West Virginia Network of Ethics Committees
WVNEC
Newsletter

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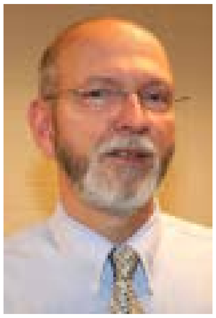
The Role of Chaplain in Healthcare Ethics



***Ed Horvat, MA, BCC**, is Chair of the Ethics Council at Mon Health Medical Center in Morgantown, WV. Mon Health has been an Institutional Member of WVNEC since its inception.*

> *"The receipt of modern health care services is among the most unnatural of human experiences. Needles, knives, and numerous otherwise dangerous objects are often purposefully directed at one's body; pharmaceuticals are frequently employed to alter one's physical and emotional states; and total strangers are commonly allowed to examine the most intimate, nonpublic and personal aspects of one's self."*
>
> *--Jason Nieuwsma, PhD; and Joe McMahan, MDiv, BCC* (1)

Nieuwsma and McMahan report that chaplains can be considered "…a bridge to the familiar, to the divine, to community, and to a fuller sense of one's identity and humanity beyond what is portrayed in the medical record. They remind us of our existence and lives outside of the role of being a patient. They remind us of our values, desire, meaning, and purpose in life. And, of course, they remind us of our relationships to God, the universe, and spiritual truths."

The role of the clinical chaplain on the healthcare team is often misunderstood, by both the treatment team and patients/families. Oftentimes, chaplaincy is confused with the role of clergy, but there is a difference. A clergyperson is a leader of a congregation within a particular faith group or denomination. The preparation of a clergyperson can vary anywhere from having a doctorate degree to a person without formal theological training, but who 'answers a call' to ministry.

By contrast, a board certified chaplain (BCC) has a minimum of a Master's Degree, along with 4 units of Clinical Pastoral Education (CPE). Each CPE unit consists of 400 supervised hours within an ACPE accredited healthcare training site. (2) The candidate

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must also have the endorsement of leadership within the chaplain's faith group – a bishop, for example, within some Christian denominations. The chaplain may or may not be a clergyperson. While being grounded in their own religious/spiritual tradition, the clinical chaplain must be familiar with, and accepting of, a variety of religious and spiritual backgrounds that patient/family/staff may possess when entering a healthcare system.

A major distinction between some clergypersons and professional chaplains centers on proselytization: "to recruit or convert, especially to a new faith, institution, or cause." (3)

Often patients/families/staff are hesitant to accept chaplaincy support as they fear they will be subject to proselytization pressure. The Code of Ethics for Chaplains affirms the dignity and value of each individual, respecting the right of each faith group (and those unaffiliated to a faith group) to hold to their values and traditions, respecting the cultural, ethnic, gender, racial, sexual-orientation, and religious diversity of other professionals and those served, as we strive to eliminate discrimination. (4)

CASE EXAMPLE

Robert, is in his early 30's and is recently diagnosed with a rare form of cancer that spreads quickly and will take his life. He is given months to live. Robert is tall and thin with long black hair and tattoos. He has a 1-month-old daughter with his girlfriend. His girlfriend has a 6-year-old son from a prior relationship to whom Robert is very close. Robert works full time in the hospitality industry and also has a part-time job. Robert has been complaining about back pain for about four months, and is passed around in the healthcare arena. It was assumed that he was complaining about pain as a way to get narcotics. A further work-up identifies the problem/prognosis, and Robert is angry. That is how I got the referral – to address his anger.

Robert is receptive to my involvement, though somewhat suspicious of my role. I introduce myself and give him an overview of the Chaplaincy Department. I validate his feelings of anger, and help him express them, giving him "permission" to own his feelings. Part of this anger is complicated by anticipatory grief. During the discussion, I learn that he is originally from the Southwest. He is Apache, and feels isolated from his culture and traditions. He expresses regret about falling away from the customs of his culture/spirituality/ethnicity. His life has been moving so fast, that these things were placed on the back burner. I assure him that many people of his age are so involved with work, a young family and other obligations, that their spirituality is not given priority. I did not want him to feel alone in this because, developmentally, this should be a consideration.

