Again, the role of hospital chaplains have changed over the years. In the US, this is largely due to the government emphasis on the privacy rights of patients as contained in the 1996 Health Insurance Portability and Accountability Act’s (HIPAA) “Final rule”¹⁵ Their new role requires them to undergo

¹³ John Swinton, “Professional Identity and Confidence,” in *Chaplaincy and the Soul of Health and Social Care: Fostering Spiritual Wellbeing in Emerging Paradigm of Care*, ed. Ewan Kelley and John Swinton (Philadelphia, PA: Jessica Kingsley Publishers, 2020), 161.

¹⁴ Second Vatican Council, “Dogmatic Constitution on the Church, *Lumen Gentium*, 7 December, 1965” in *Vatican Council II: The Conciliar and Postconciliar Documents*, ed. Austin Flannery (New York: Costello Publishing Company, 1975) sec. 31.

¹⁵ Michele Le Doux Sakurai, “The Challenge and Heart of Chaplaincy” *Health Progress* (January – February 2003): 27-8.

training and certification. In the US, they are required to have graduate theological education and Clinical Pastoral Education or its equivalent. Their training and certification ensure that they are theologically and clinically competent to protect the rights of patients and their families and to hear and honor their sacred stories. Today, we have men and women, ordained and non-ordained who serve in health care facilities as chaplains. These chaplains are hospital staff and members of the interdisciplinary team. This is unlike the community clergy who were guests to the health care facility.

As hospital employees, chaplains have access to patients' medical records. Indeed, chaplains have become important and integral part of patients' care. As Michele Le Doux Sakurai observes, "the chaplain has increasingly become the voice of advocacy for the patient. In a crisis, it is often the chaplain who acts as a liaison for the patient (as a member of a faith community) and medical personnel."¹⁶ It is mostly in this sense, responding to the spiritual needs and providing spiritual support for all people of faith, that chaplains are hired to work in different institutions where there are needs for spiritual care and support.

Changes in health care and advancement in technology have significantly impacted the role of chaplains. Chaplains are expected to have knowledge of crisis intervention, risk assessment, cultural and religious diversity, advocacy, ritual support, end-of-life issues, bereavement and grief. Fully integrated into hospitals' interdisciplinary team, hospital chaplains provide spiritual assessments, interventions and documentations

¹⁶ Sakurai, "Heart of Chaplaincy," 28.

in patients' charts. Sakurai observes that in addition to the above relatively new roles of chaplains, advances in medicine over the past decade has further impacted the challenging role of hospital chaplains especially in the US. According to her, technology in the field of medicine has made available various tools to enhance and prolong life. This situation puts more choices on the table for patients and their families. This increase in choices complicates the role of chaplains, as they have to get ready for a new depth of dialogue with patients and their families concerning these choices.¹⁷ Citing the Oregon state legalization of physician-assisted suicide and the implications for catholic chaplains, Sakurai observes: "Chaplains are continually called to walk the line between medicine's institutional tendencies and individual conscience."¹⁸

There are chaplains, who, by virtue of their ordination or religious affiliation, are hired specifically to provide services to the members of their community of faith. For instance, some chaplains are hired as Catholic Priest Chaplains entrusted with the responsibility of administering the sacraments and other pastoral care services to Catholic patients in the hospital. The writer of this thesis is a Catholic Priest Chaplain and Coordinator of Catholic Pastoral Services in a hospital. The discussions about chaplains reflect mostly the writer's experiences and roles as Catholic Priest Chaplain.

There are also Inter-Faith Chaplains, whose responsibilities involve ministering to all patients irrespective of their faith affiliations including the 'nones'¹⁹. In their

¹⁷ Sakurai, "Heart of Chaplaincy," 27.

¹⁸ Sakurai, "Heart of Chaplaincy," 27.

¹⁹ Nones: Those who do not identify with any faith or religious affiliation.

discussion of required skills, attitudes and practices for selecting, training and utilizing chaplains, Lindsay B. Carey and Bruce Rumbold made an explanatory study, which “presents an overview of explanatory research regarding the skills, knowledge, attitude, and practices considered necessary for chaplains to be highly competent in providing holistic care to clients and staff.”²⁰ Among the issues discussed, these authors note that “a chaplain, as part of his or her pastoral care role, may willingly, or be required to, provide spiritual care to someone of a different religious faith or, indeed, to someone of no faith at all.”²¹ In preparation for this inter-faith ministry, chaplains are trained by taking Units of courses in Clinical Pastoral Education.

Pat O’Donovan describes chaplains as specialists in pastoral duties, and notes that this role “presents many ministerial and professional challenges that need to be discerned, acknowledged and addressed....”²² Donovan expresses that “Each challenge is also pregnant with opportunity that we as spiritual care practitioners, and as pastoral educators, can midwife into birth.”²³ Chaplains being at the intersection of end-of-life conflicts between physicians and families is a notable challenge of hospital chaplaincy

²⁰ Lindsay B. Carey and Bruce Rumbold, “Good Practice Chaplaincy: An Explanatory Study Identifying the Appropriate Skills, Attitude and Practices for the Selection, Training and Utilization of Chaplains,” *Journal of Religion and Health* 54, no. 4 (2015): 1416.

²¹ Carey and Rumbold, “Good Practice Chaplaincy,” 1420.

²² Pat O’Donovan, “Healthcare Chaplaincy,” *The Furrow* 59, no. 5 (2008): 264.

²³ O’Donovan, “Healthcare Chaplaincy,” 264.

services. This challenge creates opportunity that we can *midwife into birth*: by crafting ethical responses. In response to the many challenges that chaplains encounter in their ministries to patients, families, and the health care staff, mostly during end-of-life care, this thesis crafts ethical responses, which offer chaplains the tools to navigate through the conflicts by neither taking sides with any of the parties, nor compromising their professional integrity. I submit that it is a problem when chaplains succumb to the divergent standpoint of either physicians or families. However, their role of *caring for the soul* of patients should remain a priority.

Hospital chaplains provide chaplaincy services within the setting of hospitals. Swinton describes chaplaincy as “a discipline which is deeply implicated in issues of values and meaning.”²⁴ In the face of suffering or loss, people struggle with meaning making, together with reconciling various life values. This author unveils the challenges that chaplains face, in his description of chaplaincy, thus: “Its daily encounter with people on an intimate and deeply trusted level, combined with the primary task of caring for the person’s spirituality, a dimension of experience which is inherently caught in systems of meaning and belief, means that ethics and moral principles provide some of the intrinsic ‘grammar’ of chaplaincy.”²⁵

This issue of ethics and morality highlights a crucial and critical aspect of chaplaincy. Most chaplains, like myself, represent a faith community. Patients and

²⁴ Swinton, “Professional Identity,” 162.

²⁵ Swinton, “Professional Identity,” 162.

families of faith community, like Catholics, often hold tenaciously to the ethics and moral principles of their faith community when faced with issues that are mostly guided by the ethical and moral standards of their faith practice. The values that patients and families care for, are at the core of chaplaincy services. In other words, a notable aspect of chaplaincy is its focus on addressing issues of ethics and moral principles that patients and families who seek chaplaincy services face. Consequently, people who identify as religious naturally want the attention of chaplains who represent their faith tradition when they are in hospital. Chaplains are seen as carriers of their faith tradition and patients and their families look up for them, especially in times of decision-making that affect their core faith teaching and doctrines.

This project is about how the chaplain could navigate through a meaningful intervention in the face of conflicting opinions of the patients and families on their religious or faith values as well as the physicians' professional values. As a Catholic priest, what I present here represents a Catholic perspective coming especially from my experience of hospital chaplaincy. The Magisterium of the Catholic Church teaches about human life and respect for human dignity from birth until death. According to the Catechism of the Catholic Church, "Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognized as having the rights of a person – among which is the inviolable right of innocent being to life.... Among such fundamental rights one should mention in this regard every human being's right to life and physical integrity from the

moment of conception until death.”²⁶ Many Catholics, in conscience, want to observe the teachings and this often comes in conflict with the ethics and practice of modern medicine. It is pertinent therefore that we highlight the Catholic teaching on the value of human life with emphasis on the dying.

1.3 The Catholic Church’s Teaching on Human Life and Dignity

In her moral theology, the Church upholds the sacredness of life. Human life is sacred and should be treated as such from its beginning until its end; it is God’s gift that involve his creative activity and God alone remains its end. As such, “no one can under any circumstance claim for himself the right directly to destroy an innocent human being.”²⁷ The Church’s teaching reflects her understanding of the fifth commandment of God, “Thou shall not kill.”²⁸ Her teaching condemns every form of intentional homicide and unjust war. Any direct or intentional killing of an innocent human person is considered a grave sin that cries out to heaven for vengeance. This is same with abortion, suicide and euthanasia. The Church teaches that “Christ’s redemption and saving grace embrace the whole person, especially in his or her illness, suffering, and death.”²⁹ As such, sick people deserve special respect and care. She condemns direct euthanasia,

²⁶ *Catechism of the Catholic Church* (Vatican City: Libreria Editrice Vaticana, 1992), no. 2270, 2273.

²⁷ *Catechism of the Catholic Church*, no. 2258, 526.

²⁸ Ex 20:13, Deut 5:17.

²⁹ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB Publishing, 2018), 25.

which is a deliberate attempt to bring an end to life of a sick, handicapped or dying person. The Church understands and appreciates the fact that the core aim of medicine in caring for the dying is the management or relief of pain and the suffering therefrom. Nonetheless, a deliberate attempt to end any life is condemnable. “Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator.”³⁰

The Church however, legitimizes the withdrawal of extraordinary means of life support to allow dying persons die naturally.

Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of “over-zealous” treatment. Here one does not will to cause death; one’s inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.³¹

Sometimes, in concrete terms, it is not very clear what constitutes extraordinary or disproportionate means. Patients and their families therefore in such critical moments turn to the chaplain for guidance. The chaplain is expected to know the ethics, moral principles and teachings of the Church in order to offer proper guidance. What is basic here is the Christian meaning of life, suffering and death. According to the Church’s teaching, life as a precious gift from God, is to be preserved and used for the glory of God. Our duty to preserve life is not absolute; there is indeed a time or stage when

³⁰ *Catechism of the Catholic Church*, no. 2276.

³¹ *Catechism of the Catholic Church*, no. 2278, 530.

medicine cannot cure. In using life-sustaining technology therefore, the Church warns against two extremes: “On the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death.”³²

The latter risk, ‘withdrawal of technology with the *intention* of causing death’, in my hospital ministerial experience, is what many families are trying to avoid in the case of their dying loved ones. The conscience of some Catholics do not allow them to permit the withdrawal of life support for fear of intending the death of their loved ones. This moral and religious value often conflicts with the moral and professional values of the physicians. The chaplain, who is both a hospital employee and a member of a faith community stands at the intersection where the traffic is busy and stuck. Our role as chaplains is to balance and make sense of the spectrums at the end-of-life situations, thinking about how to fill the gaps that exist between the two poles. Effective navigation at this intersection requires the chaplain’s professional integrity.

1.4 Chaplains: Maintaining Professional Identity

In their ministry, hospital chaplains strive to meet the pastoral and spiritual care needs of patients and their families. This often comes with the challenge of attempting to fix the *presenting problems* as a way of fulfilling their ministerial role. On one hand, this challenge is generated by the expectations of patients and their families on chaplains to

³² United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 6th ed. 26.

provide desired intervention to their spiritual care needs. This situation presents the temptation whereby chaplains assume to solve all of people's problems and being unmindful of their human limitations. In this situation, chaplains are to eschew the temptation of assuming to solve all of people's problems. Instead, they should rather be mindful of their limitations, as well as their needful interventions. According to Lindsay B. Carey and Bruce Rumbold, chaplains are not to over-extend themselves in trying to fix the problems of patients, as well as not proceeding beyond their professional boundaries: "[We] can't necessarily cure anyone, but we can certainly care for people while they work through their life journey—whatever might be on their way to healing."³³

On the other hand, chaplains face the challenge to their professional identity coming from the hospital administration. In health care facilities, for instance, there is an increasing pressure put on chaplains to show the effect chaplaincy services have on health care outcome by the hospital administrators.³⁴ In doing so, emphasis is sometimes placed on the quantity rather than the quality of care by spiritual care givers. While trying to demonstrate the impact of their services to the facility, chaplains ought not to compromise their identity as ethical spiritual care givers. Rather, they should, to the best of their ability, offer quality care that impact care receivers profoundly. Time, attention, and resources spent in trying to resolve one end-of-life case, for instance, impacts the quality of health care outcome significantly.

³³ Carey and Rumbold, "Good Practice Chaplaincy," 1426.

³⁴ Koenig, McCullough, and Larson, *Handbook*, 460.

1.5 Overview

1.5.1 Physicians' and Patients' Families' Conflict

This project discusses end-of-life crises where there are conflict of values between physicians and the families of dying persons, and postulates how chaplains' interventions can be transformative. It deals with a case scenario that highlights conflict between physicians and patients' family during end-of-life care. In this case scenario, it was noted that there had been a "stand-off" between the physicians and family of a patient. The ethics consultation convoked several meetings that involved physicians, nurses, social workers, and family. Having tried all they could do for the patient, the physicians stated that further treatment would be futile. They also noted that some other patients who could benefit from intensive care were being denied the bed. Therefore, the physicians recommended the removal of the breathing machine and sought permission for Do Not Resuscitate (DNR) order. But the patient's daughter, Pam, did not comply. She declined the DNR order and insisted that the medical team code (resuscitate) her father until he is brain dead. She claimed that the physicians were asking her family to murder their father, and expressed that her insistence on having her father coded until he is brain dead is her family's belief.

Pam's claim, as noted herein, depicts the understanding of most families when DNR order is proposed during end-of-life care. In a study that addressed how change of words from Do Not Resuscitate (DNR) to Allow Natural Death (AND) could impact

decisions during end-of-life care, S. S. Venneman, et al, referencing C. Meyer,³⁵ write: “Family members often misunderstand a do not resuscitate order (DNR) as giving permission to terminate a loved one’s life, leading to conflict and often resulting in unnecessary suffering by the patient.”³⁶ Instead of yielding to physicians’ recommendation for DNR, most families, especially Catholics, insist on allowing their family members die a *natural death*, that is, the choice of dying without human (medical) interference in the dying process.

Although chaplains were not mentioned as participants in the ethics consultation presented in the case scenario, the incident of the case scenario is a typical example of cases where chaplains are invited to be part of the conversation where physicians and families disagree on end-of-life care of patients. As noted in the description of the case scenario, patient’s daughter’s insistence on coding her father till he is brain dead is based on the family’s belief. It is mostly on such issues, like family’s belief, that chaplains are often called in to provide spiritual care and support. Hospital chaplains encounter ethical dilemmas in their ministries to patients, when physicians and families disagree during end-of-life issues. Based on this, discussion is focused on how chaplains are caught in-between this conflict, and further addresses the problem of the pressure on chaplains by physicians and patients’ families during end-of-life care. While physicians try to use the

³⁵ Chuck Meyer was Vice President of Operations and Chaplain at St. David’s Medical Center in Austin, Texas.

³⁶ S. S. Venneman, P. Narnor-Harris, and M. Perish, “Allow natural death” verses “do not resuscitate”: three words that can change a life,” *Journal of Medical Ethics* 34 (2008): 2, <https://jme-bmj-com.ezproxy.bu.edu/content/medethics/34/1/2>.

chaplains to get what they want, pulling life-support, families also try to use chaplains to get what they want, prolonging life. Some chaplains mistake yielding to physicians as a way to keep peace with the hospital's interdisciplinary team; others yield unduly to patients' families as a way of showing solidarity. This project notes that both responses are out of joint.

The importance of faith or religion is noted as being crucial to most patients. In my ministry as a hospital chaplain, I have encountered patients and families who expressed that nobody could hear them, that only God could hear them. For these patients and families, this is why they request for the presence of a chaplain. They believe that chaplains do "God's work" and are able to hear them. Most of the patients and families I ministered to, especially during those moments of feeling unheard by anyone else except God, acknowledge being comforted by the chaplain's ministries of compassionate presence and supportive listening. With this in mind, it is important to note that the role of a chaplain during end-of-life conflicts is not solely a mediator. Worthy of note also is the fact that not all of the situations of end-of-life ministries that chaplains engage with patients, physicians, and staff, are conflictual. In other words, as much as chaplains experience ethical challenges in responding to the incidents of conflicts between physicians and families during end-of-life care, not all the end-of-life care ministries of chaplains are conflictual. There are also numerous instances of end-of-life care that go well without conflicts between physicians and families, invariably, without constituting ministerial dilemma's for chaplains. Most of the end-of-life care conflicts that require

intervention of chaplains occur in the Intensive Care Units. This takes us to a conversation on ICU as a notable unit of end-of-life conflicts.

1.5.2 Intensive Care Unit: Notable Unit of End-of-Life Care Conflicts

From my ministerial experiences in the hospital, most of the end-of-life cares take place in the Intensive Care Units (ICUs). As a result of the critical nature of their illnesses, most patients in the ICUs struggle between life and death, that is, their conditions raise concerns about their chances of recovery and the fear of their dying. Daniel Winiger writes, “When patients are admitted to intensive care units, their conditions are to various degrees critical. For many patients, their days in an intensive care unit are their last.”³⁷ The knowledge of one’s imminent death could be overwhelming to patients and their families. While some patients and families understand and accept the information provided by the medical team concerning imminent death, some rather live in denial of the fact that death is imminent. Whichever is the case, in the face of death, patients and families are weighed down by anticipatory grief and loss, a state of mind that alters their very being.

In a Podcast hosted on Hidden Brain Media, this alteration of personhood is expressed in these words, “Many of us believe we know how we’d choose to die. We have a sense of how we’d respond to a diagnosis of an incurable illness. This week, we have the story of one family’s decades-long conversation about dying. What they found is that people we are when death is far in the distance may not be the people we become

³⁷ Winiger, *Physicians’ Perceptions of the Chaplain’s Roles in Critical Care*, 9.

when death is near.”³⁸ When patients get to the point of requiring intensive care, and in most cases, transitioning to Comfort Measures Only (CMO), it often creates anxiety and desperation for families. The Catechism of the Catholic captures the impact of illness, thus: “Illness can lead to anguish, self-absorption, sometimes even despair and revolt against God. It can also make a person more mature, helping him discern in his life what is not essential so that he can turn toward that which is. Very often, illness provokes a search for God and a return to him.”³⁹

When illness leads to anguish, there tend to be rash and extreme behavior while coping with such distressful situation. An example of this is the insistence by families on continuing *aggressive* treatments for patients even when it becomes obvious that medical intervention could no longer change the situation. Such insistence creates conflict between families and physicians. Writing on ethical conflicts experienced by Intensive Care Unit health care professionals in a regional hospital, Limpopo province in South African, Dorah U. Ramathuba and Hulisani Ndou express, “Family members are also a source of conflicts in health settings as they sometimes impose their values and beliefs in the care of the patient.”⁴⁰ The family members’ imposition of their values and beliefs in

³⁸ Shankar Vedantam, “The Ventilator,” *Hidden Brain Media*, Podcast audio, <https://hiddenbrain.org/podcast/the-ventilator/>

³⁹ *Catechism of the Catholic Church*, no. 1501.

⁴⁰ Dorah U. Ramathuba and Hulisani Ndou, "Ethical conflicts experienced by intensive care unit health professionals in a regional hospital, Limpopo province, South Africa," *Journal of Interdisciplinary Health Sciences* 25, no. 5 (2020): 5, https://link.gale.com/apps/doc/A623223279/AONE?u=mlln_b_bumml&sid=AONE&xid=b502ba3c.

the care of the patient, as Ramathuba and Ndou noted, is mostly triggered by the difficult decisions they have to make, as well as the fear of losing a family member. This could be overwhelming. Winiger's finding explains the dilemma that families face during end-of-life care. According to him, "Many of these patients' health have deteriorated to the point where families have to make difficult decisions on behalf of these patients. Chief among these decisions is to withdraw aggressive treatment, such as life support. The withdrawal of life support, (e.g., mechanical ventilation, dialysis, or any other life sustaining treatment) results in the demise of the patient."⁴¹

The Catechism of the Catholic Church referenced above note how the search for God and return to him is often provoked by illness. This is typical of Catholic patients and families, especially when a family member is struck by life-threatening illness. Moved by their faith and quest for God, they mostly request for chaplains. Winiger observes that "The challenges requiring the intervention of chaplains often involve cases where religious matters have become complicated to manage, and families poorly cope with the medical realities at hand."⁴² The expressed need for chaplains when families cope with medical realities at hand points to the relevance of religious coping when patients are critically ill in the Intensive Care Units. Chaplains assist patients and families in navigating through the difficult moments of poor diagnosis and end-of-life situations.

⁴¹ Winiger, *Physicians' Perceptions of the Chaplain's Roles in Critical Care*, 9.

⁴² Winiger, *Physicians' Perceptions of the Chaplain's Roles in Critical Care*, 10.

Harold G. Koenig, et al, discuss the need for chaplain services in healthcare settings. Referencing Parkum's (1985) survey of 432 patients at six hospitals in Pennsylvania, a study that examined patients' satisfaction with chaplain services, these authors note that "... it appears that chaplain services fill an important need that is not addressed by other hospital staff."⁴³

With their knowledge of the Bible, theology, the bio-ethical teachings of the Church, and Clinical Pastoral Education (CPE), Catholic chaplains provide supportive ministries to patients and families in moments of critical illnesses and life-threatening health issues during admissions in the Intensive Care Units. Winiger's observation buttresses this claim, "As families make heart-wrenching decisions, they have to negotiate complex medical information with faith. Trained and experienced chaplains are able to support and guide families through the decision-making process."⁴⁴ It is important to note that chaplains' supportive ministry to families as they process complex medical information in the Intensive Care Units often meet with difficulties while standing at the intersection of the conflicts that ensue between physicians and families regarding end-of-life care plan. A portion of this project is devoted to a discussion on end-of-life care in Intensive Care Units and how this poses problem for the services of chaplains.

1.5.3 Scope of Discussion

⁴³ Koenig, McCullough, and Larson, *Handbook*, 421.

⁴⁴ Winiger, *Physicians' Perceptions of the Chaplain's Roles in Critical Care*, 10.

Chaplains work in different institutions, like prison, school campus, and hospital. Our discussion on chaplains focuses on hospital chaplains. Grounded in Clinical Pastoral Education (CPE) that encompasses the knowledge of psychology, spirituality, theology and religion, hospital chaplains, through ministries of presence, supportive listening, building relationship of trust, as well as other notable interventions, provide pastoral care and counseling, spiritual and emotional supports to patients, families, and staff. Christina M. Puchalski, a medical doctor and an internationally recognized pioneer in the field of spirituality and health, and Betty Ferrell, a registered nurse and research scientist, present discussions that focus on integrating spirituality into the care of patients. These authors' described CPE in their discussion. Their description offers a broad knowledge of what CPE is: "CPE is an interfaith professional education for ministry. It brings theological students and ministers of all faith (pastors, priests, rabbis, imams, and others) into supervised encounters with persons in crisis. Out of an intense involvement with persons in need, and the feedback from peers and teachers, students develop a new awareness of themselves as persons and the needs of those to whom they minister."⁴⁵

Hospital Chaplains participate in providing pastoral care for patients, family and staff. Karen Lepacz and Joseph D. Driskill describe pastoral care as "the broad term used by mainline Protestants to encompass any caring action performed by pastors and other recognized religious leaders who minister by virtue of their ordination or office on

⁴⁵ Christina M. Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality Into Patient Care* (West Conshohocken, PA: Templeton Press, 2010), 159.

behalf of a community of faith.”⁴⁶ By participating in this basic ministry of care, chaplains enter into the *sacred spaces* of those they minister to. For instance, they are privileged to be entrusted with the *ups and downs* that happen in the lives of the patients.

This project does not seek to explore and discuss all chaplains in all denominations and faith groups at the intersection of end-of-life conflicts between physicians and families. Rather, it focuses on situations that have antagonistic relationship between physicians and Catholic families regarding end-of-life decisions and need a chaplain to mediate. The use of the word, “chaplain”, in this thesis mostly refers to Roman Catholic hospital chaplains. Chapter two of this project draws attention to Catholic patients and their value for dignity of life, as an intrinsic part of their faith and belief. For these Catholic patients, life is sacred, and as such, the dying should be allowed a *natural death*. By dying a *natural death*, we mean there should be no human (medical) interference in the process of dying either by withdrawing nutrition, treatment, or by directly administering medication that could lead to death.

It is also important to note that my discussion about hospital chaplains (notably Catholic Hospital Chaplains) being at the intersection between physicians and families during end-of-life care is predominantly with these in mind: dealing with the expectations of physicians and families regarding withdrawing care and insisting on continuing care, respectively. Families hold on to their Catholic faith and doctrines. For instance, the Catholic Church emphasizes the sacredness of life and respect for human dignity. The

⁴⁶ Lebacqz and Driskill, *Ethics and Spiritual Care*, 61.

physicians hold on to their professional views, like doing no harm, and medically-informed perspectives. Chaplains can find themselves in-between the conflict of pulling off or keeping life-support during end-of-life care, a situation that is challenging to their ministerial roles. It is a challenging situation for chaplains because some may take side with the physicians as a way of demonstrating their loyalty to the hospital that they work for, while some may take side with the families as a way of showing faith solidarity.

1.5.4 My Vision

Chaplains can stand at the intersection where physicians and families collide during end-of-life care and provide new possibilities for physicians and families as they relate to one another. For instance, instead of giving in to the pressure from the hospital medical team to accept the proposal of pulling life-support, or to fight thoughtlessly on behalf of a family in a state of grief-induced denial, it is ideal for chaplains to be mindful of their calling: “to relieve spiritual distress, ease guilt⁴⁷, and to provide comfort,”⁴⁸ and pastoral care to patients, their families, and staff.⁴⁹ They do this as they are guided by the

⁴⁷ Physicians and families may deal with the guilt of violating the Hippocratic Oath of not doing harm (as families unduly insist on continued treatment) and the guilt of not resisting the process of ‘ending’ the life of a helpless family member (as physicians unduly attempt to remove life support), respectively. Chaplains play the role of providing comfort that alleviates guilt in both parties.

⁴⁸ George Grant et al., “Chaplains’ Role in End-of-Life Decision-Making: Perspectives of African American Patients and their Family Members (S711),” *Journal of Pain and Symptom Management* 49, Issue 2 (February 2015): 413, [https://www.jpsmjournal.com/article/S0885-3924\(14\)00776-3](https://www.jpsmjournal.com/article/S0885-3924(14)00776-3)

⁴⁹ The idea of chaplains providing pastoral care to patients, families, and staff is reflected in the standard job description of chaplains: “The Staff Chaplain provides pastoral/spiritual care for patients/residents, their loved ones, and the healthcare staff,” <https://www.hmachaplains.org/sample-job-description-for-staff-chaplain/>

ethical standards of their roles, and as they work with Hospital Ethics Committees to resolve conflict between physicians and the families of patients when patients are in critical conditions during end-of-life care. Chaplains are there to create new possibilities.

Chaplains create new possibilities by building trust through ensuring ministry for both physicians and families, and establishing mutual respect, and good communication. Richard Eyer expresses it this way: “A complementarity between religion and medicine in which both spiritual and physical needs are met, fosters mutual trust and respect which enable doctor and chaplain to have their own needs met when faced with their own loneliness, sense of failure, ethical dilemmas, and the loss of income and/or authority in medicine.”⁵⁰ Fostering mutual trust and respect opens up the possibility of compromise. As Marc Gopins explains: “There is no compromise without trust and respect, and being heard, being acknowledged and honored are critical to building trust and respect.”⁵¹ When all goes well, chaplains create new possibilities by changing a conversation that is stuck.

They also create new possibilities by introducing an idea like “dignified death,” which creates common ground for both parties. The understanding of dignified death may vary between medical, family, and various religious perspectives. However, it means that

⁵⁰ Richard Eyer, “Building Mutual Trust and Respect within the Chaplain/Physician Relationship,” *Journal of Health Care Chaplaincy* 3 no. 2 (1991): 30-31, <https://www.ncbi.nlm.nih.gov/pubmed/10110936>.

⁵¹ Marc Gopin, *Healing the Heart of Conflict: 8 Crucial Steps to Making Peace with Yourself and Others* (Emmaus: PA, Rodale Books, 2004), 42.

“the dying needs to be assured that their lives will not be arbitrarily shortened, ... that they will not be subject to unreasonable and burdensome therapies, that medical technology will be used for their integral well-being, that their free and informed decisions will be respected, and that they will not be marginalized or abandoned by the community in their dying.”⁵² An ideal like “dignified death” can address the physicians’ desire to keep patients free from prolonged suffering, while also meeting the families’ need to know that the patient’s life is not arbitrarily shortened. It is a concept that chaplains may use to build a bridge between physicians and patients’ families.

This approach, which centers on trust and a dignified death can bring peace and comfort. It is not about keeping peace by joining with one side against another, but about moving both sides to a different and better place. That kind of peace is kingdom peace, which reflects the description of harmonious correlation in Isaiah 11:6-9.⁵³ That kind of peace and comfort is an expression of Jesus’ own mission as expressed in Luke 4:18, “The Spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor; he hath sent me to heal the brokenhearted, to preach deliverance to the captives, and recovering of sight to the blind, to set at liberty them that are bruised.”⁵⁴ An end-of-

⁵² Thomas R. Kopfensteiner, “Death with Dignity: A Roman Catholic Perspective,” *The Linacre Quarterly* 63, no. 4 (1996): 64, <http://epublications.marquette.edu/Inq/vol63/iss4/8>

⁵³ Referring to the Messianic Kingdom where all of God’s creatures will live together in peace and harmony.

⁵⁴ King James Version (KJV) Translation.

life conflict can be heartbreaking for both physicians and families. The chaplains' work can afford peace and comfort by healing these brokenhearted parties.

1.5.5 Filling the Gap

To fill the gap between the problem and my vision, this project seeks concrete measures of crafting an ethical response to conflicts over end-of-life care between physicians and patients' families, by chaplains. First, chaplains are to assume the duty of ethical leadership. The understanding of ethical an leader deployed here is taken from Walter Fluker who explains: "Leaders who are able to stand at the intersection of personal reality and possibility (character), social reality and possibility (civility), and spiritual reality and possibility (community) and consciously set goals and objectives and implement life-affirming resolutions are what we are terming ethical leaders."⁵⁵ By being ethical leaders⁵⁶, chaplains will be able to stand at the intersection between physicians and families during end-of-life care.

