Spiritual and religious assistance in the hospital context: notes on bioethics and professional ethics

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Abstract

Professional spiritual and religious caregiving assistance often includes ethical aspects. This study aims to briefly address some issues in bioethics and ethics associated with the scope of hospital chaplaincy in health institutions. Although this work is not a broad review of the literature, through a bibliographic and narrative approach, it provides important data on the ethical nature of the hospital chaplain's work. Thus, roughly speaking, it appears that ethical issues in health chaplaincy take two directions: (1) focused on the intervention of faith in potential conflicts in health outcomes (bioethics), or (2) focused on the role of the chaplain in his practice (intrinsic to praxis). In this context, at first, bioethical discussions are highlighted, which include themes related to issues involving the beginning and end of life, ethics in research with human beings, ethics of the patient-health provider relationship, with an emphasis on the doctor-patient relationship, and ethical training of health professionals. In these scenarios, chaplains are in a privileged position to mediate conflicts of values or misunderstandings between patients, members of the medical team, and other employees of the institution providing care, forging an environment conducive to decision-making. In the second moment, three approaches are indicated that coex-

ist in a fully formulated professional chaplaincy ethics, namely: (1) chaplaincy ethics as a medical ethics tool; (2) chaplaincy ethics as an ethics of responsibility; and (3) chaplaincy ethics as ministry ethics. Ethical issues present in hospital chaplaincy in the face of pluralism and individualism in spirituality and religiosity make each clinical situation unique, with profound implications for ethical analysis and decisions. In other words, conflict and confrontation are commonplace in a scenario of pluralism. Therefore, communication and cooperation are essential.

Keywords: Bioethics. Ethics, Professional. Chaplaincy.

Resumo

A assistência do cuidador espiritual e religioso profissional frequentemente inclui aspectos éticos. Este estudo tem como objetivo abordar brevemente algumas questões em bioética e ética associadas ao âmbito da capelania hospitalar em instituições de saúde. Embora este trabalho não seja uma ampla revisão da literatura, por meio de uma abordagem bibliográfica e narrativa, traz dados importantes sobre a natureza ética da atuação do capelão hospitalar. Assim, grosso modo constata-se que as questões éticas na capelania em saúde tomam duas direções: (1) voltadas à interveniência da fé em potenciais conflitos em desfechos de saúde (bioética); ou (2) voltadas à função do capelão em sua prática (intrínseca à práxis). Nesse contexto, no primeiro momento apontam-se as discussões bioéticas que incluem temas relacionados a questões que envolvem início e fim da vida, ética em pesquisa com seres humanos, ética da relação paciente-provedor de saúde, com ênfase na relação médico-paciente, e formação ética de profissionais de saúde. Nesses cenários, os capelães estão em posição privilegiada para mediar conflitos de valores ou mal-entendidos entre pacientes, membros da equipe médica e outros colaboradores da instituição prestadora da assistência, forjando um ambiente propício à tomada de decisão. No segundo momento, indicam-se três abordagens que coexistem em uma ética profissional de capelania totalmente formulada, a saber: (1) ética de capelania como ferramenta de ética médica; (2) ética de capelania como ética de responsabilidade; e (3) ética de capelania como ética do ministério. Parece explícito que questões éticas presentes na capelania hospitalar em face de um pluralismo e individualismo na espiritualidade e religiosidade tornam cada situação clínica única, com implicações profundas

para a análise e decisões éticas. Em outras palavras, em um cenário de pluralismo, o conflito e o confronto são lugares-comuns. Assim, a comunicação e a cooperação são essenciais.

Palavras-chave: Bioética. Ética profissional. Capelania.

1 INTRODUCTION

Formally, the values are the object of the study of ethics and axiology. Axiology (based on the theory of values) refers to the part of philosophy that generally investigates values, while ethics specifically, is the discipline of investigation of moral values (the term "moral" is here understood as any action related to the preservation of integrity in any of the human dimensions, the opposite of "immoral") (MARTINS, 2012; NOGUEIRA, 2007). Thus, the academic-philosophical study of ethics is divided into metaethics, normative ethics, and applied ethics (practice).

