Clergy and Spiritual Leaders

Spiritual comfort during an outbreak of a potentially fatal disease is an issue that deserves some comment. It was specifically raised by a Protestant clergyman, who asked the Commission:

> What is the role of the clergy and spiritual leaders in the health care system of Ontario?

Because the issue is marginal to the Commission's terms of reference and produced only one response, the Commission makes no recommendation other than to say it needs to be addressed by the health system, the chaplaincy community and those it serves.

The clergyman noted that during SARS, clergy were barred from visiting patients in some hospitals, long-term care facilities and nursing homes. One Toronto hospital declared its chaplain non-essential staff during the crisis and sent him home. This was part of the overall attempt to limit SARS exposure and lessen the chances of spreading the virus. Some hospitals did allow clergy visits if precautions were taken, but a clergyman who addressed the Commission complained of inconsistency and different interpretations of rules established by health officials.

He summed up the problem:

> There exists a large percentage of the population for whom religious faith is important. They deserve spiritual care at crisis points in their lives and hospital admission is almost always a crisis point.
>
> While it varied from hospital to hospital, during the recent SARS crisis many clergy were denied access to patients. I want to be clear that when professional clergy visit they do so primarily and almost exclusively to people of faith.

He said that throughout the SARS crisis his parish was prevented from bringing the sacraments to a nursing home. He felt there was no reason why professionally trained

clergy cannot follow the same basic hygienic and infection control practices as doctors and nurses.

The clergyman is not alone in his belief that spiritual care is important to medical care. A study at the University of Pennsylvania shows that 45 per cent of a study group reported that religious beliefs would influence their medical decisions if they become gravely ill.[842]

Some medical practitioners feel that patients and the health system benefit from having clergy involved. A doctor writing in the *New England Journal of Medicine* said:

> Even as we ponder whether or how we should step inside the religious worlds of our patients, we should also ask whether members of the clergy should enter more deeply into our clinical sphere. There is a great imbalance of power between patient and doctor. Often, I have been insensitive to this imbalance and have taken a patient's silence to represent tacit assent to my recommendations.
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> A member of the clergy can speak to a doctor at eye level and act as an advocate for a patient who may be intimidated by a physician and reluctant to question or oppose his or her advice. A priest, a rabbi, or an imam can help patients to determine which clinical options are in concert with their religious imperatives and can give the physician the language with which to address the patient's spiritual needs.[843]

Clergy visits have been part of the hospital system since the beginning. Some hospitals have their own chaplains, whom they pay to provide spiritual care to anyone who desires it. Clergy from outside the institution visit when requested by patients, patients' relatives or staff. They sometimes are asked by a hospital chaplain's service to volunteer to handle spiritual matters many hours a week in certain parts of the institution.

Rules and practices related to clergy visits, however, have become confused and inconsistent, mainly because of privacy concerns. It used to be, and still is the case in some hospitals, that visiting clergy are given access to a patients' list that includes religious

842. Do Patients Want Physicians to Inquire About Their Spiritual or Religious Beliefs If They Become Gravely Ill? *Archives of Internal Medicine;* Vol. 159 No. 15, August 9, 1999.
843. "God at the Bedside", Jerome Groopman, *The New England Journal of Medicine*, March 18, 2004.

denominations. Only clergy who have been pre-screened to ensure they have valid qualifications are allowed to see the list. An Anglican priest, for instance, is allowed to see the Anglican list, then proceeds to a nursing station and asks to visit the Anglican patients whom he or she has noted from the list. The practice, according to this clergyman, is to ask the patient if he or she would like the minister to stay and visit. If the answer is no, then the clergy person leaves:

> They are not attempting to evangelize those who are weak and vulnerable but rather seek to bring comfort and support to people of faith.

The information on religious affiliation used to be collected by hospital admitting staff when patients arrive at the hospital. However, this clergyman told the Commission that very often the question of religious affiliation is not asked. Some staff think that asking for religious affiliation is a privacy issue, but he said the people being asked are free to note their religious tradition, or simply to say they have none.

He added:

> For some reason the staff in the hospitals feel reluctant to put the question, thereby denying patients access to spiritual care. I would like to see a concerted effort by hospital staff to provide this information to community clergy. It's a question that needs to be thoroughly discussed hospital by hospital.

An Anglican chaplain has noted publicly that in at least one Toronto hospital she is now forced to make "cold calls" on patients, walking door to door in the hospital looking for Anglican patients.[844] Sometimes she relies on sympathetic staff to tell her which patients might wish to see her.

A nurse who contracted SARS on the job and was hospitalized raised the issue of patient privacy before the Commission. She complained that while in hospital she felt abandoned, not having been visited by any managerial staff and the chaplain with whom she had worked closely. Later, when she asked the chaplain why he had not contacted her during her illness, he said he tried but hospital managers cited confidentiality concerns and refused to give him a list of names.

844. "Privacy laws force chaplains to make 'cold call'", *The Anglican Journal Canada*, April 2004 (The Anglican Journal).

She added:

> And that was always something that was so special. that the chaplains were always there for the staff. They knew us. They knew what was going on in our lives.

A clergyman writing in the *Anglican Journal* said there is a concern among Ontario's churches that new privacy legislation will limit pastoral care in hospitals. The article said churches have asked for changes that "clearly state that providing basic information to clergy and religious caregivers is not a violation of the Act."[845] and that chaplaincy be included in the definition of health care providers.

The clergyman who contacted the Commission expressed concerns about a climate of fear and mistrust, which had significant impact on the Toronto Asian community. He also noted that part of the SARS crisis occurred at Easter of 2003 and that warnings against large gatherings reduced church attendance. He said:

> Fear is not a positive attitude. Faith can be an antidote to fear. People cut off from their spiritual traditions get unhealthy. People who find faith important find strength that helps them live their lives. We must guard against denying people their religious freedoms.

The Commission notes how one religious group managed to observe quarantine and still bring Easter services to its members. Bukas Loob Sa Diyos (BLD), Roman Catholic charismatic group, had its 500 members quarantined over Easter because of a SARS contact. Although there had been concern that some members might attend church despite the quarantine, the group's leaders arranged to broadcast Easter services over cable TV, and set up home delivery of Communion.

The clergy concerns brought before the Commission raise some sensitive issues that should be addressed. Few people would deny that there is a role for clergy in hospitals in offering spiritual support to those who want it. There are, however, those who resent any religious intrusion on their personal privacy. However, there are no overall policies or protocols that would provide some clarity and consistency to the situation. In order to address this gap, the Commission recommends that the Ministry of Health and Long-Term Care and the Ontario Hospital Association and the chaplaincy community engage in multifaith consultations toward the development of the

845. *The Anglican Journal*, April 2004.

policies and protocols required to address chaplaincy services during an outbreak of an infectious disease. These consultations could address the difficult questions of how to make chaplaincy service available to those who want it, without intruding on the privacy of those who do not.