In imagining a solution to the challenge that chaplains encounter in standing at the intersection where physicians and families collide at end-of-life care of patients, it is pertinent for chaplains to explore theories of transformational leadership that would inform solutions. In the hospital context, chaplains could think of assisting physicians and families to be empathetic with one another. In "The Many Faces of Emotional Leadership," Ronald H. Humphrey notes, "Empathy is shown to be an important variable

⁵⁵ Walter Earl Fluker, *Ethical Leadership: The Quest for Character, Civility, and Community* (Minneapolis, MN: Augsburg Fortress, 2009), 166.

⁵⁶ In a preferred sense, "ethical personnel."

that is central to both emotional intelligence and leadership emergence.”⁵⁷ On one hand, chaplains should encourage physicians to be empathetic to the distressful anxieties and dilemma of families on the difficult decision of removing life-support. On the other hand, chaplains should also be mindful to the moral distress, which physicians in the consciousness of their Hippocratic Oath are concerned about doing harm to patients, rather than good. Chaplains should apply the use of story-telling in ministering to physicians’ and patients’ families during end-of-life care. William G. Kirkwood, Assistant Professor of Communication, East Tennessee University, suggest that the beliefs and attitudes of listeners are challenged by some stories.⁵⁸ By applying the use of story-telling in conflict resolutions during end-of-life care, chaplains stand the chance of evoking challenging intervention that could transform the beliefs and attitudes of physicians, patients and their families. Story-telling is a veritable tool for the formation of personnel in conflict transformation. This is reflected in Fluker’s description of a new generation of leaders, which “will require a methodological emphasis on the power of story and the practice of remembering, retelling, and reliving these stories through imaginative journeying to meet the unicorn.”^{59,60} By this approach, chaplains will be able

⁵⁷ Ronald H Humphrey, “The Many Faces of Emotional Leadership,” *The Leadership Quarterly* 13, no. 5 (October 2002): 493.

⁵⁸ William G. Kirkwood, “Storytelling and Self-Confrontation: Parables as Communication Strategies,” *Quarterly Journal of Speech* 69, no. 1 (1983): 59.

⁵⁹The expression “to meet the unicorn” here means arriving at a perspective that is shared and not one-sided.

⁶⁰ Fluker, *Ethical Leadership*, 166.

to draw out each party's story, and respectively tell these stories to the other. The effect of this story telling is that physicians will be able to better hear the patients' family's stories, and the patients' families in turn will be able to hear the physicians' stories. By hearing each other's story, chaplains will be able to build a bridge between physicians and patients' families. This will provide chances for understanding and acknowledging each other's stand on the issue at hand.

Understanding and acknowledging the stories of others can change a conflict. Jasmine R. Linabary, Arunima Krishna, and Stacey L. Connaughton note that "Storytelling has transformative potential."⁶¹ This potential could be as straightforward as simply arousing empathy between two opposing parties. Obviously, when someone empathizes with another, new possibilities open up in conflict situation. Empathizing with others can make them feel heard, and "being heard, being acknowledged, and honored are critical to building trust and respect."⁶² Narrating one's story, at some point, can offer others the opportunity to connect with one's perspectives and make them feel that their concerns have been reflected. This can create a moment of resolution toward peace. In a nutshell, storytelling creates empathy, and empathy helps resolve conflicts.

In the process of storytelling, there are possibilities of *exhuming* forgotten or unidentified pieces that may resonate with both parties and move conversation forward.

⁶¹ Jasmine R. Linabary, Arunima Krishna, and Stacey L. Connaughton, "The Conflict Family: Storytelling as an Activity and a Method for Locally Led, Community-Based Peacebuilding," *Conflict Resolution Quarterly* 34, no. 4 (Summer 2017): 446.

⁶² Gopin, *Healing the Heart of Conflict*, 42.

This is what Fluker describes in his presentation of *Remembering Our Stories*:
“Remembering our stories offers entrée into forgotten worlds of meaning that allow recovery of dismembered bodies of experience otherwise invisible to consciousness.”⁶³
Recoveries of these bodies of experiences can usher in the feelings of being welcomed and honored. In this sense, Gopin writes, “When someone is feeling respected, welcomed, honored even, then they are much more likely to feel like being generous in the emotional sense of the term, and generosity of spirit is critical to healing.”⁶⁴ In storytelling, “Words and rhythms, images and expressions, meanings that are now nuanced, now replete with common sense, the humorous, the predictable, and the unexpected are juxtaposed in ways that coinvolve the partners in a dance of dialogue.”⁶⁵

One way for chaplains to create a comfortable platform where everyone’s voice could be heard is by exploring the resources of conflict transformation, specifically the Circle Process. Kay Pranis describes the Circle Process as “a story-telling process,”⁶⁶ where “participants explain themselves by telling their stories.”⁶⁷ Referencing Janelle Smith, Jessica Metoui notes that “A peacemaking circle process incorporates components

⁶³ Fluker, *Ethical Leadership*, 168.

⁶⁴ Gopin, *Healing the Heart of Conflict*, 42.

⁶⁵ Jack Finnegan, “Dialogue and Theory in Clinical Supervision,” in *The Soul of Supervision: Integrating Practice and Theory*, ed. Margaret Benefiel and Geraldine Holton (New York: Morehouse Publishing, 2010), 122.

⁶⁶ Kay Pranis, *The Little Book of Circle Process: A New/Old Approach to Peacemaking* (Philadelphia: Good Books, 2005), 4.

⁶⁷ Pranis, *The Little Book of Circle Process*, 8.

of interest-based negotiation, mediation, and consensus building.”⁶⁸ Pranis highlights this in his definition of Conflict Circles: “A Conflict Circle brings together disputing parties to resolve their differences. Resolution takes place through a consensus agreement.”⁶⁹ He presents the idea of Circle Process this way:

Participants sit in a circle of chairs with no tables. Sometimes objects that have meaning to the group are placed in the center as a focal point to remind participants of shared values and common grounds.... Using very intentional structural elements--ceremony, a talking piece, a facilitator or keeper, guidelines, and consensus decision-making—Circles aim to create a space in which participants are safe to be their most authentic self.... By allowing only the person holding the talking piece to speak, a Circle regulates the dialogue as the piece circulates consecutively from person to person around the group. The person holding the talking piece has the undivided attention of everyone else in the circle and can speak without interruption.... The facilitator of the Peacemaking Circle, often called a keeper, assists the group in creating and maintaining a collective space in which each participant feels safe to speak honestly and openly without disrespecting anyone else.... Participants in a Circle play a major role in designing their own space by creating the guidelines for their discussion.... Decisions in a Circle are made by consensus.⁷⁰

The Circle Process is relevant to my context because it is a participative and dialogical activity. As a pedagogy, it includes a dynamic of active participation of all participants as well as a critical reflective component. As a peacemaking activity, it aids in resolving conflicting issues that affect the interest of the living and the dying, the hospital staff and management as well as the family of the patient. The aim is to honor

⁶⁸ Jennifer Metoui, “Returning to the Circle: The Reemergence of Traditional Dispute Resolution in Native American Communities,” *Journal of Dispute Resolution* 2007, no. 2 (2007): 527.

⁶⁹ Pranis, *The Little Book of Circle Process*, 16.

⁷⁰ Pranis, *The Little Book of Circle Process*, 11-13.

the dying and to make peace among the living as professional, cultural and religious interests are at stake. It is my expectation that the storytelling and the decision making process of the activity would give both parties the attention and understanding or values they seek.

In addition to Pranis's description of Circle Process, it is pertinent to note that participants have the opportunity to fully express their emotions while others listen attentively. The facilitator moderates with discretion. Every person has a story. By engaging in the Circle Process, everyone's voice is heard. When everyone's voice is heard, the goals of peacemaking circle are achieved. Citing Costello, Metoui highlights these goals: "The goals of the peacemaking circle, much like the goals of restorative justice are "to restore dignity, to bring peace to the parties involved, and to sustain community health by repairing relationships damaged in conflicts."⁷¹ The complete procedure of Circle Process⁷² may be difficult to work out in a hospital setting where the physicians are busy with hospital schedules, and patients' families occupied with anxiety and distractions. However, chaplains can use the storytelling part of it to intervene during end-of-life care.

⁷¹ Metoui, "Returning to the Circle," 527.

⁷² For instance, "It draws on the ancient Native American tradition of using talking piece, an object passed from person to person in a group and which grants the holder permission to talk." – Pranis, *The Little Book of Circle Process*, 3.

Chapter Two

2. Addressing the Problem

2.1 Insight into Chaplains' Ministry during the Problem of End-of-Life Conflicts

After a week of “stand-off” between the family and health care team, the ethics consultation continued and involved several meetings between physicians, nurses, social workers, and family. The patient had not responded to treatment and had become steadily worse. His physicians and nurses stated further treatment was “futile.” Also, other patients who could benefit more from intensive care were being denied the bed. They recommended to the daughters that the breathing machine be removed and, if his heart stopped, that he be allowed to die without massaging his chest or restarting his heart by electroshock. They needed to write a DNR order. Pam objected, saying again, “You are asking us to murder our father. This is our belief. We want him coded (resuscitated) until he is brain dead!” In desperation, a physician turned to a nurse and said, “Do we have to take this? What can physicians and nurses do when the law gives the family the upper hand in a dispute like this? What can we do about our own ethical position of not inflicting torture on this hopelessly ill patient? And what about the injustice to other patients?”⁷³

This case scenario was presented by John C. Fletcher, a former Episcopal priest and leading biomedical ethicist, in his discussion on decisions to forego life-sustaining treatment when the patient is incapacitated. It was an encounter between a patient's family and health care team during an end-of-life care. Although chaplains are not mentioned among the participants of the several meetings that involved the family and the healthcare interdisciplinary team, this case scenario is a typical example of an end-of-life conflict between physicians and family where chaplains are engaged in spiritual care consults. As noted above, patient's daughter insisted that her father be coded until he is

⁷³ John C. Fletcher, “Decisions To Forego Life-Sustaining Treatment When the Patient is Incapacitated,” in *Introduction to Clinical Ethics*, ed. John C. Fletcher et al. (Frederick, MD: University Publishing Group Inc: 1995), 151.

brain dead. She expressed that her family's preference is the belief of her family. This preference of insisting on belief during such critical moment like end-of-life care points to the fact of how religion helps in coping with challenging issues of health. In their presentation on debating religion's effect on health, Harold G. Koenig, et al, discussed religious coping in the light of patient's experience. These authors note that "Religious coping appears to increase as the severity of the medical condition and the level of distress increase, perhaps as persons turn to religion for comfort as their health becomes less and less under control."⁷⁴ It is in the context of patients and families insisting on their religious beliefs during end-of-life care that the services of chaplains are mostly requested.

Christiana M Puchalski and Betty Ferrell's description of the role of clergy or religious leaders during end-of-life is relevant to the role of hospital chaplains during end-of-life care. These authors write, "Clergy or religious leaders understand that caring for those at the end of life is part of their role. They are often very receptive to training regarding end-of-life palliative care issues."⁷⁵ Hospital chaplains encounter ethical dilemmas in their ministries to patients, when physicians and families disagree during end-of-life issues. The case scenario reflects the problem that this project seeks to address.

⁷⁴ Koenig, McCullough, and Larson, *Handbook*, 94.

⁷⁵ Puchalski and Ferrell, *Making Health Care Whole*, 160.

Chaplains are often caught between physicians and families over end-of-life care. Notably, conflicts arise when physicians and families think differently on their understanding of what constitutes the quality of life of the human person. While some/most physicians consider patients at the Persistent Vegetative Stage (PVS) as having less quality of life because of the less likelihood of their survival, many families want to keep their sick loved ones breathing until nothing else could be done to keep them alive. Some of these conflictual perceptions may arise from differences in cultural, religious, ethnic, social, political, and ethical ideologies. Whereas physicians may deem it appropriate and necessary to withdraw care from patients who by their judgement could no longer benefit from medical care and intervention, families of patients mostly insist on prolonging life-support in hopes of a miracle or unexpected recovery.

For a non-negligent population, faith or religious beliefs are crucial in their perception of care and cure. Most Catholics, for instance, following their church teaching and doctrine believe in the dignity and respect according the human person at every stage of life. On the hospital bed and at the most critical stage of life, such persons expect the dignity and rights they claim arising from their belief system. The Catholic Church is Pro-Life and upholds the inviolability of life from conception, through life, to death. According to the Catechism of the Catholic Church, “Every human life, from the moment of conception until death, is sacred because the human person has been willed for its own sake in the image and likeness of the living and Holy God.”⁷⁶ This view about life being

⁷⁶ *Catechism of the Catholic Church*, no. 2319.

sacred explains the positions of many Catholic families and patients on nothing but *natural death*, that is, the choice of dying without human (medical) interference in the dying process. The idea of *natural death* could be an issue of controversy between physicians and families, considering the varied understanding of what it might mean for both parties. Consequently, it is mostly challenging to be accorded one's wish of dying a *natural death* when Catholics receive care in the hands of medical personnel and from healthcare institutions that do not uphold the Catholic teaching and doctrine about life.

The Catechism of the Catholic Church emphasizes the sacredness and inviolability of human life, thus, "Human life is sacred because from its beginning it involves the 'creative action of God,' and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can, in any circumstance, claim for himself the right to destroy directly an innocent human life."⁷⁷ In the light of this, the Catholic Church declares the teaching on the inviolability of life a moral truth. In his Encyclical Letter, *Evangelium Vitae* (*The Gospel of Life*), Pope John Paul II writes, "In effect, the absolute inviolability of innocent human life is a moral truth clearly taught by Sacred Scripture, constantly upheld by the Church's Tradition and consistently proposed by her Magisterium."⁷⁸ Following the teaching of the Catholic Church on human dignity and sanctity of life, and the professionalism of most physicians, Catholic chaplains face challenges of conflicts

⁷⁷ *Catechism of the Catholic Church*, no. 2258.

⁷⁸ John Paul II, *Evangelium Vitae* (Vatican City: Vatican Press, 1995), sec. 57.

between families and physicians on issues of pulling off and keeping life support during end-of-life care. Unfortunately, some of these chaplains are “tempted” to give in to persuasions by physicians, which is invariably akin to betrayal of trust and confidence in the relationship they establish with families. On the other hand, some Catholic chaplains are motivated by their personal views on the sanctity of life, which do not concur with the official teaching of the Catholic Church. By this motivation, they openly take side with physicians on issues of pulling off and keeping life support during end-of-life care.

2.2 Chaplains at the Intersection between Physicians and Patients’ Families

It is not uncommon for physicians to unduly pressure family members to yield to their proposal of pulling life-support from a family member. Often, they do not give families time to process the dilemma of letting go of their loved one, nor do they make resistance easy. In contradiction to their professional and ethical roles, chaplains are also pressured by physicians to help families decide to pull off life support during end-of-life care. Think of a situation where physicians exert relentless pressure on family members to yield to the proposal of pulling off life-support from a family member when they have not fully processed the dilemma of letting go of their beloved one; think of a likely case where a medical team, after much futile persuasion for the family (including a designated and recognized legal proxy) to give up, evaluates the capacity of a dying patient who is scarcely responsive and proceed to resolve on withdrawal of medical care based on their assessment that patient wishes not to live on; finally, think of a re-evaluation of this patient by the chaplain during assessment for spiritual care needs at the request of family members and the result was different: patient wishes to live on. These are the kind of

conflicting circumstances that chaplains find themselves in their work as caregivers. According to their training and faith, they try to resolve this manner of conflict between physicians and families for the good of the health facility and families.

Physicians often argue that the families are putting the medical staff in moral distress which has the tendency of making them do harm rather than good, which is a violation of their Hippocratic Oath. Sometimes family members insist on endless treatment of a family member, even when it becomes obvious that nothing else could be done medically to assist: This is a situation where every possible medical intervention has been explored, as in the case of one whose life depends perpetually on a breathing machine.

One of the reasons for the disagreement between physicians and families is the religious perspectives of patients' families. Julia Bandini, et al, identified this in their discussion on cases related to Life Support Treatment (LST). According to them, "Religious beliefs have been at the centre of many high-profile cases involving conflict over LST."⁷⁹ The result of the religious component in these conflicts means that chaplains *are* often invited to mediate. This practice can assist patients and families. Referencing Thiel MM and Robinson MR, Stephen G. Post, Christina M. Puchalski, and

⁷⁹ Julia I Bandini et al., "The Role of Religious Beliefs in Ethics Committee Consultations for Conflicts over Life-sustaining Treatment," *Journal of Medical Ethics* 43 (2017): 353.

David B. Larson note, “Referrals to chaplains can be critical to good health care for many patients, and can be as appropriate as referrals to other specialists.”⁸⁰

2.3 Chaplains’ Unique Positions in Conflict Mediation

Holistic approach in caring for patients during hospital admissions involves the multi-dimensions of the human person: physical, psychological, and spiritual. Daniel Winiger, a then Doctor of Ministry student at Asbury Theological Seminary, Wilmore Kentucky, reports the tension that emanates from medicine and faith in the care of patients. According to him, “Because both physiological and spiritual needs culminate during critical illness, they pose a challenge to the collaboration between physicians and chaplains.”⁸¹ Sometimes the physicians, aware of the unique position of Chaplains as caregivers, seem to want to use them to their medical advantage. They appear to woo chaplains to implore family members to alter their decisions.⁸² Imagine a situation where in an end-of-life case, a meeting is held by the medical team with family of patient to consider treatment plan. Now physicians recommend withdrawal of care on the ground that all options for cure have been explored and nothing else could be done medically to assist patient but the family insists on continued care/support. The physicians at this point tries to implore the chaplain to persuade family to accept their recommendation. In some

⁸⁰ Stephen G. Post, Christina M. Puchalski, and David B. Larson, “Physicians and Patient Spirituality: Professional Boundaries, Competency, and Ethic,” *Annals of Internal Medicine* 132, no. 7 (April 2000): 580.

⁸¹ Winiger, “Physicians’ Perceptions of the Chaplain’s Roles in Critical Care,” 13.

⁸² The decision not to end life-support.

of these instances,⁸³ physicians, knowing too well about chaplains' ability to relate with families, and aware that often families' positions are predicated on religious reasons persuade them to get what they want from patients' families: pulling life support.

Physicians, however, are sometimes reluctant to turn to chaplains. They want to handle the matter themselves without a third party. In recording his conversation with a member of the critical care group during his research on how physicians perceive the role of chaplains during critical care, Winiger reveals a likely reason for these physicians' approach: "You know, we [the critical care group] do not invite chaplains to conversations with families regarding end-of-life issues because you all, not you personally, always make families decide against the removal of life support."⁸⁴ Winiger reported his understanding of this incident, that the physician's relationship with chaplains was marred, which constituted to his (as well as others in the medical team) decline of inviting chaplains to crucial meetings of end-of-life discussions with families.⁸⁵ This implies that the physician's expression of not inviting chaplains to conversations with families during end-of-life issues does not apply to all physicians. Most other physicians request for the services of chaplains. This is largely because of the belief in the impact of the spiritual or faith dimension and the relationship of trust that often exists between families and chaplains.

⁸³ Writer's personal experiences.

⁸⁴ Winiger, "Physicians' Perceptions of the Chaplain's Roles in Critical Care," 3.

⁸⁵ Winiger, "Physicians' Perceptions of the Chaplain's Roles in Critical Care," 3.

The question of inviting or not inviting chaplains to meetings concerning end-of-life issues allude that chaplains are not seen as key-role-players in healthcare institutions. Winiger writes, “Chaplains practice their ministry as a minority in a biologically and technologically driven environment.”⁸⁶ He further expresses that “physicians are the primary decision makers in hospitals and decide how closely they want to work with others.”⁸⁷ As much as this is true, most families, driven by religious values, tend to significantly involve chaplains on issues pertaining to their faith and religion, mostly where medicine and faith tenaciously hold divergent perspectives. Winiger identifies how this could be a problem: “Chaplains tend to overlook that while they only have to be concerned about patients and families’ spiritual wellbeing, physicians are solely responsible for all aspects of patient care and their recovery.”⁸⁸

2.4 Triangulation of Chaplains by Physicians and Patients’ Families

Chaplains may not be considered as key players in medical care as people like Winiger would hold. Nonetheless, they often hold pivotal position in resolving conflicts – or they aspire to do so, at least, as we have been able to demonstrate so far in this chapter. Theologically speaking, they are peacemakers and mediators or at least are supposed to be. The chaplain’s role as a mediator is crucial in healthcare institutions because “Peacemaking is a natural function in institutional ministry. Chaplains are often in unique

⁸⁶ Winiger, “Physicians’ Perceptions of the Chaplain’s Roles in Critical Care,” v.

⁸⁷ Winiger, “Physicians’ Perceptions of the Chaplain’s Roles in Critical Care,” v.

⁸⁸ Winiger, “Physicians’ Perceptions of the Chaplain’s Roles in Critical Care,” 5.

positions to assist communications and negotiations between hospital staff, family members, and associates in conflicts.”⁸⁹ This task of assisting in communications and negotiations between physicians and families, which is aimed at ushering in peace, could pose ethical dilemmas for chaplains with regards to honoring the ethical values of their professions.

The mediating role of chaplains is obvious during end-of-life crisis. If the physician’s own recommendation to withdraw life-support meets resistance, for instance, he or she often turns to the chaplain for support. Thus, physicians resort to wooing chaplains, hoping to use them to convince family members to alter their decision not to end life support. This is because these physicians recognize that chaplains have the ability to relate with families, and have their trust. Indeed, some “critical care physicians perceive [that] chaplains are most important for providing ministry to patients’ families, who are experiencing acute grief as their loved ones face critical illness and possible death.”⁹⁰ Consequently, the physicians believe that chaplains have the ability to persuade patients’ families to change their minds. Persuading chaplains to help families choose to remove life support is an attempt by physicians to get what they want. If chaplains yield to such persuasion, it would be at the expense of the patients and families. Invariably, such compliance would undermine the professional and ethical duties of chaplains.

⁸⁹ Frank T. Wiley, “The Chaplain as Mediator: A Ministry of Presence and Productivity,” *Journal Care Giver* 6, no. 1 (1989): 77.

⁹⁰ Winiger, “Physicians’ Perceptions of the Chaplain’s Roles in Critical Care,” 5.

Similarly, families can triangulate chaplains, trying to use them to beat back the physician's suggestion to terminate life-support. They implore chaplains for spiritual and pastoral assistance, hoping for responses in their favor through chaplains' competence of identifying and clarifying the religious beliefs, moral norms and spiritual ideals of the patient, which are crucial in the practice of health care ethics. This is indeed expected from patients and their families, as a matter of fact. Patients' family members try to get chaplains' voices to speak for their expectations of an unexpected recovery, or their decisions to prolong life-support. They do this, in most instances, by appealing to the spiritual values and emotions of the chaplains, knowing fully well that chaplains uphold the sanctity of life and are charged with the responsibility of easing anxiety, as well as helping them to deal with overwhelming situations such as grief. While for families, it may seem appropriate and normal for the chaplain to advocate for them, physicians expect the chaplain, as a fellow hospital staff and caregiver, to work with them as a team to achieve the facility's treatment plan and goal of care. The chaplain is sometimes stuck in such situations of an appeal to faith/empathy and teamwork.

Unfortunately, some chaplains are tempted to give in to these persuasions from physicians and patients' families. Some chaplains unduly mistake yielding to physicians as a way to keep peace with the hospital's interdisciplinary team; others yield unduly to patients' families as a way of showing solidarity. Both responses are out of joint. Edwin H. Friedman writes, "The basic law of emotional triangles is that when any two parts of a system become uncomfortable with one another, they will "triangle in," or focus on a

third person, or issue, as a way of stabilizing their own relationship with one another.”⁹¹

In our context, chaplains get “triangled” when they get “caught in the middle as the focus of such an unresolved issue,”⁹² like end-of-life care.

Friedman notes that “To the extent a third party to an emotional triangle tries unsuccessfully to change the relationship of the other two, the more likely it is that the third party will wind up with the stress for the other two.”⁹³ Chaplains are in a unique position, but sometimes they fail to make the system healthier. By unduly wanting to appease either the family or the doctors, they do not fundamentally challenge or transform the dynamic that produces the conflict of end-of-life care. Therefore, they need to find a new way to relate with both physicians and families alongside the rest of the hospital interdisciplinary team. They need to escape being triangulated, instead using their unique position to open new generative conversation between the medical staff and families.

2.5 Intensive Care Unit and Ethical Conflicts

In a study that investigated ethical conflicts experienced by intensive care unit (ICU) healthcare professionals working in a regional hospital, Limpopo province of South Africa, Dorah U. Ramathuba and Hulisani Ndou described the relevance of ICU as well as some issues associated with its setting. According to them, “Intensive care units

⁹¹ Edwin H. Friedman, *Generation to Generation: Family Process in Church and Synagogue* (New York: The Guilford Press, 1985), 35.

⁹² Friedman, *Generation to Generation: Family Process in Church*, 35.

⁹³ Friedman, *Generation to Generation: Family Process in Church*, 37.

have advanced complex technology to support critically ill patients in healthcare settings; however, the hospital environment can be distressing to patients, relatives and health professionals when tension arises in the process of providing care.”⁹⁴ Most of these tensions are often experienced during end-of-life care in the ICUs. Among other factors that propel these conflicts, ethical conflicts are mostly common. Ramathuba and Ndou noted, “Ethical conflicts are a daily occurrence in healthcare settings especially in high care and ICUs.”⁹⁵ They reported that conflicting values exist between nurses, patient’s families, and patients.⁹⁶ It is not uncommon for chaplains to witness most of these ethical conflicts that notably occur in the Intensive Care Unit (ICU). Not only that chaplains often witness these conflicts, they are also often called to mediate, especially when conversations between families and healthcare team get stuck with issues that relate to the religion and faith of the patients. Ramathuba and Ndou hint on an aspect of such conflicts, which are experienced in the ICU. According to them, “Conflicts arise when healthcare providers disagree about providing optimal care to critically ill patients where resources and services are constrained.”⁹⁷

When a family member is admitted in the Intensive Care Unit, it often generates anxieties for the rest of the family members. Shiva Khaleghparast, et al, note, “The

⁹⁴ Ramathuba and Ndou, "Ethical Conflicts Experienced by Intensive Care Unit," 6.

⁹⁵ Ramathuba and Ndou, "Ethical Conflicts Experienced by Intensive Care Unit," 8.

⁹⁶ Ramathuba and Ndou, "Ethical Conflicts Experienced by Intensive Care Unit," 1.

⁹⁷ Ramathuba and Ndou, "Ethical Conflicts Experienced by Intensive Care Unit," 1.

critical condition of these patients is a source of pain and stress and even crisis for themselves and their families,”⁹⁸ and “The critical conditions of these patients or the possibility of their death make the need for their family to visit crucial. This has become a challenge because of the physical space constraints.”⁹⁹ The period of admission could be overwhelming for the families of patients. As a way of coping with the tensions created by these admissions, family members desire to spend time around their beloved ones. Khalenghparast, et al, observe, “Being with the patients in ICU is as important for their family as being informed about their illness.”¹⁰⁰

However, visits to the ICUs are strictly regulated. Regulated visits are better known as limited visits, in contrast to open visits: “Limited visiting is a method that allows visitors presence during a specific time, while open visiting allow [sic] visitors to be with their family and friends at any time they want.”¹⁰¹ Limited visiting could be frustrating to family members who have to adjust their schedules in order to comply with the visitors’ policy. Notably, the issue of family visit in the ICUs during end-of-life care (or when a patient is critically ill) is one of the conflicts that exist between families and the healthcare team. Heije Faber writes, “We have seen how deeply important the companionship of the family is to the dying. This is, of course, difficult to arrange in a

⁹⁸ Shiva Khaleghparast et al., “A Review of Visiting Policies in Intensive Care Units,” *Global Journal of Health Science* 8 (2015): 267.

⁹⁹ Khaleghparast et al., “A Review of Visiting Policies in Intensive Care Units,” 271.

¹⁰⁰ Khaleghparast et al., “A Review of Visiting Policies in Intensive Care Units,” 272.

¹⁰¹ Khaleghparast et al., “A Review of Visiting Policies in Intensive Care Units,” 271.

hospital, where the patient is constantly being attended to by the medical and nursing staff, and where there is little possibility of accommodating the family overnight, to enable them to be at hand, should the situation become worse.”¹⁰²

Allowing open visits, on the other hand, “interferes with nurses’ and doctors’ work and makes patient care more difficult for them.”¹⁰³ On a general note, during the period of admissions of patients in the ICUs, open visits usually impacts all involved: the doctors, nurses, patients, and family members. Citing Berwick and Kotagal (2004), Khalengparast and Joolae, et al, write: “open visiting hours can cause some major concerns for the nurses and the doctors: 1) it can increase the patients’ physiological stress; 2) it can interfere with nurses’ care and 3) it can lead to physical and emotional exhaustion of the families.”¹⁰⁴

Getting updates about the health condition of a family member in the ICU often helps the family members in dealing with the anxieties of the moment.¹⁰⁵ Although families rely on the competence and professionalism of the healthcare teams, they also desire to be updated with the health conditions of their loved ones. Ramathuba and Ndou write, “Previously healthcare professionals were unilaterally taking decisions on behalf of patients based on their own professional values and understanding. Patients and relatives

¹⁰² Heije Faber, *Pastoral Care in the Modern Hospital* (Philadelphia, PA: Westminster Press, 1971), 63-64.

¹⁰³ Faber, *Pastoral Care in the Modern Hospital*, 273.

¹⁰⁴ Khaleghparast et al., “A Review of Visiting Policies in Intensive Care Units,” 267.

¹⁰⁵ Writer’s experience.

are now concerned with the health conditions of their loved ones and need to be involved in the process of care.”¹⁰⁶ The concern for the health conditions of their loved ones often showcases the anxieties of families; and the desire to be involved in the process of care reflects their commitments towards ensuring the best quality care for their loved ones. However, in most cases, these updates are either delayed or are not sufficient. Ramathuba and Ndou note the importance of communication between family members and healthcare teams in an ICU setting.¹⁰⁷ Efficient communication eases the worries of families as they feel greatly concerned about what goes on with their family members in the ICUs. These authors observe, “Families are usually under duress if they realise [sic] that communication is not forthcoming, or less information is provided.”¹⁰⁸ Poor communication between families and healthcare professionals is a notable conflict during end-of-life care. As observed by Ramathuba and Ndou, “Health professionals face these challenges of ... poor communications between staff and family and poor decision-making in poor resource settings, resulting in moral distress and depersonalisation.”¹⁰⁹

When families entrust their loved ones to the care of healthcare professionals, they hope for the best. When the best they hoped for are not forthcoming due to some likely negligence on the part of the healthcare team, families get frustrated. Often, this

¹⁰⁶ Ramathuba and Ndou, "Ethical conflicts experienced by intensive care unit," 7.