Galvão (2016, p. 143) highlights that "in normative ethics, substantive questions are discussed about what should be done and what is good or valuable. Metaethics investigates the nature of this type of discussion, dealing with metaphysical, epistemological, and semantic problems raised by ethics". In turn, applied ethics can be seen as the third main area of study of ethics or as a subarea of normative ethics; In any case, it focuses on practice, that is, it refers, for example, to professional ethics, scientific ethics, bioethics, etc. It should be noted that many of the most debated issues in applied ethics concern the beginning or end of human life (GALVÃO, 2016).

In all contexts of human life, the intrinsic need to experience the sacred becomes evident. This religious contact, normally formed by a set of scriptures or teachings, culminates in the development of the beliefs and values of an individual or community (KOENIG, 2015). Spirituality, assimilated as a profound search for meaning in life within an intangible dimension, manifests as an experience that can permeate the practice of religious rituals. It elevates human beings to experience something greater than their existential nature (TEIXEIRA, 2012).

The themes "spirituality" and "religion" are often related to the health context. In the last decade, there has been a 600% increase in scientific publications on the subject, showing that the purely biological approach is insufficient to cover the psychic, social, and spiritual dimensions of individuals' suffering (KOENIG, 2015). The interplay between religion and spirituality in a patient's life can significantly influence clinical outcomes. In this aspect, bioethics is essential for valuing spirituality and its relationship with a person's health.

Hospital chaplaincy, serving as a collaborative strategy with medical services, aims to provide spiritual care that benefits individuals undergoing illness and/or treatment within a hospital set-

ting (SILVA, 2013). This service meets individuals' spiritual needs, thereby preserving their unique individuality, beliefs, and values (FRANCISCO *et al.*, 2015). Given its importance and frequency in the hospital context, it is crucial to underscore the need for reinforcing the bioethical dimensions within hospital chaplaincy practices.

Among the national contributions concerning bioethical aspects, Ferreira and Zitti (2010) mention common issues addressed within the scope of hospital chaplaincy and develop associated ethical, legal, and theological aspects, namely, genetic research (human cloning), contraceptive methods (abortion), blood transfusion, euthanasia, suicide, human organ donation and transplants, cremation, and others. Although they were not mentioned by Ferreira and Zitti (2010), the methods of assisted reproduction and xenotransplantation have also been considered bioethical issues associated with spiritual and religious meanings in the Brazilian reality (RODRIGUES; RODRIGUES; BAIARDI, 2014).

Therefore, this study aims to briefly address issues in bioethics and ethics associated with the scope of hospital chaplaincy in health institutions. Although this work is not a broad review of the literature, through a bibliographic and narrative approach, it provides important data on the ethical nature of the hospital chaplain's role. The intention is to present a short communication (theoretical essay) regarding some ethical aspects related to the chaplain's conduct that can and should be deepened for a different and competent presence.

Thus, broadly speaking, it can be seen that ethical issues in health chaplaincy take two directions: (1) focused on the intervention of faith in potential conflicts in health outcomes (bioethics) or (2) focused on the role of the chaplain in their practice (intrinsic to praxis).

2 FAITH IN THE FACE OF POTENTIAL CONFLICTS (BIOETHICS)

Although there is some variation in conceptualization among bioethics scholars, there is a certain convergence. Thus, as Rodrigues, Rodrigues, and Baiardi (2014, p. 26) explain, bioethics "can be understood as a sector of ethics that studies the problems inherent to the protection of life and in particular the ethical implications of biomedical sciences". Häyry (2015) highlights that approaches to bioethics are naturally varied, and there are at least two reasons that explain this. Firstly, bioethical issues include practical issues within medicine, health, research, and ecology, as well as theoretical issues relating to "doctrines" and their assumptions. Therefore, practical issues mainly need solutions, while theoretical ones more readily demand clarification. Second, both sets as mentioned above of questions can be approached from many or even overlapping angles, such as pragmatic, political, theological, and epistemological perspectives.

