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Abstract
Over the last twenty years, ethics has been expanding in health care and chaplains comprise one of the key groups that provide ethics consultation services in the German arena of psychiatry. Like all professional actors in the practical arena, chaplains perform their role. Performance happens in relation to others who occupy positions that allow more or less exercise of power. This architecture of relational positioning and territory constitutes the social space. The question is, whether ethics in psychiatry can overcome the determination of positioning within the social space, and if yes: what is the scope of ethics? This article investigates into the role of chaplaincy as ethical agents (in Germany) on the basis of theoretical and empirical studies over the last 10 years. The meaning of social space in the field of psychiatry is explored by taking Pierre Bourdieu's work into account. For illustration, a case study is given.

Key words chaplaincy, ethics, psychiatry, social space

If Ethics in Psychiatry is the Answer - What was the Question?[1] Exploring Social Space and the Role of Clinical Chaplaincy

HELEN KOHLEN

Introduction

> How am I able to follow a rule? If this is not a question about causes, then it is about the justification for my following a rule in the way I do.
>
> If I have exhausted the justification I have reached bedrock, and my spade is turned. Then I am inclined to say: This is simply what I do.[2]

It is a fact that people in their everyday lives and in real space and time generally do not practice the kind of reflection that Wittgenstein points to in his philosophical investigations.[2] People learn social rules in order to successfully perform their roles in a given social order; they are not raised to resist these rules or question this order. According to Pierre Bourdieu,[3] social rules have not really changed over time, but the same ones continue to persist. In his work on Masculine Domination, he is surprised that people more or less accept the rules governing social order and thus reproduce it and relationships of power over and over again.[3] He explains that,

> …the established order, with its relations of domination, its rights and prerogatives, privileges and injustices, ultimately perpetuates itself so easily, apart from a few historical accidents, and […] the most intolerable conditions of existence can so often be perceived as acceptable and even natural".[3p1]

Bourdieu's sociology (1980, 1982, 1997, 2001) is not based on prefabricated assumptions about the social world, but on his observations of how individual members of a society find their place and position and how these positions relate to each other.[3-6] Therefore a social topology is necessary. On the one hand it consists of a place (topos) where a

single human being, a collective actor, or an institution is located as an absolute position within the social world: A is situated in field X in the position Y. It is a powerless position. On the other hand, social topology determines relational place within a social order or organization. The place of A is characterized by its proximity to B, C, and D and its distance to K, L, and M, which hold dominant positions in the field. For Bourdieu, relational localization is crucial since it describes the position that A holds and from which A perceives the field. To illustrate this kind of social topology, according to Bourdieu, one should depict the social world as a multidimensional space which originates from the process of mutual positioning. While physical space is marked by the fact that things are put in order of co-existence, social space is defined by the distinctions of positions.[5] To put it more generally: distinctions and exclusions determine mutual positioning.

This reproduction of an established order accounts, I think, for the hierarchical organization of hospitals, including the psychiatric clinic, to this day. Despite some maneuvering on ethics within the clinical setting over the last 20 years in order allow space for all actors involved in patient care, social rules that determine the hierarchical organization of these institutions continue to persist. Social positions of professional actors are relational and constitute the social space that directs who can exercise more or less power, who can define patient behaviour, and whether or not ethical questions count as something relevant.

Applied ethics in healthcare has been growing as an interdisciplinary enterprise since the 1960s, and in Europe, the field has expanded greatly over the last 15 years.[7] The demand for ethics in healthcare goes back to the bioethics movement in the US, which adopted the tone of the social movements of the 1960s and 1970s with their emphasis on autonomy and rights. The patients' rights movement reflected an increasing distrust of medical authority and was critical of the paternalism that was deeply entrenched within medical encounters.[8] Ethicists are now called upon to serve as expert consultants in numerous legal political, educational, industrial, and health care areas.

Not surprisingly, psychiatric practice has become the focus of growing ethical interest since it has become increasingly understood that psychiatric diagnoses are closely connected to cultural understandings of how people should behave. A diagnosis affects whether or not a particular behaviour is accepted as an individual character trait or is perceived as a deviant psychiatric disorder. Since psychiatric practices basically aim to change people's behaviour--to train "normal" behaviour--they demand the right to intervene into a patient's personality. Questions about patient autonomy and patient needs, as defined by patients themselves or someone in the role of advocate, have been stimulated by an ethical perspective.