¹⁰⁷ Ramathuba and Ndou, "Ethical Conflicts Experienced by Intensive Care Unit," 7.

¹⁰⁸ Ramathuba and Ndou, "Ethical Conflicts Experienced by Intensive Care Unit," 7.

¹⁰⁹ Ramathuba and Ndou, "Ethical Conflicts Experienced by Intensive Care Unit," 8.

remissness could be structural, mechanical, operational, or relational. For instance, Ramathuba and Ndou observe that “Patients' care needs were compromised because of the unavailability of beds and high-technology equipment, such as well-functioning ventilators.”¹¹⁰ This manner of compromise could be frustrating to families considering the evolution of attitude towards the sick. Faber notes that “the sick man in a primitive culture was treated as the ‘other’, the outsider, the one who is placed outside the boundaries of the community.”¹¹¹ With reference to Isaiah 53:2f, Faber recalls how the healthy regarded one who was sick in ancient Israel:¹¹² “He had no form of godliness that we should look at him, and no beauty that we should desire him. He was despised and rejected by men; a man sorrows, and acquainted with sickness; and as one from whom men hide their faces he was despised and we esteemed him not.”¹¹³

Faber admits the evolving changes in our attitude towards the sick in many respects: “Many diseases can now be cured and they are, therefore, no longer ‘dangerous’; consequently, the sick are only temporarily ‘out’ of action.”¹¹⁴ This author explains further the significance of medical and technical knowledge in the evolution of attitude towards the sick, thus, “The expansion of medical and technical knowledge has

¹¹⁰ Ramathuba and Ndou, "Ethical Conflicts Experienced by Intensive Care Unit," 1.

¹¹¹ Faber, *Pastoral Care in the Modern Hospital*, 9.

¹¹² Faber, *Pastoral Care in the Modern Hospital*, 4.

¹¹³ Isaiah 53: 2f.

¹¹⁴ Faber, *Pastoral Care in the Modern Hospital*, 14.

fundamentally altered our approach to the sick. It has created the possibility of treating the sick man as a ‘normal’ person and not as an outsider, as one who does belong, even though for a time he is out of action.”¹¹⁵

In the light of this, compromising patient’s care needs as a result of unavailability of basics for quality healthcare – structural, mechanical, operational, and relational – could create the feelings of objectification and isolation of patients, which exhumes the thought of the primitive culture’s attitude towards the sick, which Faber noted while discussing the attitude of the ancient to the sick.

In these instances that propel conflicts between healthcare teams and patients/families during admissions in the Intensive Care Units, chaplains are often called to mediate, notably when it is hoped that appealing to the emotions, faith and religious values of patients/families could change the conflicting situations. Very often, chaplains miss the opportunity to bring the desired change that necessitated the recourse to their roles and ministries. Consequently, they miss the opportunity for responsible caring. In the description of Faber, “Responsible caring implies a double approach to the sick, who on the one hand are in need of warmth, security, and rest, but on the other hand also have the right to think and decide for themselves.”¹¹⁶ In most instances, some chaplains seem not to be aware of Faber’s latter description of responsible caring. For instance, some incidents of end-of-life conflicts in the ICUs and the modes of interventions of chaplains

¹¹⁵ Faber, *Pastoral Care in the Modern Hospital*, 2.

¹¹⁶ Faber, *Pastoral Care in the Modern Hospital*, 2.

tend to suggest unawareness or not recognizing that patients and families have the right to think and decide for themselves.¹¹⁷ This happens when chaplains allow themselves to be used by the medical team to persuade patient/families to shift their positions. Faber's noted impression of chaplains in this regard highlights this problem, which chaplains face in working with families and healthcare professionals:

My impression is that the regular hospital chaplain, living as he does within the pattern of the hospital, is tempted subconsciously to identify himself with the attitude of the staff. Sometimes he joins in regarding the patients as the objects of (pastoral) care. He then sees them as people for whom he is responsible: he wants to speak *to* them, perhaps to educate them, to help them find their place in the hospital, to gain a better attitude towards themselves and life, in short, to 'treat' or manipulate them with the tools of his trade.¹¹⁸

This impression about chaplains portrays an image of seeing themselves as problem-solvers. By seeing themselves as problem-solvers, chaplains tend to assume that their interventions would necessarily be viable options for patients and their families to choose. For instance, given that the Ethical and Religious Directives for Catholic Health Care Services (often called ERDs) issued by the United States Conference of Catholic Bishops offers moral guidance in dealing with ethical health care issues, some chaplains present the recommended options in manners that do not honor the fact that families could choose. The Part Five of the ERD (Ethical and Religious Directives) discusses issues in care for the seriously ill and dying. In its directive, it provides options for families, stating a person's moral obligation to use ordinary or proportionate means

¹¹⁷ Writer's experience.

¹¹⁸ Faber, *Pastoral Care in the Modern Hospital*, 17.

(“those that in the judgment of the patient offer reasonable hope or benefit and do not entail an excessive burden or impose excessive expense on the family or the community”¹¹⁹) as well as a person’s moral obligation to forgo extraordinary or disproportionate means (“those that in the person’s judgment do not offer a reasonable hope or benefit or entail an excessive burden, or impose excessive expense on the family or the community”¹²⁰) of preserving life. Think of a chaplain who communicates these options to a patient’s family in a manner that seems imposing an option on them. What might be burdensome to one patient and family may not be burdensome to another patient and family. Therefore, such information like proportionate and disproportionate means of care ought not to be presented to patients and their families by any way that suggests imposing any option on them. Chaplains are there not to impose the teachings of the Catholic Church on patients and their families but to guide them on the beliefs of the Catholic Church and honor their option to choose. It is the responsibility of patients and their families to live with the options they choose from the teachings of the Catholic Church.

Faber’s description of responsible caring could also be applied in chaplain’s relationships with the medical team. In the course of mediating between the medical team and patients/families, some chaplains tend to overstep their bounds, which becomes

¹¹⁹ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 6th ed., 26-27.

¹²⁰ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 6th ed., 27.

suggestive of not recognizing that the medical teams have the right to think and decide for themselves too. Standing between the medical teams and patients/families during end-of-life care in the Intensive Care Units is a crucial role for chaplains. It is a role that puts chaplains on the spot, challenging their professional integrity. Writing about chaplains being at the intersection between staff (medical and nursing) and patient, Faber notes, “We notice that in order to gain some sense of security in an uncertain position, he will often identify himself with the staff and with the patient in turn.”¹²¹ Ideally, chaplains should not take sides. However, identifying with the staff and patients merely to gain some sense of security in job position can as well compromise the professional identity of chaplains.

2.6 Issues of Conflicts during Conversations

Physicians and families often get tied up in some conversations while attempting to figure out the best care and interventions for patients during end-of-life care. Chaplains are often called in to mediate, especially when physicians identify patients or families to be religious, or when their objections are religious-based. There are lots of key issues that generate conflicts during conversations. These issues often lead to invitation of chaplains for mediations and supports. Some of these key issues are: Natural Death; Brain Death; and Compassionate Extubation. Natural Death and Brain Death present differences in contexts in which death occurs.

2.6.1 Natural Death

¹²¹ Faber, *Pastoral Care in the Modern Hospital*, 17.

If at any time I am in a terminal condition and become comatose or am otherwise rendered incapable of communicating with my attending physician, and my death is imminent because of an incurable disease, illness or injury, I direct that life-sustaining procedures be withheld or withdrawn, and that I be permitted to die naturally.¹²²

In the above quote, Cathy Gilmore and Joyce A. Thorpe present a section of patient's declaration and directive to physicians as seen in a report of the Congregational Report Service. The wish and directive of the dying patient in this context is withholding and withdrawing life sustaining procedures and the permission to die naturally. In some cases, this directive could be construed as refusing care. Contrary to this thought, Albert R. Jonsen writes, "However, persons who sign a Natural Death Directive are not refusing care. If they read the small print they will find they are refusing useless care, i.e, care which even if it is provided will not restore health."¹²³ There are lots of questions that come up at the point of discussing natural death. These questions constitute conflicts between physicians and families during end-of-life care. Some of these questions are: What does it mean to die a natural death? Does the idea of natural death mean the same thing for both physicians and families of patients? "At what point in the course of events surrounding critical care can it be said with moral certitude, "death is imminent, whether or not treatment is provided."¹²⁴

¹²² Cathy Gilmore and Joyce A Thorpe, "Comparative Analysis of State Statutes Recognizing a Patient's Right to Die a Natural Death," *Congregational Research Service*, Report No. 83-113A, R724 (June 3 1983): 22, <https://congressional-proquest-com.ezproxy.bu.edu/congressional/docview/t21.d22.crs-1983-aml-0003?accountid=9676>.

¹²³ Albert R. Jonsen, "Dying Right in California – The Natural Death Act," *Clinical Toxicology* 13, no. 4 (2008): 517.

¹²⁴ Jonsen, "Dying Right in California," 518.

Seema K. Shah writes, “Death was traditionally determined to occur when a person’s heart stops beating and circulation ceases, and these functions could not be restarted.”¹²⁵ This traditional determination of death applies to the understanding of death by different manners. However, the concept of ‘natural death’ is still mostly assumed and differentiated from other manners of death. In one of the *Aftermath* publications (Specialists in Trauma Cleaning and Biohazard Removal), the understanding of natural death is “When someone dies of old age or as a result of health condition or illness, his or her death is considered a natural death.”¹²⁶ This publication lists five manners of death, which it claims that majority of states recognize:

- **“Natural.** As mentioned before, a natural death is one that occurs as a result of the aging process or disease.
- **Homicide.** A death is considered to be a homicide when a person is killed by one or more persons.
- **Accident.** A death is considered to be an accident when the fatal outcome was unintentional and there is no evidence that the injuries occurred with intent to harm.

¹²⁵ Seema K Shah, “Rethinking Brain Death as a Legal Fiction: Is the Terminology the Problem?” in *Defining Death: Organ Transplantation and the Fifty-Year Legacy of the Harvard Report on Brain Death*, ed. Robert D. Truog et al (Boston, MA: Hastings Center Report, November – December 2018), S49.

¹²⁶ “What is the Definition of a Death by Natural Causes,” in *Aftermath* (Specialists in Trauma and Biohazard Removal), <https://www.aftermath.com/content/natural-causes-definition-death/>.

- **Suicide.** A death is considered to be a suicide when a person intentionally takes his or her own life.
- **Undetermined.** A death is considered undetermined “when the information pointing to one manner of death is no more compelling than one or more other competing manners of death when all available information is considered,” according to Harris County Institute of Forensic Sciences.”¹²⁷

These listings present and affirm the ideas of natural and non-natural deaths. In line with these concepts, Manfred Oehmichen and Christoph Meissner note that “In the industrialized countries of the West, for example ‘natural death’ is thought of as the opposite of non-natural types of death such as accidental death, suicide, and homicide.”¹²⁸ These ‘non-natural’ types of death tend to unanimously establish the notion of ‘natural death’ and death that is considered unnatural. There still exists controversy over the idea of natural death, however. For scholars like Jacques Loeb, disease, which is considered by some as a way of natural death, is considered along the line of death by mechanical violence or by poison. This is because, according to him, no human being can escape all these agencies that bring about the permanent cessation of respiration.¹²⁹ The

¹²⁷ “What is the Definition of a Death by Natural Causes,” <https://www.aftermath.com/content/natural-causes-definition-death/>.

¹²⁸ Manfred Oehmichen and Christoph Meissner, “Natural Death,” *Gerontology* 46, no. 2 (February 2000), 105, <https://doi.org/10.1159/000022143>.

¹²⁹ Jacques Loeb, “Natural Death and Duration of Life,” *The Scientific Monthly* 9, no. 6 (December 1919): 579.

insistence on patients dying natural death and the doubt whether such thing as natural death exists constitute conflict between physicians and families during end-of-life care.

In their discussion of “the meaning of the term ‘natural death,’ under a clinical, forensic and scientific point of view with regard to recent developments especially in molecular biology,”¹³⁰ Oehmichen and Meissner argue that “If there are ‘external’ physical influences, a medical-technical manipulation, a therapeutic or molecular biological intervention cannot be definitely ruled out as the cause of death, the use of the term ‘natural death’ in general is open to question.” They also noted, “...any attempt to define the term ‘natural death’ ... encounters difficulties in defining what is meant by ‘natural.’”¹³¹

The difficulty associated with the definition of ‘natural death’ is one of the issues of conflicts between physicians and families during end-of-life care. As noted in the case scenario presented at the beginning of this chapter, Pam, the daughter of the dying man, insisted to have her father coded (resuscitated) until he is brain dead. This is a way of expressing that her father be allowed to die a ‘natural death’. Contrary to this end-of-life decision, we see in the opening citation in this discussion of *Natural Death* that the patient rather signed a directive for physicians to withdraw life-sustaining procedures to make way for ‘natural death’ when faced with terminal condition and death is imminent. These opposing family/patient decisions underscore the point that the conflict, which

¹³⁰ Oehmichen and Meissner, “Natural Death,” 105.

¹³¹ Oehmichen and Meissner, “Natural Death,” 105.

arises from the understanding of natural death during end-of-life care does not only exist between physicians and families, it is also witnessed between family members themselves. There has been instances where family members disagreed among themselves with regards to the understanding of ‘natural death’.¹³² This makes end-of-life decisions difficult and prolonged.

2.6.2 Brain Death

Shah notes the possibility of patients persisting on ventilators for long periods following the 1950’s and 1960’s advent of intensive care unit technologies and organ transplantation.¹³³ She explains, “The Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death proposed a new way to determine death based on neurological criteria in these patients for two pragmatic, consequentialist reasons: to ease the burden on families and hospitals of caring for patients....”¹³⁴

Thaddeus Pope notes that “The determination of death by neurological criteria - “brain death” – has long been legally established as death in all U.S. jurisdictions.”¹³⁵ However, referencing Margaret Lock, Veena Das and Clara Han note that “even medical

¹³² Writer witnesses these in the course of his ministry as chaplain in hospitals.

¹³³ Shah, “Rethinking Brain death as a Legal Fiction,” S49.

¹³⁴ Shah, “Rethinking Brain death as a Legal Fiction,” S49.

¹³⁵ Thaddeus Pope, “Brain Death and the Law: Hard Cases and Legal Challenges,” in *Defining Death: Organ Transplantation and the Fifty-Year Legacy of the Harvard Report on Brain Death*, ed. Robert D. Truog et al (Boston, MA: Hastings Center Report, November – December 2018): S46.

scientists now argue over the criteria and boundary of life and death.”¹³⁶ The declaration of brain death constitutes one of the conflicts that exist between physicians and families during end-of-life care. Some families question the criteria and boundary of life and death when the updates from the health care team communicate the “brain death” of a family member. Nonetheless, Pope affirms that “Despite ongoing academic debates, the law concerning brain death has remained stable for decades.”¹³⁷ Some physicians express helplessness over the provisions made by the law regarding brain death. As seen in our case scenario, at the objection of Pam,¹³⁸ the daughter of the dying man, a physician turned to a nurse and said, “Do we have to take this? What can physicians and nurses do when the law gives the family upper hand in a dispute like this?”¹³⁹ This doctor’s framing suggests an inclination to power struggle and competition. Instead of inclining towards power dynamics, we submit in this thesis that attention should be focused on the common good of the patient – qualitative and dignified care.

Some of the “upper hand” that the law gives the family, as noted by this physician, are highlighted in Pope’s discussion of the legality of accepted medical standards for determining brain death. In this discussion, Pope presented three challenges

¹³⁶ Veena Das and Clara Han, *Living and Dying in a Contemporary World: A Compendium* (Berkeley, CA: University of California Press, 2015): 630.

¹³⁷ Pope, “Brain Death and the Law,” S46.

¹³⁸ Pam objected to the recommendation of the physicians to put a Do Not Resuscitate (DNR) order and insisted that they should code him till he dies.

¹³⁹ Fletcher, “Decisions to forgo Life-Sustaining Treatment” 151.

to the legal status of brain death. He noted the first challenge as the most serious.

According to him, “It contends that the way in which physicians determine that a patient is brain-dead does not satisfy legal requirements in the Uniform Determination of Death Act.”¹⁴⁰ This is one of the recurrent problems that is often encountered when physicians and families meet to discuss a patient’s brain-death status.¹⁴¹

The health care team’s declaration of brain-death, in this case, is met with some push-backs from families who invoke the legality of the determination of brain-death. An example of some families’ *recourse* to the law is captured in Pope’s citation of the provision of the Uniform Determination of Death Act:¹⁴² “An individual is dead, if the individual sustains irreversible cessation of ...all functions of the entire brain, including the brain stem. A determination of death must be made in accordance with generally accepted medical standards.”¹⁴³ Three notable words that appear in this citation often pose difficulties in conversations between physicians and families during end-of-life care: “irreversible,” “all,” and “entire.”¹⁴⁴ Referencing L. S. M. Johnson (2014), Seema K. Shah explains, “brain-dead individuals frequently maintain neurological functioning that

¹⁴⁰ Pope, “Brain Death and the Law,” S46.

¹⁴¹ Writer has experienced this during family meetings between the hospital interdisciplinary teams and families in the course of his ministry as chaplain.

¹⁴² Uniform Determination of Death Act, 12A Uniform Laws Annotated 777 (2008), <http://www.uniformlaws.org/Act.aspx?title=Determination%20of%20Death%20Act>

¹⁴³ Pope, “Brain Death and the Law,” S46-S47.

¹⁴⁴ Writer has experienced this during family meetings between the hospital interdisciplinary teams and families in the course of his ministry as chaplain.

is not captured by tests to determine death by neurological criteria.”¹⁴⁵ Analyzing this reference, Shah notes, “In other words, existing medical criteria for determining death by neurologic criteria do not actually establish the “irreversible cessation of all functions of the entire brain”.”¹⁴⁶

In some given cases, families argue or challenge the legality of the “generally accepted medical standards.” For instance, Pope’s reference to a Supreme Court’s inquiry and judgment highlights an instance of a family’s concern: “In 2015, the Supreme Court of Nevada strongly questioned whether commonly used medical criteria for measuring brain death meet the UDDA requirement of being “medically accepted standards.” The court made no definitive final ruling on this question. The patient in that case, Aden Hailu, was determined dead on cardiopulmonary criteria, and the case was dismissed.”¹⁴⁷

Conflicts between physicians and families during end-of-life care involve the families’ difficulty in comprehending the standards of determining brain death. This challenge often arises from fact that “there is gap between the medical and legal criteria for brain death such that one could be medically dead yet not legally dead.”¹⁴⁸ This gap created by the medical and legal criteria constitutes an aspect of difficult conversation and conflict between physicians and families during end-of-life care. Shah presents some

¹⁴⁵ Shah, “Rethinking Brain death as a Legal Fiction,” S50.

¹⁴⁶ Shah, “Rethinking Brain death as a Legal Fiction,” S50.

¹⁴⁷ Pope, “Brain Death and the Law,” S47.

¹⁴⁸ Pope, “Brain Death and the Law,” S47.

evidence that accumulated over time “that brain-dead individuals do not comport with either the legal criteria for neurological determination of death or the standard biological conception of death.”¹⁴⁹ Notably, while physicians uphold medical determinations of death, families often hold on to the biological conception of death.¹⁵⁰ Shah relates the conflicts this way: “Current practices of determining death ...do not abide by either the existing legal standards or the standard biological conception of death.”¹⁵¹ This is a notable problem to our subject matter.

The second challenge to brain death, as Pope explains, is that before physicians conduct brain death diagnostic tests, it is imperative for them to obtain surrogate consent; and if families object to brain death testing, physicians must honor the objection.¹⁵² It is not uncommon for families to object to brain death testing. Although the objection of the patient’s family, as presented in the case scenario at the beginning of this chapter, not to allow the physicians place a DNR order was not an incident of brain death test, it presents an example of how families also object to the recommendation for brain death testing. Pope expresses that the practical consequence of the imperativeness of physicians obtaining surrogate consent before conducting brain death diagnostic tests is “to allow the family opt out of a brain death diagnosis.”¹⁵³ The frustrations of physicians with this

¹⁴⁹ Shah, “Rethinking Brain death as a Legal Fiction,” S50.

¹⁵⁰ Writer’s experience.

¹⁵¹ Shah, “Rethinking Brain death as a Legal Fiction,” S50.

¹⁵² Pope, “Brain Death and the Law,” S47.

¹⁵³ Pope, “Brain Death and the Law,” S47.

second challenge to brain death, obtaining consent and honoring the objections of families, is clearly understood from Pope's discussion on this issue: "Objecting families have almost no legal right to demand "treatment" after death. Therefore these families focus on asserting rights when they still have them, before death."¹⁵⁴ This explains further the frustration of the physician in our case scenario, who turned to a nurse at the objection of patient's family over placing a DRN order, wondering what physicians and nurses could do when the law gives families upper hand in such issue. Pope's further analysis of this second challenge provides an in-depth insight to the conflict of end-of-life care between physicians and patients. According to him, "By objecting to the apnea test, some families have been able to prevent clinicians from determining brain death. If clinicians cannot make this determination, then they cannot declare the patient dead."¹⁵⁵

Pope names the right to religious based exemption from brain death as the third challenge of brain death. He states, "The third challenge to brain death contends that even if clinicians diagnose brain death, they may not declare the patient dead if the patient has a religious objection. The general (and still well-settled) rule is that clinicians have no duty to continue physiological support after brain death. But this presents a profound problem for patients with religious objections."¹⁵⁶

¹⁵⁴ Pope, "Brain Death and the Law," S47.

¹⁵⁵ Pope, "Brain Death and the Law," S47.

¹⁵⁶ Pope, "Brain Death and the Law," S48.

Obviously, the complication in understanding brain death constitutes an aspect of the conflicts between families and physicians during end-of-life care. Citing “Call to Revamp Death Definition,”¹⁵⁷ Abigail Rian Evans notes Professor Kellehear’s remark on how brain death criteria makes the decisions to permit the removal of breathing machine potentially unsettling for the bereaved:

Forty years ago, being dead used to be very simple – it was at the point at which your heart stopped beating. Now, death itself has been complicated by the fact that we can keep alive people who are brain dead almost indefinitely. Brain death is the point at which doctors can switch off machines or begin harvesting organs, but, to relatives, brain dead is not the same as being a corpse.¹⁵⁸

2.6.3 Compassionate Extubation

The case scenario presented at the start of this chapter showcases a “stand-off” between a family and health care team. The ethics consultation involved several meetings with the hospital’s interdisciplinary team as a way of resolving the conflict. His physicians and nurses stated that further treatment was futile because his condition deteriorated steadily. The recommendation to remove the breathing machine and allow him to die without massaging, if his heart stopped, was the physicians’ way of alleviating his sufferings and withdrawing from “endless” treatment that is perceived to be futile.

¹⁵⁷ “Call to Revamp Death Definition,” *BBC News Online*, September 12, 2007, <http://news.bbc.co.uk/2/hi/health/6987079.stm/>

¹⁵⁸ Abigail Rian Evans, *Is God Still at the Bedside: The Medical, Ethical, and Pastoral Issues of Death and Dying* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2011): 187-188.

This process of removal of ventilator support is known as compassionate (or palliative) extubation.

Ana L Coradazzi, et al, explain, “Palliative (or compassionate) extubation consists of the withdrawal of mechanical ventilation when the absolute priority in care delivery is to afford comfort and allow for natural death to occur. Palliative extubation may be considered when all attempts at weaning from ventilation have failed and when maintenance from ventilator support become futile.”¹⁵⁹ This explanation highlights the intention of affording comfort and yielding to the occurrence of natural death. According to these authors, it is patient-focused, and its essential goal is direct patient benefit.¹⁶⁰ However, the idea of compassionate extubation and its process could be bewildering to families of patients. Alongside the issue of misunderstanding the process of compassionate extubation, families also deal with anxieties in thinking about the practice. Coradazzi, et al, note that it demands clearly defined and meticulous planning because of its complex procedure, and warned that its inadequate planning may significantly increase the risk of difficult bereavement for the attending family members.¹⁶¹

Obviously, the term – compassionate extubation, could be confusing and challenging to most families. For instance, most Catholic families express deep religious

¹⁵⁹ Ana L. Coradazzi et al, “Palliative Withdrawal Ventilation: Why, When and How to It?” *Hospice & Palliative Medicine International Journal* 3, no. 1 (2019): 10.
<https://mdecraveonline.com/HPMIJ/HPMIJ-03-00141.pdf>

¹⁶⁰ Coradazzi et al., “Palliative Withdrawal Ventilation: Why, When and How to It?” 10.

¹⁶¹ Ana L. Coradazzi et al., “Palliative Withdrawal Ventilation: Why, When and How to It?” 10.

concerns about possible participation in euthanasia.¹⁶² Conversations are most likely to get stuck when the concept of compassionate extubation is not clearly communicated to patients' families. When end-of-life conversations are stuck, conflicts of interests between physicians and patients' families creep in. In most cases, patients' families lean more towards their religious perspectives and consequently resist the recommendation of compassionate extubation. Chaplains are often called in to provide spiritual care, pastoral guide and support, and to help in clarifying the religious concerns of patients' families. In most cases, chaplains also respond to the health care team staff, who may have significant emotional and spiritual needs regarding their involvements in the compassionate extubation.

The conflicts that ensue between physicians and patients' families during end-of-life care also stems from the discrepancies between conforming to medical and family dictates of consciences. These conflicts mostly heighten when physicians and families engage in conversations regarding compassionate extubation. Sometimes, physicians tend to refuse or withdraw care when they believe that it is futile. Addressing the issue of increasing quality and reducing cost during end-of-life care in the Intensive Care Unit, J. Randall veena, Ruth A. Engelberg, Mark E. Bensink, and Scott D, write: "Critical care clinicians are often powerfully distressed by caring for these patients, and many believe

¹⁶² Writer has experienced this during family meetings between the hospital interdisciplinary teams and families in the course of his ministry as chaplain.

this “futile care” represents an important focus for cost savings.”¹⁶³ Sakurai writes, “Chaplains are continually called to walk the line between medicine’s institutional tendencies and individual conscience.”¹⁶⁴ This continual call points to the need for chaplains at the intersection where physicians and families collide during end-of-life care. Sakurai’s presentation offers an insight on the relevance of chaplains’ involvement in the conflicts between physicians and families of patients during end-of-life conflicts. Chaplains are mostly needed at such moments because “In a crisis, it is often the chaplain who acts as liaison between the patient (as a member of a faith community) and medical personnel.”¹⁶⁵

2.7 Patients’ Families’ Concerns: The Bedrock of End-of-Life Care Conflicts

Palliative care for patients is a critical concern between families and health care team. In most cases, it is difficult to come into an agreement on what is most appropriate in caring for a dying patient. While some physicians insist on decisions based on science and professional experience, some families raise concerns that are deeply rooted in culture, religion and family ideologies. For instance, in the case scenario presented at the beginning of this thesis, Pam, the daughter of the dying man, objected to the health care team’s recommendations to remove the breathing tube and place a DNR¹⁶⁶ order, if his

¹⁶³ J. Randall Curtis et al., “End of Life Care in the Intensive Care Unit: Can We Simultaneously Increase Quality and Reduce Cost?” *American Journal of Respiratory and Critical Care Medicine* 186, no. 7 (2012): 588.

¹⁶⁴ Sakurai, “Heart of Chaplaincy,” in *Health Progress*, 27.

¹⁶⁵ Sakurai, “Heart of Chaplaincy,” in *Health Progress*, 28.

¹⁶⁶ DNR: Do Not Resuscitate.

heart stopped. Pam's objection highlights some of the family concerns during end-of-life care: "You are asking us to murder our father. This is our belief. We want him coded (resuscitated) until he is brain dead!"¹⁶⁷ This insistence on continued care for Pam's father reflects the positions of most families during end-of-life care. Such incidents lead to conflicts and tensions between families and the healthcare team.

Whereas families, in most cases, insist on continued medical care for their family members, physicians, on the other hand, strive to resist the pressures, offering explanations on the futility of such medical cares, as seen in the case scenario. The insistence by families, for instance, expressively holding tenaciously on the *will of God* for a family member who is critically ill, creates conflicts and tensions between them (families) and the healthcare team. Sometimes, it is difficult for families to yield to yield to physicians' concern of doing harm to patients. Patients get harmed because of strong medications and complicated technology. Physicians strive to provide the care possible. In the course of this, patients and families sometimes feel neglected, not respected, and their spiritual values not honored. The conflict between physicians and families of patients during end-of-life care can lead to preventable harm. Understanding the meaning of preventable harm will offer an insight into how it could be caused by the conflicts and tensions between families and physicians. Mohammed Nabhan, et al,

¹⁶⁷ Fletcher, "Decisions to Forego Life-Sustaining Treatment,"151.

present a systemic review of definitions of preventable harm in healthcare. According to these authors,

Preventable harm, therefore, appears to be best defined by three criteria: (a) harm with an incidence that can be reduced by virtue of detecting and intervening or preventing a causal event or chains of events (an error, an error-prone process, deviation from best practice), (b) the causal effect of chain of events by their nature can be detected before the harm takes place, (c) there is evidence that an intervention is efficacious in reducing or eliminating the harm by virtue of eliminating the offending cause of disrupting a harmful chain of events.¹⁶⁸

Going by these definitions, one could understand preventable harm in relation to medical errors and physical harms. However, referencing the Institute of Medicine's journal (*To Err is Human: Building a Safer Health System*), Lauge Skol-Hessner, Patricia Henry Folcarelli, and Kenneth E F Sands note, "The 1999 Institute of Medicine (IOM) Report *To Err is Human* found that existing definitions and systems for preventing harm were inadequate and recommended urgent, decisive steps to raise 'standards' and expectations for improvement safety."¹⁶⁹ These authors also referenced the World Health Organization's Conceptual Framework for the International Classification for Patient Safety, noting that "To date, the patient safety movement has focused primarily on physical injury, but definitions of harm in healthcare are much broader."¹⁷⁰

¹⁶⁸ Nabhan et al., "What is preventable harm in healthcare?" 7.

¹⁶⁹ Lauge Skol-Hessner, Patricia Henry Folcarelli, and Kenneth E F Sands, "Emotional Harm from Disrespect: The Neglected Preventable Harm," *BMJ Quality and Safety* 24 (June 2015): 550.

¹⁷⁰ Skol-Hessner, Folcarelli, and Sands, "Emotional Harm from Disrespect," 550.

