Application and adaptation of Symphonology Bioethical Theory (SBT) in pastoral care practice

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Abstract

In an environment which is ethically and from a human rights point of view overly sensitive and in which interculturism is becoming more and more a norm, pastoral care practitioners need to be committed to providing services that are ethical, intercultural and respecting. patients' rights. This article demonstrates how application of the Symphonology Bioethical Theory (SBT) as the framework for practice in pastoral care and counselling can help Pastoral Care Practitioners (PCP) to be ethical while upholding patients' human rights, and it can also help to bridge the intercultural chasm while simultaneously explaining the rationale for the practice. Symphonology is a context-driven, ethical decision-making model guiding holistic interaction between patients and PCPs. The Symphonological decision-making matrix is based on a practitioner-patient agreement for pastoral care that emphasizes patient preferences, pastoral psychological and theological knowledge, the pastoral care content and the context of the situation. The goal of the PCP is to ethically incarnate the divine presence and thus to bring about hope and emancipation to the patient using the bioethical standards of autonomy, freedom, objectivity, self-assertion, benevolence and fidelity.

1. INTRODUCTION

"Can the two walk (work) together unless they are *in agreement?*" (Am 3:3, paraphrased). Implicit in this question, is that for people to work together effectively, they need to have an agreement (Latin *symphonia*) as the foundation for their collaboration to succeed. This article explores the nature of agreements in pastoral care and counselling between a pastoral care

practitioner (PCP)[1] and a patient/counselee in diverse clinical settings. In a PCP-patient relationship, how can an agreement that is ethical and patient rights-respecting be established? Agreement is often taken for granted in such relationships; although many approaches to pastoral care and counselling have been proposed and studied, the SBT has yet to be applied to pastoral care and counselling. A lack of clear guidelines, expectations and understanding relating to the cause of action to be taken often leads to the trumping of patients' human rights. Whereas professional bodies such as the *American Association of Pastoral Counsellors* (AAPC) and the *Association of Professional Chaplains* (APC)[2] have *general* professional ethical guidelines regulating the professional conduct of their respective professionals, they often lack the necessary specification.

While I contend that the Symphonology Bioethical Theory (SBT) provides this necessary specification in specific pastoral care practitioner-patient/counselee encounters, I also argue that by relating to the patient through the SBT approach, the PCP would be acting not only as an effective agent for both a patient and God, but can also bring respect and an ethical dimension into the PCP-patient/counselee relationship. The SBT approach encapsulates not only what the pastoral care is about, namely living out one's faith in the midst and context of the other's pain and suffering. It also prescribes what is necessary in forming an agreement to enter into such a relationship where a PCP participates in another's subjective world of pain and suffering. It further rids pastoral care practice of overly paternalistic stance.

PCPs are often called upon to help patients and families in making life and death decisions. This is because they are perceived to be not only God's representatives, but also to be closer to God; and therefore the *perception* is that God heeds their prayers more than those of other people.[3] Unfortunately, this perception may give some PCPs the impression that they have a special

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[1] While a distinction is often made between pastoral care and pastoral counselling, PCP as used here incorporates functions of both; pastoral counselling is a dimension of pastoral care. PCP is further understood here as an umbrella term for religious oriented health care professionals offering spiritual counselling and support in a professional clinical setting. The term therefore covers duly trained chaplains, clergy and others so trained.

[2] I am formally a certified member of the APC as BCC (Board Certified Chaplain); also see www.professionalchaplains.org for such ethical guidelines.

[3] See for example the North Carolina Army National Guard recruitment promotional advert which reads: "… Chaplain corps bringing God closer to the soldier and the soldier closer to God", available at http://www.nc.ngb.army.mil/recruiting/documents/ChaplainFlyer.doc, (accessed 16 May, 2007); see also See Sarah Funke "God's representatives: a new look at *imago Dei*" available at http://www.bagpipeonline.com/index.php?path=/archives/000200.php, (accessed 16 May, 2007).

and unique access to God. As a result, they may misapply themselves by reinforcing this perception in the manner and attitude in which they relate to patients. [4] Biblically and ontologically, they do not occupy any place of significance better than that of a patient, for we are all *equally* made in the image and likeness of one God.