An increase in ethical concerns has brought philosophers and theologians, as (bio)-ethics experts, to the health care arena. Chaplains comprise one of the key groups that provide ethics consultation services in the hospital.[9,10] This article will focus on chaplaincy in an attempt to understand the meaning of ethics in psychiatric practice. The questions raised include: what kind of role does clinical chaplaincy play in the hospital arena and what effect does an ethical perspective have on the positions that chaplains occupy (or re-occupy).

This first part of the article that follows will provide an explanation of the concept of social space and the hospital chaplain's position in relation to other professional groups. Part two will provide an overview of the different understandings of the role of chaplaincy. In it I will draw on anthropological and sociological studies,[11-14] but will also include theological discussions.[15,16] Although chaplains have a key role to play in clinical ethics, the literature on their actual practice is rare, especially in psychiatry. Part three will present a case story illustrating the reach of the chaplain's ethical role in practice, and its relational position and its importance in the social space of clinical psychiatry. Although this case study is not representative of all ethical work in clinical psychiatry, it serves to illuminate research on the role of clinical chaplains, especially with regard to their ethical role in psychiatry. Above all, it offers a detailed account on relational positioning and the power of medical definitions. To end, I will critically reflect on the concept of social space and how ethics can (or cannot) provide answers to conflicts in psychiatric practices.

Ethics in the hospital arena

In Germany, nearly every hospital over the last 15 years has developed an instrument to address ethical issues. Basing the Clinical Ethics Committees (CEC) on those established in the US has been the preferred method, since the American model is seen as adequate to deal with ethical training, case discussions, and policy making.[9]

Field studies of ethics in health care have demonstrated the practice of ethics in the hospital arena and how it has been shaped.[9,17] In the clinical setting, ethics deals mainly with questions of decision-making at the end of life. Ethical questions based on principles and with a focus on autonomy

frame these discussions while questions concerning social rules that might have caused the problems the first place are sidelined and dismissed. Studies reveal that structural issues like the hierarchical organisation of the hospital and questions of working conditions are marginalized. Finally, the question of who is or is not authorized to define an ethical problem is never tackled.[9,17]

As Chambliss remarks:

> Talk of 'ethical dilemmas' diverts attention from the structural condition that has produced the problem in the first place. This is naturally in the interest of the status quo and is relatively unthreatening to powerful interests within the hospital. This is why so many hospitals can readily accept an 'ethics committee' and its debates about ethical issues.[17p92-93]

Social space and the position of hospital chaplaincy

Although the notion of space is still neglected, space is considered a basic sociological concept.[18,19] Because the term social space does not tempt one to use metaphors or to assume that space is a purely geographical concept, it is preferable to use words such as territory or location. In Bourdieu's sense, space is not thought of merely as a "container" filled with things, substances, or separate individuals, but rather is itself constituted from the coexistence of and relationships among objects and people, which therefore determines their position relative to each other.[6,3]

When the concept of social space is transferred to the microcosm of the hospital, separate professional actors are positioned in particular ways both to one another as well as to patients and their families. This relative positioning also holds true for medical devices, especially in intensive care units. Each position is therefore determined or relationally defined by its relation to other positions. The position of the hospital chaplain is determined by his or her closeness to patients and their families as well as by the social proximity to the senior physician and the head nurse. The dominant position of hospital physicians has been determined by the relatively weaker positions of chaplains and nurses within this space.[5]

Relational analysis is useful to capture both the formation and the interactive determination of significant differences.[5] The relational position of hospital chaplains within the institutional social space influences clinical practice. Chaplains' responsibilities originate in this social space from mutual positioning, associated role ascriptions, and transfers of responsibility, as well as the withdrawal, relief, or revocation of these responsibilities. In sum, mutual position reference is the only way that separate individuals can be connected within social space. If social space therefore gains shape through a mutual determination of social position, what constitutes social positions?

The social norms that are bound to a social position affect the individual, emerging as behavioral expectations that cannot be withdrawn from without punishment.[5,6] Consequently, a directive exists to arrange each position--a kind of script determines the social role that has to be played. In the field of health and disease, and especially in a hospital setting, a physician's position is associated with an expectation to cure, while a caring role is attributed to other actors (nursing, social work, and hospital chaplaincy). While the curing role is associated with knowledge of technology, the so-called hard skills, the caring role often requires the use of "soft skills". Those with a stronger claim to the use of hard skills, however, enjoy higher prestige.[5] The position of surgeons, for example, is a higher status that that of physicians involved in geriatrics, for example, which is associated with both curing and caring roles. Because the caring role is so strongly attributed to both chaplains and nurses, they are thus seen to have a less prestigious status.