With highlights from Governance for Quality and Patient Safety Steering Committee, Lauge Sokol-Hessner, et al, present preventable harm as “any ‘outcome that negatively affects the patient’s health and/or quality of life.”¹⁷¹ Reporting on patients’ responses to their research on emotional harm from disrespect (as a neglected preventable harm), these authors note that patients emphasized emotional harm more than physical harm with regards to consequences of adverse events. Lauge Sokol-Hessner, et al, defined emotional harm in terms of dignity and respect, thus: “Emotional harms can be conceptualized as harms to a patient’s dignity which can be caused by a failure to demonstrate adequate ‘respect’ for the patient as a person.”¹⁷² This definition captures one of the recurring concerns of families during end-of-life care. Families often bemoan lack of adequate respect for their beloved ones, which inflicts emotional harm on them. This feeling often generates conflicts as physicians and families often see things from different perspectives. Chaplains often deal with working with families and the healthcare teams in such difficult situations where conversations get stuck as a result paralleled and divergent views.

When physicians recommend withdrawal of care of a patient, it could be possible that they have witnessed multiple incidents of the patient’s situation, and were fully aware, following past experiences, that death had become inevitable at that point. On the other hand, it could be possible that the family were experiencing such for the first time.

¹⁷¹ Sokol-Hessner, Folcarelli, and Sands, “Emotional Harm from Disrespect,” 550.

¹⁷² Sokol-Hessner, Folcarelli, and Sands, “Emotional Harm from Disrespect,” 551.

Even if it was not their first experience of such situation, they could be dealing with the anxiety of anticipatory loss. Das and Han note, “The frequency of death does not undermine its pain or poignancy for the living.”¹⁷³ This provides an insight into the pains and challenges families have when faced with the hard decisions of yielding to the healthcare team’s recommendations for withdrawal of care and placing patients on Comfort Measures Only (CMO). Very often, chaplains are invited to mediate in this conflicting situation between families and the healthcare team. As physicians face moral injuries resulting from the pressures of being compelled to do harm, and families/patients face emotional harm resulting from lack of adequate respect for patient and family, chaplains also face moral and emotional distress because they are situated in the hospital supporting patient and staff. Overall, both physicians, families, and chaplains face moral injuries during end-of-life conflicts. An understanding of moral injury will be helpful to have an idea of how it applies to all involved in the end-of-life care of patients. Lindsay B. Carey, et al, offer the following collation:

Moral injury originates (1) at an individual level when a person perpetuates, fails to prevent or bears witness to a serious act that transgresses deeply held moral beliefs and expectations which lead to inner conflict because the experience is at odds with their personal core ethical and moral beliefs, and/or (2) at an organizational level when serious acts of transgression has been caused by or resulted in a betrayal of what is culturally held to be morally right in ‘high-stakes’ situation by those who hold legitimate authority.¹⁷⁴

2.8 Physicians’ Concerns: A Notable Factor of End-of-Life Conflicts

¹⁷³ Das and Han, *Living and Dying in a Contemporary World*, 635.

¹⁷⁴ Carey et al., “Moral Injury, Spiritual Care and the Role of Chaplains,” 1220.

Our case scenario reports the family's objection to the recommendations of the health care team. Their recommendations were based on the facts that the "patient had not responded to treatment and had become steadily worse,"¹⁷⁵ which was their reason for considering any further treatment as "futile." One can imagine how frustrating this objection could be for the family. Their frustrations were reflected in the response of one of the physicians: "Do we have to take this? What can physicians and nurses do when the law gives the family the upper hand in a dispute like this? What can we do about our own ethical positions of not inflicting torture on this hopelessly ill patient? What about the injustice to other patients?"¹⁷⁶ This physician's *desperation* reflects the concerns of physicians during end-of-life care conflicts: the feeling of despair that families are favored by the law in end-of-life care disputes; the concern of being coerced into unethical practice in the care of patients; and the "injustice" to other patients.

The physician's *outburst* in our case scenario speaks much about the feeling of disappointment when their sincere efforts in caring for the sick seems not to have been appreciated. It is frustrating! The frustration as a result of ingratitude could come either from a patient or from patient's family. It is an example of appallingly difficult encounter between physicians and patients. Writing on "Difficult Physician-Patient Encounters," K. J. Breen and P. G. Greenberg note, "As consultant physicians, we sometime meet patients, and families and carers of patients who leave us feeling helpless, frustrated,

¹⁷⁵ Fletcher, "Decisions to Forego Life-Sustaining Treatment," 151.

¹⁷⁶ Fletcher, "Decisions to Forego Life-Sustaining Treatment," 151.

irritated and even angry.”¹⁷⁷ These authors further express, “Particular patient behaviours make some of us feel uncomfortable. Examples include patients who are perceived to be demanding, needy, abusive, inflexible, argumentative, vexatious, or overtly familiar or flirtatious.”¹⁷⁸ The helplessness, frustration, irritation, anger, and uncomfortable feelings expressed by these consultant physicians, which stem from perceived particular patient behaviors, are some of the *catalysts* responsible for the conflicts between physicians and families during end-of-life care.

Beyond these seeming or perceived patients’ behaviors, some family members go as far as inflicting guilt on the physicians, blaming them for the deteriorations of the quality of life of their family members.¹⁷⁹ The health care team, in some given cases, labels this kind of family member or patient as being “difficult.” Breen and Greenberg present some clinical situations that might lead the difficult encounters. According to them, “These include encounters with patients who prove to be excessively demanding, ... patients who complain about us and/or other clinicians, are non-compliant, engender strong negative emotions in us, or who have very different backgrounds or beliefs to our own.”¹⁸⁰ When adverse feelings, such as strong negative emotions, are invoked in the

¹⁷⁷ K. J. Breen and P. B. Greenberg, “Difficult Physician-Patient Encounter,” *Internal Medicine Journal*, 40 (2010): 682.

¹⁷⁸ Breen and Greenberg, “Difficult Physician-Patient Encounter,” 682.

¹⁷⁹ Writer has experienced this during family meetings between the hospital interdisciplinary teams and families in the course of his ministry as chaplain.

¹⁸⁰ Breen and Greenberg, “Difficult Physician-Patient Encounter,” 683.

health care team, these could impact the dispositions of engaging in meaningful and productive conversations during end-of-life care family meetings. This becomes challenging for chaplains, mostly when the conversation is faith-driven. Winiger observes that “Physicians get frustrated or become irritated when they face religious arguments that challenge their medical assessments.”¹⁸¹ In situations where physicians feel that religious arguments challenge their medical assessments, which possibly give rise to difficult physician-patient encounters, chaplains are often called in to mediate.

From the foregoing discussion on families’ and physician concerns as factors that generate EOLs conflicts, it has been noted that chaplains are often involved in working with families and the health care teams in such difficult situations. Incidents of divergent views and conflicting perspectives create difficulties in physician-patient encounters. Meharban Singh writes, “Rude and aggressive behaviors of the patients or their family members, and arrogant and lackadaisical approach of the doctor, adversely affect the doctor-patient relationship and the outcome of the patient.”¹⁸² When these happen, communications between physicians and families are adversely impacted. When communications between physicians and patients/families are adversely impacted, referrals are often made to chaplains. It could be challenging and overwhelming when

¹⁸¹ Winiger, *Physicians’ Perceptions of the Chaplain’s Roles in Critical Care*, 11.

¹⁸² Meharban Singh, “Intolerance and Violence Against Doctors,” *The Indian Journal of Pediatrics* 84 (August 2017): 768. <https://link.springer.com/article/10.1007/s12098-017-2435-9>.

chaplains play the role of providing comprehensive pastoral care when notable issues of concerns between physicians, patients and their families are referred to them.

Chapter Three

3. Towards an Ideal

3.1 The Ethical Ministry of Chaplains

In end-of-life cases, hospital chaplains are usually confronted with challenging ethical situations that involve mediating between physicians and patients' families. Such situations offer them the opportunity to resource the ethical richness of their profession and the faith they profess. Chaplains, therefore, can stand at the intersection where physicians and families collide during end-of-life care and provide new possibilities for physicians and families as they relate to one another. For instance, instead of giving in to the persuasions from the hospital medical team to accept the proposal of pulling life-support, or to be driven by sympathy in advocating for a family in a state of grief-induced denial, it is ideal for chaplains to be mindful of their calling: "to relieve spiritual distress, ease guilt¹⁸³, and to provide comfort,"¹⁸⁴ and pastoral care to patients, their families, and staff.¹⁸⁵ They do this as they are guided by the ethical standards of their roles, and as they work with Hospital Ethics Committees to resolve conflict between physicians and the

¹⁸³ Physicians and families may deal with the guilt of violating the Hippocratic Oath of not doing harm (as families unduly insist on continued treatment) and the guilt of not resisting the process of 'ending' the life of a helpless family member (as physicians unduly attempt to remove life support), respectively. Chaplains play the role of providing comfort that alleviates guilt in both parties.

¹⁸⁴ George Grant et al., "Chaplains' Role in End-of-Life Decision-Making," 413.

¹⁸⁵ The idea of chaplains providing pastoral care to patients, families, and staff is reflected in the standard job description of chaplains: "The Staff Chaplain provides pastoral/spiritual care for patients/residents, their loved ones, and the healthcare staff." - <https://www.hmachaplains.org/sample-job-description-for-staff-chaplain>.

families of patients when patients are in critical conditions during end-of-life care.

Chaplains are there, in part, to create new possibilities.

3.2 Creating New Opportunities at the Intersection

Chaplains create new possibilities by building trust through ensuring ministry for both physicians and families, and establishing mutual respect, and good communication. Eyer writes, “The chaplain would do well to become a friendly protagonist for moral integrity and communal-benefit in an age of relativism and personal self-interest. In this regard, the physician needs to know that the chaplain can “take it,” that the mutual trust and respect is strong.”¹⁸⁶ Fostering mutual trust and respect opens up the possibility of compromise. As Marc Gopins explains: “There is no compromise without trust and respect, and being heard, being acknowledged and honored are critical to building trust and respect.”¹⁸⁷ When all goes well, chaplains create new possibilities by changing a conversation that is stuck. Elaine Greta McInnis describes the unique positions of chaplains this way:

A central component of providing spiritual care in the face of impending death is one’s encounter with suffering. Suffering impacts a patient’s body, mind and spirit. The interprofessional healthcare team meets individuals across the life span and often at crossroads of suffering and loss. We are in unique positions to help individuals and their significant others who may be in physical, emotional, social and/or spiritual pain related to impending loss or fear of the unknown.¹⁸⁸

¹⁸⁶ Eyer, “Building Mutual Trust and Respect,” 29-30.

¹⁸⁷ Gopin, *Healing the Heart of Conflict*, 42.

¹⁸⁸ Elaine Greta McInnis, “Improving the Quality of Spiritual Care to End-of-Life in Canada: Alleviation of Suffering, Perspectives of the Terminally Ill, their Families and Professional Caregivers” (D.Min. Thesis, St. Stephen’s College, 2013), 2.

Chaplains can also create new possibilities by introducing an idea like “dignified death,” which can create common ground for both parties. The understanding of dignified death may vary between medical, family, and various religious perspectives. However, it means that “the dying needs to be assured that their lives will not be arbitrarily shortened, ... that they will not be subject to unreasonable and burdensome therapies, that medical technology will be used for their integral well-being, that their free and informed decisions will be respected, and that they will not be marginalized or abandoned by the community in their dying.”¹⁸⁹ An ideal like “dignified death” can address the physicians’ desire to keep patients free from prolonged suffering, while also meeting the families’ need to know that the patient’s life is not arbitrarily shortened. It is a concept that chaplains may use to build a bridge between physicians and patients’ families.

This approach, which centers on trust and a dignified death can bring peace and comfort. It is not about keeping peace by joining with one side against another, but about moving both sides to a different and better place. That kind of peace is kingdom peace, which reflects the description of harmonious correlation in Isaiah 11:6-9.¹⁹⁰ That kind of peace and comfort is an expression of Jesus’ own mission as expressed in Luke 4:18, “The Spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor; he hath sent me to heal the brokenhearted, to preach deliverance to the captives,

¹⁸⁹ Kopfensteiner, “Death with Dignity,” 64.

¹⁹⁰ Referring to the Messianic Kingdom where all of God’s creatures will live together in peace and harmony.

and recovering of sight to the blind, to set at liberty them that are bruised.”¹⁹¹ An end-of-life conflict can be heartbreaking for both physicians and families. The chaplains’ work can afford peace and comfort by healing these brokenhearted parties.

In research that looked into the possibility of healthcare chaplains reducing suffering and disparities in end-stage cancer care, Holly G. Prigerson, et al, note the relevance of the supports that chaplains provide in critical moments of end-of-life cares.

These authors write:

Our research has shown that advanced cancer patients who receive religious/spiritual care are not only more likely to have their spiritual care needs met, but also report less physical pain and are more likely to die where they wish compared to those not receiving such care. We find that healthcare chaplain visits promote patients’ peaceful acceptance of being terminally ill, which has been linked to higher rates of advance care planning (e.g., end-of-life discussions and completion of Do Not Resuscitate (DNR) orders).¹⁹²

The findings of these authors provide guide for chaplains in working with physicians, patients, and families during end-of-life conflicts. Chaplains can focus on their ability of assisting patients and families in processing and peacefully accepting the fact of the patient being terminally ill. Chaplains can do this by exploring the religious issues that propel the options of patients and families. This will enable chaplains to

¹⁹¹ King James Version (KJV) Translation.

¹⁹² Holly G. Prigerson, Alan B. Astrow, and Paul K. Maciejewski, “A Divine Idea: Can Healthcare Chaplains Reduce Sufferings and Disparities in End-Stage Cancer Care?” *European Association for Palliative Care Blog*, February 7, 2022, <https://eapcnet.wordpress.com/2022/02/07/a-divine-idea-can-healthcare-chaplains-reduce-suffering-and-disparities-in-end-stage-cancer-care/>.

create the opportunity of mutual understanding between physicians and families for the common good of patients.

3.3 Maintaining Professional Identity: A *Sine Qua Non* for Ethical Ministry

As noted in chapter two of this project, Daniel Winiger's recorded conversation with a member of the critical care group reveals some physicians' impression of chaplains: "You know, we [the critical care group] do not invite chaplains to conversations with families regarding end-of-life issues because you all, not you personally, always make families decide against the removal of life support."¹⁹³

Winiger's recording presents an instance of how the professional identity and integrity of chaplains could be challenged. This member of the critical care group that Winiger referenced expresses frustration that chaplains take sides with families' decision against the removal of life-support. If this claim is true of chaplains' practice during end-of-life care, it raises questions on the authenticity of their professional identity as well as the appropriateness of their ethical ministry. Considering such allegation, chaplains should therefore to be guided by their ethical responsibilities in the course of their ministry. On this note, Margaret E. Mohrmann draws attention to the fact that "Chaplains are obligated to provide care with substantive content, reflecting their professional education and training – care that includes, but goes beyond the comfort of a listening ear."¹⁹⁴

¹⁹³ Winiger, *Physicians' Perceptions of the chaplain's Roles in Critical Care*, 3.

¹⁹⁴ Margaret E. Mohrmann, "Ethical Grounding for a Profession of Hospital Chaplaincy," *Hastings Center Report* 38, no.6 (2008): 19.

Physicians, as presented in chapter two, often turn to chaplains for support when their recommendations to withdraw life-support meets resistance. Knowing too well about chaplains' ability to relate with families, physicians woo them to get what they want from families: pulling the life-support. The idea of physicians turning to chaplains for support during end-of-life conversations with families points to what I may describe as interdisciplinary solidarity to the hospital. Mohrmann hints at this notion, thus, "Chaplains and health care professionals alike have moral obligations toward the institution of which they are a part, and these, too, may at times conflict with other professional commitments."¹⁹⁵ Chaplains face the challenge of *aligning* themselves to the policies and practices of the hospitals where they work. As members of the interdisciplinary team, chaplains often yield to physicians' requests as a way of showing solidarity and loyalty to the healthcare institutions; and probably ensuring that their jobs are secured. It is not out-of-place for chaplains to comply with the norms of the healthcare institutions where they work. However, aligning with the physicians' requests to remove life-support against the families' decisions would be unfair to families.

By virtue of their ministry as spiritual care providers, chaplains are entrusted with the spiritual care needs of the patients. Patients should therefore be the primary focus of care by chaplains. In other words, chaplains have the duty to be primarily concerned about the wellbeing of the patient. Nonetheless, chaplains should not be over-sentimental in playing this all important role, but should endeavor to guide families along the path of

¹⁹⁵ Mohrmann, "Ethical Grounding for a Profession of Hospital Chaplaincy," 19.

making ethical decisions for the good of the patient as provided in the bioethical teachings of the Catholic Church concerning end-of-life care. Also, as a go-between, the chaplain ought to acknowledge the moral distress that may ensue from playing his professional role in the ministry of caring for patients. Indeed, the chaplain is confronted with the task of providing supportive ministry to physicians as they process the moral distress they experience during end-of-life care. According to Michael Guthrie, “One of the greatest ministry needs that surface for healthcare providers is processing the moral distress they experience while caring for patients.”¹⁹⁶ As noted in Chapter one, the moral distress of healthcare providers creates conflicts between them and families of patients during end-of-life care. In the course of their ministries, chaplains strive to make peace between healthcare providers and families of patients. It is not uncommon that one of the challenges chaplains deal with is the acknowledgement of the moral distress of healthcare providers. It is ideal for chaplains to be aware of the moral distress, acknowledge it, and address it when they have the privilege of mediating between healthcare providers and families during end-of-life care. Addressing the moral distress of healthcare providers could make them feel heard, and as well help patients’ families as they process the conflicts of end-of-life care.

It is important for chaplains to be duly trained and be competent in addressing issues of moral distress. Guthrie describes the relevance of this training this way:

“Professional chaplains that have specific training about the issue of moral distress

¹⁹⁶ Michael Guthrie, “A Healthcare Chaplain’s Response to Moral Distress,” *Journal of Health Care Chaplaincy* 20, no. 1 (February 2014): 12.

represent a valuable resource to their team for support and counsel. They foster communication so that issues leading to moral distress can be identified. Professional chaplains possessing the tools to facilitate a deeper understanding of the phenomenon of moral distress can respond with a compassionate pastoral model”¹⁹⁷

Most of the issues that arise during end-of-life conflicts might be challenging to the perspectives of chaplains. Chaplains should be firm and enduring in the heat of ordeals that challenge their perspectives. What Christina Puchalski and Betty Ferrell recommend for health care professionals in their services and relationship with patients is a piece to be pondered over by chaplains. According to these authors, “When health care professionals are able to respond to their own sense of altruism in their professional work and act out of their spiritual values and beliefs, it can transform their relationship with their patients.”¹⁹⁸ This is more so about chaplains who are spiritual care givers and as well represent different religious affiliations. Again, chaplains’ altruism in their care of souls could transform their ministries and relationships with physicians and families, especially during end-of-life conflicts. However, acting out of their personal spiritual values and beliefs, as Puchalski and Ferrell recommend for health care professionals, may not be ideal for chaplains. This is because, even though the patient may have the same faith affiliation and creed as the chaplain, they may have different spiritual values. This is important, to avoid relativism, which may be contradictory to what the ethics of their

¹⁹⁷ Guthrie, “A Healthcare Chaplain’s Response to Moral Distress,” 12.

¹⁹⁸ Puchalski and Ferrell, *Making Health Care Whole*, 175.

profession requires. Rather, they ought to be guided by the ethical guidelines for their professional integrity. As chaplains called to provide pastoral support and ministry of consolation to people, it would be ideal to accompany them in their struggles, stand by them, mostly when there are such concerns on feelings of neglect, unfair treatment, disparity, and hostile attitudes.

In line with the above recommended ethical guideline for chaplains, they ought to avoid the temptation of wanting to fix all of people's problems. The mindset to fix others' problems exposes professionals to over-identification with people and boundary crossing. Chaplains, therefore, are to be mindful of their limitations, as well as their needful interventions. This approach is reflected in Lindsay B. Carey and Bruce Rumbold's report of a chaplain summarizing the need for chaplains not to over-extend themselves in trying to fix the problems of patients, as well as not proceeding beyond their professional boundaries: "[We] can't necessarily cure anyone, but we can certainly care for people while they work through their life journey—whatever might be on their way to healing."¹⁹⁹

3.4 Understanding Patients' Families' and Physicians' Dynamics: Veritable Tool for Chaplains

It is important to understand the dynamics that inform the decisions of families and physicians in the end-of-life care of patients. This understanding provides guiding ways for chaplains and the hospital interdisciplinary team to move conversations forward with families during end-of-life conflicts. For instance, it is not uncommon for families to

¹⁹⁹ Carey and Rumbold, "Good Practice Chaplaincy,"1426.

hold on to the expectations of miracles as part of their decisions for not “letting go” of a family member contrary to the medical advice by hospital physicians. This is religious coping. According to Harold G. Koenig, et al, “*Religious coping* is defined as the extent to which persons use their religious beliefs and practices to help them to adapt to difficult life situations and stressful events.”²⁰⁰ In line with this definition, Bandini, et al, identify religion and miracle as sources of coping by patients and families in matters of end-of-life care. According to these authors, “Religion was often a source of coping for patients and families, providing hope, strength and meaning in difficult situations around end-of-life treatment.... A belief in miracles seemed to be a source of coping and making sense of these difficult situations for patients and/or families.”²⁰¹

Indeed, Religion offers hope and comfort to those who practice it. A lot of life events can trigger families to seek for the miracles and comforts that religious faith brings. End-of-life issue is one of such triggers. Besides hoping for miracles, families are comforted by the hope that through their religious beliefs, in most cases, prayer, critically ill family members would recover. Bandini, et al, explained belief in miracle to mean that “families anxiously, and often persistently, held hope that the patient would recover against all odds.”²⁰² It is important for chaplains to be mindful of this family norm,

²⁰⁰ Koenig, McCullough, and Larson, *Handbook*, 502.

²⁰¹ Bandini et al., “The Role of Religious Beliefs in Ethics Committee Consultations for Conflicts over Life-sustaining Treatment,” *Journal of Medical Ethics* 43 (2017): 355.

²⁰² Bandini et al, “The Role of Religious Beliefs in Ethics Committee Consultations,” 355.

validate their belief in miracle, without compromising the realities of medical updates. Validating the beliefs and hopes of families is a way of helping them cope with their anticipatory grief. It is ideal for chaplains to strive to see that this concern of patients and families regarding their belief in miracle - hope for recovery - is not undermined. Koenig, et al, present a distinct explanation of religious coping, this way: “If one relies and depends on a higher power, one feels less pressure to control circumstances and to worry about results. This way of appraising stressful life situations cognitively may relieve anxiety and counteract feelings of hopelessness and despair, even in the most desperate of circumstances.”²⁰³

An example of one of such most desperate of circumstances is when patients are on life-sustaining treatments. Hye Ri Choi, a Post-Doctoral Fellow at the School of Nursing, Hong Kong, et al, explored the experiences of nurses, physicians and families on withholding or withdrawing life-sustaining treatment in an intensive care unit. In their presentation, they explained life-sustaining treatment this way: “Intensive Care Units (ICU) provide the highest level of treatment and care for the most critically ill patients. However, when the treatment becomes medically futile and can no longer contribute to the recovery of the patient, it is now considered life-sustaining.”²⁰⁴ It is ideal for chaplains to provide ministries of compassionate presence and supportive listening at

²⁰³ Koenig, McCullough, and Larson, *Handbook*, 225.

²⁰⁴ Hye Ri Choi, Sheila Rodgers, Jennifer Tocher, Sung Wook Kang, “Nurse, Physicians, and Family Member’s Experiences of Withholding or Withdrawing Life-Sustaining Treatment Process in an Intensive Care Unit,” *Journal of Clinical Nursing* 2023, no. 32 (2022): 4828.

such moment of desperation like life-sustaining treatment. This is crucial, considering the conflicts of faith and medicine that arise from such situations. Winiger acknowledges that the domains of faith and medicine are kept separate and could be reasonably kept apart. However, he identifies the overlapping of domain of faith and medicine in moments like life-sustaining treatments. According to him, “when patients become severely ill medical treatment options are running out, or death may be inevitable, the two domains start to overlap. This overlap of domains peaks when families are asked to make the heart-wrenching decision to disconnect their loved one from life support or other life sustaining treatments.”²⁰⁵ The services of chaplains are mostly requested in times like this. Winiger notes that “Trained chaplains are able to provide guidance and support to the family as well as to the physician during medical decision-making time.”²⁰⁶ The guidance and support, which chaplains provide to families and physicians, could serve as a bridge between them during end-of-life treatments of patients.

Writing on the role of religious beliefs in conflicts over life-sustaining treatment, Bandini, et al., affirm: “Chaplains also assisted patients and families in understanding end-of-life care and discussed decisions around goals of care.”²⁰⁷ Notably, chaplains explore the usefulness of religious beliefs in journeying with families during end-of-life care, mostly when patients are on life-sustaining treatments. It is pertinent here to note

²⁰⁵ Winiger, *Physicians’ Perceptions of the Chaplain’s Roles in Critical Care*, 12.

²⁰⁶ Winiger, *Physicians’ Perceptions of the Chaplain’s Roles in Critical Care*, 12-13.

²⁰⁷ Bandini et al., “The Role of Religious Beliefs in Ethics Committee Consultations,” 355.

with Courtney S. Campell that: “While religious based dissent can help determine the feasibility of public policies, we should avoid constructing religion as necessarily a “problem,” or what Richard Rorty referred to as a “conversation stopper” that impedes bioethical integrity and public policy efficiency.”²⁰⁸ From the above assertion of Campell, religion and spirituality ought to be integrated into end-of-life conversation. This is important because some non-religious healthcare professionals see religion as a cog or stopper in conversation and decision-making in end-of-life cases. We therefore submit that chaplains should stand with patients and their families who may raise religious concerns regarding treatment plans and goals of care during end-of-life care.

When patients face life-threatening sicknesses, palliative care seeks to prevent and relieve the sufferings of patients. Palliative care also focuses on supporting the best quality of life for these patients. Often, families do not perceive these gestures of “relieving” the sufferings of patients and the intended support for their best quality of life as such. Rather, in most cases, families claim that their concerns were neither addressed nor understood. One of the family concerns in this regard, which relates to the services of chaplains, is religious or spiritual beliefs and practices. Referencing Tracey A. Balbodini, et al (2007), George Handzo writes, “Furthermore, religious and spiritual beliefs and practices have been shown to be a major component of how patients cope with serious

²⁰⁸ Courtney S. Campbell, “Imposing Death: Religious Witness on Brain Death,” in *Defining Death: Organ Transplantation and the Fifty-Year Legacy of the Harvard Report on Brain Death*, ed. Robert D. Truog et al (Boston, MA: Hastings Center Report, November – December 2018), S57.

illness.”²⁰⁹ Chaplains, in their mediatory roles, can communicate to the medical team, in clearer terms, the concerns of the family with religious and spiritual beliefs and practices. They can do this by highlighting the relevance of spiritual care dimension in the holistic care of patients.

In their discussion of “Working with Families in Palliative Care: One Size Does not Fit All,” Deborah A King and Timothy Quill write, “Comprehensive palliative care requires that family concerns are understood and addressed. Yet the medical professionals frequently lack formal training in family systems concepts and, therefore, may be unprepared to engage in family-inclusive approaches to treatment.”²¹⁰ King’s and Quill’s submission on the frequent lack of formal training in family system concepts by medical professionals is a notable issue of great concern in discussing the conflicts between physicians and families during end-of-life care. As part of their training, chaplains are grounded in the competencies of family system concepts. Therefore, they should be mindful of King’s and Quill’s submission and be available to provide support when needed.

²⁰⁹ George Handzo, “The Process of Spiritual/Pastoral Care: A General Theory for Providing Spiritual/Pastoral Care Using Palliative Care Paradigm,” in *Professional Spiritual and Pastoral Care: A Practical Clergy and Chaplain’s Handbook*, ed. Stephen B. Roberts (Woodstock, VT: Skylight Paths, 2012), 22.

²¹⁰ Deborah A King and Timothy Quill, “Working with Families in Palliative Care: One Size Does Not Fit All,” *Journal of Palliative Medicine* 9, no. 3 (2006): 704, <https://doi.org/10.1089/jpm.2006.9.704>.

While not undermining the challenges that physicians may face in handling end-of-life situations, it is imperative for physicians to understand the concerns of families who are burdened with the anxieties of losing a beloved relative. The physicians' recommendation, as presented in our opening case scenario in chapter two, was the removal of the breathing machine because every other further treatment was considered futile due to the fact that the patient's health had become steadily worse. They considered further treatment as futile. The hospital's interdisciplinary team met severally to address the issue of the "stand-off" between the family and the health care team. The reaction of patient's daughter, Pam, that the health care team should continue to code her father until he dies, presents a great example of family system concept that needs to be well understood by the health care team in order to make their approach to the treatment family-inclusive. Chaplains ought to be mindful of the divergent dynamics of families and physicians on issues of end-of-life decisions, and explore recommendations that could be helpful for their engagement in the conversations about end-of-life treatments and conflicts. J. Randall Curtis, et al, present their view on the issue of withdrawing treatments due to the thoughts of further attempts being considered futile. According to these authors, "Refusing or withdrawing such treatments over patient or family objections is difficult, requires a fair process, and may have adverse consequences for family members."²¹¹ As already noted, an aspect of patient or family objections is deeply rooted in religion and spirituality. It is ideal for chaplains to understand the dynamics of

²¹¹ Curtis et al., "End of Life Care in the Intensive Care Unit," 588.

physicians' thoughts of further attempts in treatment as futility, and the adverse consequence of this for family members. This knowledge can help chaplains to generate conversations that would address the religious or spiritual issues of patients. Harold G. Koenig et al, note that "In the United States, surveys of primary care patients and the general population indicate that the majority of patients would like their physicians to address religious or spiritual issues in the context of their medical visit."²¹²

In discharging their duties as spiritual caregivers, chaplains ought to accompany both families of patients and physicians in their moral distress of decision-making during end-of-life care. Referencing Jameton A et al, write, "Moral distress occurs when individuals believe they are unable to act in accordance with their ethical beliefs due to hierarchical or institutional constraints."²¹³ Everyone in the end-of-life conflict deserves to be heard. The feeling of not being heard or trusted could be frustrating. Chaplains should be able to understand the moral distress and helplessness of physicians, and how these impact their relationships with patients' families during end-of-life conflicts. One of the impacts of physicians' helplessness, as noted by Dzung, et al, in their reference to studies by Dyrbye et al, and Brazeau et al, is cynicism: "In light of this perceived helplessness, physician trainees can become emotionally detached and cynical, and may dehumanize their patients in order to protect themselves. Prior reports have highlighted

²¹² Koenig, McCullough, and Larson, *Handbook*, 94.