2. LITERATURE REVIEW

The Symphonology Bioethical Theory was developed by Husted and Husted (2001), particularly for application in nursing. Although the theory is steadily gaining ascendancy and currency in nursing, it has yet to make inroads into other related disciplines such as pastoral care and counselling. There are however, a number of works worth mentioning, that, although not addressing the SBT, will nevertheless help elucidate this subject. These, among others, include Patton (2005), Sperry (2001), Purves (2004) and Lynch (1999). All these books address the pastoral relationship in some way. Patton puts more emphasis on the "pastoral presence" and its many shades. In addition, many authors on narrative approaches have restored "patients' voices." All these authors, however, have one thing in common: they do not address the topic of concern in this article: agreement in pastoral care and counselling.

3. SYMPHONOLOGY BIOETHICAL THEORY

The key word in defining Symphonology Bioethical Theory is *agreement*. Husted and Husted (2001:xviii) define symphonology (from the Greek word, *symphonia*, meaning agreement) as:

> the study of agreements in the health care arena between health care professionals and patients. It is a study of the ethical implications of the health care professional/patient agreement … [it] is … a practice-based ethic appropriate to people practicing as professionals. It is a set of standards of behaviour, preconditions necessary to agreement and professional interaction, requiring contextual understanding and application for ideal interactions in the health care setting.

3.1 The basis for Symphonology Bioethical Theory

Symphonology is based on the supposition that, for a proper human progress and collaboration, agreement must exist between all rational beings.

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[4] Incidentally, the terms "patience" and "patient" are both derived from the Latin word that means to suffer or to endure and from which the term "compassion" is also derived (Patridge 1966:475). As such, by extension, all PCPs are also patients. A PCP self-knowledge as a patient "helps generate compassion and patience" (Patton 2005:62).

> Symphonology is a system of interpersonal ethics based on the terms and preconditions of an agreement. In the health care setting this is the agreement that establishes the nature of the relationship between a patient and a health care practitioner (such as PCP). Ethical and professional responsibilities are set by this relationship. Ethical responsibilities centre on the situation of a patient, a professional's understanding of the demands of effective interaction, and the nature of the human values a professional can bring to their relationship.
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> (Husted & Husted 2001).

SBT establishes a perspective from which both a professional and a patient can perceive and understand each other and direct the manner in which they interact with each other. Ethical decisions in health care profoundly affect the lives of people and as such SBT has certain principles, called bioethical standards, that structure, guide and define the professional-patient agreement. There are six such principles or standards:

- autonomy
- freedom
- objectivity
- self-assertion
- beneficence and
- fidelity

The adapted symphonological decision-making matrix is based on a PCP-patient agreement that emphasises patient preferences, PCP knowledge and the context of the situation, constructs that are integral to evidence-based practice. This is anchored by the content of pastoral care (the reality of God: the story of His involvement with us *and* the reality of humanity: the story of a personal history which all meet in the pastoral care situation (De Jongh van Arkel 2000:40).

3.2 The rationale for Symphonology Bioethical Theory in pastoral care

At least three rationales for the application of the SBT in pastoral care profession are advanced. Firstly, daily life demands major choices and decisions in general, but in particular, in a clinical setting, choices and

decisions are often matters of life and death. Agreements (*symphoniae,* singular: *symphonia*) must be foundational to these choices and decisions. Secondly, the SBT could serve as the pastoral care framework for situating pastoral care practice within the framework of bioethical standards. In the South African and the African context, where professional pastoral ministry has, for many years, been dominated by Western ideologies and views of the *other*, in which the other is often conceived both as inferior and different, the SBT serves as a corrective orientation that not only restores human dignity but also elevates the other to the same level. Thirdly, the SBT standards can serve to operationalise the "cultural engagement"[5] approach, especially in diverse cultural situations. "Engagement" is the key here; it is a reciprocal process of communication and dialogue in which one individual's values and expectations, especially regarding health and religious beliefs are freely made explicit to the other individual, thus promoting common understanding.

Geertz (1973:89) describes culture as "a historically transmitted pattern of meanings embodied in symbols … by means of which men (sic) communicate, perpetuate, and develop their knowledge about and attitudes toward life." Although ideally both the PCP and the patient should understand each other's culture, with the proper application of the SBT standards, the PCP will be exhibiting cultural understanding skills.