Perspectives on the role of clinical chaplaincy and the psychiatric field

To understand a chaplain's perspective on ethical conflicts requires both a historical perspective on and a current knowledge of practice.Chaplaincy has long been linked to the Christian church, and chaplains have been drawn from its priests and ministers.

> While the history of the terms chaplain and chaplaincy suggest that ordained clergy are attached to a chapel, such as a hospital chapel, in many settings the majority of healthcare chaplains are not ordained clergy.[20p10]

However, chaplaincy has been affected by new understandings of the relationships between spirituality and institutional religion.

The role of the chaplain in the modern-day hospital is diverse and challenging. Kevin Franz explains that in responding to the needs of individuals in the modern healthcare system, chaplaincy has brought a distinctive knowledge base and set of skills that are integral to understandings of care.[21] While physicians might limit their perspective on patients to physical findings of measurable data, chaplains look for

the person behind the symptoms of a disease, diagnosis, or therapy.

Chaplains as ambivalent figures

Nonetheless, in her ethnographic study, Norwood comes to the conclusion that the role of the chaplain is an ambivalent one.[13] Her observations of their everyday practices in modern-day hospitals reveal how chaplains negotiate both structural and ideological marginality. At times they embrace their connection to medicine and at other times they embrace their connection to religion and religious practices. For her "the result is an ambivalent chaplain who strategically embraces one or the other paradigm in order to survive".[13p1] The presence of marginalized practices is not unique but a regular occurrence within the hospital setting. And although a range of activities from the sacred to the profane situates chaplains somewhat precariously between competing paradigms of science and religion, the role is not without agency.[p3] As Norwood's study demonstrates, "the margins are active, dynamic, and contested grounds where agents negotiate for power and for place".[13p25]

Chaplains as translators and possible trouble-makers

Hospital chaplains work with patients primarily by talking and listening.[15p184] They seek to understand what it means to be a human confronted with a disease or imminent death, and what consequences personal relationships can have on dealing with that situation. Consequently, hospital chaplains often describe their job as a form of *translation work* between patients' lived-in worlds and their hospital worlds.[11] Although it is usually interpreters who work with words and translators with texts, chaplains use this metaphor to point out that for them, it is more about trying to comprehend the underlying nature of what patients really want to say when they speak (or do not speak) about something. Hospital chaplains do not view the meanings of statements and silences as being isolated from patients' backgrounds and lived experiences, but rather, they always endeavor to understand the context. Hille Haker is convinced that the most important part of a hospital chaplain's work consists of interpreting the stories that he or she hears.[15p185] Hospital chaplains thus have the capacity and resources to render their patients' social worlds accessible, and to understand and speak the language belonging to it.

While these authors agree that hospital chaplaincy fills a gap in patient care, they also contend that a chaplain's work is not a clearly defined service. In his sociological-empirical research project, Raymond de Vries studied the role of chaplaincy in healthcare, and in 2008, he and his co-authors drew attention to the fact that hospital chaplains should consider how best to translate the meaning and value of their work into a language that hospital administration could understand.[11] They pointed out that in order to be perceived as a profession, an occupational group has to define a clear boundary of its work.

Doris Nauer understands the role of chaplaincy as one of advocacy on behalf of patients who might otherwise be incapable of acting for themselves.[16p232] In her sociologically oriented concept of diaconal chaplaincy, hospital chaplains do not limit their activity to focusing solely on patients' needs and sufferings but also address problems patients might have with hospital staff and management. For her, authentic chaplaincy means that chaplains deal with the hospital system and its structures in a constructivist-critical way, intervening, for example, in cases of what they perceive as unfair—when people in powerful positions define patient behavior as abnormal without knowing the particular patient well while people in less powerful positions do not have a say about treatment despite their concrete knowledge of the patient. Nauer's claims are situated within the German context where chaplains working in the hospital are not necessarily paid by the hospital but by the church, and can thus work more independently.[16] This independence allows chaplains to shift into the field of (institutional) politics by claiming that they will not shy away from conflicts and questions regarding preexisting institutional hegemonic structures. However, by actively resisting the social rules of the hospital system, chaplains can be understood as "trouble-makers".