The origins and history of bioethics have been a topic of increasing interest in recent decades, due, in part, to greater knowledge of the precursors of bioethical thought, favoring different per-

spectives along the way. Two moments have been commonly considered the development and origins of bioethics. The first is that at the beginning of the 20th century in Europe, where there were the contributions of the theologian and physician Albert Schweitzer, who proposed the concept of "sacredness of life", in parallel to those of the German philosopher and theologian Fritz Jahr, who in 1926 was the first to use the word "bioethics" ("*bioethik*").

The second moment concerns the fact that, in the 1960s and 1970s in the United States of America (USA), the term "bioethics" began to gain greater visibility and relevance given the increasing incorporation of technologies in the field of health (GARCIA *et al.*, 2019). Among these advances, Rhodes (2013) highlights the development of the contraceptive pill and the positive pressure mechanical ventilator to provide artificial respiration in the 1960s, the development of hemodialysis (between 1960 and 1970), and the first test tube baby (1978). There is also a certain civic, political, and legal unrest in the USA, as historic decisions are made on a series of medical issues (contraception, abortion, right to refuse medical treatment, right to discontinue life-preserving treatment, etc.).

In his article, Rhodes (2013) also highlights that in philosophy there was an important contribution from John Rawls with the publication of the book *The Theory of Justice*, in 1971, in which he emphasizes autonomy and introduces a series of concepts that have informed discussions about ethics since then, such as "primary social goods", "veil of ignorance", "original position", "fair equality of opportunity", "difference principle" and others. In any case, two concepts are highlighted that dominated debates in bioethics in the second half of the 20th century: autonomy (in clinical matters) and protection of human subjects (in research ethics).

Garcia *et al.* (2019) indicate the critical interdisciplinary proposal of Potter's initiative when commenting on bioethics as a formal discipline, as well as the contribution made by Beauchamp and Childress (2013) in their book *Principles of biomedical ethics*, in 1979, in which they formulated some ethical principles, namely, "respect to the autonomy", "non-maleficence", "beneficence" and "justice". It is argued that the "four principles" have almost always existed and governed the ethical behavior of human societies, applying to any culture and society. Thus, the authors' statement has been tested by research carried out in different cultures and societies (AKSOY; TENIK, 2002).

Compared to North America, Latin America saw a rather late development in the field of bioethics, and only in the 1980s were the first disciplines and postgraduate institutions dedicated to its study established. In an overview of Latin American academic-scientific production, bioethics has been guided by the following themes: issues involving the beginning and end of life; ethics in research with human beings; ethics of the patient-health provider relationship, with emphasis on the doctor-health provider relationship; and ethical training of health professionals (GARCIA *et al.*, 2019).

To bioethics in the training of health chaplains, Smith and Morgan (1998), in their article on bioethics' education within the scope of the Clinical Pastoral Education Program (CPE) in the American experience, record that since the first years of the EPC at the *College of Chaplains* (now called *Association of Professional Chaplains*) discipline was present, given that, for many people, their clinical dilemmas and conflicts intertwined ethical rights and duties with spiritual meanings and religious beliefs. Smith and Morgan (1998) further explain that the pluralism of values, communities, religions, and theologies further contribute to this contemporary clinical complexity by incorporating a wide variety of social and community identities, languages, customs, symbols, religious practices, sacred and secular texts, and belief systems. The authors also emphasize that this pluralism is the result of identifiable groups coming from outside and inside the USA (SMITH; MORGAN, 1998).

Therefore, chaplains, nurses, and doctors cannot assume that they know a patient's values and beliefs once their religion has been identified, since the mix of religious beliefs and practices can work differently for each person. Ergo, this pluralism, and individualism in spirituality and religiosity can make each clinical situation unique, with profound implications for ethical analysis and decisions. In other words, conflict and confrontation are commonplace in a scenario of pluralism, and communication and cooperation are essential.

One of the achievements of bioethics over the past three decades has been the identification and development of language, principles, concepts, moral frameworks, and methodologies that are acceptable to people with diverse perspectives. Thus, Thornton, Callahan, and Nelson (1993) identify six key areas with which every serious student of bioethics should be familiar: 1) the history of medical ethics and bioethics; 2) theoretical foundations and analysis methods; 3) comparative analyses and scope of the issues covered by the term "bioethics"; 4) moral issues of professionalism; 5) cultural contexts of bioethics; and 6) resources in the field (bioethics is interdisciplinary, which is sometimes particularly challenging for locating and retrieving information).