²¹³ Elizabeth Dzung et al., "Moral Distress among American Physician Trainees Regarding Futile Treatments at the End of Life: A Qualitative Study," *Journal of General Internal Medicine* 31, no.1 (2015): 93.

the negative effects of cynicism and burnout on empathy, patient care, and the culture of medicine.”²¹⁴

Although physician trainees are particularly mentioned here, this is a likely occurrence with physicians too. Some physicians can get burnout due to lack of self-care and may display cynical attitude in the discharge of their professional duties. It is important, therefore, for chaplains to understand how cynicism impacts the functionality of physicians. Dzung, et al, write, “Cynicism can alienate young physicians from their profession, as they begin to wonder whether their efforts are meaningless or harmful.”²¹⁵ Another notable factor that the medical team deals with, during end-of-life-care, is decreased autonomy. In reference to a study by Bede Papathanassoglou et al, Dzung, et al, note that “decreased autonomy was associated with increased frequency and intensity of moral distress amongst nurses.”²¹⁶ The feeling of not being able to do what one does in an expected manner could be frustrating. Understanding this distressed feeling of loss of autonomy could help chaplains gain insights into the perspectives of the medical teams, mostly when conversations get stuck during end-of-life conflicts between medical teams and families. This knowledge could offer chaplains a thoughtful way of mitigating the distressed feelings of the medical team through spiritual counseling and care (for those of them who are open to this), by validating their expressed distress and offering meditative

²¹⁴ Dzung et al., “Moral Distress,” 97.

²¹⁵ Dzung et al., “Moral Distress,” 97.

²¹⁶ Dzung et al., “Moral Distress,” 97.

words that are capable of making them feel some measures of appreciative restoration. Imploring the services of chaplaincy would help chaplains to situate themselves in these interventions suggested here. In a survey of 100 Roman Catholic Chaplains conducted from March 1 to May 31 2020, Waldemar Glusiec²¹⁷ investigates the frequency and issues where chaplains' ethical advice are asked for during difficult medical decisions. The results of the survey show that 29% of the participants confirmed being asked for advice in making a morally difficult medical decision. Glusiec presents details of the requests for chaplains' ethical advice this way:

Requests for advice in making a difficult medical decision are directed to chaplains both by patients and/or by their families (as indicated by 27% of the respondents) and by doctors and/or other medical personnel (as indicated by 19% of the respondents). Patients (19%) do ask for such advice exactly as often as their relatives (19%). Doctors (16%) are most frequently turning for chaplains' advice, followed by nurses (11%).”²¹⁸

Glusiec's findings from the survey of the 100 Roman Catholic chaplains, as noted above, has much relevance to this thesis project as it crafts ethical responses to the conflicts of end-of-life care between physicians, patients and their families.

Considering the importance of chaplains not being one-sided in mediating between physicians and patient's families during end-of-life care, chaplains should help families to become curious and confident in the physicians. Overall, it is ideal for chaplains to focus on interventions that would ensure mutual care and support for both

²¹⁷ Waldemar Glusiec is Chair and Department of Humanities and Social Medicine, Medical University of Lublin, Poland.

²¹⁸ Waldemar Glusiec, “Hospital Chaplains as Ethical Consultants in making Difficult Ethical Decisions,” *Journal of Medical Ethics* 48, no. 4 (April 2022): 257.

physicians and patients' families during end-of-life conflicts, without undermining the dynamics of any of the parties. Understanding the dynamics of physicians and patients' families is a veritable way of helping chaplains to provide quality care and interventions void of favoritism and partiality. This will help to ensure a focused care for the common good of the patient. Referencing the works of some authors, Alexander Tartaglia, et al, write, "Staff chaplains have participated in regular discussion groups with staff colleagues (King et al., 2005), facilitated nursing support groups for nurse managers (Willis and Limehouse, 2011), and collaborated in debriefing sessions to enhance self-care and wellness in the workplace (Stilos et al., 2021)."²¹⁹

3.5 Honoring Human Dignity: An Ideal Ethical Response to End-of-Life Conflicts

It is ideal for the dignity of patients to be honored during end-of-life care, and the moral distress of physicians acknowledged. The respect for human dignity has no bounds, is not discriminatory, nor circumstantial. In *Dignitatis Humanae*, a document of the Vatican II Council, the Council declares that "the right to religious freedom has its foundation in the very dignity of the human person as this dignity is known through the revealed word of God and by reason itself."²²⁰ It emphasizes that "This freedom means that all men are to be immune from coercion on the part of individuals or of social groups and of any human power, in such wise that no one is to be forced to act in a manner

²¹⁹ Alexander Tartaglia et al., "Supporting Staff: The Role of Health Care Chaplains," *Journal of Health Care Chaplaincy* 30, no.1 (2024): 61.

²²⁰ Second Vatican Council, "Declaration on Religious Liberty *Dignitatis Humanae*, 7 December, 1965" in *Vatican Council II: The Conciliar and Postconciliar Documents*, ed. Austin Flannery (New York: Costello Publishing Company, 1975) sec. 2.

contrary to his own beliefs, whether privately or publicly, whether alone or in association with others, within due limits.”²²¹ The problem about the conflicts that exist between physicians and families during end-of-life care often arises when the dignity of either of the parties is not honored. For instance, the dignity of a patient could be dishonored by a physician who purposefully neglects the patient’s concerns with religious and cultural values. On the other hand, the dignity of a physician could as well be dishonored when his concern with “doing no harm” is ignored by patients and their families.

Mohsen Adib-Hajbaghery and Mohammad Aghajani speaking about patients dying, note, “Dignity is fundamental to the well-being of every individual in all societies. It is a basic human right for all, and health care organizations should pay special attention to this individual need.”²²² The emphasis on dignity as a “basic human right for all” calls attention to the fact that no one is excluded in the order of honoring human dignity. The call for health care organizations to “pay attention to this individual need,” is further stressed by the Pontifical Council for Pastoral Assistance to Health Care Workers, thus, “The Church therefore calls health care workers to professional integrity, which tolerates no action that destroys life.”²²³ When Catholic chaplains feel pressured by physicians to

²²¹ Second Vatican Council, “Declaration on Religious Liberty *Dignitatis Humanae*, sec. 2.

²²² Mohsen Adib-Hajbaghery and Mohammad Aghajani, “Patients Dignity in Nursing,” *Nursing and Midwifery Studies* 4, no.1 (March 2015): e22809.

²²³ Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, no. 52 (National Catholic Bioethics Center, Philadelphia: PA, 2016), 44.

take advantage of their relationships with families to talk them into accepting withdrawal of care for their family members, they should be mindful of this sacred admonition to healthcare workers, which also applies to them. It is therefore ideal for Catholic chaplains to align themselves with the directive of the Church, which through the United States Conference of Catholic Bishops, which states, “The inherent dignity of the human person must be respected and protected, regardless of the nature of the person’s health problem and social status.”²²⁴

Highlighting the importance of human dignity, Pope Francis expressively states, “...every violation of the personal dignity of the human being cries out in vengeance to God and is an offense against the creator of the individual.”²²⁵ It is pertinent for chaplains to understand that respect for human dignity is crucial in the relationship among physicians, patients and families. Physicians are not to perceive patients as objects with little or no value, but as subjects – in relationship. They are not to be color-blinded to the value system of patients and their families. Families in turn are to honor the professional ethics of physicians. In this way, the relationship among the trio could be rid of violation of the human dignity. The expectation is that chaplains should not yield to pressures from physicians or families by taking sides with either party, especially when it is not in the interest, and for the desired good of the patient. Chaplains should rather anchor their end-

²²⁴ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 6th ed, 16.

²²⁵ Pope Francis, *Evangelii Gaudium* (Vatican City: Libreria Editrice Vaticana, 2013), sec. 213.

of-life ministries on such recommendation, as provided by Mary Diana Dreger and James S. Powers: “The patient’s physical, intellectual, emotional and spiritual needs are to remain central to all decisions related to the plan of care. There is no more important time to recognize the human person’s dignity.”²²⁶

Instead of allowing themselves to be used by either patients’ families or physicians in pushing the interests of any of these parties, chaplains should maintain the respect for the dignity of the human person by not engaging in the role of talking them into thwarting their consciences. Writing about conscience protection, Christopher Kaczor notes, “conscience is better understood as an agent’s reasoned judgment of whether or not to perform an action, reasoning which should be informed by careful consideration of moral truth and relevant circumstances.”²²⁷ Going by this definition, whereas physicians have reasoned judgements over their choice of recommending removal of life supports; families, on the other hand, have reasoned judgments over their insistence on not removing life support until patient dies a ‘natural’ death. The moral truth, from the perspectives of both physicians and families, inform their reasoned judgements. It is therefore important for chaplains to be mindful of these and avoid the temptation of ‘convincing’ either of both parties to act against their consciences by

²²⁶ Mary Diana Dreger and James S. Powers, “Caring for Older Adults,” in *Catholic Witness in Health Care: Practicing Medicine in Truth and Love*, ed. John M. Travaline and Louise A. Mitchell (Washington, DC: The Catholic University of America Press, 2017), 282.

²²⁷ Christopher Kaczor, *A Defense of Dignity: Creating Life, Destroying Life, and Protecting the Rights of Conscience* (Notre Dame, IN: University of Notre Dame Press, 2013), 154.

consenting to the perspective of the other. Kaczor admonishes, “Prima facie, it is wrong to force another person to do anything, for in doing so, one makes the other person into simply a means to achieve one’s own plans, as if that person were a tool or a slave.”²²⁸

The responsibilities entrusted to chaplains is void of *compelling* neither physicians nor families in following the dictates of their consciences on end-of-life issues. Kaczor reiterates the need for honoring the conscience of others in these words, “There is a prima facie obligation to refrain from forcing others to violate their consciences.”²²⁹ Instead of engaging in interventions that could violate the consciences of physicians and families of patients, chaplains should rather be guided and uphold the knowledge for conscience protection. It is important for chaplains to understand conscience. Understanding conscience would help chaplains to honor the consciences of physicians and patient’s families in moments of conflicts during end-of-life decisions. The *Catechism of the Catholic Church* states that conscience: “is a judgment of reason whereby the human person recognizes the moral quality of a concrete act that he is going to perform, is in the process of performing, or has already completed.”²³⁰

Going by this definition, two things stand out for consideration: judgment of reason and recognition of moral quality of concrete act. These imply that every person “is obliged to follow faithfully what he [or she] knows to be just and right,”²³¹ as the

²²⁸ Kaczor, *A Defense of Dignity*, 154.

²²⁹ Kaczor, *A Defense of Dignity*, 155.

²³⁰ *Catechism of the Catholic Church*, no. 1778.

²³¹ *Catechism of the Catholic Church*, no. 1778.

Catechism of the Catholic Church elaborates. Robert Constable, writing on moral agent in his discussion of conscience protection and practice in relation to social workers, asks some questions that help in thinking about conscience and understanding it:

Is conscience a still voice that tells us what we should or shouldn't be doing? Is it a body of values, preferences, and habits or a decision-making act? Is it mostly rational or emotive? If it is simply emotive or intuitive, how does it relate to science or rationality? Is it something mostly religious, or at least rooted in religion? Is there such a thing as a professional conscience, or is conscience always personal? Can conscience be badly formed or mistaken in its judgments? Should it be protected at all, if it is merely a relic for private observance, or if it runs counter to other overriding rights? Is it worth discussing if it only applies to a few people? Or does it apply to everyone?²³²

It is important for chaplains to recognize and honor the inner voice that tells physicians and families of patients what they should or should not be doing.

Understanding conscience as mostly being deeply rooted in religion is pertinent for chaplains in working with families. The religious tenets of Catholics are contributing factors in the formation of their consciences. This knowledge could help chaplains in understanding the strong positions of patients and families in difficult moments when conscience protection is invoked. However, it is also pertinent for chaplains to note that conscience can as well be mistaken. Constable notes, "Conscience can be mistaken. It can fall into laxity or scrupulosity in its judgments."²³³ Since there could be laxity or scrupulosity in the judgments of conscience, chaplains should endeavor not to be compelled to push the thoughts of any of the parties in a bid of wooing over the other as a

²³² Robert Constable, "Social Workers, Conscience Protection and Practice," *Journal of Religion and Spirituality in Social Work: Social Thought* 32, no.2 (2013): 120.

²³³ Constable, "Social Workers, Conscience Protection and Practice," 121.

way of resolving conflicts. Rather, utilizing compassionate and supportive listening, and encouraging both parties to do so, is an ideal way of responding to the difficulties posed by recourse to conscience protection.

In response to the question of whether religious grounds are necessary for conscience protection, Constable notes, “The law points out that in these matters conscience can be protected whether one acts on religious, or on the basis of moral convictions alone (or both).”²³⁴ This explanation offers chaplains a tool to hold on to in dealing with issues of conflicts between physicians and families. It is ideal for chaplains to be mindful, and as well honor the perspectives of both conflicting parties when issue of conscience protection is at stake, irrespective of one’s basis of action – religious or moral.

As noted in the previous chapter, one of the problems that Catholic chaplains encounter during end-of-life ministries is responding to the concern of patient’s dignity not being honored, mostly as Catholics receive care in other hospitals that are not guided by the values of Catholic tenets. Dreger and Powers note that sometimes, physicians lose sight of the sufferings and pains of families while being preoccupied with treatment plan. Citing the *Charter for Health Care Workers*, these authors²³⁵ note the ability of contemporary medicine to artificially delay death, an intervention that is not beneficial to the patient; that the patient is being merely kept alive consequentially with severe

²³⁴ Constable, “Social Workers, Conscience Protection and Practice,” 119.

²³⁵ Dreger and Powers, “Caring for Older Adults,” 278.

suffering; and that this practice is described as “therapeutic tyranny.”²³⁶ We recommend that in responding to such situations that dishonor the dignity of the human person, chaplains should have recourse to the teaching of the Catholic Church on human dignity, recognizing that every human life has value. Catholic chaplains should avoid personal opinions and conclusions on issues that require adherence to the ethical standards and directives of the Catholic Church.

Considering the fact that chaplains would be doing a disservice to patients and the ecclesiastical institutions they represent,²³⁷ if they do not resist the temptation to be used as catalysts in altering resolutions of families grounded in faith and religion, it is ideal to be mindful that “Theologically speaking, a Christian faith community becomes “a sanctuary for injustice” rather than justice-seeking beloved community when it colludes with systems of corruption and exploitation, and contributes to the public legitimization of such reality.”²³⁸ It is ideal for chaplains to avoid the pressure of helping families decide to take off life-support. Chaplains can be well informed by discussion of Fletcher on the decisions to forego life-sustaining treatment. Fletcher recommends, “In cases where the dispute is largely about the patient’s “quality of life,” respect for family wishes

²³⁶ “Therapeutic Tyranny” according to the Pontifical Council for Pastoral Assistance to Health Care Workers, consists in the use of a method that brings a patient to an artificially prolonged agony; it is indeed an exhausting and painful procedure.

²³⁷ For instance, Catholic Chaplains have the obligation to honor and abide by the teachings and positions of the Catholic Church on bio-ethical issues.

²³⁸ Mai-Anh Le Tran, *Reset the Heart: Unlearning Violence, Relearning Hope* (Nashville, TN: Abingdon Press, 2017), 66.

is appropriate, since families are generally in a better position to evaluate quality of life issues.”²³⁹ Reiterating this recommendation, Fletcher adds, “To take unilateral action to withdraw treatment (e.g, turn off a ventilator, remove feeding tubes, etc.) over family objections in such situations runs contrary to a moral perspective of care that allows the family to be the final interpreters of what quality of life means for their members.”²⁴⁰

Fletcher’s recommendation provides thoughtful guide for chaplains in resisting the tendency of suggesting withdrawal of care to families based on the issue of quality of life. While chaplains are guided by the knowledge of appropriateness of the respect for family wish regarding quality of life, it is also pertinent for them to be aware of *the other side of the coin*. This implies having knowledge of what is attainable by physicians when harm is imminent. On this note, Fletcher writes, “However, if the case clearly involves harm to patients by continuing treatment, health care professionals’ first loyalty is to the patient and to prevent harm.”²⁴¹

3.6 Dignified Death: A Thoughtful Panacea to Conflicting Views on Natural Death

Death imposes fear and uneasiness on humanity. Robert Veatch and Edmund Wakin identify some of these fears: “There is fear of the dying process and of the pain and suffering that might accompany it. There is the fear which arises from separation

²³⁹ Fletcher, “Decisions to Forego Life-Sustaining Treatment,”153.

²⁴⁰ Fletcher, “Decisions to Forego Life-Sustaining Treatment,” 153.

²⁴¹ Fletcher, “Decisions to Forego Life-Sustaining Treatment,” 153.

from family, from the community, from the familiar and reassuring world around us.”²⁴² These fears are apparent during the process of dying. The process of dying itself takes a toll on the human person. Because of the complexities that surround death and the process of dying, the dying person or the family of the dying person seeks for help and support when death and dying become concerns.

In their discussion of death and dying, Veatch and Wakin note, “The medical profession and the church are the two institutions to which we turn when faced with death.”²⁴³ The reference to the medical profession and the church alludes to the context in which chaplains, with particular reference to Catholic chaplains, practice their professions. The chaplains, as representatives of the church’s spiritual care, minister within the setting of health care. Their ministries, in most cases, position them in a situation that requires them to attend to the demands of medicine and faith, which may sometimes have divergent views. One of such divergent issues of medicine and faith, which ushers in conflicts between physicians and families, is the notion of death and dying.

As noted in the previous chapter, death could be described by different modes of dying, for example, *natural* or *normal* death. Veatch and Wakin note, “Many patients die by gradually evolving into a state of less consciousness, then lapse into a coma, and finally the bodily process cease. This might be called a “normal” way for death to

²⁴² Robert Veatch and Edward Wakin, *Death and Dying* (Chicago: Claretian Publications, 1973), 7.

²⁴³ Veatch and Wakin, *Death and Dying*, 36.

occur.”²⁴⁴ Because of the recurrent varied viewpoints of physicians and families regarding natural death, chaplains find themselves in a difficult position of mediation. Instead of being driven by any of the perspectives held by either physicians or families, exploring the idea of dignified death could be an ideal way of thinking about end-of-life situations.

Chaplains can mediate between physicians and patients’ families with the idea of a “dignified death.” The understanding of dignified death may vary between medical, family, and various religious perspectives. However, it means that “the dying needs to be assured that their lives will not be arbitrarily shortened, that they will not have to suffer uselessly, that they will not be subject to unreasonable and burdensome therapies, that medical technology will be used for their integral well-being, that their free and informed decisions will be respected, and that they will not be marginalized or abandoned by the community in their dying.”²⁴⁵ Since physicians and patient’s families often hold on to different perspectives on what should be the quality of life; and physicians often express their obligation to keep patients out of suffering, while patients’ families often prefer to prolong life-support in hopes of a miracle or unexpected recovery, the idea of “dignified death” will be ideal for chaplains to build a bridge between physicians and patient’s families.

²⁴⁴ Veatch and Wakin, *Death and Dying*, 37.

²⁴⁵ Kopfensteiner, “Death with Dignity,” 64.

Building a bridge between physicians and patient’s families with the idea of dignified death during the conflicts of end-of-life care requires chaplains to be well-informed that “In the terminal stage, the dignity of the person is elucidated in his right to die with as much serenity as possible, and with the human and Christian dignity that is owed to him.”²⁴⁶

3.7 Catholic Church and End-of-Life Care

One of the challenges that chaplains face during end-of-life care is the task of accompanying patients and families in decisions that are informed by their religious practices. Some people of faith do not accept certain medical interventions that do not conform to their tenet. For instance, referencing Z. M. Bodnaruk et al, and C. J. Gannon et’ al, Joseph A. Posluszny Jr. and Lena A. Napolitano write, “The management of Jehovah’s Witness (JW) with anemia and bleeding present a clinical dilemma as they do not accept allogeneic human blood or blood product transfusion.”²⁴⁷ The refusal of Jehovah’s Witness patients to accept allogeneic human blood or blood product transfusion is a great issue of concern during end-of-life care. Posluszny and Napolitano present it this way: “The refusal of allogeneic human blood and blood products by Jehovah’s Witness (JW) complicates the treatment of life-threatening anemia.”²⁴⁸ For Catholics, whereas the use of adult stem cell for therapy is allowed, the use of embryonic

²⁴⁶ Pastoral Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, 107.

²⁴⁷ Joseph A. Posluszny Jr. and Lena A. Napolitano, “How do We Treat Life-Threatening Anemia in a Jehovah’s Witness Patient?” *Transfusion* 54 (December 2014): 3026.

²⁴⁸ Posluszny Jr. and Napolitano, “How do We Treat Life-Threatening Anemia,” 3026.

stem cell for therapy is unacceptable. Contrary to the unacceptance of embryonic stem cell for therapy by the Catholic Church, Kevin D. O'Rourke notes, "Many scientists, ethicists, and health-care advocates maintain that because of the great good that might be achieved, the use of embryonic stem cells in research and therapy should be accepted as an ethical procedure."²⁴⁹

Because instances like this are religious-related, chaplains often find themselves at the intersections of the conflicts of patient's/family's decision, informed by the patient's/family's religious belief of not accepting embryonic stem cell therapy, and the physicians' recommendation of it as a necessary qualitative care approach. Knowledge and understanding of the Church's teaching on issues of ethical medical concern, like stem cell therapy, are necessary for chaplains as they provide spiritual and pastoral guide to patients and their families on decision-making that are informed by the Catholic teachings. O'Rourke explains the Catholic Church's unacceptance of the advocacy on the use of embryonic stem cell: "because of the manner in which they are obtained, using stem cells obtained by destroying human embryos is unacceptable."²⁵⁰

The Congregation for the Doctrine of Faith declares, "Research initiatives involving the use of adult stem cells, since they do not present ethical problems, should be encouraged and supported."²⁵¹ In an address to an international congress on stem cell

²⁴⁹ Kevin D. O'Rourke, "Stem Cell Research: Prospect and Problems," *The National Catholic Bioethics Quarterly* 4, no. 2 (2004): 293.

²⁵⁰ O'Rourke, "Stem Cell Research: Prospect and Problems," 293.

²⁵¹ Congregation for the Doctrine of Faith, *Dignitas Personae*, sec. 32.

therapy, Pope Benedict XVI affirms, “The prospects opened by this new chapter in research are fascinating in themselves, for they give a glimpse of the possible cure of degenerative tissue diseases that subsequently threaten those affected with disability and death.”²⁵² Chaplains are therefore encouraged to acquaint themselves with the teaching of the Church on stem cell therapy so as to rightly guide patients and their families on what is acceptable and unacceptable by their religious tenets.

As noted in the introduction, our conversation on the religious-informed decisions of patients and families, with regards to end-of-life care, focuses on the perspectives of the Catholic Church in reflection of writer’s faith tradition and ministry. In abiding by the tenets of the Catholic Church regarding the sacredness of life, Catholic patients and families, for instance, are mostly concerned about participating in euthanasia. The case scenario presented in the previous chapter highlights this concern:

After a week of “stand-off” between the family and health care team, the ethics consultation continued and involved several meetings between physicians, nurses, social workers, and family. The patient had not responded to treatment and had become steadily worse. His physicians and nurses stated further treatment was “futile.” Also, other patients who could benefit more from intensive care were being denied the bed. They recommended to the daughters that the breathing machine be removed and, if his heart stopped, that he be allowed to die without massaging his chest or restarting his heart by electroshock. They needed to write a DNR order. Pam objected, saying again, “You are asking us to murder our father. This is our belief. We want him coded (resuscitated) until he is brain dead!”²⁵³

²⁵² The Holy See, Address of His Holiness Benedict XVI to the Participants in the Symposium on the Theme: “Stem Cell: What Future for Therapy?” Organized by the Pontifical Academy for Life, Hall of the Swiss, Castel Gandolfo, Saturday, 16 September 2006.

²⁵³ Fletcher, “Decisions to Forego Life-Sustaining Treatment,” 151.

This scenario offers insight to some of the concerns of Catholic families during end-of-life care. These are Euthanasia Physician Assisted Suicide. Most Catholics are deeply worried about taking part in any of these acts.

3.7.1 Euthanasia

The United States Conference of Catholic Bishops define euthanasia as “an action or omission that of itself or by intention causes death in order to alleviate suffering.”²⁵⁴ This definition suggests that euthanasia could be carried out either by action or by omission. It could occur by action, when the step taken is aimed at ending life; and by omission, when what should have been done to possibly save life is ignored. Josef D. Zalot and Benedict Guevin offer elaborate explanations on euthanasia that occurs by commission (something we do), and euthanasia that occurs by omission (something we do not do). According to these authors, “Euthanasia by commission occurs when one performs with full knowledge and full intent an act that will directly end another’s life.... Euthanasia by omission occurs when one deliberately withholds, or removes an ordinary proportionate treatment necessary to maintain life.”²⁵⁵

Most Catholic families are often worried about being enablers and partakers in euthanasia, either by commission or omission.

²⁵⁴ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 5th ed., 27.

²⁵⁵ Josef D. Zalot and Benedict Guevin, *Catholic Ethic in Today’s World* (Winona, MN: Anselm Academic, 2011), 238.

Richard J. Devine provides an insightful etymology and meaning of euthanasia. According to him, the term “euthanasia” is derived from two Greek words, *eu* and *thanatos*, meaning “good death” or “happy death.”²⁵⁶ Devine further notes, “In contemporary usage, however, the qualification “good” refers to pain and suffering. Hence, this “happy death” is one that releases an individual from pain, a death that ends suffering. For this reason, euthanasia is often used to mean the same as “mercy killing” in much contemporary discussion.”²⁵⁷

In this explanation, Devine calls attention to the understanding of euthanasia as “a death that ends suffering,” “mercy killing.” This implies mercifully ending the life of someone with the intention of ending the person’s suffering.

In their discussion of medical ethics at the end of life, Zalot and Guevin ask pivotal questions that reflect the critical concerns of end-of-life care:

What forms of medical care are necessary when people are at or near death? Is it ever morally permissible to refuse medical care? If yes, under what conditions? Can people at the end stages of a terminal disease directly end their lives through recourse to euthanasia? How about physician assisted suicide? What about patients in a persistent vegetative state – Can we ever remove artificial nutrition and hydration from them?²⁵⁸

Considering the challenge these concerns pose to chaplains in working with families and physicians during end-of-life care, it is pertinent for them to be well

²⁵⁶ Richard J. Devine, *Good Care, Painful Choices: Medical Ethics for Ordinary People* (New York: Paulist Press, 2004), 224.

²⁵⁷ Devine, *Good Care, Painful Choices*, 224.

²⁵⁸ Zalot and Guevin, *Catholic Ethic in Today’s World*, 230-231.

informed about the teachings of the Catholic Church on end-of-life care. In the fifth edition of the *Ethical and Religious Directives for Catholic Health Care Services*, the United States Conference of Catholic Bishops discussed issues in care for the seriously ill and dying. According to this document,

The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives and, hence, do not have absolute power over life. We have a duty to preserve our life and use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options.²⁵⁹

This offers insight to what could be considered during end-of-life care: rejecting “life-prolonging procedures that are insufficiently beneficial or excessively burdensome;” as well as what could not be accepted during end-of-life care: “Suicide and euthanasia.” How may chaplains understand and communicate the recommendation that insufficiently beneficial or excessively burdensome life-prolonging procedures may be rejected by patients and their families? The *Catechism of the Catholic Church* provides this desirous understanding. The Catholic Church teaches, “Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of “over-zealous” treatment. Here, one does not will to cause death; one’s inability to impede it is merely accepted.”²⁶⁰

²⁵⁹ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 5th ed., 25.

²⁶⁰ *Catechism of the Catholic Church*, no. 2278.

This teaching of the Catholic Church could be challenging for some Catholic families. Therefore, in ministering to Catholic patients and families during end-of-life conflicts with physicians, it is ideal for chaplains to understand and be able to communicate this teaching of the Catholic Church to families. This communication should, however, be for the purpose of providing guidance aimed at making informed decisions, and not for the purpose of pressuring families into altering their decisions for the end-of-life care of their beloved family members. It is pertinent for chaplains to know how difficult it could be for families to process such teaching of the Catholic Church that seem not to offer them the grip to hold on to the expectation of not withdrawing care. Therefore, Catholic chaplains should be able to guide families in the knowledge that “Refusing to prolong the dying process is radically different from ending the living process.”²⁶¹

Because Catholic families are concerned about not enabling and participating in euthanasia, this noted difference of prolonging the dying process and ending the living process will be an ideal way for chaplains to provide reassuring support for Catholic families, who may be uneasy with the teaching of the Catholic Church on discontinuing burdensome, dangerous, and extraordinary medical procedures. The teaching of the Catholic Church about death being “senseless” on one hand, and “rightful liberation” on the other hand, is an essential recourse for chaplains in their participation in conversations during end-of-life care. In *The Gospel of Life*, Pope John Paul II writes,

²⁶¹ Veatch and Wakin, *Death and Dying*, 30.

“Death is considered “senseless” if it suddenly interrupts a life that is still open to a future of new and interesting experiences. But it becomes a “rightful liberation” once life is held to be no longer meaningful because it is filled with pain and inexorably doomed to even greater suffering.”²⁶² This is to say that even though the death of a loved one is not desired, it is accepted when their continued existence becomes excessively burdensome and insufficiently beneficial. In whichever case it is pertinent for chaplains to also be mindful of the Catholic Church’s declaration that “The deliberate decision to deprive an innocent human being of his life is always morally evil and can never be licit either as an end or as means to a good end.”²⁶³

Veatch and Wakin elucidate the position of the Catholic Church on euthanasia this way: “The Catholic position is clear. Positive euthanasia – taking action to hasten death – is against Catholic ethical teaching.”²⁶⁴ These authors’ affirmation of the teaching of the Catholic Church on euthanasia elucidates the content of the Catechism of the Catholic Church in these words: “Whatever its motives and means, direct euthanasia consists [of] putting an end to the lives of the handicapped, sick, or dying persons. It is morally unacceptable.”²⁶⁵ Chaplains should be able to communicate the teachings of the Catholic Church, as well as every other religious denomination and faith practice, with

²⁶² John Paul II, *Evangelium Vitae*, sec. 104-105.

²⁶³ John Paul II, *Evangelium Vitae*, sec. 93.

²⁶⁴ Veatch and Wakin, *Death and Dying*, 30.

²⁶⁵ *Catechism of the Catholic Church*, no. 2277.