Chaplains as ethical authority figures

The same services and rituals found in the traditional religious role of chaplains are also performed in psychiatry, although since patients do not die in psychiatric facilities on a regular basis, chaplains there rarely address grief and end-of-life issues.[12] Mary Strachan Scriver (2006) states that "… ideally, a chaplain would hold ethical and emotional authority equal to the substantial power of doctors".[22p454] She believes that the chaplain's religious concerns should be directed towards "justice, protection, and the sustenance of hope for both doctors and patients".[22p454] Gwendolin Wanderer picked up this idea as a starting point for her research in the field of psychiatry, when she investigated the potential for chaplains to become ethical and emotional authority figures.[14] In her in-depth interviews with chaplains on

their working conditions in German psychiatric hospitals, she focussed on ethical issues and the roles that they considered crucial.[14p297] The interviews revealed that patients on psychiatric wards basically have a greater interest in talking to chaplains when compared with those on non-psychiatric wards.[14p299] Nearly all of the interviewees considered religious services--the traditional roles of chaplaincy in conducting worship, performing religious rituals, and leading prayer--to be very important.[p301] When psychiatric hospital chaplains were asked about their ethical role, however, they were rather ambivalent. While some clearly identified with the role of a patient's advocate or guardian, others were not convinced and would even deflect any kind of ethical responsibility for psychiatric patients. They described structural institutional problems to be of high relevance for their work, but felt unable to influence change. None of the chaplains considered writing letters to people in positions of management to be fruitful. They also considered their time spent in committees to be irrelevant in making the institution a better place for both staff and patients.[p303] When they were asked what they would immediately change in psychiatric hospitals if they could, nearly all of them said:

> … that in the treatment of the mentally ill [there is] too much focus on psychopharmacology … many illnesses or symptoms could be better healed in therapy including conversation and individual care for patients, which unfortunately seems to be reduced as a result of cuts in the public health services' budget. [14p303]

In the chaplains' experiences, physicians very rarely asked for consultation, rejecting the idea of teamwork.[p304] Most important to all chaplains was their ability to spend time with patients.[p306]

According to Wanderers' study, chaplains played only a marginal role as ethics consultants in psychiatric clinics. The interviews demonstrated that chaplains were very much aware of having to walk a fine line between criticizing members of the treatment team on the one hand, and being responsible to their mentally ill patients on the other. The findings from this study complement another investigation into the views of hospital directors on the importance of various roles in the clinical setting.[12] Here the research team discovered that the administrators accepted the chaplain as ethical consultant to some degree, but that social workers and physicians were less willing to see them in this role. And while the administrators identified patient safety to be a job for everyone, chaplains were not yet fully integrated into the team.[12p222-4]

Kevin Franz, in writing about the role of chaplaincy in psychiatry, argued that "the 'place' of the chaplain is one which takes its character not from the institution but from the task: the spiritual care offered both to individuals and to the institution, from a place which may be described as 'marginal' or 'counter-cultural'".[21p124] According to him, an important question to ask is: "As they seek to be regarded as fellow professionals by others, and as they are properly accountable within the structures of health service, do they become 'insiders', part of the establishment, distinct from the person they seek to accompany?"[21p126]

The case story of "Kabila's dogs in Germany"

This case study is taken from a collection of written narratives by chaplains who were participating in an advanced class (2009-2010) at the Goethe University of Frankfurt. All students in the class were asked to contribute a story based on their clinical experience as ethical consultants.[2][23] The following, slightly abbreviated story refers to one chaplain's experience in a psychiatric setting.[3][24]

Patient information

This situation takes place in a rural German hospital for mentally ill people. Around 5 p.m., Dr. Mitterer[4], the senior physician in general psychiatry, calls me on the emergency mobile phone. She explains that she is worried about a patient from South Africa. She tells me quickly that the patient, Mr. Lumbado, is a Catholic priest, is 55 years old, was born in Southwest Africa, and has been working for approximately 10 months as a chaplain in village A. She explains that from a medical point of view, it is totally unclear what is wrong with him. The previous night, under "dubious and unclear" circumstances, Father Lumbado was delivered by police, handcuffed, from the county hospital 30 km away. He was very distrustful and appeared strange: "Just moved the mattress from the bed to the ground just like that." Dr. Mitterer emphasizes that under orders from her boss, Father Lumbado was not to leave the hospital before the middle of the following week. When I ask why, Dr. Mitterer answers that "the previous night at the county hospital, the patient took off his clothes and barricaded himself in his room". For the sake of gaining his confidence, Dr. Mitterer asks me to establish contact with him as soon as possible. She herself was about to leave for an off-duty weekend.

