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Pastoral Care and Epidemics: 
A Hospital Chaplain’s Preliminary Thoughts

News of the swine flu outbreak in Mexico, with related cases in the US, Canada, and other countries is capturing international attention. We all hope that this outbreak will be contained quickly, as the SARS outbreak in 2003 was, and that fears of a pandemic will not come to pass.

However, even the possibility raises serious questions for chaplains in any field of health care. Certainly, some experts have been thinking about these questions for years, but from what I can tell, there is far more discussion in medical ethics literature than in pastoral care sources. I appreciate that some colleagues with specialties in disaster care or the military have dealt with these questions. I hope they and others will share their thoughts. [1]

I am a staff chaplain at a major university hospital, covering medical and oncology units and rotating coverage for traumas and other emergencies. As a practitioner working with patients, families, and staff, I began to imagine: what would a mass casualty situation be like? What would be my role?

First, I would like to say that in brief discussions with a number of colleagues, the focus is almost immediately on the “wrong” questions. Questions such as the ethics of allocating scarce resources or even denying care are tremendously important in the planning stages. (Extensive plans and possible scenarios have been worked out already in the US and Canada, with little input from pastoral caregivers, as far as I know.) Since these plans are largely in place (though always subject to change) they don’t address the questions that an ordinary chaplain would face in a crisis. We would not be making the policies; we would be providing pastoral care under these criteria.

Second, while there is a considerable amount of ethics literature about an outbreak of pandemic influenza (or similar illness) that might affect millions over many months, much of the disaster/mass casualty discussion for civilians has been incident based – a short term event (9/11, a hurricane) where the actual cause ends in days or even minutes, not continuing for many months, and the incident is localized, not national or international.

Let me briefly raise a few of the questions chaplains might deal with:

1) Patients and families. In a disaster mass casualty triage situation, however defined, some patients will be denied care, and those receiving care may have it discontinued (due to a shortage of vents, ICU beds, or other medical support.) For example, the US Agency for Healthcare Research and Quality (2005) says, for “current patients, such as those recovering from surgery or in critical or intensive care units…certain lifesaving efforts may have to be discontinued.” [2]

A Canadian protocol [3] for influenza pandemic says, “The patient is excluded from admission or transfer to critical care if any of the following is present:

A) Severe trauma…
C) Cardiac arrest [unwitnessed or recurrent]…
D) Severe baseline cognitive impairment…
J) Age >85 yr…”
These criteria are “tiered,” that is they could be modified as the crisis continues to include or exclude more people from the more intensive treatments.

We may also be dealing with distraught families in situations where bedside visits are not allowed, and physicians are simply unavailable to update families. In addition, religious sensitivities may be ignored. “It may not be possible to accommodate cultural sensitivities and attitudes toward death and handling bodies.” [4]

2) Care for staff. Chaplains play a key role in staff support. How will we offer support to people working extended hours, making far more life and death decisions than usual? Staff will have had to shift from the ordinary standards of care in developed countries which focus on the most acutely ill to protocols focused on sharing limited resources (including staff time). This means denying care to some in order to help many. “Part of an institution’s plan for coping with disasters should be provisions for debriefing and psychological counseling.” [5] What about staff who are concerned about their own families and loved ones? What do we say to a physician who is offered one of the limited prophylactic immunizations (as a direct care provider) who begs that it be given to her five year-old son instead (who is not on a priority list)? Can we provide support in a command situation, where ethics committees will not likely have time to meet, regardless of our personal beliefs?

3) Care for selves. How will we function in many more situations where we are de facto hospice chaplains, even for those who in ideal situations might be medically “saved?” (Those patients deemed “expectant” – i.e. expected to die.) We may be called on fill unfamiliar roles: “Non-clinical personnel and family members may be asked to assist with administrative and environmental tasks…” [6] How do we find support and rest? How do we and our colleagues cope with many deaths, including deaths of children? How do we manage cares about our own health and family? Do we continue to show up to work, whatever the risks? [7]

In summary, I am not opposed to discussion of the larger ethical dilemmas and issues of potential disasters such as a pandemic. Pastoral care should request a seat at the table, to the degree that this is still an ongoing discussion. However, I would really like to see in these pages some more intense discussion of the down-to-earth questions that might face us, (including chaplains in non-hospital settings), on a daily basis were such a crisis come to pass.

Footnotes:
[1] I would like to thank Chaplain John Ehman for assembling a selection of articles on ethics and mass casualty situations. Go to http://www.ehman.org/panelarticles.html to review.

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