I let Robert know that we had Native American spiritual care providers as part of the Pastoral & Spiritual Care Department, and I offered to introduce him if he would like. I let him know that all of our consultants were from Eastern Woodland tribes, and apologized that none were Apache. His mouth dropped open. He said, "I thought hospitals only had Protestants or Catholics pushing their wares. Did you say that I could meet with an Indian?

During months of readmissions, he met several of our Native American providers. He began assembling a medicine bag. He wanted a piece of coal for it because it was native to West Virginia and that is where he has been living and loving. He was rediscovering his spirituality and was encouraged to do so by most staff. At one point, one of our staff saw him assembling his medicine bag and said, "Oh, you think that is going to help you?" Robert was able to let that remark roll off of his back because of the support he was given by most staff to cope with this crisis in his own way.

Robert was married in the hospital. His girlfriend was Christian, so her pastor and one of our Native spiritual care providers performed the ceremony. I remained involved in Robert's care, but the spiritual care he was provided was definitely shared, and the Native providers were the most important element. I recall sitting with Robert through several panic attacks, and once held his head as he threw up blood. Regarding complementary modalities, a special tea was brewed for Robert. The provider wanted Robert's physicians to be aware of the ingredients due to the possibility of interaction with medications. His spiritual care was documented by me in the medical record.

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We arranged for Robert to be videotaped holding his daughter, telling her that he loved her, passing on his heritage. We arranged for a paternity test to prove his fatherhood so that his daughter would be able to claim native heritage and any future advantage that may hold for her. Robert took a new name while hospitalized, letting go of his "Anglo" name. He became a new man. I saw a strong life force in him.

My chaplaincy relationship with Robert was terminated when he was discharged from the hospital and went home with hospice. Our Native providers continued their involvement in the home setting and later conducted his funeral service, which I was invited to attend.

REFLECTION:

Although this case example does not directly include a reason for a formal ethics consultation, it does demonstrate the ethical role of a professional clinical chaplain in a healthcare setting. Note "Robert's" suspicions of the role of chaplain, thinking that he may be subject to proselytization. Notice also that another staff person did question the value of assembling a medicine bag. It is important to know that a professional chaplain will bring resources to help a patient/family cope with a crisis based on their values and beliefs. Can you imagine the struggle he may have had – in addition to dealing with his health crisis – if his spirituality were challenged instead of respected?

As members of health care ethics committees and consultation services, professional clinical chaplains play a crucial role: "Chaplains may be of assistance to health care ethics committees as they discuss the questions of philosophy, theology, spirituality, human values and morals, which are integral to ethical questions." (5)

References:

1. Jason Nieuwsma and Joe McMahan, "Using ACT in the Context of Health Care Chaplaincy," in ACT for Clergy & Pastoral Counselors: Using Acceptance & Commitment Therapy to Bridge Psychological & Spiritual Care, Oakland, CA, Context Press, 2016, p. 220

2. Association for Clinical Pastoral Education (ACPE) https://www.acpe.edu/

3. Merriam-Webster Dictionary https://www.merriam-webster.com/dictionary/proselytization.

4. Chaplaincy Code of Ethics http://www.professionalchaplains.org/files/professional_standards/common_standards/common_code_ethics.pdf

5. Association of Professional Chaplains: Guidelines for Chaplains Role in Healthcare Ethics http://bcci.professionalchaplains.org/files/application_materials/guidelines_for_chaplains_role_in_healthcare_ethics.pdf

Ethical Challenges for Community Palliative Care Teams

by Chris Zinn, MSc, BSN

Executive Director of the Hospice Council of West Virginia

In "Palliative Care Ethics" Randall and Downie assert that 'the supremacy of the patient autonomy movement…has very serious consequences for patients and health care professionals today and in the future.' This is true for West Virginia's community palliative care teams, most of which have been set up by community hospices. Beneficence and truth telling used to be as important as patient autonomy, but now patient-centered care and concerns about patient satisfaction have made it more difficult for health professionals to say no when a family demands treatment that is no longer effective. Whereas the hospice nurse has the support of the interdisciplinary team, including chaplains and social workers, the palliative nurse practitioner may be the only one visiting the patient and family at home. This model presents more ethical challenges for these nurses.