4. EXPLICATION OF A PASTORAL CARE PRACTITIONER

A PCP could be defined as both an agent and a catalyst. She/he is an agent of both God and a patient at the same time. As a patient's agent, a PCP represents the desires and the yearnings of a patient to God and, in a limited sense, to the community as well; she/he attends primarily to the spiritual well being of a patient, and attempts to walk alongside the patient, helping the patient to reconnect with the divine. She/he is a "spiritual healer[6]." When a believer is well, the locus of the believer's encounter with God are often the scriptures, sacraments, church attendance, et cetera. Upon becoming a patient, a believer may no longer be able to do and participate in these things and one's perception of encounter with God is disrupted as one begins to question the role of God in all this. During the time of extended illness and suffering, some people's faith in the God who heals is radically challenged; they vacillate between believing in the healing God and the God who may not

[5] For a definition of cultural engagement, see Michele Carter and Graig Klugman's (2001) "Cultural engagement in clinical ethics: A model for ethics consultation" *Cambridge Quarterly of Healthcare Ethics*, 10:16-33.

[6] Spiritual healing, as envisioned here, differs from the usage by the Christian science; as used here, it focuses on a deeper meaning of illness and/or suffering and how a patient can work/exist within that meaning. In reality only God can heal, but a PCP, as a spiritual healer creates a mutual context in which healing can take place.

be so healing. This could lead to resorting to some deistic worldview of God, in which God is indifferent to one's pain and suffering and/or to a *Deus absconditus* understanding, where God is understood to be hidden and unapproachable. This is where a PCP comes in. A patient, whose locus of encounter with God has been shattered either by a serious illness or by his or her perception thereof, shifts his or her locus of encounter with God to God's agent, the PCP. Incidentally, when this shift happens, the first steps of the PCP-patient agreement take place. PCPs must be acutely aware of their role and responsibilities. One of the key roles a PCP may be called to perform may be that of a spiritual healer.

There are at least three essential conditions a spiritual healer must meet, two of which Nouwen (1979) identifies. First, is the ability to "recognise his sufferings in his own heart" and the second condition is compassionate empathy (vicarious introspection), which is the capacity to think and feel oneself into the inner life of another person. The third condition is that a PCP be a person devoted to personal prayer and study. Here, in prayer and study, is where the PCP is rejuvenated, refreshed and kept abreast of the latest trends in the profession.

The work of a PCP is possible, because there is an assumption that there is a relationship between the metaphysical world and physical existential realities, as well as between health and spirituality. Therefore a PCP fits well in the modern health care setting as a member of the interdisciplinary team. However, a PCP is unlike any other health care professional in several ways. Concerning other health care professionals, such as nurses, physiotherapists et cetera, there is tacit expectation from patients to be visited by such professionals. Generally, there tend to be no such expectation from patients that a PCP should visit them; when people are admitted to the hospital, they are primarily admitted for some physical condition and not a spiritual condition. Further, unlike other professionals, a PCP's relationship with patients is distinctively characterised by the "I – Thou" relationship, as well as *be*in*g* (the ministry of presence) rather than *do*ing. This means that a PCP-patient relationship is uniquely relational and representative – a PCP represents the God who is always present to comfort, especially, in times of sorrow, pain and difficulty. Patton (2005:25) writes:

> The presence a PCP offers is more than his presence. He is a reminder and representer of God, faith, the church, and all that religion may represent to the person cared for … the carer is a part

> of bringing that presence into some kind of awareness in the person cared for and in himself.[7]

The focus of the PCP's work as a health care practitioner therefore has to be on how to *be* in relation to a patient. What does it mean to be in an authentic professional and ethical relationship with a patient?

5. TOWARD A PASTORAL THEOLOGY OF RELATIONSHIPS

Patients often vacillate between the two poles of despair and hope. They exist – and their stories are wrapped – in temporality. Lester (1995) observes that pastoral theology must begin its study of hope and despair on the anthropology cornerstone of human temporality. When people are distressed, they often vacillate between these two poles and more so toward the pole of despair. One of the resources that a PCP has, is the ability to assist sufferers in recovering their own locus of hope. This is done by pointing them to the connectivity of the three dimensions of time-consciousness; their past stories (which may or may not be the basis for either their hoping or despairing process), their present stories (which, based on the past stories, may precipitate the present story in view of the future story). Pastoral theology understands hope as:

> ... rooted in the past because we remember the mighty acts of God and our personal encounters with the transcendent. Hope is empowered from the future where it receives its vision. Finally, hope is active in the present as it energises and motivates us to live so that God's "will be done on earth as it is in heaven".
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> (Lester 1995:22)