Encountering the patient

I visit the ward to see Father Lumbado. In the ward office, medical director Professor Dr. Schön approaches me, confirms the senior physician's information and impressions,

and mentions that the patient might not be truly mentally ill because his diabetes is out of order. Nevertheless, according to Dr. Schön's impressions, the priest is scared and not oriented. Dr. Schön asks me to build up the patient's confidence and to try to make him stay voluntarily at least. I ask him whether Father Lumbado has spoken about suicide or acted aggressively. He answers that anything is possible, because he was violent with the police.

At this time, no contact information for the patient's family, friends, or colleagues is available. The conversation with the medical director ends with reference to the senior physician, Dr. Baier, who was Catholic himself, and was on duty and aware of the situation.

Father Lumbado is located in a single room. After greetings and introductions, the first contact between the priest and me, he remains silent. He is sitting on his bed, arms crossed, looking at me emptily. He rises, takes the mattress off the bed frame, puts it on the ground, sits down on it, and says with a firm voice, "Please leave and come back tomorrow." The atmosphere is frosty and oppressive and filled with distrust. I can clearly sense that any additional word might violate Father Lumbado's boundaries and his need for protection. I understand that any additional attempt to communicate would be neither helpful nor reasonable at this time. I promise to visit him again but he answers only with a nod to my "goodbye".

Inwardly, this short first encounter with Father Lumbado bothered me a lot. His name isn't shown in the patient register where it should be. The whole situation seems suspicious, and I wonder: What does it mean to each of us in this psychiatric context when we are both "pastoral colleagues"-- with him in the role of a patient and me as a professional chaplain and ethics consultant? Is he willing to have contact with me at all? What has to be considered about his cultural origins? Are there political issues to be considered? Is he afraid of the German system?

Saturday afternoon, the nurse describes an obvious improvement in Father Lumbado's condition compared to the early morning. She describes his mood as relaxed and easygoing. She states: "Father Lumbado is talkative, funny, interested in a variety of topics, speaking German fluently. However, he stayed awake all night and refuses food and drinks only very little." I also am aware that this poses a medical problem for his diabetes. Any sedatives he strictly refuses. However, his condition deteriorated approximately one hour ago. He does not want to leave his room anymore. The senior physician, Dr. Baier, is notified--hoping for clarification and improvement with my help.

As I enter the room, Father Lumbado claps his hands, telling me that in his home country, friends are greeted that way. He calls me a friend because I am visiting him on a Saturday. His eyes shine, he smiles. His bed is messy, crumpled papers are scattered throughout the room. He offers me a chair, asks whether I have got time since he desperately needs to talk to me. He starts the conversation by telling me that we are both full-time Christians. He explains his observations about parallels: similar oppressive mechanisms of the male church against women, devaluation of women and black people. He talks about the war between rebel groups in his home country, about grave human rights violations, about using systematic violence against women as a weapon of war. The tempo and volume of his speech increases. He talks about rage and experiences of powerlessness. He doesn't accept my inquiries, gives testy replies, and requests that I should listen quietly. He continually tells me: "My soul is screaming! They came to get me--brought me here in handcuffs. Kabila's dogs in Germany, too. With drugs you beat me--but to no avail. Jesus is the victor!" He repeats these sentences with a fading voice.

Senior physician Dr. Baier enters the scene. Right away, Father Lumbado asks me to leave and to administer Communion on Sunday. Later, I meet Dr. Baier in the ward office. He intends to transfer the patient to a secure ward because he won't take tranquillizers (diazepam). He doesn't comment on the nurse's observation that, in the early morning, Father Lumbado was in better general condition. He also doesn't respond to me when I point out that he has suffered terror in his home country, and that his state of excitement could stem from a re-traumatization by the night time police operation he had to suffer. Dr. Baier interprets Father Lumbado's statements in the context of a psychosis. He emphasizes that it is imperative that the patient take medications.

A discussion arises concerning the patient's anxieties regarding his past experiences of violence and his current experiences at the clinic. For Dr. Baier, pharmacological treatment has priority. He emphasizes that it is he alone who is fully responsible for the patient's well-being. He overlooks the fact that I do not share his diagnosis of delusion and that ethical questions have to be raised before coming to a quick medical solution. For the first time since my collaboration with Dr. Baier, I fully realize the different ways of thinking, feeling, and reasoning of the two professions we are in.

Refusal of medication and its consequences

In the private ward office, the nurse informs me that Father Lumbado, after consultation with Dr. Baier and at the behest of the physician on duty, has been transferred to the secure ward. The reasons mentioned were: barricading himself in his room, refusal of any medication or food, and loud praying.

On the secure ward, the nurse in charge informs me that things escalated during the morning. Father Lumbado again refused taking any psychotropic medication. Moreover, he rejected any offer to talk. It was noticed that he was less dismissive of female staff. Nursing staff decided that Mrs. Ruffing should be his primary nurse.