Palliative care teams were initially established in acute care hospitals in the 1990s and for many patients served as a transition to hospice care in the community. However not all patients/families want, or are eligible for, hospice so community palliative care teams are being developed to offer them support. Community palliative care is now available in Morgantown, Charleston, Huntington, Beckley and Princeton and moves hospice upstream to support those with serious illness and prevent hospitalizations.

The hospice philosophy was founded on truth telling, upholding patient autonomy and neither hastening nor postponing death. Community palliative care has had to shift away from some of these principles to honor patient autonomy first and foremost. This has a potential to create moral distress for the staff, especially for those who were formerly hospice nurses.

Ethical issues can arise when the palliative nurse practitioner visits the patient and family to clarify goals and what matters most to them. Patients may have very unrealistic expectations about their prognosis and may be pursuing aggressive treatment in the hope of a cure. The referring specialist often consults the palliative care team to provide "hospice-like" support, knowing that the family is not ready to hear that the prognosis is poor. In these cases, patients are suffering and the family may have difficulty providing the care due to its complexity. Treatments such as dialysis, mechanical ventilation and artificial feeding may be prolonging dying and creating unnecessary suffering.

In some cases, the physician may hope that the palliative care team can transition the patient onto hospice as hospice provides much more comprehensive support as well as coverage for medications, medical equipment and supplies. Conversations about prognosis can be difficult and time-consuming. It may be easier for the palliative nurse practitioner to begin this conversation when spending more time with the patient/family in the comfort of their home. If it is important for them to remain at home, they may be ready to hear about how hospice can help them. However some patients are not ready for any discussion about their prognosis or hospice. Good communication is at the heart of effective palliative care. When the palliative care team cannot share truthfully with a patient/family and witness ongoing needless suffering, it can result in moral distress or compassion fatigue.

See* Ethical Challenges *on page 7

An Ethical Case for Interprofessional Collaborative Practice in Heathcare

Renee McGinnis, PT, DPT, OCS, COMT
Assistant Professor

Ralph R. Utzman, PT, MPH, PhD
Professor and Director of Clinical Education

WVU School of Medicine
Department of Human Performance and Applied Exercise Science
Division of Physical Therapy

According to the World Health Organization[1], interprofessional collaborative practice occurs when "…multiple health workers from different professional backgrounds work together…". The concept of health professionals working together seems simple. However, today's increasingly complex healthcare environment presents numerous challenges for clinicians in all health disciplines. Amid national debates regarding how to reduce healthcare costs while expanding equitable access to care, healthcare providers are bombarded with regulations and flooded with data. Rapid technological expansion and scientific advances have been met with increasing specialization in many professions, while others have experienced expanding scopes of practice and responsibilities. Within this environment, communication and coordination among healthcare providers and patients are essential for avoiding errors and producing positive patient outcomes.

The Interprofessional Professionalism Collaborative (IPC)[2] has adopted the following definition of interprofessional professionalism:

Consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of altruism, excellence, caring ethics, respect, communication, accountability to achieve optimal health and wellness in individuals and communities.

This definition suggest that even though each health profession has its own traditions and norms, we share a common set of core ethical values that should drive teamwork among different healthcare providers and the patients, families, and caregivers they serve. The case that follows (based on real patient of one of the authors) demonstrates successful interprofessional professionalism and communication.

Medial compartment knee arthroplasty is a surgical intervention for the management of knee arthrosis. During the surgery the articular surfaces of both the tibia and femur are replaced by prosthetic components but only within the medial, or inner portion, of the knee.[3] Sally was a 54 year old female who was an avid gardener and participated in animal rescue. Her active lifestyle and a prior knee injury contributed to the development of significant left knee medial compartment arthrosis. When conservative care and pharmacologic management no longer resolved her symptoms, she underwent a medial compartment knee arthroplasty. Following her surgery, Dr. Murphy, Sally's orthopedic surgeon advised out-patient physical therapy a normal component of recovery.