5.1 Theology of relationships

In this article, symphonology theory is located within a larger theology of relationships. According to Dayringer (1998:22), "… a theology of relationship (embedded in human story in temporality: past-present-future) assumes that life is a process of achieving identities that sustain and move each person toward true fulfilment." This theology of relationship finds its best expression in the person and ministry of Jesus the Christ. "Religion was to Christ a matter of

[7] For extended discussion of the dimensions of the pastoral presence see Patton (2005:28-30).

active relationship" (Dayringer 1998:28). Christ summed up all Scripture in terms of relationship when he said, "love the Lord your God … (Mt 22:37-40). Also, the parable trilogy (lost coin, sheep and son) in Luke 15 emphasises a restoration of broken relationships. The attitude and stance of Christ in this trilogy are important and exemplary. His role was not to blame, but to extend restoring grace in spite of carelessness (sheep), accident (coin) or poor choice (son). The conventional "wisdom" would blame other people or circumstances – or condemn the son for having made a wrong choice in the first place. Christ is saying "a new law I give you is this: 'care for the lost and extend grace to them in the spirit of acceptance and non-judgemental.'" The theology of relationship is by definition a theology of care.

5.1.1 The relational nature and role of pastoral care[8]

Stewart (1970:37) sees the concept of "role" as central in the counselling relationship; he defines it as "an interpersonal relationship within a social system …" In the context of the PCP-patient relationship, role expectations are those that both a PCP and a patient place on each other. A patient's expectations of the "pastoral role" are often different from the PCP's own role expectations. PCP's expectations of the patient's role are also different from the patient's own role expectations. Expectations emanate from one's own desires and fears. As such, it is important to understand the important role these two human motivations (desires and fears) play in framing and shaping human future stories.

Conventionally, society has a certain prism through which it views and understands a patient's role, especially if hospitalised. Society tends to see a patient as someone who is weak, vulnerable, (temporarily) not normal, passive, incapable of making sound decisions, and the like. An SBT oriented PCP may empower a "patient" by modelling an egalitarian "I-Though" (Buber 1958) relationship with the patient.

In order for there to be a meaningful collaborative progress, as structured by the SBT standards, between a patient and a PCP, there must be a shared understanding of each other's role expectations. Expectations and roles would therefore need to be clarified. The first step toward improving and enriching the feelings which human beings have for each other, is to clarify the roles that each plays or ascribes to the other (Levy 1938:65). The basic premise of the SBT provides a better model for this, because it goes far beyond just understanding between the two – it seeks agreement between the two. This agreement is predicated upon the bioethical standards which serve as preconditions of agreement. However, as important as agreement is, it has

[8] For an expanded discussion of pastoral roles, among others, see Richard Dayringer (1998).

to be anchored by one's socio-theological anthropology. This is where a PCP can draw deep from both Christian and appropriate socio-cultural resources. For Christians, one such a resource is the emulation of Christ's view of people as well as an appropriation of the biblical notion of the *imago Dei*. This aught to command not only respect and affinity for human persons, but also a genuine sense of positive regard. Christ displayed this model.

PCPs are individuals who have undergone formal training in helping relationships (psychology & counselling) and theology; however, what makes one a PCP, in the first instance, is not his/her training but his/her role and calling (the authority and mandate referred to below). PCPs roles entail visiting and comforting the sick and the distressed. Their calling, in the Christian tradition, arises from two related motifs: *imitatio Dei* / *Christi* (imitating God/Christ) and the *imago Dei* (image of God) and is rooted in the crucifixion and resurrection of the Christ (a hope-giving event). The Christ event reminds us to *go* and *be with* those in distress – just like Christ who came and immersed himself in human experience, becoming fully human while remaining fully God (healthy balance of attachment and detachment at the same time). In this way a PCP is reminded to fully immerse him- or herself in the lives of those who may be going through, and experiencing, a difficult phase in their lives, while at the same time maintaining a healthy balance of attachment-detachment (as Christ did).