Mrs. Ruffing accompanies me to his room. Father Lumbado sits on his blanket, fixating on ties hanging from his bed. When opening the door, he says aloud, "Stop, no further!" When seeing me behind Mrs. Ruffing, he calls out, "Finally, finally. I won't survive this. Are you bringing Communion?" Nurse Ruffing leaves the room, saying to call her in case anything happens. The priest starts reciting prayers in Latin and French as well as in a presumably African language, all very low-voiced and quickly. I remain silent, then recite the Our Father in Latin and hand him the Communion Plate. No eye contact on his part, not a word, nothing. After receiving Communion, he says the Magnificat in Latin aloud again, followed by a determined, "Jesus lives--so do I!" He intones a Hallelujah, claps his hands, establishes eye contact, gives thanks, addresses me by my name, and with a tired look approaches me. He emphasizes how thankful he is for my coming as well as for the Communion. He also says that he will be able to feel himself again and that no one can bring him to his knees.

Eventually we begin to talk. He talks delightedly of his church's Sunday services "with African charm". He also tells of the rivalry between Dean Altmeyer and him, of racist devaluations he is also encountering with senior physician Baier, although he refuses my request to explain. He is afraid that he'd have to bear the cost, and besides, he is not willing to stay here for long. Communion has given him the strength to tear it all down, the whole ward. I tell him that I am worried about him and the other patients. He points out that he would not harm a fly. His mood ranges from being intimidated and scared, to being boastful and aggressive. He asks me whether I knew what it meant to live as a black person among white people. He talks about "black theology", the meaning of oppression and resistance. He declares that his forefathers would protect him, and states that we Europeans have no idea about the African faith in Christ. However, women might understand.

The keyword "woman" makes him pause in his monologue. He asks me about my family situation and mentions his nephew living 150 km away. I offer to telephone his nephew about his stay at the clinic, and he gives me his number. He calms down, and the fear and aggression wear off. He lies down on his bed, saying that he feels better, assuring me that I could leave and shouldn't worry. With the promise to visit him again the next day, I say goodbye.

In the office, I meet Dr. Baier, who has requested to see a judge to begin the procedures to involuntarily confine the patient and start compulsory treatment. According to his assessment, the patient is suffering from absurd racist delusions and needs medication instantly. My pointing out the ethical aspects that work against justifying his decision is ignored by him and we become involved in a controversial discussion concerning religious mania and the experience of faith in other contexts. A medical emergency call for Dr. Baier abruptly ends the conversation.

In the late afternoon, the primary nurse informs me that Father Lumbado's condition has deteriorated. By the time I arrive, Dr. Baier and six nurses are in the office. Dr. Baier states that Father Lumbado is in an extreme state of excitement, needing a sedative shot right away. He has been refusing everything, blares out threats, wanting only to talk to me. Dr. Baier advises against this. Based on this morning's experiences, I suggest visiting him to see if I can make some kind of connection and get him calmed down. Dr. Baier agrees, but points out that he and the crisis intervention team don't have all the time in the world.

As I enter, Father Lumbado is alone in his room. He seems anxious, threatening to set the ward on fire. We discuss the situation and he states clearly that he refuses psychotropic drugs. He is not ill, not psychotic; rather, he feels homeless and all alone. He describes his situation as "deracination". His aggression turns into sadness, he has tears in his eyes. Then he talks about his mother and siblings, asks about his nephew whom I have not yet been able to reach. The situation is noticeably becoming more relaxed.

Twenty minutes later, Dr. Baier, holding a syringe and accompanied by four nurses, enters the room. Father Lumbado starts shivering. I ask Dr. Baier for an ethical counseling session. He agrees, and we leave the room. I inform Dr. Baier about the course of events during this most recent contact, referring to my experiences in relaxing Father Lombado and to the opportunities that his good relationship with his nephew might provide. I also point out that his ability to express

himself clearly is important from an ethical perspective. Finally, I request more time to continue a peaceful dialogue to prevent violence. The term violence causes vigorous outrage in Dr. Baier, who refers to his medical obligation to act, saying that the patient does not understand his disease and that he has to be cooperative. After all, in his condition, according to Dr. Baier, he is unable to make autonomous decisions. Thus, there is a need for action. He emphasizes that the "fixation team" had been waiting for more than 35 minutes already. I try to explain my point of view and my ethical concerns from a chaplain's perspective. I question the time pressure for the decision on treatment since Father Lumbado is not in any life-threatening condition. I mention the patient's state of excitement that would be reinforced by medical intervention. I explain that from an ethical point of view, a violent medical intervention denies the patient's right of self-determination and discretionary competence. Dr. Baier disagrees, explaining that poor discretionary competence is a symptom of the patient's disease. He does not offer a verified diagnosis. Although I notice the contradictions to an ethical manoeuvre, I do not inquire any more and try to make sure that the nurses' perspectives are considered.