“respect, love, and support to patients or residents and their families as they face the reality of death.”²⁶⁶

3.7.2 Physician Assisted Suicide

Another concern of Catholic families during end-of-life care is Physician Assisted Suicide (PAS). Citing AMA Council on Ethical and Judicial Affairs, *supra* note 37, Charles A. Hite and Mary Faith Marshall note, “Physician assisted suicide is said to occur when a doctor “facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act.”²⁶⁷ By this definition, a direct involvement of physicians towards life-ending act is implied, which, according to the Catholic teaching, is “contrary to the moral law.”²⁶⁸ Catholic families are worried about physicians providing means or information, which they perceive as aimed at ending the life of their family members, as we saw in the case scenario presented in chapter two. In the case scenario, following the deteriorating state of the patient, the health care team made recommendation of removing breathing machine and needed to write a DNR (Do Not Resuscitate). The objection of the patient’s daughter, Pam, is an example of the expressed concerns of Catholic families who are apprehensive of Physician Assisted Suicide. It should be recalled that Pam, the patient’s daughter objected: “You are asking

²⁶⁶ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 5th ed., 25.

²⁶⁷ Charles A. Hite and Mary Faith Marshall, “Death and Dying” in *Introduction to Clinical Ethics*, ed. John C. Fletcher et al (Frederick, MD: University Publishing Group Inc, 1995), 125.

²⁶⁸ *Catechism of the Catholic Church*, no. 2282.

us to murder our father. This is our belief! We want him coded (resuscitated) until he is brain dead.”²⁶⁹

Some people, however, do not see PAS as evil. For them, it is a way of assisting the dying to expire with dignity. These advocates lobby for the legality of PAS.

Referencing K. Hedberg, et al, Samuel M. Brown, et al, write, “In parallel with ethical and practical advances in the care of patients with end-stage medical disease, some advocates of “dignified” dying have successfully lobbied for the legality of what is called “physician-assisted suicide” (PAS) in three U.S. states and two European countries.”²⁷⁰

This reference to “dignified” dying in relation to the lobbying for the legality of PAS raises the issues of multifaceted perceptions of what dignified death is. Because of the seeming divergent views about PAS in relation to dying with dignity, it becomes necessary to make presentations of arguments for and against PAS as guide for chaplains in the end-of-life ministry. Zalot and Guevin listed some of the most common reasons why people support euthanasia and PAS. These are excerpts from the lists:²⁷¹

1. Autonomy: Human beings are autonomous beings.
2. The Rights Argument: People have the right to determine when to die.
3. Human Dignity: Euthanasia and Physician Assisted Suicide allow people to die in a dignified manner.
4. Dependency and Burden: Euthanasia and PAS allow people to die before they become completely dependent on others, and thus avoid being an imposition on them.

²⁶⁹ Fletcher, “Decisions to Forego Life-Sustaining Treatment,” 151.

²⁷⁰ Samuel M. Brown, C. Gregory Elliott, and Robert Pain, “Withdrawal of Nonfutile Life Support after Attempted Suicide,” *The American Journal of Bioethics* 13, no. 3 (2013): 4.

²⁷¹ Zalot and Guevin, *Catholic Ethic in Today’s World*, 239-240.

5. Mercy: Ending one's life, or the life of another, is an act of mercy because it alleviates this unnecessary pain and suffering.
6. Quality of Life: where life is "no longer worth living."
7. Resources: Euthanasia and PAS prevent the "wasting" of scarce and often expensive medical resources on terminally ill patients.

These lists presented by Zalot and Guevin are only a few among other numerous common reasons why people support euthanasia and PAS. Some other authors present other reasons and arguments. For instance, Referencing Arthur J. Dyck, Hite and Marshall write, "Arguments favoring euthanasia and physician-assisted suicide focus on two concerns: compassion for the incurably ill who suffer intolerable pain and respect for their human dignity and freedom."²⁷² In a similar line of argument, these authors note that Joseph Fletcher (a pioneer in the bioethics field), "argued that failure to permit or encourage euthanasia demeans the dignity of persons."²⁷³ The issues of intolerable pain, as well as respect for human dignity and freedom, are recurring issues during end-of-life care. Being acquainted with the arguments in support of euthanasia and physician-assisted suicide is a helpful guide for chaplains during end-of-life conversations.

Zalot and Guevin also listed some of the most common theological and philosophical arguments against euthanasia and PAS. The following are excerpts from the lists:²⁷⁴

1. Gift of God: Human life is a gift from God. Euthanasia and PAS are wrong because they are a rejection of this sacred gift from God.

²⁷² Hite and Marshall, "Death and Dying," 126.

²⁷³ Hite and Marshall, "Death and Dying," 126.

²⁷⁴ Zalot and Guevin, *Catholic Ethic in Today's World*, 241-242.

2. The taking of life: Euthanasia and PAS are moral evils because they violate the fifth commandment (“You shall not kill”) and they transfer to human beings (patients, HCPs, family members, etc.) God’s prerogative of determining when we die.
3. Lack of hope in God: Recourse to euthanasia and PAS constitute an abandonment of hope in God.
4. Dignity: Choosing to end one’s life or the life of another violates human dignity.
5. Misuse of freedom: Related to dignity, human beings are moral agents who make rational, free decisions. Does it make sense that we use our rationality and freedom to destroy ourselves?
6. Slippery slope: Euthanasia and PAS can begin a “slippery slope” that results in both involuntary euthanasia (ending the lives of others without their consent) and the killing of those who are deemed “undesirable.”
7. Patient/professional relationship: Euthanasia and PAS can, in various ways undermine the relationships between patients and their HCPs.

Whereas proponents of euthanasia and physician-assisted suicide hold on to such arguments like people have the right to determine when to die, that euthanasia and PAS allow people to die in dignified manner, and that not permitting or encouraging euthanasia and PAS demeans the dignity of the person, Hite and Marshall note, on the other hand, that “Opponents of euthanasia and physician-assisted suicide claim that allowing these practices would undermine trust in the patient-physician relationship and lead to involuntary killing of the handicapped, the poor, or the disenfranchised members of the society.”²⁷⁵

The reasons listed for and against euthanasia and physician-assisted suicide provide insights for Catholic chaplains as they engage in difficult conversations with physicians and families during those moments of end-of-life care. It is therefore ideal for

²⁷⁵ Hite and Marshall, “Death and Dying,” 126.

Catholic chaplains to be well informed about the variances of thoughts regarding euthanasia and physician-assisted suicide. This knowledge will position them in a place of providing constructive mediation between physicians and families when the need arises. It is important for chaplains to remain focused on the fact that the patient is at the center of every argument that stems in the process of end-of-life care. With this in mind, chaplains ought not to allow themselves to be driven into conversations that tend to showcase the ability of exerting one's thoughts over that of another, with reference to physicians and families. For instance, Catholic chaplains, by virtue of the ministries, should not yield to the moments of physicians soliciting their help in talking families into the needs to understand and accept the recommendations of euthanasia or physician-assisted suicide.

The argument for alleviating suffering and ending pain through euthanasia or physician assisted suicide may sound plausible. Zalot and Guevin note that the opponents of euthanasia and physician-assisted suicide are stereotyped by their opponents as lacking compassion for those who are suffering. However, the authors emphasize that nobody would like to suffer unduly or see someone's beloved suffer unnecessarily. Their recommendation regarding this, is a good fit for Catholic chaplains in acquiring the knowledge of the reasons for and against euthanasia and physician-assisted suicide. According to these authors, "But understanding the reasons why people request euthanasia or PAS should help us to appreciate why the Catholic Church, other people of faith, and many people with no particular faith, do not see these practices as humane.

Rather, euthanasia and PAS are inhumane, a misguided form of compassion, both final and definitive “solutions” to a medical condition that is usually treatable.”²⁷⁶

Catholic chaplains, by adhering to the teachings of the Catholic Church, and conforming to the ethics of their job, should not see their role of speaking up for the common good of the spiritual care of patients as taking side with families during conflicts of end-of-life care. Also, they should not see their role of helping families understand the recommendations of the Church on the option to “reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome”²⁷⁷ as taking side with physicians. Since patients are the main focus of care, and their religious values are important to them, especially during such critical time as end-of-life care, Catholic chaplains should endeavor to communicate the need to honor that, which means so much to patients and families as dictated by their religion and faith. On this note, it would not be out-of-place for Catholic chaplains to bring into conversation the most notable of the position of the Catholic Church, which states that “Suicide and euthanasia are never morally acceptable options.”²⁷⁸ Suicide, in this case, includes PAS. Paul John Paul II elucidates the rejections of suicide and euthanasia in these words, “Not only must human life not to be taken, but it must be protected with loving concern.”²⁷⁹

²⁷⁶ Zalot and Guevin, *Catholic Ethic in Today's World*, 243.

²⁷⁷ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 5th ed., 25.

²⁷⁸ United States Conference of Catholic Bishops, *Ethical and Religious Directives*, 5th ed., 25.

²⁷⁹ John Paul II, *Evangelium Vitae*, sec. 81.

Bringing notable teachings of the Catholic Church into conversation does not imply that chaplains assume the role of telling physicians and families what to do. Rather, since the primary focus of conversation is the patient, it is a needful way of ensuring that the religious values of Catholic patients are not dishonored and overlooked during end-of-life cares. It is ideal for Catholic chaplains to bring into conversations, recommendations aimed at providing the most desired care for patients during end-of-life care. For instance, Anderson, recommends, “We should respond to suffering with true compassion and solidarity. Doctors should help their patients to die a dignified death of natural causes, not assist in killing.”²⁸⁰ Anderson’s recommendation about responding to suffering with true compassion and solidarity evokes the fundamental ministries of chaplains.

In his encyclical on the Gospel of Life, *Evangelium Vitae*, Pope John Paul II teaches, “True “compassion” leads to sharing another’s pain, it does not kill the person whose suffering we cannot bear.”²⁸¹ The idea of Doctors helping patients die a dignified death corroborates the recommendation of this thesis. However, Anderson’s recommendation for Doctors to help patients to “die a dignified death of natural causes” may usher in difficulty in conversation because of the discrepancies that may arise from the understanding of “death of natural causes.” Therefore, chaplains should be aware that words and expressions matter so much moments of conflicts, like end-of-life.

²⁸⁰ Anderson, “Always Care, Never Kill,” 1.

²⁸¹ John Paul II, *Evangelium Vitae*, sec. 66.

3.8 Provision of Health Care: General Principles

In their discussion of medical ethics, Zalot and Guevin presented two general principles regarding the provision of health care: “the principle of double effect, which helps us determine what we can and what we cannot do, and the principle of legitimate cooperation, which helps us determine to what extent we can cooperate with a morally evil act.”²⁸² These authors note that these principles are “vitaly important for any discussion of contemporary medical ethics.”²⁸³ These principles come into discussion here considering the fact that hospital chaplains practice their ministries in a health care setting.

3.8.1 Principle of Double Effect

According to the principle of double effect as propounded by Thomas Aquinas, an action might have two effects: one intended and the other unintended. The principle applies only when an action is performed with good intention and with the intent to produce one effect only. Discussing the formulation of the principle of double effects, Alison McIntyre writes, “Thomas Aquinas is credited with introducing the principle of double effect in his discussion of the permissibility of self-defense in the *Summa Theologica* (II-II, Qu. 64, Art.7).”²⁸⁴ This later became a major teaching in the Catholic

²⁸² Zalot and Guevin, *Catholic Ethic in Today's World*, 201.

²⁸³ Zalot and Guevin, *Catholic Ethic in Today's World*, 201.

²⁸⁴ Alison McIntyre, "Doctrine of Double Effect," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta (Spring 2019), 1, URL = <https://plato.stanford.edu/archives/spr2019/entries/double-effect/>

Church. The usage and application of the principle of double effect developed to a broadly discussion of other critical ethical issues other than self-defense.

Lucius Iwejuru Ugorji, a moral theologian and one-time researcher in Philology at the University of Munster and Rector of Klarastift Altenheim Munster W/Germany (currently the Catholic Archbishop of Owerri in Nigeria) writes, “the principle of double effect applies to acts with an apparent double moral character, that is to say, it governs acts that can be judged morally right because of the values they produce and at the same time morally wrong because of the moral disvalues (intrinsic evil) they bring into existence.”²⁸⁵ An instance of double effect with an apparent double moral character is a case of ectopic pregnancy where the fetus develops outside of the uterus, thereby constituting danger to the life of the mother. As earlier established in this thesis, the Catholic Church teaches that every life sacred and ought to be preserved. This is to say that the life of the mother, as well as the life of the baby has value. In applying the principle of double effect here, the death of the fetus becomes an unintended effect of the good intention of saving the life of the mother. The end-of-life care herein applies to the care of the fetus whose inevitable death is a loss to the family.

Zalot and Guevin stated that “The principle of double effect comes into play when a particular decision will have both positive and negative consequences.”²⁸⁶ As this thesis

²⁸⁵ Lucius Iwejuru Ugorji, *The Principle of Double Effect: A Critical Appraisal of its Traditional Understanding and its Modern Reinterpretation* (Frankfurt, Germany: Peter Lang 1985), 55.

²⁸⁶ Zalot and Guevin, *Catholic Ethic in Today's World*, 201.

seeks to craft ethical response for chaplains at the intersection of the conflicts between physicians and families during end-of-life care, it is important to note that the role of chaplains in working with physicians and families at such moments when a particular decision will have both negative and positive consequences is laden with ethical challenges. In as much as these ethical challenges may not be applicable to all chaplains, considering their different faith tenets, however, Catholic chaplains ought to respond in conformity with the recommendations of the Catholic Church in such moments, whereby their ministries are primarily directed to the spiritual care and support of Catholic patients. For instance, as noted earlier in the discussion of euthanasia, the Catholic Church teaches that “Whatever its motives and means, direct euthanasia consists [of] putting an end to the lives of the handicapped, sick, or dying persons. It is morally unacceptable.”²⁸⁷

3.8.2 Principle of Legitimate Cooperation

The principle of legitimate cooperation is related to the principle of double effect. The former applies to the latter to situations pertaining to cooperating with another person’s actions. In discharging our legitimate duties, we usually cooperate with others in carrying out moral actions. Sometimes, people expect us to perform actions that are not morally good. The principle of legitimate cooperation suggests that we cooperate with them only to the extent we consider the action as good. According to Zalot and Guevin, “The principle of legitimate cooperation establishes the parameter by which an individual

²⁸⁷ *Catechism of the Catholic Church*, no. 2277.

(or institution) may legitimately cooperate with another in the performance of a morally evil act.”²⁸⁸ With particular reference to Catholic chaplains, providing spiritual care in health care institutions raises the concern of the extent at which chaplains should cooperate when ethical issues arise. This poses some questions: On the one hand, can a Catholic chaplain unequivocally align with physicians as a member of the hospital interdisciplinary team to advocate for euthanasia or physician-assisted suicide during end-of-life care of patients? Can a Catholic chaplain, on the other hand, glaringly stand with families against the recommendations of the health care team? In end-of-life situations, physicians sometimes persuade families to accept euthanasia or physician assisted suicide as veritable treatment plan. This amounts to asking families to cooperate in doing what they perceive, by their religious belief, as morally wrong. Sometimes they also seek the intervention of chaplains to help in realizing their objective. As earlier noted, it is important to keep in mind that the patient is the primary focus of care. Therefore, Catholic chaplains’ mediation, in such moments when issues of legitimate cooperation arise, should focus on the desired and common good of the patient, which includes the patient’s spiritual options and religious/faith values.

In chapter two of this thesis, it was noted that while for families, it may seem appropriate and normal for the chaplain to advocate for them, physicians expect the chaplain, as a fellow hospital staff and caregiver, to work with them as a team to achieve a common purpose. It was also noted that some chaplains unduly mistake yielding to

²⁸⁸ Zalot and Guevin, *Catholic Ethic in Today’s World*, 203-204.

physicians as a way to keep peace with the hospital's interdisciplinary team, while others yield unduly to patients' families as a way of showing solidarity. The profession of chaplains has two dimensions: spirituality and health care. They provide spiritual care in a health care setting. This could be challenging. As Margaret E. Mohrmann noted, "Hospital chaplains then have differing, and potentially conflicting, moral obligations entailed by their adherence to two relatively distinct professions."²⁸⁹ However, as chaplains are spiritual care givers who take care of souls, they are primarily obligated to be supportive to the spiritual care needs of patients and their families. Notably, the moral obligations of Catholic chaplains working in hospital could be conflicting. Mohrmann explains this in these words, "Chaplains and health care professionals alike have moral obligations toward the institution of which they are a part, and these, too, may at times conflict with other professional commitments."²⁹⁰

Considering the conflicts with other professional commitments in relation to chaplains' moral obligations towards health care institutions, the question of the extent of their cooperation with the health care team during end-of-life conflicts becomes more imperative. This explains further, the reason for our discussion of legitimate corporation in this thesis. Zalot and Guevin write, "The principle of legitimate cooperation helps us evaluate whether it is ever permissible to participate in morally evil act, and, if so, to what extent."²⁹¹ The extent of Catholic chaplains' cooperation with the healthcare team,

²⁸⁹ Mohrmann, "Ethical Grounding for a Profession od a Hospital Chaplaincy," 19.

²⁹⁰ Mohrmann, "Ethical Grounding for a Profession od a Hospital Chaplaincy," 20.

²⁹¹ Zalot and Guevin, *Catholic Ethic in Today's World*, 203.

as well as their spiritual care support for families, should be guided by the ethical code of their profession.

As we can see, chaplains play critical and crucial roles in health care. This ought to be appreciated by the medical team, patients and families. The practical ways by which chaplains could tangibly minister during end-of-life care are discussed in the next chapter.

Chapter Four

4. Crafting Ethical Response to End-of-Life Conflicts

4.1 Walter Fluker's Narrative-Based Ethics and Circle Process

Having examined the challenges facing the Catholic hospital chaplain, especially in end-of-life situations in trying to mediate between hospital physicians and patients' families, what remains is a consideration of how to fill the yawning gap. How can the chaplain navigate the tension between the two parties without taking sides? How can the hospital chaplain help resolve the conflicts that arise in his ministry without compromising the ethical standard of his ministry? In what ways can the chaplain demonstrate authentic ethical leadership at the intersection where interests of those he ministers tend to collide? We have adopted Walter Fluker's storytelling ethics as a veritable model for ministry in the face of end-of-life conflict that arise between hospital medical team and families of patients.

This chapter demonstrates how Fluker's narrative-based ethics forms a pastoral ethical ministerial model, which provides a dialogical praxis for group support and peacemaking. We shall discuss the narrative-based ethics alongside the circle process, which is praxis-oriented. While the former provides the theoretical framework, the latter offers a practical ministerial step. The blending of storytelling and circle process becomes a powerful tool in the hand of the chaplain in the face of conflict resulting from end-of-life disorientation.

4.2 Walter Fluker's Notion of Ethical Leadership

Leadership is a phenomenon we commonly engage with but not very much understood. Because of its association with power and authority, people often confuse leadership with them. While leaders may have authority or power conferred on them by virtue of their position, leadership can be described as “a practice, an activity that some people do some of the time.”²⁹² Leaders are those who have the capacity to inspire and guide others in certain ways or direction. In institutions and nations, leaders pilot the affairs and lead others toward the attainment of their common or collective goal. A leader, according to Howard Gardner, “is an individual (or, rarely, a set of individuals) who significantly affects the thoughts, feelings, and/or behaviors of a significant number of individuals.”²⁹³

A leader has to have the capacity to impact the thoughts or action of a significant others. Fluker believes that there has to be something attractive rather than repulsive about the personality of a good leader. This is why for him, character or personality is crucial to ethical leadership. Leadership is about service; service is not simply an activity carried out on one’s behalf but on behalf of others, a people or community.²⁹⁴ The good leader, therefore, constantly bears in mind the good of the community. The element of the

²⁹² Ronald Heifetz, Alexander Grashow, and Marty Linsky, *The Practice of Adaptive Leadership: Tools and Tactics for Changing Your Organization and the World* (Boston, MA: Harvard Business School Publishing, 2009), 24.

²⁹³ Howard Gardner, *Leading Minds: An Anatomy of Leadership* (New York: Basic Books, 1995), ix.

²⁹⁴ Susan Wood, “The Priestly Identity: Sacrament of Ecclesial Community,” *Worship* 69, no.2 (March 1995): 115.

good or welfare of others brings out the ethical element of leadership. According to Walter Fluker, a social ethicist, the sole aim of ethical leadership is, therefore, to serve the collective good.

I describe ethical leadership as the critical appropriation and embodiment of moral traditions that have shaped the character and shared meanings of a people (an ethos). In fact, ethical leadership does not emerge from a historical vacuum but from the lifeworlds of particular traditions and speaks authoritatively and acts responsibly with the aim of serving the collective good. Ethical leaders, therefore, are those whose characters have been shaped by the wisdom, habits, and practices of particular traditions – often more than one – yet they tend to be identified with a specific cultural ethos and narrative. Finally, ethical leadership asks the question of values in reference to ultimate concern.²⁹⁵

Writing from an African American perspective, Fluker believes that an ethical leader should be able to draw from his personal and collective stories, inspire and guide others through a courageous transformation of systemic injustice. Like James Burns²⁹⁶, leadership for Fluker is therefore, far from being transactional; it is transformational. It is not based on exchanging one thing for another but involves the recognition and exploitation of existing needs, seeking to fulfill higher needs, and transforming persons into moral agents. Crucial to ethical leadership for Fluker, as it is for most proponents of authentic or ethical leadership, therefore, is the personal tradition of leaders as well as their moral vision.

Leaders who stand at the intercession, where they are caught between the often conflicting moral languages that form and shape moral vision and action, need to think about strategies that both heal and prevent the rupturing of their ethical centers. It is important, therefore, that leaders pay close attention to personal narratives that inform thoughts, feelings, and behaviors at the intercession.

²⁹⁵ Fluker, *Ethical Leadership*, 33.

²⁹⁶ James Burns, *Leadership* (New York: Harper Colophon Books, 1978), 4.

Leaders who are unable or ill prepared to reenter their own personal constructions of morality have difficulty appreciating and participating in the lifeworlds of others.²⁹⁷

Accordingly, for Fluker, leadership finds its basis in one's personal story and the appropriation of one's roots. To attain personal and social transformation, ethical leaders must therefore possess certain virtues and good habits that drive behaviors and social practices at both personal and public domains. This requires the development of character, civility and sense of community by leaders.

As leaders with character, ethical leaders according to Fluker inculcate the virtues of integrity, hope, and empathy. These virtues (integrity, hope, and empathy) represent the moral, psychosocial and spiritual dimensions of character. Ronald Humphrey puts a premium on empathy. In "The Many Faces of Emotional Leadership," he notes: "Empathy is shown to be an important variable that is central to both emotional intelligence and leadership emergence."²⁹⁸ In crafting a response in a conflictual situation, there opens up new possibilities for moving forward. Empathizing with others can make them feel heard, and "being heard, being acknowledged, and honored are critical to building trust and respect."²⁹⁹ Though not above mistakes, leaders are to seek wholeness and authenticity, be able to put themselves in the other's situation, and genuinely anticipate the future.

²⁹⁷ Fluker, *Ethical Leadership*, 56.

²⁹⁸ Ronald H Humphrey, "The many faces of emotional leadership," 493.

²⁹⁹ Gopin, *Healing the Heart of Conflict*, 42.

The hospital chaplain who finds himself or herself attending to the sacred stories of those dealing with professional and moral issues finds herself in an ethical leadership position. As a member of the hospital's interdisciplinary team and a middle person between the physicians and patient's family, the demonstration of authentic character, civility and sense of community is required to guarantee effective negotiation at the intersection where physicians and families collide at the end-of-life care of patients. The character of the chaplain go with it the virtues of empathy, integrity and hope. The chaplain demonstrates the ability to be with others in their pains, sensing their emotions and expressing interest in their concerns (empathy); shows steadfastness and a healthy sense of self (integrity); and is able to inspire an optimism, and anticipation of a future filled with new possibilities in the face of challenges (hope). The quality of civility carries with it the sense of respect and recognition. The chaplain in attending to the sacred stories of patients, families and the health care professionals becomes aware of himself or herself and others and accepts others as true and genuine subjects (recognition) as well as the recognition that every human person has dignity (respect). Finally, the sense of community inspires courage, justice and compassion. In the course of ministry, the chaplain stands on the side of justice as fairness, expresses concrete action to identify with those he ministers to (compassion) and ought to display a confident character, which shows faith, that is, being able to act in the face of the possibility of failure, disgrace and shame (courage).³⁰⁰

³⁰⁰ Fluker, *Ethical Leadership*, 133.

4.3 Storytelling as Narrative-based Ethics

Stories are a significant part of people's lives. Stories are an embodiment of our life experiences and as such have terrific power on us. They reveal our joys and sorrows, our concerns and aspirations, our past and future, our belief and thought processes, our fears and hopes. In *Soul Stories*, Anne Streaty Wimberly underscores the importance of stories in our lives: "Throughout every generation, stories reveal the very lives persons live and the lives for which they hope. Stories reveal persons' yearning for God's liberating presence and activity in their lives. And they reveal person's yearning for meaning and purpose in life."³⁰¹

Wimberly, a professor of Christian Education, writing from an African American perspective suggests story-linking process³⁰² as a method and a veritable pedagogy in the Christian education of African Americans in a manner that it is grounded in biblical hermeneutic. Because stories reveal the kind of life persons live and their purpose in life, they go a long way to help us understand their personality, mentality, perception of reality, belief, aspirations and worldview. Such stories as advocated by Wimberly are stories of liberation and vocation that reflect their history as African Americans. These certainly touch both their private and public lives. As individuals, stories shape the perception of self and the individual's relationship with others and society. Beyond the individual, the lives and worldviews of communities revolve around significant stories

³⁰¹ Anne Streaty Wimberly, *Soul Stories: African American Christian Education* (Nashville, TN: Abingdon Press, 1994), 38.

³⁰² Wimberly, *Soul Stories*, 39.

they share as a people. Storytelling is therefore, a basic form of communication that gives order and meaning to human experience.³⁰³ Contemporary scholars in the areas of religious education, practical theology, communication and social ethics have all emphasized the significance of stories and storytelling in our everyday lives, our relationship with God, in meaning making and very importantly in conflict resolution.³⁰⁴

Fluker, a social ethicist, from an ethical leadership point of view sees stories as an ethical tool. Stories are an irreplaceable part of our nature; we are storied creatures as stories shape our view of the world as well as our place in the world.³⁰⁵ Storytelling as an exercise in self-discovery helps us leaders to reread their past and so make an entry into the often forgotten worlds of meaning which are important for realizing a meaningful life in the present. Because ethics is about doing, about fundamental moral norms largely shaped by habits and practices that we form in a given community or communities, there are necessarily various ways of doing ethics.

Consequently, ethics in modern times is not perceived from a single perspective. It is largely viewed from the lens of rationalism, empiricism and relationalism. To the above three modern perspectives to ethics and leadership, Fluker proposes a fourth – storytelling. According to him, storytelling as a way of doing ethics provides a

³⁰³ Walter R. Fisher, “Narration as a Human Communication Paradigm: The Case of Public Moral Argument,” *Communication Monographs* 51, no. 1 (1984), 6.

³⁰⁴ Details about relevance of stories to the various disciplines mentioned will be elaborated later in the chapter.

³⁰⁵ Fluker, *Ethical Leadership*, 52.

conceptual framework for making good morally veritable decisions. It would indeed be too simplistic, if not untrue, to assume that any kind of story is beneficial and transformational. Certainly, people tell so many stories for various reasons and purposes. Fluker and other pro- stories scholars are talking about specific stories. Fluker for instance, coming from an African American perspective is talking about African American historical stories, the stories of their struggle and survival against injustice and oppression.

As a disciple of Howard Thurman³⁰⁶, Flucker highlights the resilience and ethical leadership examples of Thurman and Martin Luther King Jr in the African American liberation movement. Stories about struggles that yielded significant and positive results for a people is important for Flucker. The stories of African American history connect them with the past, inform their present reality and help them project into the future. Flucker therefore maintains that storytelling is narrative-based and involves the processes of remembering, retelling and reliving people’s stories. “Remembering personal and collective stories of which one is a part allows leaders to experience a sense of wholeness, harmony, and integration, or better, a sense of *integrity*.”³⁰⁷ The act of remembering helps us to connect the past in the present in relation with the future. In remembering, we become aware of the past, which in turn informs the present. It involves

³⁰⁶ Howard Thurman (1899-1981) was an African America author, theologian, preacher, mystic, educator, and civil rights leader. He played a key role in the social justice movements and organizations of the 20th century as a religious figure.

³⁰⁷ Fluker, *Ethical Leadership*, 167.

an ethics of recognition and responsibility. The Christian political ethics of recognition and responsibility, according to Hille Haker, “is a political ethics of remembrance and witnessing”³⁰⁸ connecting people’s past with the future in such a manner that it informs their present action.

Remembering of stories makes little or no meaning without a critical evaluation of the stories. The interrogation of the belief systems and mores behind the stories is necessary. Storytelling therefore involves retelling and reframing of stories, which necessarily bring about self-reading, self-authoring and self-revision. The retelling of our stories furnishes us with new insights and revelations, which call on us to live these stories in the present. When family members, for instance share stories or memories of their dying ones or retell their cherished values, this could help them gain insights about and direct their attitudes and responses to end-of life matters.

For Fluker, people’s stories and experiences must be taken seriously. In making sound ethical decisions, therefore, we must demonstrate the ability and disposition (willingness) to look, listen and learn from others’ stories.³⁰⁹ In his narrative-based ethics, therefore, Fluker emphasizes the three steps of looking, listening and learning. The ethics of looking, listening and learning involves a dialogue in which each party has an opportunity to speak and be given attention. For Arch Chee Keen Wong, et al, dialogue is an important part of our being both as individuals and as a community of persons as

³⁰⁸ Hille Haker, “Compassion for Justice,” in *Mercy*, Concilium Series, ed. Lisa Cahill, Diego Irarrazaval, and Joao Cha (London: SCM Press, 2017), 60.

³⁰⁹ Fluker, *Ethical Leadership*, 41-42.

storied beings. “Dialogue is thus a subject-to-subject encounter in which two or more people share and hear their reflective stories and visions. By such human dialogue, the world can be named and a common consciousness created for its transformation.”³¹⁰

Thomas Groome, a contemporary religious educator and practical theologian strongly believes in the transformational and emancipating potential of dialogue and calls his approach to dialogue, *Shared Christian Praxis*.³¹¹

Ultimately, the position of the above scholars accentuate Fluker’s emphasis on the trio steps of storytelling – looking, listening to, and learning from others’ stories. By looking, we can become aware of others’ feelings, expressions and body language; by listening to them, we can understand and appreciate their stories, and ultimately learn from their narratives. An engagement in dialogue makes this possible. A dialogue process that is based on storytelling involves the ethical practice of self-revision. Self-revision for Fluker has to do with the consideration of others’ views and judgements. In initiating and leading a story-based dialogue, it would be helpful and fruitful if the one anchors the conversation in such a manner that it creates space for participants to air their views and concerns. This is because “One of the greatest challenges of leaders is the ability to look, listen and learn from others who share a common vision and mission within

³¹⁰ Arch Chee Keen Wong et al., “Learning through Shared Christian Praxis: Reflective Practice in the Classroom,” *Teaching Theology and Religion* 12, no. 4 (October 2009), 307.