Fleenor *et al.* (2022), in their contribution to the prevalence and types of ethics education in clinical pastoral education programs, maintain that chaplains often serve on ethics committees as consultants and as members of the institutional review committee in hospitals. Based on results from 84 EPC residency programs in the US, accredited by *The Standard for Spiritual Care*, the authors highlight that three-quarters of them had a mandatory ethics curriculum, another 10% were in the process of developing it, and 18% did not have one. There was great variability in ethics curricula among different programs, concluding that developing guidelines for a standardized curriculum could help healthcare chaplains provide more effective services as consultants on ethics committees and as Institutional Review Board members in hospitals.

In this sense, Carey (2012), in his research on bioethical issues and chaplaincy in a region of New Zealand,

maintains that the majority of the people linked to chaplaincy (chaplains and lay chaplain assistants) were involved, in one way or another, in bioethical issues and issues related to decision-making. The author also indicated that this participation was carried out predominantly to help patients and families in facing dilemmas, and, to a lesser extent, involvement with the clinical staff on bioethical issues (CAREY, 2012).

Simmonds (1994) emphasizes that, in bioethical discussions, chaplains can interpret patients' values for the health team, pointing out their impact on the delivery of treatment and, eventually, making recommendations. Furthermore, they are in a privileged position to mediate conflicts between values or misunderstandings between patients and team members or other employees of the institution providing care. Another task is to help in the process of identifying options, given that your abilities to listen, discern, and be reflective to contribute to patients, families, and employees discovering their values, forging an environment conducive to deciding to follow a course of action.

The important role of chaplaincy in mediating and conducting bioethical issues can be seen in the interesting contribution by Ebner, Ostheimer, and Sautermeister (2020) on the role of religious beliefs in the acceptance of xenotransplantation in the experience of hospital chaplains of different religious confessions (Christians, Jews, and Muslims) in German-speaking countries (Austria and Germany) through a dialogue framework. The authors argue that the continuation and further development of a specialized discussion represents a focus, an influential building block for constructing a concept of pastoral care to deal with xenotransplantation. They also suggest that, in addition to biomedical progress, psychosocial and pastoral dimensions need to be taken into account, as practice requires (EBNER; OSTHEIMER; SAUTERMEISTER, 2020).

Similarly, Wagner and Higdon (1996), in their article on the role of the chaplain in spiritual issues and bioethics in the intensive care unit (ICU), draw attention to the challenges of chaplaincy in this context, by indicating, among other points, that the various chaplain roles and levels of ministry tend to blend and are less distinct. They propose that when deeper levels of ministry are provided to patients and team members, the many "hats" of this professional may change frequently, even sometimes in a single conversation.

Another emphasis is given to seriously ill patients who generally have less energy to talk, even if they are conscious and able to communicate. Within this horizon, it takes exceptional skill to identify an ethical concern, clarify it as an issue that requires further attention, build a consensus that it should be addressed, and finally initiate the request for an ethics consultation. Wagner and Higdon (1996) exemplify this process as follows: if a nurse is worried, the chaplain can enhance the resolution process by asking a series of questions, such as: "Are your other teammates as worried as you are?"; "Did you speak to your supervisor?"; and "Did you or anyone else talk to the doctor about this concern?" The objective is to

help the team explore these points carefully, as, by doing so, they can resolve the problem themselves without the need to take the matter to the institutional bioethics' committee.

3 PROFESSIONAL ETHICS OF THE PROFESSIONAL HEALTH CHAPLAIN

In his thought-provoking article on the ethical foundation for a hospital chaplaincy profession, Mohrmann (2008) points out that the movement towards "professionalization" brings with it the need for professional ethics. This requirement raises questions of both what the specific ethical principles of chaplaincy are or should be and what constitutes its theoretical basis. Thus, three approaches are identified and developed, which coexist in a fully formulated chaplaincy ethics, namely: chaplaincy ethics as a medical ethics tool; chaplaincy ethics as an ethics of responsibility; and chaplaincy ethics as ministry ethics. The author concludes that any professional ethics for chaplaincy must contain a careful consideration and explanation of the particular ethical obligations arising from the healthcare context, not only because of the vulnerability of the patient, but in function of the intensity of commitment that characterizes the work of healthcare professionals. According to him, it is necessary to pay careful attention to the demands, dangers, and limitations inherent in the moral practice of ministry, outlining and justifying the responsibilities of chaplains, as well as protecting both spiritual and religious caregivers and their patients (MOHRMANN, 2008).