At the out-patient facility, Sally met Robin, a physical therapist with seven years of experience. Robin instructed Sally in the post-operative protocol emphasizing gradual return to physical activity, modalities to assist with swelling and pain, and adequate rest to allow the body to heal for optimal recovery. Sally progressed quickly, she restored her range of motion easily, and frequently wanted to complete more difficult exercises than advised. At six weeks post-operative, Sally reported to Robin she frequently was walking three to four miles per day with her dogs and completing housework that included frequent trips up and down stairs. Despite initially having minimal pain and soreness, Sally was now having increased pain and swelling in her left medial knee. Robin completed a thorough examination and detailed her evaluation to Sally. Sally was clearly overdoing it. Robin instructed Sally to lessen her walking, comply with daily ice application, and take frequent rest breaks all consistent with the post-operative protocol.[4] Robin then communicated her findings to Dr. Murphy via letter.

Despite Robin's insistence to decrease activity, Sally continued her busy days. She returned to physical therapy after a post-operative consultation with Dr. Murphy with a new referral instructing Robin to use therapeutic ultrasound over the medial knee area to assist with decreasing pain and swelling. Sally was excited to try this new modality to decrease her pain and swelling so she could continue her active lifestyle. She expressed frustration when Robin adamantly refused to apply ultrasound. Robin recognized the need for additional communication between the patient, Dr. Murphy, and herself to maximize Sally's prognosis and continue safely with treatment.

At six weeks post-operatively, some patients still require an assistive device to normalize walking. Many are just returning to basic activities around the home and require frequent rest breaks. Robin felt Sally's increased pain and swelling was the result of completing activity at intensity levels beyond the normal post-operative guidelines.[4] Robin was concerned that Sally did not understand failure to follow post-operative instructions would delay recovery. She was further concerned that despite her prior letter, Dr. Murphy was unaware of the extent of physical activity Sally was completing and unaware of the contraindications and precautions of ultrasound use of the area of a cemented joint prosthesis.[5] The use of ultrasound in the presence of artificial joint components may have a detrimental effect on the cement and polymer components of the joint replacement.[5] Robin discussed this with Sally and explained why ultrasound was not an appropriate treatment. Robin then called Dr. Murphy to discuss her concerns, emphasizing the contraindication for use of ultrasound. Dr. Murphy was receptive to this communication from Robin. He was unaware of the contraindication and potential risks. Based on the information Robin provided, he agreed with her recommendations. As a team, Sally, Robin, and Dr. Murphy collaborated to find a solution to best address Sally's increased pain and swelling.

In this case, both Robin and Dr. Murphy's behaviors demonstrated core values of altruism, excellence, caring, respect, communication, and accountability promoted by the IPC. A breakdown in communication could have led to poor outcomes for Sally. If Robin had not reported her initial concerns to Dr. Murphy, Sally would have continued overusing her knee. If Robin had rejected her own professional judgment and provided the ultrasound treatment to avoid potential confrontation, Sally's newly repaired knee could have been ruined. Had Dr. Murphy not been receptive to Robin's concerns and suggestions, Sally may have stopped receiving therapy services altogether. With all members of the care team and the patient communicating together, it was easy to form a plan. Sally decreased her activity around the house, increased her application of ice at home, and movement-based solutions to address swelling and pain were further incorporated into the treatment plan.

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1.World Health Organization. Framework for action on interprofessional education & collaborative practice. Geneva: World Health Organization. http://apps.who.int/iris/bitstream/10665/70185/1/WHO_HRH_HPN_10.3_eng.pdf.

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4.Brigham and Women's Hospital. Physical Therapy Standards of Care and Protocol. https://www.brighamandwomens.org/patients-and-families/rehabilitation-services/physical-therapy-standards Accessed June 4, 2018.

5.Cameron MH. Ultrasound. In: Physical Agents in Rehabilitation – from research to practice. Fourth ed. St. Louis, MO: Elsevier;2013:173-198.

West Virginia Center for End-of-Life Care

Update on e-Directive Registry

Good news! The West Virginia e-Directive Registry will be BACK ONLINE THIS SUMMER. The West Virginia Health Information Network (WVHIN) will be sending out an updated participation agreement that your institution will need to sign to access the Registry. We will let you know when this agreement is available.