³¹¹ Thomas Groome’s *Shared Christian Praxis* is a participatory and dialogical pedagogy that has five movements namely, naming the present action, critical reflection on the present action, making the Christian Story and Vision accessible, appropriating the Christian Story and Vision, and decision/response.

organizational and communal structure that work for change.”³¹² For a change or transformation to take place in an institution, leaders must be ready and willing to create space to bring about the desired transformation. In such instances that involve adaptive challenges and not mere technical problems³¹³ (like end-of-life issue in the hospital setting), ethical and adaptive leadership skills are required to move involved parties to a fruitful deliberation, discernment and taking decision. In a given situation, the chaplain as an ethical leader should be able to find a third way of bringing the existing rules of practice (thesis) and the conflicting views (anti-thesis) to create a substantially different and transformative decision (synthesis) that benefits the institution and families.

We must observe that Fluker did not cover the area of conflict resolution in his storytelling as an ethical tool for ethical leaders. He set out to ground leadership in story and the appropriation of the leader’s roots as a basis for personal and social transformation. Nonetheless, he submits that in any fruitful transformative conversation, people must learn to listen to others’ story without judgment or blame. Others are important others in my story; they show empathy as well as are able to ask the often hard questions we may not be comfortable to ask ourselves. In so doing, they add value to my story. For Fluker, compassion is ‘the highest and noblest of expression of ethical leadership.’³¹⁴ It is the virtue or quality of character that invites the leader to share in the

³¹² Fluker, *Ethical Leadership*, 170.

³¹³ Ronald Heifetz, originator of Adaptive Leadership distinguishes adaptive leadership challenges from technical problems. Technical problems simply require career expertise while adaptive leadership requires change that enable the capacity to thrive.

³¹⁴ Fluker, *Ethical Leadership*, 187.

other's sorrow and tragedy as well as in his hopes and aspirations. This element of compassion is crucial in storytelling as a conflict resolution method. Henry Ogbuji who in his book, *From Where Shall Our Help Come*, expounds the concept of compassion, strongly argues for the restorative and transformative power of compassion. Compassion includes actions by which pains are relieved and wounds are healed. It envisions a life of mutual dignity and flourishing for everyone and has the potential to heal human relationships.³¹⁵

For conflict resolution, it is important to see storytelling as a communication tool. Here, the conversation moves from the qualities of the individual like character and civility to the practical ability to initiate and bring about a meaningful dialogue by the help of stories. For instance, during an end-of-life dialogue, the hospital chaplain's ability to hold a storied dialogue where participants are able to look, that is, become aware of others' feelings, listen and learn from others, will so help in deliberating, discerning and taking appropriate decisions, and finally in resolving their conflict. Chaplains as ethical leaders find themselves standing at an intersection where they are held between the often conflicting moral or ethical situations that form and shape moral decisions and actions. They are members of the hospital ethical committee and the expectation is that that they mediate in ethical issues especially as they concern the hospital as an institution and the community they serve.

³¹⁵ Henry Onwusoro Ogbuji, *From Where Shall Our Help Come: The Lament of Abused Persons* (St. Louis, MO: En Route Books and Media, 2023), 174.

End-of-life situation is a critical stage in medical care and life that is ethically perceived differently by different people. As ethical leaders, it behooves chaplains to excogitate strategies and plans ‘that both heal and prevent the rupturing of their ethical centers.’³¹⁶ We argue that a dialogue based on storytelling is a way to go in resolving issues of end-of-life in the pastoral care of the hospital chaplain.

4.4 Storytelling and Conflict Resolution

Storytelling from the history of oral tradition has been identified a veritable communicative tool among various peoples of the world and cultures. In modern times, there are ways of using storytelling in peacemaking and managing conflicts. Recently, storytelling has been seen as an activity and a method for resolving various conflicts bothering on social, economic, political as well as health problems. It has been proposed as a means for co-constructing meaning and encouraging dialogue that could bring about productive action towards transformation.³¹⁷ The Conflict Family and Circle Process are among the modern conflict dialoging and resolving techniques or methods that have become so effective in their applications to various life strata including workplaces, families, and schools. We shall discuss the duo approaches and will appropriate elements of both methods for the hospital chaplain for his ministry in resolving conflicts during end-of-life dilemma.

4.4.1 Conflict Family: Storytelling as a Means of Making Peace in a Community

³¹⁶ Fluker, *Ethical Leadership*, 56.

³¹⁷ Linabary, Krishna, and Connaughton, “The Conflict Family,” 432.

As conflicts bedevil people and communities, scholars have continued to explore possible ways and means of resolving and reconciling those social problems with the affected groups or communities. The Conflict Family was a community-based participatory research (CBPR) approach by researchers of Purdue Peace Project of Purdue University to address conflicts at community level. The research conducted in Ghana, West Africa by researchers from Purdue University and Boston University demonstrates how storytelling can function as a co-constructed, culturally relevant, reflexive, collaborative and participatory strategy for a concrete action.³¹⁸ Jasmine Linabary, Arunima Krishna and Stacey Connaughton in their research, which involved the bringing together into a dialogue of persons from two conflict-torn communities, submitted that storytelling is a method and activity that generates co-construction of meaning, peacemaking and transformation.

The Conflict Family approach involves what Groome in his Shared Christian Praxis calls focusing activity, that is, an exercise or story that serves to dispose and engage participants in a dialogue to focus on the theme or topic of discussion.³¹⁹ The story or focusing activity is usually related to the topic and serves to lead participants into the subject matter under discussion. This is what stories do in storied dialogue setting. According to Linabary et al, in Conflict Family, storytelling is a key element. These authors note,

³¹⁸ Linabary, Krishna, and Connaughton, “The Conflict Family”, 431.

³¹⁹ Thomas Groome, *Sharing Faith: A Comprehensive Approach to Religious Education and Pastoral Ministry* (Eugene, OR: Wipf and Stock Publishers, 1998), 146.

Storytelling serves three primary functions: epistemological, transformative, and methodological. In its epistemological function, storytelling is a means of creating knowledge and by which knowledge is shared, identity is formed, and socialization takes place.... Meaning is co-created in the storytelling process either through listeners' own interpretations or through participation in the storytelling process. As a shared process, storytelling can facilitate mutual recognition and the formation of collective identity.... Stories can be used to explain and make sense of complex issues.... Within peace building, storytelling as a method may be a means to foster understanding about the roots of a conflict, to be heard and build empathy for a side's viewpoints, and to engage in collective restoration or reconciliation process.³²⁰

Stories shared here could be those that are related to the issue in contention. In the African setting (as in the Conflict Family) where stories of animals serve as educative and learning narratives for humans, animal stories that highlight the bone of contention are told. Storytelling in these instances creates space to listen to the other's story, and bolster empathy for a party's perspective, and the courage to engage the other in a restoration or reconciliation process.³²¹ This element of courage is very crucial. Shirley Jackson, following same Ethical Leadership line as Fluker, describes courage as virtue that enables people to make difficult choices and to be willing to confront knife-edge issues.³²²

Storytelling also has transformative force. Participation in a storytelling activity in which case one has the space to share one's personal or communal experience, and the

³²⁰ Linabary, Krishna, and Connaughton, "The Conflict Family", 435.

³²¹ Linabary, Krishna, and Connaughton, "The Conflict Family", 435.

³²² Shirley Ann Jackson, "Ethical Leaders for the Twenty-First Century: Science, Technology, and Public Policy," *Educating Ethical Leaders for the Twenty-First Century*, ed. Walter Fluker (Eugene, OR: Cascade Books, 2013), 59.

feeling of one's story or perspective being heard has to potential to bolster self-empowerment. Again, the opportunity to hear another's story or perspective could be transformative. It could lead to a self-revision of one's perspective and consequently to change one's mentality and attitude. The act of storytelling from the Conflict Family approach can thus lead participants to critically evaluate of their attitudes and beliefs. This critical reflective process confronts their assumptions, attitudes and beliefs and can foster a consideration of them in a manner that may produce resistance, paradigm shifts, and in some instances leading to transformative decision or action.³²³

Referencing similar researches on the transformative potential of storytelling, Linabary, Krishna and Connaughton concluded that personal and biographical storytelling has been used as part of peace and post-conflict reconciliation and healing efforts. They gave as specific examples the, 'Healing Through Remembering Project in Northern Ireland' and the 'Jerusalem Stories.'³²⁴ Ultimately, stories can move people from a certain place or position to another. They can transform their mentality and communities' worldviews. A story carries in itself the potential to provide creative possibilities especially in situations that they exceed individuals or communities' espoused values and beliefs. Let us take for instance, a hospital setting where physicians and patient's family may have divergent opinions about end-of-life decisions. Family may be reacting to the fear of stepping into the unknown in the face of imminent death of

³²³ Linabary, Krishna, and Connaughton, "The Conflict Family", 435-6.

³²⁴ Linabary, Krishna, and Connaughton, "The Conflict Family", 436.

their *bread winner*. The ability of the physicians to listen to the family's stories with deep concern may bolster understanding, empathy, and improve their manner of communication with the family about the reality of the end-of-life situation.

Storytelling has methodological potential also. As a method, storytelling is flexible and accessible. This is because depending on the situation or context, it can take on a variety of forms; literacy is not a prerequisite. From an economic point of view, storytelling is not expensive; it is low-tech, and so does not require so much of equipment or particular training. Participants in a storied dialogue all have the same tool (that is, their own story) for the activity. They all come with their story, experience to share, and be listened to. It must also be mentioned that storytelling has cultural significance. Linabary et al write, "In certain contexts, specific forms of storytelling (e.g., parable, proverbs, and metaphors) may be commonplace in everyday conversations or within particular settings as a means for information sharing, socialization, or even conflict resolution."³²⁵

The activity of the Conflict Family research carried out by Linabary et al, took place in a two-day workshop that lasted for some hours each day. These authors reported that "The goal of the workshop was for participants for brainstorm potential peacebuilding strategies, engage in dialogue with various actors about the land disputes, and propose action plans to carry out in their communities."³²⁶ At the end of the

³²⁵ Linabary, Krishna, and Connaughton, "The Conflict Family," 436.

³²⁶ Linabary, Krishna, and Connaughton, "The Conflict Family," 438.

conversation where every person's voice was heard, it was observed that people began to think differently. It created a consciousness or what Paulo Freire calls *conscientization* and thus people are able to see what they ought to see and hear what they ought to hear.³²⁷ The activity not only aroused critical reflection but also helped in meaning making.

We are aware that dialogue can be difficult because of delicate nature of issues on the table or personality or attitude and disposition of participants. Storytelling as a method of dialogue engagement can help diffuse tension in such tough situations. Injection of humor into the conversation, as observed by the researchers, can smoothen the deliberation. Notably, storytelling can “promote a safe and open environment, and empathy among participants.”³²⁸ The ability of the process to bring about empathy, that is, the capacity to sense the emotions of the other, understand their point of view and assume an active interest in their concerns³²⁹ as generated from narrative-based dialogue attests to the potential of storytelling.

However, what kind of story and how a story is told makes a whole difference. The success of an activity depends largely on its structure and procedure. Circle Process, a storied dialogical process, as developed in modern times contains a curriculum and pedagogy that is practical, workable and transformative. The application of the Circle

³²⁷ Paulo Freire, *Pedagogy of the Oppressed* (New York: Bloomsbury, 2012), 160.

³²⁸ Linabary, Krishna, and Connaughton, “The Conflict Family,” 436.

³²⁹ Fluker, *Ethical Leadership*, 71.

Process involving stories that confer meaning to participants and the subject matter can be a veritable conflict-resolving tool such as in end-of-life crises.

4. 5 Circle Process

Like the Conflict Family, Circle Process is a method of resolving conflicts among persons or groups, which involves storytelling. It is a gathering together of people for the purpose of connecting together, supporting one another and solving problems. The idea of Circle Process provides a common platform for all to meet and have meaningful conversation. It could be viewed as a center for differences, a gathering place where people with different thoughts, ideologies, world views, and orientations safely meet to engage in healthy talks for the common good. Its attribute of providing “a safe space enough for the telling and hearing of stories”³³⁰ is quite thoughtful in relation to conflict resolution. In highlighting the relevance of Circle Process, Pranis writes:

Peacemaking Circles bring together the ancient wisdom of community and the contemporary value of respect for individual gifts, needs, and differences in a process that:

- honors the presence and dignity of every participant
- values the contributions of every participant
- emphasizes the connectedness of all things
- supports emotional and spiritual expression
- gives equal voice to all.³³¹

³³⁰ Stephanie Hixon and Thomas Porter, *The Journey: Forgiveness, Restorative Justice and Reconciliation* (New York: Women’s Division, The General Board of Global Ministries, 2011), 14.

³³¹ Pranis, *The Little Book of Circle Process*, 6-7.

This implies that no voice is lost, which is crucial because efforts to resolve conflicts become difficult, if not impossible, when voices are subdued. Peacemaking process appears new to modern western society. But it is really an old way of dialoging and peacemaking that is traceable to many ancient peoples and cultures including ancient Native Americans.

4.5.1 The Historical Context of Circle Process

Arguably, ancient people, across cultures, had traditional ways of addressing difficult issues that arose between and among persons or communities. In these ways, they managed their differences as much as possible and may have different names to the method of resolving conflicts. In this project, we focused on ancient Native Americans' way of resolving conflict. They had the Talking Circle, whereby people gather in a circle for conversation, as a traditional way of handling important community matters. The Talking Circle was a dispute resolution process through which they resolved "legal" issues within the community. The indigenous dispute resolutions preceded the development of laws and the judicial systems.³³² It involved sitting in a circle to discuss these matters of importance with the aim of resolving the issues.³³³ As Daicoff narrates, "These forms of dispute resolution may evoke commonly held, deeply human needs for particular values, qualities, sequences, or experiences, in resolving interpersonal

³³² Susan Swaim Daicoff, "Families in Circle Process: Restoration Justice in Family Law" in *Family Court Review* 53, no. 3 (July 2015), 430.

³³³ Pranis, *The Little Book of Circle Process*, 7.

conflicts.”³³⁴ The process involves the use of an object, the talking piece, which was passed round to all participating in the discussion. The talking piece grants the holder the permission to speak as every other person listens.

What we have today in the modern western culture as Peacemaking process has its roots in this Native American culture of Talking Circles, which was a traditional way of dialoging and peacemaking. The Circle method of conversation has been practiced by individuals in the context of sharing their experiences with others. However, the use of Circles in a systematic way in public processes such as the justice system is relatively new and grew out of works carried out in the early 1990s in places like Canada and Yukon.³³⁵ In the US, the Circle Process started in the Minnesota criminal justice system. It came to birth under the philosophy of restorative justice to take care of crime victims and those impacted by the crime. Circle Process is a form of restorative justice that gets diverse voices to the table of dialogue. Restorative Justice according to Howard Zehr seeks address the harms, needs, and obligations of those who have a stake in a particular offense or harm in order to heal and put things in the right as far as possible.³³⁶

Soon, various communities, rural, suburban, and urban across the cultural communities in the US (Euro-American, African American, Latin American, Cambodian and Native American) began to use the Circle Process to address criminal cases that

³³⁴ Daicoff, *Families in Circle Process*,” 431.

³³⁵ Pranis, *The Little Book Circle Process*, 8.

³³⁶ Howard Zehr, *The Little Book of Restorative Justice* (New York: Good Books, 2015), 48.

involve juvenile as well as adult crime cases. The Circle was effective and so with time, corrections practitioners discovered other applications of the process within the criminal justice system. They began to apply Circles as a method of facilitating the re-entry into community by persons who have been in prison as well as a means of improving the effectiveness of community supervision for persons under probation.³³⁷

Interestingly, Circles, which began in Minnesota as a part of the criminal justice system spread everywhere across the US. Volunteer workers in the justice circle ventures discovered that the approach could be applied to other strata of society. Thus, the spreading of Circles into schools, churches, workplaces, social services, families and neighborhoods.

4.5.2 The Nature and Potential of Circle Process

Circle Process as earlier indicated is a form of restorative justice and as such brings a wide range of voices to the table. Daicoff, speaking about the Circle Process as used in family law matters, observes that the process can involve the assemblage of “as large as the entire community (in small communities) or as small as a facilitator or circle keeper, the parties, and their supporters. It can include their extended families, other interested persons, and legal personnel. Circle Process can involve a multistep procedure that includes: extensive preparation of each person by the facilitator, problem-solving

³³⁷ Pranis, *The Little Book of Circle Process*, 10.

circles, and follow-up circles to monitor compliance with outcome chosen in the earlier circles.”³³⁸

The aim of the Circle Process is to create a space conducive enough for people to address issues of concern to them while being their authentic selves. The Circles according to Pranis:

...provide a way to bring people together to hold difficult conversations and to work through conflict or differences. The Circle Process is a way to getting the most complete picture of people can of themselves, of one another, and of the issues at hand to enable them to move together in a good way. Circles are based on an assumption of positive potential: that something good can always come out of whatever situation we are in. Circles also assume that no one of us has the whole picture, that it is only by sharing all of our perspectives that we can come closer to a complete picture. Sharing individual perspectives and wisdom creates a collective wisdom much greater than the sum of the parts.³³⁹

The undying assumption in the Circle Process is that the parties or individuals involved want to talk. They want to be heard. They are aware of an existing conflict or differences and they have the willingness to seek for peaceful resolution. This does not necessarily mean that all the parties of individuals would begin or are ready to initiate the peaceful conversation. People could be disposed or talked into seeking a peaceful way of handling their differences. Those who are involved in reconciling conflicts can find in the Circle Process a method that has huge positive outcome.

The underlying philosophy of Circles acknowledges that we are all in need of help and that helping others helps us at the same time. The participants of the circle benefit from the collective wisdom of everyone in the Circle. Participants are not divided into givers and receivers: everyone is both a giver and a receiver.

³³⁸ Diacoff, “Families in Circle Process,” 430.

³³⁹ Pranis, *The Little Book of Circle Process*, 67-8.

Circles draw on the life experience and wisdom of all participants to generate new understandings of the problem and new possibilities for solutions.³⁴⁰

The element of new understanding and new solutions underscore the transformational potential of the Circle Process. People come together in the Circle to address difficult talks with the aim of resolving the issues or differences. It involves participants sitting around in a circle form for a dialogue. The sitting arrangement is meant to douse every disparity and hierarchy while creating an equal space for all. We must quickly observe here that this objective is not always achieved by the Circle. We do not intend to claim that the Process resolves every conflict that it attempts to resolve. If Circle Process resolves all conflicts that it attempts to handle, then we would have less or no conflicts in our world today, among persons, institutions and nations. However, it is a conflict resolution strategy for those who understand and value it.

The storytelling component also fosters transformation. The Circle Process is a storytelling activity. Like Fluker's ethical leadership approach and the Conflict Family affirm, storytelling has a prominent place in the Circle Process. This is because of its huge transformational potential. On the transformational potential of Circle Process,

Pranis writes:

Circles are a storytelling process. They use the history and experience of everyone in the Circle to understand the situation and to look for a good way forward – not through lecturing or giving advice or telling others what to do, but through sharing stories of struggle, pain, joy, despair, and triumph. Personal narratives are the source of insight and wisdom in the Circles.³⁴¹

³⁴⁰ Pranis, *The Little Book of Circle Process*, 6.

³⁴¹ Pranis, *The Little Book of Circle Process*, 39-40.

The Circle process through the sharing of the history and experience of participants in the Circle facilitate the understanding of the matter under consideration and strive to come up with a good way forward. It does not necessarily go the route of lecturing, giving advice or telling others what to do; it strives on the sharing of stories of struggle, pain, joy, despair, and triumph. Indeed, personal narratives constitute the cardinal source of insight and wisdom in the Circle process.

Circles as applied in various contexts such as schools, prisons, workplaces, churches and communities has served individuals, groups and institutions a great deal and provided support that people needed to integrate and find meaning. It has been demonstrated that in schools, the use of Circles create a good classroom atmosphere and resolve behavior issues.³⁴² In neighborhoods, they serve to give support for persons harmed by crime, and help decide sentences for those involved in crime. In social services they develop more organic support systems for people struggling to pull themselves together, and in workplaces, they help resolve conflicts.³⁴³

4.5.3 Structure of the Circle Process

Circles have developed to include structural elements that help to attain fruitful and transformational outcomes. They include: Ceremony, guidelines, a talking piece, facilitation and consensus decision making. These elements help to create a conducive space for people to connect with others with the intent to resolve difficult or conflicting

³⁴² Pranis, *The Little Book of Circle Process*, 4.

³⁴³ Pranis, *The Little Book of Circle Process*, 3-4.

issues. The structural elements of the Circle Process is such that it can help create the much needed conducive environment to attain the required outcome of a fruitful and meaning dialogue. As the Circle Process found expressions in various settings for different purposes, it has served for healing, talking, understanding, sentencing, support, community-building, celebration, reintegration and conflict resolution purposes. These various kinds of Circle are distinguished by their function. The aim however, is to provide support to people in various needs, enhance institutional developments, celebrate people and building connections among people. The structure of the process helps to attain the desired outcome of the activity.

4.5.3.1 Ceremony

Every activity performed in time and space has a beginning and an end. The opening and closing ceremonies of the Circle mark the time and space of the activity as separate space. They are sacred moments that invite people to lay aside masks and shields that suggest differences between and among them and put on values that profoundly connect them with others. Pranis believes that the Circle has a distinctly different pace and tone and as such, the ceremony ought to be organized in such a manner that participants leave behind the ordinary life pace and tone to assume the Circle connecting space. The Circle Process can promote instead, the sense of community, that is, the communal concept of human person or society where persons are understood more in connection with the larger social whole, with values of attachments, relatedness, oneness

and dependence priced over independence and individuality.³⁴⁴ While respecting the autonomy of individual participants in the dialogue, the facilitator highlights the importance of connectedness and mutual respect.

The Circle has values that make it what it is; opening formalities ought to highlight these values. “Opening ceremonies help participants to center themselves, be reminded of core values, clear negative energies from unrelated stresses, encourage a sense of optimism, and honor the presence of everyone there.”³⁴⁵ As the opening ceremony prepares participants for the activity with others, the closing rites get them ready for the ordinary life. According to Pranis, “Closing ceremonies acknowledge the efforts of the Circle, affirm the interconnectedness of those present, convey a sense of hope for the future, and prepare participants to return to the ordinary space of their lives.”³⁴⁶ In the case of a hospital chaplain’s meeting with physicians and family of the dying patient, beyond preparing people for the ordinary life routine, the ceremony should prepare participants with the reality of the outcome of the conversation. Both the opening and closing formalities are arranged in such a way that they take into cognizance the peculiarities of each group of participants and also provide opportunities for cultural responsiveness.

4.5.3.2 Guidelines

³⁴⁴ Boyung Lee, *Transforming Congregations through Community: Faith Formation from Seminary to the Church* (Louisville, Kentucky: John Knox Press, 2013), 8-9.

³⁴⁵ Pranis, *The Little Book of Circle Process*, 33.

³⁴⁶ Pranis, *The Little Book of Circle Process*, 33.

Before the conversation proper, there should be a consensus agreement on the principles to guide the Circle. Guidelines therefore refer to the promises or commitments, which the circle participants make to each other on how to conduct themselves throughout the process. The purpose of the guidelines is to ensure clear expectations for conduct based on what the persons need to do to create a healthy and safe space where each person is able to speak authentically and also be heard. The guidelines guarantee respect and confidentiality.³⁴⁷

Without laid down principles, Circle is bound to fail. This is because people come from various backgrounds and have different personality types. Matters that the Circle sets out to handle are often those of conflict and often people nurse anger and resentment. At the same time, people want to be heard. Setting principles for mutual speaking and listening is, therefore, necessary. It is the responsibility of both the facilitator and participants to create and implement the guidelines. So, the guidelines “may be developed by the circle keeper or by the participants, “in circle”. Even the questions addressed in the process may be developed by the participants. The process is calm, respectful, and each person is given an opportunity to speak and be heard by all.”³⁴⁸ Guidelines therefore are not rigid constraints impeding people’s freedom but rather consensus commitments come about to ensure behavioral conduct of Circle participants in view of getting the expected

³⁴⁷ Pranis, *The Little Book of Circle Process*, 34.

³⁴⁸ Daicoff, “Families in Circle Process,” 430.

outcome. Talk about guidelines is crucial and aid Circle participants speak and act with intentionality rather than from impulse.

The creation of the guidelines is not usually a smooth process. Persons may disagree with certain elements of the guidelines. Pranis anticipates this kind of situation. Thus she advocates for a discussion that explores the purpose of the guidelines and the concern raised. “The guidelines arise out of asking people what they want for themselves from others.”³⁴⁹ The hospital chaplain who engages the Circle Process ought to ascertain from the medical team and patient’s family what they value, and what could constitute guidelines for them for the Process. The aim is to come to a mutual understanding and a common ground to establish a conducive and safe space that would guarantee respect for all and the desired outcome.

4.5.3.3 Talking Piece

The talking piece is an object that gives one an authority to talk during the conversation. It is usually something that has a symbolic meaning to the participants. As the name implies, the person holding it has the floor as long as he/she holds it while every other person listens without any attempt to make a response. Speaking about the significance of the talking piece, Pranis writes:

The talking piece is a critical element of creating a space in which participants can speak from a deep place of truth. It assures speakers that they will not be interrupted, that they will be able to pause and find the words that express what is on their hearts and minds, that they will be fully and respectfully heard. The talking piece slows the pace of conversation and encourages thoughtful and reflective interactions among participants. It often carries symbolic meaning

³⁴⁹ Pranis, *The Little Book of Circle Process*, 35.

related to the group's shared values and thus is a concrete reminder to the speaker of those values.³⁵⁰

Pranis further notes that the talking piece gives all participants an equal opportunity to talk and to be listened to. It passes the message that everyone has something important to say; instills a sense of order in the conversation and gives room for the expression of emotions yet managing them and ensuring they do not get out of control. In the Circle, the talking piece is usually passed round participants. This does not imply that the holder is obliged to speak. It simply means that he/she may decide to hold it and then hand it over to the next person without talking.³⁵¹

4.5.3.4 Facilitation

Someone has the onus of anchoring the conversation. In our case, it is the hospital chaplain. The facilitator has the responsibility of initiating the space for the dialogue and to engage persons in sharing responsibility for the provided space. The facilitator is often called the steward or keeper. Whatever the name, their duty is to initiate and direct the conversation and ensure it is respectful and safe. The process should therefore bolster “mutual respect, equality, dignity, voice, tolerance of differences, community, collaboration, and interconnectedness.”³⁵²

The facilitator assists the group to access both its individual as well as collective wisdom. This is achieved by his/her ability to keep the space and monitor it well

³⁵⁰ Pranis, *The Little Book of Circle Process*, 35.

³⁵¹ Pranis, *The Little Book of Circle Process*, 35.

³⁵² Daicoff, “Families in Circle Process,” 430.

throughout the conversation. The facilitator is part of the dialogue and so can contribute to the process by offering his/her thoughts, ideas and stories.

4.5.3.5 Decision-Making

The Circle process often culminate a decision-making situation. The decision-making is usually a consensus. It is a natural outcome of a profound and respectful listening and talking among all participants of the process. It implies the willingness and readiness of all participants or parties to accept and implement the decisions arrived at during the Circle Process. When participants feel they are truly heard and that the process addressed their needs, a consensus decision is expected. This is not to say that each of the decisions is always what they want. Now they are able to compromise certain needs in order to resolve the conflict situation being addressed. Decisions have to address the needs and interests of each party to a certain degree.

Consensus decision-making is grounded in a deep commitment to understand the needs and interests of all participants and to work toward meeting all of those needs. It requires deep listening and reflection before making decisions. A commitment to consensus engages participants in helping others meet their needs while also meeting the participant's own needs. Consensus challenges participants to speak truthfully if they cannot live with a decision, and then to help the group find a solution they can live with that meets the needs of the group as well.³⁵³

Decision-making that is transformative, according to Groome, could come in various categories. They can emphasize cognitive, affective or personal behaviors; they could be on personal, interpersonal social levels; they may have to do with individual or community activities, and could be effected within the immediate group or outside it.³⁵⁴

³⁵³ Pranis, *The Little Book of Circle Process*, 38.

³⁵⁴ Groome, *Sharing Faith*, 268.

Decision-making is a ‘defining moment’ with the expectation that participants make resolutions that would impact personal and/or communal interest. Defining moments, however, for Fluker “do not always call for shrewd, pragmatic, and politically astute action. Sometimes they require gentleness, humility, and compassion.”³⁵⁵ These virtues help to bring about peace and appreciation of others’ perspectives. Because participants’ interests are addressed to some degree, everyone has something to gain at the end of the process; it is not a total win, it is not a total loss. The above structure of the Circle Process from the forgoing creates the needed space where people are able to get to the best version of themselves to reach out to others and make concerted connections at deep and fulfilling levels.

For the hospital chaplain who often is greeted with overwhelming circumstances of ministering in end-of-life situations, the Circle can be a veritable tool to mediate between physicians and families of dying patients. In a hospital setting, for instance, a consensus decision through the Circle Process does not necessarily mean the physicians agreeing to all that the families said, nor does it require the patients’ families agreeing to all that the physicians say. It may require a two-way-shift, in the sense that on the one hand, physicians will be able to understand the profound and frantic concerns of the patients’ families, which might usher in a new way of thinking about the end-of-life care of the patients; and on the other hand, patients’ families will be able to grasp the factual medical-informed views of the physicians, which might as well usher in a new way of

³⁵⁵ Fluker, *Ethical Leadership*, 183.

thinking about the end-of-life care of the patients. When this happens, we expect to have mutual understanding, and a common goal of care (GOC) will be established. In as much as physicians have the primary care of patients in the hospital, families have the ultimate say when it comes to the fate of a dying family member.

4.6 The Hospital Chaplain: Crafting an Ethical Response

Every hospital has the well-being and rights of patients at the center of health care. Sickness confronts people with their mortality and thus their vulnerability. The hospital is a site where people bring their struggles with life and death, hope and fear, pain and anguish, joy and sadness, love and anger. The role of chaplaincy is to affirm these common human needs by giving them space and revering them. The chaplain's duty is determined by the spiritual and human needs expressed by patients, their families and other medical staff as well. It is my duty as a chaplain to use the beliefs and needs of patients and their families in their efforts and struggles to heal or cope with dying, grief and loss.