From this perspective, Sulmasy (2012), in his work on ethical principles for pastoral care, highlights that the moral guarantee for spiritual intervention does not reside in the patient's preferences or health outcomes, but rather in the intrinsic nature of care in health and the nature of spirituality; that is, to be human is to be spiritual. The author emphasizes that human beings, when injured or sick, naturally seek answers, meaning, values, and relationships in the transcendent. Therefore, meeting the spiritual needs of patients is not an option, but a moral imperative, and it is this imperative that underpins the ethics of spiritual care (SULMASY, 2012).

Next, the author suggests, among the ethical principles for spiritual care, the following: patient-centered care (the focal point of all pastoral care and all clinical care is the patient, who is first and foremost a person); holism (care for the patient as a whole person); discretion (spiritual care is discreet in its interventions); and accompaniment (attentive to spiritual needs). Finally, he proposes a selection of ethical issues specific to the chaplain's work, such as proselytism, tolerance, confidentiality, believing in miracles, praying with patients, etc. (SULMASY, 2012).

When outlining the ethical perspectives of spiritual care, Jobin (2020) discusses the ethical issues involving the communication of information, arguing that the fundamental aspect of professional secrecy arises from the point of intersection between two fundamental normative realities. This point is, in fact, a place of tension between the patient's right to privacy (professional secrecy)

and the need (imperative) to share information with the system and health professionals to ensure effective care delivery. On the one hand, the author emphasizes that the ethical issues surrounding communication can be summarized as follows: what information should the chaplain enter into an electronic health record (medical record)? What criteria should be used to classify all collected information? What justification should be required if a chaplain communicates information? What to do with information that could compromise patient safety or influence the quality of the care relationship? On the other hand, for chaplains, the principle of mapping is already accepted, since "it is important to leave footprints", since "if it wasn't mapped it didn't happen", according to the clinical saying (JOBIN, 2020).

Next, Jobin (2020) points out that the professional imperative of documenting the spiritual process is necessary to allow other clinical workers to know what the chaplain did and what his recommendations were for the team. The author highlights the distinction between "information collected under the confessional seal" (confidential), which should never be mapped, and that collected during a conversation that is not secret and that, with due pastoral sensitivity, can be inserted into the record, with the caveat that they may be shared with other staff verbally if the chaplain determines it is appropriate or is too sensitive to include in the report. The author also suggests that, if necessary, the patient's consent is obtained so that sufficient information is communicated to other members of the clinical care team, respecting their privacy (JOBIN, 2020).

4 FINAL CONSIDERATIONS

The chaplain's role goes beyond physical action, and the scope of their role meets the spiritual needs. In the hospital context, meeting these patient needs is not characterized as an option, but a duty that needs to be guaranteed. It is at this juncture that the application of ethics takes place in its two dimensions: normative ethics and applied ethics (practice). It is important to highlight that hospital chaplaincy, when used ethically in spiritual care, tends to alleviate spiritual discomforts and contribute to clinical improvement.

Patient-centered care carried out by a multidisciplinary team focuses on holistic assistance, discretion in interventions, and support for family members. Proper preparation of the hospital chaplaincy grants autonomy to mediate conflicts and suggest alternatives in the face of clinical conditions, which can be improved with spiritual action strategies and even serve as support for the healthcare team. It seems clear that ethical issues present in hospital chaplaincy in the face of pluralism and individualism in spirituality and religiosity make each clinical situation unique, with profound implications for ethical analysis and decisions.

In other words, conflict and confrontation are commonplace in a scenario of pluralism. Therefore, communication and cooperation are essential. Given these considerations, it is hoped that this study

will encourage new reflections regarding the application of ethics in the context of hospital chaplaincy.

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