Dr. Baier refuses any assessment by nursing staff, especially by the primary nurse. He leaves unanswered the question of what the medical consequences would be of not administering the injection. He tells us that he now has to do his job as a doctor and ends the discussion. He asks me to leave the patient alone for the rest of the day. He leaves the office, briefly speaks to the nurses, and two accompany him to the patient's room. "Too bad. Here comes another trauma for the patient", Mrs. Ruffing, the primary nurse, comments on the scene. I feel impotent, furious, and exhausted.

Asking for an ethical case review

On the following day I asked for an interdisciplinary team meeting to suggest an ethical reflection on what had happened and what could have happened differently. Professor Schön explains that Dr. Baier did not have any other choice in his actions. I receive no response to my request for an ethical reflection on the situation. When I finally contact Father Lumbado's nephew, he tells me that his uncle has had traumatic war experiences and that he has been feeling upset for a long time.

Interpretation of the case story

In this section I take a closer look at the conflicts, how they are defined and by whom, and of the kinds of responses they elicited. In so doing, I will shed light on the role of the chaplain and the place she (re-)occupies.

At the very beginning, the female hospital chaplain in this story notices that the psychiatric hospital is located in a rural area. Patients who are immigrants, however, are rarely treated in rural German hospitals.

Patient information: Missing context and trust-building as an order

Via an emergency mobile phone, the senior physician in the general psychiatric department passed on the little information known about Father Lumbado to the chaplain. He does not, however, provide any background context. And although it is later admitted that the patient's fear may be attributable to his diabetic condition, and that he might not indeed be mentally ill, this lead is not pursued and an appropriate diagnosis of exclusion is not made.

The physician ordered the chaplain to get in contact with the patient straight away, specifically charging her to initiate measures to build the patient's confidence. The doctor wanted to ensure that the priest remained voluntarily, which would allow him to avoid a holding order. Confidence building is expected to be a readily available service provided by hospital chaplains, delegated because no one else is available.

Encountering the patient: Interruptions, different behavior definitions and perspectives

On her first encounter with Father Lumbado, the chaplain realizes through his body language that he clearly rejects her, and as a result, she removes herself from the situation. Nonetheless, she is worried about his behavior and begins to reflect on his status as a priest and what it means to him --a male priest in a patient's role. She also begins to wonder what experiences could have led Father Lumbado to act the way he did and considers the possibility that he had to protect himself in his home country for political reasons. She also figures that he might feel threatened by the "German system". With all of these questions, she is searching for the context of his behavior as well as for the person behind the unsupported psychiatric diagnosis. When she returns the following day, the priest begins to think of her as a friend, and over the course of their meeting, she proves to be a patient and mindful listener, learning that the factors of gender and power play a role in his life.

For the physician, however, pharmacologic treatment had priority. Although the chaplain pointed out that Father Lumbado had suffered terror in his home country, and that his state of excitement could be interpreted as a re-

traumatization by the night time police operation, Dr Baier derided the hospital chaplain's attempts to explain the patient's delusions. Only then does the chaplain realize the differing perspectives between the medical practice of psychiatry and pastoral care, and she asks herself how best to communicate her thoughts that were in conflict with the psychiatrist's order.

Refusal of medication and consequences: Violence as an answer

Eventually, the nurse in charge explains that the priest has barricaded himself in his room, refusing to take any medication or food, praying loudly and threatening people, and the senior physician transfers him to the secure ward. Still, Father Lumbado refuses to take psychotropic medication, remains strictly unapproachable, and refuses offers of talks. It is observed that he is less wary with female nursing staff as well as with the female hospital chaplain, whom he thankfully welcomes. Although he briefly mentions the senior physician's racist devaluations, the chaplain believes that he does not mention details for fear of negative consequences. The patient's mood swings between fear and aggression but he begins to calm down when the subject of family issues and women comes up. The chaplain does not make any more attempts to reassert her observations with respect to the senior physician's therapeutic intentions.