As a chaplain therefore making my usual rounds on the floor of the hospital, I do not know when I may be thrust into the middle of an unexpected death, end-of-life and an overwhelming grief situation. Events twist so suddenly in hospitals as patients' diagnosis and prognosis could change unexpectedly for the worse. In such situations, patient's family is first contacted to inform them of the turn of condition of their loved one and usually they require them to come around. Often, the Catholic families request for the visit of the chaplain to patient for the administration of the sacrament of the sick/dying even before their arrival to the hospital. Catholics attach much importance to the 'last

sacrament' as it gives them hope of afterlife. Things are a little easier for the chaplain if the case is about a certain and inevitable death situation. In such case, pastoral care consists of prayer and attentive presence with the family and the dying. As William Alberts observed, "Pastoral care is about listening and feeling, as well as talking. It has a universal language: it is about being fully present and staying with grieving loved ones."³⁵⁶

However, as we have established in previous chapters, there often arise situations of end-of-life where there are tense and uncompromising issues between the families of dying patients and physicians on the treatment plan or dying process of the dying. We argue in this project that the chaplain in this case can intervene meaningfully as an ethical leader to assuage or resolve the conflicting situation.

The personality and training of the chaplain is crucial here. For Fluker, as we highlighted earlier in the chapter, an ethical leader should be able to pay close attention to their personal narratives that inform thoughts, feelings, and behaviors. In hospital pastoral care, premium is also given to the feelings and attitudes of chaplains. Through the Clinical Pastoral Education³⁵⁷ that chaplains undergo, they learn to pay attention to their humanness. As Alberts writes:

A hospital is a unique crossroads of humanity.... For me, the pastoral care of hospital patients begins with the humanness of the chaplain. The inward journey

³⁵⁶ William Alberts, *A Hospital Chaplain at the Crossroads of Humanity* (Middletown, DE: Emi Feist, 2017), 28.

³⁵⁷ The Clinical Pastoral Education (CPE) is a requirement for hospital chaplains. It is an educational program that has different units and most hospitals require their chaplains to acquire.

where one becomes self-aware, and is in touch with and accepting of oneself. The more such self-awareness the better prepared one is to understand and accept patients and their loved ones as themselves, and to experience their reality not interpret it. We chaplains have to know where we – and our god – are coming from in order to know where patients and their families – and their god – are at [sic]. Self-knowledge helps one avoid the counter-transference of getting in one's own way in living and working with and providing care for people.³⁵⁸

This experience of this author-chaplain aligns with Fluker's emphasis on a leader's ability for self-revision and the capacity to reenter their own personal constructions of morality. A test of this self-knowledge is the ability of the chaplain to look, listen and learn. For Fluker, one who wants to navigate through ethical matters should be able to manifest positive attitude toward the trio attitudes of looking, listening to others and learning from them.³⁵⁹ In a hospital setting, the chaplain is expected to pay attention to the feelings of patients (that is, looking, using Fluker's term). He should be able to observe the room and the body language of the patient. A thorough look and keen observation would help him to know the feeling and state of patients. This would help him in ministering to their emotional and pastoral needs. This knowledge will help in the kind of questions or conversation he would engage them with. This is same with patients' families who come to visit their loved ones.

In chaplaincy, patients and their families take the lead while the chaplain follows; the chaplain is more the listener than the speaker. "Pastoral care is about enabling patients to tell their stories, the sharing of which affirms and empowers the teller and

³⁵⁸ Alberts, *A Hospital Chaplain*, 16.

³⁵⁹ Fluker, *Ethical Leadership*, 41-2.

often provides wisdom for the listener.”³⁶⁰ Every opportunity in pastoral care of patients and their families therefore provides the chaplain an aperture to look, listen to others’ narratives and to learn so as to enable him provide the required pastoral care.

Applying the narrative ethics or virtue ethics of Fluker, which deals with experience and tradition as the kernel of ethical life and practice, the chaplain can craft an ethical response that is transformational and empowering. Coming to the hospital setting, the physicians have so much experience from the practice of medicine and treatment of patients. Families of dying patients have unique stories and experiences that form their perspective of care and cure. Chaplain as moral agents and leaders coming from a particular religious tradition and ministering to patients and families across various religious and cultural settings have experiences and stories to share that could help them resolve conflicts encountered during his ministry. As a matter of fact, the experiences of the physicians and family of patients both matter. In the same vein, the medical traditions of medical team members, the cultural and religious traditions of families must be respected and should count. “Human life and history are seen as a network of interlocking stories that aspire to truth.”³⁶¹

While not eschewing the rules and ends of the hospital and medical practice, and relatedness with the team, the chaplain, attentive to a narrative-based ethics, creates an environment that invites all to share their experiences and stories. In imagining a solution

³⁶⁰ Alberts, *A Hospital Chaplain*, 39.

³⁶¹ Fluker, *Ethical Leadership*, 49.

to the challenge that chaplains encounter in standing at the intersection where physicians and families collide at end-of-life care of patients, it is pertinent for chaplains to explore theories of transformational leadership that would inform solutions. In the hospital context, chaplains could think of assisting physicians and families to be empathetic with one another. On one hand, chaplains should encourage physicians to be empathetic to the distressful anxieties and dilemma of families on the difficult decision of removing life-support. On the other hand, chaplains should also be mindful to the moral distress, which physicians in the consciousness of their Hippocratic Oath are concerned about doing harm to patients, rather than good.

The hospital chaplain in his ministry is confronted with a crowded intersection that is difficult to navigate. He is often seen as a middle person between patients' families and the hospital medical team during end of life situations. As an ethical leader, the chaplain should be able to implore compassionate-praxis ministerial approach that proves him as an effective and efficient leader. How can he mediate in a manner that brings trust and confidence? How can the hospital chaplain use storytelling as an ethical tool for conflict resolution especially in end-of-life cases?

One way for chaplains to create a comfortable platform where everyone's voice could be heard is by exploring the resources of conflict transformation, specifically the Circle Process. We submit that the Circle Process, with its structure and storytelling element, will constitute a veritable method through which the hospital chaplain can establish a pastoral ministerial praxis with transformational and empowering outcomes.

Kay Pranis describes the Circle Process as “a story-telling process,”³⁶² where “participants explain themselves by telling their stories.”³⁶³ Jessica Metoui notes that “A peacemaking circle process incorporates components of interest-based negotiation, mediation, and consensus building.”³⁶⁴

4. 7 Applying Circle Process to Hospital Pastoral Care

Throughout this project, we argue that end-of-life situation can raise difficult and conflicting issues between the hospital staff and family of dying patients and that the chaplain can help resolve these issues in the shrewd discharge his ministry. If this is true, then it behooves the chaplain to devise ministerial strategies to enable him address this challenge. We also noted that not all end-of-life situations are conflictual. As we pointed out in chapter two, patients’ families often look up to chaplains to help them navigate the dilemma and deal with the disorientation resulting from the imminent death of their loved ones and the physicians recommendations about the dying process, on the one hand. On the other hand, physicians also look up to them in some difficult cases to make families of patients to accept their own professional decisions and resolutions. The application of the Circle Process could help the chaplain to navigate this tense and difficult situation.

To go about this process, we recommend that the chaplain gets trained in the Circle Process. Most advocates of Circles recommend that facilitators undergo the

³⁶² Pranis, *The Little Book of Circle Process*, 4.

³⁶³ Pranis, *The Little Book of Circle Process*, 8.

³⁶⁴ Metoui, “Returning to the Circle,” 527.

training. This would guarantee a good pedagogy and outcome. A few, however, are of the opinion that it suffices for the facilitator or keeper to have a simple idea of the process and how to conduct it. In either case, the chaplain gets as much knowledge of the Circle as could help him ensure a fruitful ministerial outcome.

Circle Process obviously is much more than arranging seats in a circle form. Its purpose is to address a conflict or harm and thus it involves steps that are geared towards attending this goal. These steps or stages are crucial for effectiveness of the process. We recommend the following steps or stages of circle process for the hospital chaplain namely, determining suitability, preparation, and convening the Circle.³⁶⁵

4.7.1 Determining Suitability

The history of human relationships and conflicts has shown various kinds of conflicts and harm that result from people's encounter with others. Circle Process does not claim to resolve all manner of differences among people. The first step therefore is for the chaplain to assess whether the Circle Process is the appropriate communicative approach to handle the matter. As we said earlier, people involved in Circle implicitly or explicitly express the desire to talk about their differences. They are willing to engage their other in a conversation. So, the first stage here will be to determine the willingness of the parties to participate in the process. Do the key players or stakeholders show willingness to engage in the Circle Process? As an activity, Circle requires time. Can the situation allow the time needed to hold the Circle? Because Circle deals with conflict or

³⁶⁵ Pranis, *The Little Book of Circle Process*, 44.

harm situations, persons may go physical or emotional. As part of determining whether the Circle Process is appropriate, the safety of participants is to be guaranteed. It must be ascertained that the physical and emotional safety of all is maintained. Since the Circle Process is to occur in a hospital, it is appropriate to ascertain that there would not be hygienic and infectious concern with the moving around of a talking piece.

The chaplain therefore is to introduce the Circle to both patient's physicians and family. He should be able to present it as a veritable tool for the formation of persons in conflict transformation and as a means to draw out each party's story, and respectively tell these stories to the other. It has the effect of making physicians being able to better hear the patients' family's stories, and the patients' families in turn being able to hear the physicians' stories. By hearing each other's story in a Circle, the process helps to build a bridge between physicians and patients' families. This will provide chances for understanding and acknowledging each other's stand on the issue at hand. Ultimately, the Circle is to be seen as a means of empowering participants especially patients and their families, aware that the hospital's priority in providing care is the well-being of patients. Indeed, "chaplaincy is about empowering patients and their families, and not imposing any belief or value system on them."³⁶⁶ So, the chaplain considers Circle Process unsuitable if the parties especially family of patient decline.

The issue of security and safety of participants is important. In offering pastoral care to family of patient, chaplain is to ensure that there is no suspicion of potential

³⁶⁶ Alberts, *A Hospital Chaplain*, 16.

violence or harm. He may possibly involve the facility security, if need be. Parties must promise to conduct themselves becomingly throughout the process.

Finally, we have the time factor. The Conflict Family workshop led by Linabary, et al, mentioned earlier in the chapter took about eight hours each of the two days. The hospital setting may not have a whole day of a conversation on a particular matter. The schedule of doctors is also a factor as they have other patients to attend to. Very importantly, we are dealing with a dying person and it has to do with time sensitivity. So, the chaplain can maximize the little time and space as the hospital can provide to carry out the Circle.

When the above issues are settled, one can then proceed to the next stage which is making the required preparations for the conversation.

4.7.2 Preparation

When it is determined that Circle Process is appropriate for the matter in hand, the next step is to make preparations toward holding the conversation. This stage involves the process of identifying the persons to participate in the process. Who has been affected by the conflicting or harming situation? Who has the knowledge, skills or resources that might be helpful for the conversation?

First, we have the family of the dying patient. This involves the patient's health proxy who may not be a member of the family so to say. The health care proxy (HCP) is a key person in the conversation. The spouse of the patient (if applicable) and all members of the family present. The family members may decide to have some members absent, some families choose who among them should be part of the conversation. There

may be family member who is not present and other family members may deem necessary that they be present. The chaplain facilitator should be ready to honor their request.

From the hospital, physicians (and the nurses) of the patient in question are part of the dialogue. The care manager and patients' advocate are invited to the gathering. The social worker who has the charge of the welfare of patients is a key player in this dialogue. In fact, the social worker will help the chaplain in coordinating the meeting of the parties. It is pertinent to be mindful that the social worker may have the resources that might be helpful for the conversation. When this is ascertained, the facilitator now begins the process of familiarizing the major parties with the process. Finally, the preparation now concludes with the exploration of the content of the conflicting matter. The facilitator inquires into the issue at this stage to enable him know how to navigate the process.

4.7.3 Convening All Parties

When all is set and all parties are gathered, the facilitator has the duty of identifying the shared values of the parties and then develop the guidelines for the process. It could include professional, family, cultural, religious values and so on. Usually, physicians emphasize the ethics of their profession. Families may have cultural and religious values they hold so dear. They may also have values that patient wants to uphold. Very importantly, HIPAA³⁶⁷ values are to be taken into consideration, aware that

³⁶⁷ Health Insurance Portability and Accountability Act is a Federal law, which requires protection of patient's privacy and prohibits disclosure of sensitive information without patient's consent.

the conversation is taking place a hospital setting. Developing the guidelines is key to success of the process. “The guidelines of the Circle are the commitments or promises that participants make to one another about how they will behave in the Circle.”³⁶⁸ They are adopted by consensus of participants based on their expectations of what is required to have a conducive environment for a fruitful and meaningful conversation where every person’s voice is heard and respected.

There is the need to build connections among participants. The encounter hitherto between medical team and patient’s family may not have been very well received by any of the parties. Now they have the opportunity to reconnect in a manner that people are given the space to express their feelings and share their concerns and expectations.

Alberts narrates his chaplaincy experience during a family meeting in the case of a dying patient. Family could not understand how a loved one who came to the hospital for a routine surgery could have a post-surgery stroke and was about to die. The nurses were only busy reassuring them that patient was given a thorough and prompt care. It took the chaplain who had developed a pastoral relationship with family to “hear and understand and reflect their feelings.”³⁶⁹ The belief that they are understood helped in building confidence and nipping a problem in the bud. The chaplain in convening people for circle should be able to build confidence in participants and help them come to grips with fear.

³⁶⁸ Pranis, *The Little Book of Circle Process*, 34.

³⁶⁹ Alberts, *A Hospital Chaplain*, 79.

What is unique about the Circle process is the use of the talking piece. The talking piece is usually an object that has symbolic meaning for the parties. I recommend the use of laminated hospice logo as an object for the talking piece. Catherine Froggatt of the School of Health and Social Care at South Bank University, London, and Tony Walter of the Department of Sociology at University of Reading, Reading UK, described and analyzed different hospice logos in the UK. These authors estimated that they had two thirds of all UK adult inpatient logos, including 13 logos from overseas hospices, which they used for illustration and comparison in their article.³⁷⁰ Froggatt and Walter note the functions of the hospice logo: advertising the hospice and its purpose.³⁷¹ These authors write, “It has both to remind the community that its members die and at the same time *not* remind them.”³⁷² They further add that “The logo must communicate the challenging distinctiveness of the hospice while at the same time giving an image of comfort and security: a difficult task.”³⁷³ Following the analysis of Froggatt and Walter, we submit that the use of hospice logo as a talking piece during Circle Process is symbolic to both physicians and families as it represents care for the dying. It should be noted that both physicians and families are involved in the common goal of the care for the dying patient and family member respectively. It is also symbolic, considering its feature of reminding

³⁷⁰ Catherine Froggatt and Tony Walter, “Global Exchange: Hospice Logo,” *Journal of Palliative Care* 11, no. 4 (1995), 39.

³⁷¹ Froggatt and Walter, “Global Exchange: Hospice Logo,” 39.

³⁷² Froggatt and Walter, “Global Exchange: Hospice Logo,” 39.

³⁷³ Froggatt and Walter, “Global Exchange: Hospice Logo,” 39.

and not reminding the community that its members die, as well as its difficult tasks of communicating the challenges of physicians in providing end-of-life care and the comfort it offers.

During the conversation, the facilitator should be able to probe the cause of the conflict or harm. He ensures that each party understands the position or arguments of the other. Participants are led through the route of generating ideas for the purpose of addressing the issue of conflict. It is pertinent to note that participants have the opportunity to fully express their emotions while others listen attentively. The facilitator moderates with discretion. Every person has a story and the persons and their stories are to be respected. As Gopin writes, “When someone is feeling respected, welcomed, honored even, then they are much more likely to feel like being generous in the emotional sense of the term, and generosity of spirit is critical to healing.”³⁷⁴

When all is set for the conversation, a space is provided where participants sit in a circle. They are to remain seated as they talk and listen to one another. The chaplain may begin the process by engaging participants in a breathing in and out exercise meant to dispose them, create self-awareness and attentiveness. Since the chaplain’s role as a spiritual or religious person is obvious, and patient’s family values often center on religious values, prayer could be part of the opening ceremony. The prayer is such that urges and disposes participants to openness to the spirit and to one another. The chaplain may proceed to introduce the subject matter. He may tell a story that is related to the

³⁷⁴ Gopin, *Healing the Heart of Conflict*, 40.

matter under discussion. This story is expected to engage them in critical reflection and is to dovetail to the matter for deliberation. Participants are then made to tell their stories one after the other in the circle. Stories of experiences of family with their loved dying one can be powerful; they may reveal some of the things they hold sacred or important. The hospital staff may share professional and personal stories they consider helpful in moving the conversation forward. The person talking at a time holds the talking piece as others listen. To listen is to seek to understand; understanding promotes empathy.

As the talking piece passes round, participants especially some family members who are not willing to talk are not obliged to do so. It is understandable the situation may be very overwhelming for some to talk. The chaplain facilitator should also be ready to support participants who are not able to hold their emotions (tears). By engaging in the Circle Process, everyone's voice is heard. When everyone's voice is heard, the goals of peacemaking circle are achieved. Referencing Costello, Metoui highlights the following goals: To restore the dignity of persons, restore peace, and sustain community health.³⁷⁵

It is our expectation that at the end we attain areas of consensus for possible action. Finally, there will be an agreement reached with clarifying responsibilities to undertaken by participants. We expect that at the end, a clear light is shed on the positions and values of the parties and each will be able give something and receive something. It is our hope that the fate of dying patients would cause less friction and conflict between families of dying patients and physicians; that through the intervention

³⁷⁵ Metoui, "Returning to the Circle," 527.

of hospital chaplains, patients are made to die with dignity when conflict ensues between physicians and families during end-of-life care. As noted earlier in this project,

Kopfensteiner describes what it means for Catholics to die with dignity:

Within the Catholic tradition, protecting a dignified death means that the dying needs to be assured that their lives will not be arbitrarily shortened, that they will not have to suffer uselessly, that they not be subject to unreasonable and burdensome therapies, that medical technology will be use for their integral well-being, that their free and informed decisions will be respected, and that they will not be marginalized or abandoned by the community in their dying.³⁷⁶

Our expectation is that the Catholic Chaplain/s mediation will help both physicians and families to be aware of the Catholic Church's views about dignified death.

With this in mind, as well as other expectations noted herein, this project would have then achieved its transformative objective. The next chapter will expound on this.

³⁷⁶ Kopfensteiner R, "Death with Dignity," 74.

CHAPTER FIVE

5. Evaluating the Expected Change

5.1 Assessments

The primary objective of this project is to provide a framework, which hospital chaplains could use as a tool for intervention in moments of conflict between patients' physicians and their families during end-of-life. The project has the expectation of transformational interventions, building relationships of trust and honoring sacred stories. This change is achievable and we believe that the hospital chaplain, as a go-between in crisis moments between the medical team and patients' families can play a crucial role here. In this last chapter, I seek to address how I will measure substantive change toward peaceful resolution of critical end-of-life crises.

Assessing or measuring a program to determine its effectiveness is a worthwhile venture. A periodic assessment of the impact of Circle Process is therefore necessary to evaluate the degree of the desired transformation. The first evaluation of the impact of the peaceful resolution of end-of-life conflicts by the chaplain via Circles will come up twelve months after its establishment. It is expected that by then there have been several Circles held in the facility and that most of the medical teams have been part of it and it is almost like part of the hospital's culture. It is my hope that both the medical team and families of patients begin to see the hospital environment as a friendly space where everyone is respected and understood, and individual values are upheld. Measuring change will come in various shapes and forms.

In fact, the first assessment would be to determine the attitude of the physicians to involve the chaplain or to accept and welcome the Circles. How comfortable is the medical team with the process? Having been involved in several Circle Processes, are the physicians ready to continue to take this route in resolving end-of-life conflicts? Are the Social Workers and other members of the medical team willing to go ahead to welcome Circles when the need arises? There may be the tendency to maintain the status quo, whereby families of patients are made to accept the physicians' position on the fate of the dying person. Still during the Process, do I, as the chaplain, perceive the possibility of expressed concerns by physicians regarding likely incidents of being confronted by families and their discomfort about a dialogue like the Circle Process that brings persons on the same table as equals convened to listen to one another? We understand that "dismantling systems, cultural norms and behaviors associated with power is difficult."³⁷⁷ A willing and ready attitude toward the process by the medical team indicates process while a negative response implies failure.

The attitude of the medical team is clearly demonstrated by their readiness or reluctance to call on or involve the chaplain when they run into crises with patients and their families especially during end-of-life care. As observed in chapter two, some physicians do not like to involve chaplains in medical care because they believe that they (chaplains) have nothing to contribute. The introduction of the Circle Process to the

³⁷⁷ Rosemary Lee-Norman, "White Followership: Creating a Pathway toward Black-Centered Leadership and Experience from the Reality of White Hegemony in an Evangelical, Urban, Multiethnic Church" (D.Min. Thesis, Boston University, 2021), 162.

facility should transform the mentality of such physicians who do not consider the involvement of chaplains as being necessary, or at least make those who acknowledge value the chaplains to involve them during such moments of conflicts. So, is the chaplain getting involved in conflict resolution matters in the hospital that concern patients' families and the medical team? An affirmative response points to progress with the process while a negative answer indicates retrogression.

The next stage of evaluation would be during the Process itself. How do physicians and families respond to the actual Circle Process? At the beginning of the Process, physicians and families may be maintaining different positions. At the end, would each party hold tenaciously to its initial position or be able to make a shift? The occurrences of shifts in physicians and families' positions will be indications that change has occurred on the issue of chaplains being at the intersection where physicians and families *collide* during end-of-life care of patients. Frequently in these situations, physicians and patients' families are frustrated with each other. The chaplain's role as one standing at this intersection is to ease these frustrations and help build trust. There will be evidence that change has taken place when the contents of ethical consults³⁷⁸ involving patients at end-of-life care reduces significantly. This is important for measuring progress because frequent ethical consults in relation to end-of-life issues mostly occur when conversations get stuck between physicians and families of patients. I will count how many consults, which happened in the year prior to my introducing this

³⁷⁸ Sometimes referred to as Family Meetings.

new conflict-reduction strategy, and then will count how many that happens in the year following.

The practice of ethical leadership and narrative ethics ought to bolster the creation of community, desire for connection and collective action. The culture of storytelling and the Circle Process ought to instill in the physicians, the medical team and other relevant hospital staff, the attitude of seeking and promoting understanding, peace and empathy in relationship with patients and their families. Frequent participation in the Circle Process is expected to make them quasi agents or facilitators of the process to such an extent that they collaborate with the chaplain in subsequent Circles. “Sharing individual perspectives and wisdom creates a collective wisdom much greater than the sum of the parts.”³⁷⁹

An exercise in recording verbatim is yet another way of evaluating the expected change. The chaplain takes note of the conversation in such a reflective manner that captures the details of the dialogue. Furthermore, the written conversation will be analyzed, emphasizing their theological, psychological, and social basis. This approach will also help me to capture how conflicts and conversations are changing during the Circle Process. In creating a verbatim report on the encounter between doctors, families, and myself – the chaplain, I will pay special attention to how language is shifting. What stories are emerging? Is the chaplain refusing to be triangulated? Do I see signs that doctors feel they are heard: for instance, reduction in the frequency of families insisting unduly on treatments of family members? Do I notice anything that demonstrates that

³⁷⁹ Pranis, *The Little Book of Circle Process*, 68.

patients' families sense the doctors' own care for the patient and empathy for the family's difficult circumstances? I will create a verbatim of the first Ethical Consult held every month for two years. I will then review them every six months with a colleague who can help me see if story-telling produces the kinds of changes I hope to generate. I will also watch the level of frustrations by physicians. The frustrations could be measured by observing their resentment, anger, biases, defensiveness, anxiety, stress, fatigue, and dogmatism. A reduction will suggest that they feel heard.

Similarly, I will look forward to seeing how physicians react to the end-of-life care concerns of patients and their families. Also, I will observe how patients and their families respond to the recommendation of pulling life-support. I will equally watch out for patients' families' "calmness," which will be indications that they have cultivated the virtue of curiosity in reposing confidence in the physicians. The calmness will be gauged by observing how families redirect their minds away from doubts and refocus themselves away from worries and fear of entrusting their family member to the care of physicians whose recommendations of removing life-support challenge their cultural and spiritual values, and their desire to prolong life.

If Chaplains get to resist the temptations of being used to get families to accept pulling life support during end-of-life care; if physicians and families of patients transcend their individual interests and excel in honoring each other's autonomy; if physicians and families become empathetic with each other's moral distress and ethical dilemma respectively; if chaplains engage more in story-telling and avoid taking sides with either party, then, there would be indication that change has happened. The

durations for looking out for change in this issue will span from twelve to thirty-six months.

5.2 Conclusion

Overall, the hospital chaplain has so much to do in his ministry as a caregiver. Contemporary chaplaincy service is more than reciting prayers for patients and administering the sacraments to them. It involves being there for patients and their families as well as for the staff, especially in moments of crises or great distress. Providing care and support during crisis moments requires the chaplain to go the extra mile to take initiative and come up with ways and means of intervention that bespeak his relevance as a caregiver. A transformative caregiving from chaplaincy service, I believe, will go a long way to mitigate the current crisis in health care. As Swinton observes, citing Stephen Platt,³⁸⁰

There is crisis in contemporary healthcare; a service that began with the noble intention of providing care, free at the point of delivery, for all finds itself facing unprecedented challenges. A chaplaincy service that is able to respond to the changing context of health and facilitate staff and patient in engaging with spiritual dimension of health and illness is needed more than ever.³⁸¹

Chaplains' attitude to their work is therefore imperative. Their ability to do their work in line with their professional integrity will make them to be more likely accepted and taken seriously in the discharge of their duties in the health care system. As Swinton

³⁸⁰ Stephen Platt, "Making Use of Models in Healthcare Chaplaincy," in *Critical Care: Delivering Spiritual Care in Healthcare Context*, ed. J Pye, G. Sedgwick, and A. Todd (London: Jessica Kingsley Publisher, 2015), 49.

³⁸¹ Swinton, "Professional Identity and Confidence," 21.

expressed, “If chaplains are to be taken seriously, it is vital that they are viewed by other professionals as engaging in forms of practice which are relevant, efficient, well informed, and credible. In order to achieve this they must be seen to be acting in a manner that is professional in the broader sense of the term.”³⁸²

Hospital chaplains’ perception of themselves as ethical leaders and the application of narrative-based ethics in their ministry is innovative and transformational. Ethical leadership principles as considered in this project are imperative. The development and appropriation of character, civility and sense of community are crucial virtues of ethical leadership. I have argued that the application of the Circle Process as a praxis in a hospital setting is a welcome development. Circle as used in other sundry institutions, including schools, has been assessed as veritable tool for institutional or organizational growth and development. The chaplain’s ability to use the Circle Process well and the collaboration of the facility staff and management is crucial. Welcoming this phenomenon will arguably mitigate the *collision* that occurs at the so many intersections in health care services in hospitals. Indeed, “Accepting the new situation, in which individuals explore life itself in dialogue with those around them, is a sound basis for sustainable chaplaincy and spiritual care.”³⁸³

³⁸² John Swinton, “A Question of Identity: What does it mean for Chaplains to become Healthcare Professionals?” *Scottish Journal of Healthcare Chaplaincy* 16, no. 2 (2003): 2-3.

³⁸³ Swinton, “Professional Identity and Confidence,” 21.



JOB DESCRIPTION
Pastoral Center
Archdiocese of Boston

JOB TITLE: Priest Chaplain/ Coordinator of Catholic Pastoral services

DEPARTMENT: Health Care Ministry

GRADE:

SUMMARY:

In accordance with the "Statement of Principle" of the Archdiocese of Boston (May 24, 1996), the Priest Chaplain/Coordinator of Catholic Pastoral services provides for the pastoral and sacramental needs of the Roman Catholic patients. As an employee of the Archdiocese of Boston, he is accountable to the Archdiocese through the Director of the Office of Chaplaincy Programs for carrying out this responsibility. He is also expected to work in collaboration with the hospitals administration.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

- Provides comprehensive pastoral care to Catholic patients and families as identified by census and referral.
- Provides Sacramental ministry to the Catholic patients and maintains the appropriate records.
- Provides pastoral support and crisis intervention to staff as needed and available.
- Produces the "on call" sacramental list by collaborating with assigned parishes who provide 24 hour "on call" emergency coverage/sacramental ministry.
- Maintains effective communication with the Vicar (or Priest Coordinator), the Director of the Office of Chaplaincy's and the supporting parishes.
- Recruits, trains, supervise and support Extraordinary Ministers of Holy Communion and other Catholic pastoral volunteers.
- Cooperates with the hospital's interdisciplinary clinical team and participates, as asked

³⁸⁴ Copyright written permission of Job Description of Priest Chaplain/Coordinator of Catholic Pastoral Service received from Deacon Jim Greer, the Director of Chaplaincy Program for the Roman Catholic Archdiocese of Boston.

- and available, in programs, services, committees and other activities.
- Assumes responsibility for administrative tasks as required by the Archdiocese and the hospital. (Reports, record-keeping, data collection, budget etc.)
 - Assumes responsibility for own professional development, spiritual well-being, and peer supervision.
 - Meets on a regular basis with the Director of Pastoral care and or Interfaith Chaplain for purposes of communication, collaboration and planning.
 - On Call, 20hrs two nights a week, full time 3 nights a week (depending on hospital)
 - Other duties as may be assigned.

QUALIFICATIONS:

- Two Units of Clinical Pastoral Education (CPE) four units preferred
- Board certified with National Association of Catholic Chaplains (NACC) or appropriate clinical pastoral agency preferred
- Ordained a Catholic Priest
- Two Years of clinical pastoral experience in a healthcare setting preferred
- Knowledge of and support for the Ethical and Religious Directives for Catholic Health Facilities
- Ability to communicate effectively through e-mail and/or telephone
- Strong service orientation.
- Ability to teach, train and mentor people in the Catholic faith.
- Knowledge and love of the Catholic faith and a desire to contribute to the mission of the Church.
- Commitment to personal spiritual growth

PHYSICAL PERFORMANCE ELEMENTS:

- Ability to use a computer keyboard for up to 8 hours/day.
- Ability to sit for up to 8 hours/day.
- Ability to lift up to 20 pounds.

The duties and requirements described above are representative of those encountered during performance of the essential functions of this job. Reasonable accommodations may be made to enable qualified individuals with disabilities to perform the essential functions.

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CURRICULUM VITAE