Please sign up to get posts from the Center for End-of-Life Care's Facebook (FB) page. More information will also be available there. Here is a FB post from earlier this week.

The name for West Virginia's POLST form is POST (Physician Orders for Scope of Treatment). Here is a short 3-minute video about when is the right time to assist a patient to complete a POST form. https://www.youtube.com/watch?v=LoGM-ayzKc0

The Registry continues to receive over a 1,000 forms per month. The number received in May was 1,247, and the cumulative total of forms received by the Registry is 87,803!

Please continue to submit patients' advance directives, DNR cards, POST forms, surrogate selection forms, and other end-of-¬life documents to the Registry.

Registry FAX number 844-616-1415

Center phone number 877-209-8086

Thank you.

Alvin H. Moss, MD
Founding Director

Ethical Challenges *from page 4*

Community palliative care teams may also be asked to withdraw treatment that has become burdensome for a patient. The "Hastings Center Guidelines for Decisions on Life-sustaining Treatment and Care Near the End of Life" emphasize that withholding treatment is ethically equivalent to withdrawing treatment. However, withdrawing treatment feels different and staff can become concerned that they are causing death or assisting suicide. It is important that community palliative care nurses have training in ethics and access to an ethics committee. When requests for withdrawal of mechanical ventilation occur, the ethics committee can validate the ethics and legality of the particular case when there is any doubt and provide support to the staff involved. This is especially important because withdrawal of mechanical ventilation usually occurs in a hospital setting with the involvement of a multi-disciplinary team including the hospital chaplain. The community palliative nurse practitioner may not have a social worker or chaplain involved due to limited funding for this service. The hospice team should be asked to assist to ensure that the patient and family have comprehensive support.

The Hastings Center Guidelines lay out an excellent foundation for care of patients at the end of life. Palliative care nurse practitioners will find this book is a valuable resource for their work. They should also participate in WVNEC education and find a mentor if they are new to this field. WVNEC also invites submission of cases that illustrate the ethical challenges of this emerging specialty.

Calendar of Events

SAVE THE DATE!

October 16, 2018 - WVNEC Noon Webinar - The webinar is in its planning stage. Information on this program will be available in the coming months.

May 8, 2019 - 32nd Annual May Symposium - This annual one day program will once again be held at Stonewall Resort in Roanoke, WV.

Web Courses Available:
Advance Care Planning: Why, What, and How - Advance care planning refers to a process of conversation between the physician (or other advance practice provider APP) and the patient, preferably with the patient's trusted family member or friend, about the patient's wishes for future medical treatment. This program will provide 1) a sequence of steps for physicians and APPs to create an advance care plan, 2) video demonstrations of advance care planning conversations with patients in good health and those with advanced illness, and 3) information on how to bill for Medicare patients for advance care planning discussions. Cost: $49.00 per person and includes CE credit.

WVNEC: Completing the POST Form - Advance care planning refers to a process of conversation between the physician (or non-physician professional) and the patient, preferably with the patient's trusted family member or friend, about the patient's wishes for future medical treatment. This program identifies the advantages of POST forms for seriously ill patients, present a step-by- step approach to completing a POST form, and describe how to bill for advance care planning including POST form completion. Cost: $25.00 per person with CE credit included in the cost.

Visit our website at www.wvnec.org for the latest information on these and other future programs.

Mission Statement: The West Virginia Network of Ethics Committees assists hospitals, nursing homes, hospices, and home health care agencies to strengthen ethics committees; provides education regarding ethical and legal issues in health care to promote ethically sound decision-making; and helps patients and families to make their end-of-life wishes known.

This is a quarterly publication of the Center for Health Ethics and Law, Robert C. Byrd Health Sciences Center of WVU, for the West Virginia Network of Ethics Committees. Questions, comments, and ideas should be submitted to:

Center for Health Ethics and Law
1195 Health Sciences North
P.O. Box 9022
Morgantown, WV 26506-9022

Phone: (304) 293-7618
Fax: (304) 293-7442
www.wvethics.org

Valerie Satkoske, MSW, PhD
Editor

Linda McMillen
Production

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