In the meantime, the senior physician has organized an involuntary commitment and has requested a judge. He attributes Father Lumbado's behaviour to "absurd" racist delusions that require medical treatment. Although the patient adamantly refuses psychotropic drugs, a "team" uses force to immobilize him.

Asking for ethical case review: No comment

The hospital chaplain's request to hold a retrospective ethical case review is not taken seriously by the medical director and instead, she was told that there had been no alternative to the way that the physician had handled the case. As the dominant member of the social space in the hierarchical organization of the hospital, the psychiatrist holds on to his position. He thinks that he knows best how to handle the resistant behavior of the patient and does not question the use of physical force to break the patient's will. The chaplain, however, is more concerned with building trust through dialogue with the patient and attempting to understand how his behaviour is connected with his background history. The psychiatrist cannot see any positive outcomes to the chaplain's proposed plan of action and the institutional structure of the hospital allows him to hold on to his powerful position and to define what is right and wrong without giving space to the chaplain's perspective on the situation.

Summarizing analysis

Metaphorically speaking, the role of chaplain runs along a "side track" of the medical practice of psychiatry. In this case, the chaplain's translation work and conversations with the patient operate beside the physician's decisions--they are tolerated but not integrated. The chaplain views the decisions of the senior physician as a form of power of institutional authority--his orders had to be obeyed. The chaplain thus finds herself caught between the requirements of the psychiatric institution for a pharmacological solution to the situation, and her patient's wish to not take any drugs. This question motivates thinking about the power of psychiatry: the psychiatric diagnosis is perceived as the "truth" about the patient's state of health, and overrules the assessments made by the chaplain and the patient himself about his condition. As the chaplain put it, her perception of what the patient did or did not want, to what extent his self-determination had to be respected, and to what extent compliance with his wishes might have caused harm, had no room within the "institutional requirements" and "psychiatric professionalism".

No discussion about treatment among the parties involved took place beyond the "necessity" of administering the psychotropic drugs. A recognition of the dialogue between the patient and the chaplain, as well as her translation work, was not included in the therapeutic approach. Psychiatry reinforced its position as part of academic medicine, and the psychiatrist's pharmaceutical knowledge, even though used to treat unclearly diagnosed illness, was viewed as professionalism. There was no provision for another perspective or for an alternate method of treatment. The patient's anger at his situation was answered with force.

In the organization of psychiatric practice, team meetings that would allow members to enhance knowledge about patients by incorporating the differing perspectives of all the professionals involved do not exist. In this account, the chaplain's contribution to decisions about the patient remains irrelevant, even if it was heard, leading to feelings of powerlessness She eventually gives up, tacitly accepting what is perceived as an inferior social position dominated by physicians--and her expertise in ethics does not make any difference.

Final remarks

At the concrete level of interaction in psychiatric hospitals, the positions and different kinds of perspectives of the professional actors involved in the institution, like clinical chaplains and psychiatrists, are in powerful competition especially when the subject of ethics comes into play. In the case story presented here, the chaplain attempted to bring about alternatives to pharmacological treatment. The psychiatrist accepted the work of the chaplain to a certain extent, but did not integrate the perspectives of either her or the nurses into his medical decision-making.

Finally, the actors in the field re-occupy a certain social space to exercise power within the limits and the scope of their position. Chaplains, especially as ethics counsellors, have begun to address the problems noted in this paper by interdisciplinary manoeuvres in ethics. In this case study, however, we found no teamwork or joint decision-making processes in this psychiatric practice. The viewpoint of the chaplain may have been consulted, but her considerations on the problem had no impact on the outcome.

In light of my analysis I believe that questions of ethics can barely challenge a hierarchical hospital social structure that works to keep the status quo. Physicians practice according to the dominant medical model of diagnosis and treatment. The issue of ethics, with its focus on respect for autonomy, challenges this practice by illuminating and supporting the validity of individual actions and reactions. Thus, from a critical ethical perspective that considers issues of power and social space, psychiatry has not yet left room for the sick individual to be considered an agent capable of intentional action.

Notes

[1]I borrowed the idea of putting the title in this kind of question from Sarah Sexton (1999): If Cloning is the Answer, What was the Question? Sara Sexton.

[2]I thank the publisher (LIT) for the permission to reprint the case story.

[3]Translation from German into English by Irina Stivaktakis and Helen Kohlen.

[4]All names are fictitious and places have been abbreviated with letters.

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Contact Information for Author:
Helen Kohlen, Ph.D.
Philosophical-Theological University of Vallendar
Pallottistr. 3, 56179 Vallendar
Germany
Email: hkohlen@pthv.de