The crucifixion reminds a despairing and suffering person that God embraced suffering as a reality of human existence and condition. On the cross, rejection, loneliness, anguish, failure, pain, betrayal, and dashed dreams are all taken up by the suffering God (Lester 1997:87). Although suffering is a reality of human condition, "the cross reminds us of another reality within this sacred story, God is with us. God is present with us in our deepest suffering, understanding and sharing our pain" (Lester 1997:87). Incidentally, this immersion in human experience, pain and sorrow finds its impulse in the *imago Dei*. *Imago Dei* implies that there is an ontological relatedness between humankind and God, which further implies care and concern for those made in God's image. The imitation motif teaches the PCP how to *be* and *act* toward those in pain and are suffering: comfort and weep with those who weep (cf Rm 12:15) and be a soothing and non-judgmental presence to them.

Pastoral care practice, like other professions, has certain premises. It affirms the reality of pain and suffering in the world and, as such, one dimension of pastoral care is to encourage the patient to stay in touch with this reality. Another premise is that each person has a sacred story that includes his or her ultimate belief about the future. According to Lester

(1997:151): "The loss or disruption of these future stories in the past can be a major cause of problems in the present." As a representer of God to patients, a PCP functions as a catalyst, enabling patients to include hopeful sacred stories in their confrontation with the crisis, illness and any other problems that they face and thus mediating the awareness of God (or the divine) and creating a healing context in patients' situation. The PCP represents the reality of hope in the face of suffering (Lester 1997:88).

Imitation of God (*imitatio Dei* motif): Just as God visits (cf Gn 18:1), comforts and heals the sick (cf Lv 16:1) and thus bringing peace, comfort and hope to them in times of distress and despair, a PCP is called to do likewise. That is, to bring comfort, peace and hope to patients and their families. The understanding that each person is a carrier of God's image means that each person has inherent worth and value and as such, any interaction with the patient is by definition sacred. The foundation of the interaction has to be based on mutual respect between a patient and a PCP irrespective of each other's philosophical or religious viewpoints but respective of each other's humanity as a carrier of God's image and likeness.

The imitation motif orients one's calling *primarily* on *being* like God and only *secondarily* on *doing* like God for at least two reasons. Firstly it is because "while people across denominational lines are interested in the minister's skill at performing (doing) tasks, they are also highly sensitive to the character (being) of the minister" (Gula 1996:32) and secondly it is because "in Biblical parlance, the individual only becomes a self by allowing the divine Other to 'summon' or 'call' it to its responsibilities for the human other" (Hermans, Immink, De Jong & Van der Lans 2002:93). For Gergen (1991:157), "the self is … a product of its various relationships, not a pre-existing interior reality."

This understanding necessarily means that PCPs begin their professional journey by focusing first on themselves (in an effort[9] to be like God), asking God to enable them to be worthy God re-presenters. Being a representer of God entails a number of things, including having compassion, love and true desire to visit and comfort the sick. Husteds and Husteds note that "While (for SBT) optimum care for a patient is indispensable, even central to a professional bioethics, (the SBT) concentrates on the welfare of the health care professional ... which is also central to the well-being and welfare of patients." [10] In this sense SBT resonates with the clinical pastoral paradigm

[9] It is an effort because, although enabled by God's Spirit, it takes personal work, in terms of Christian disciplines and cultivation of Christian virtues, to become more like Christ.

[10] Husted & Husted's Symphonology Bioethical Theory at http://www.nursing.duq.edu/faculty/husted/bioethical/details.html accessed Feb 06 2007.

(Patton 1993) in which emphasis on the person giving care lies in *being*, *knowing* and *doing* of the PCP. This is what Patton (1993:4) calls "*pastoral wisdom* … which includes academic knowledge. Much of it is knowledge gained through the actual practice of ministry and reflection on that practice" (emphasis added).

The term "pastor" is both a relational communal term; to be "pastoral" is to be relational and in community. To be in a relationship already assumes permission and agreement of some sort between the parties in a relationship, a PCP-patient relationship is hardly possible without permission and agreement. For a PCP, a pastoral symphonological ethic is an ethic based on patient's purposes as codified in PCP-patient agreement, grounded in *PCP-God agreement,* and guided by the PCP-community-patient agreement. Properly understood and applied in pastoral care, SBT gives meaning and structure to this tripartite agreement. It answers the question, "how can a PCP *be* in relation with the patient, the community (this includes both the practitioner and or religious or civil communities) and God for the benefit of a particular patient?"

5.1.2 The mandate and authority of the pastoral care practitioner

The mandate and authority of the PCP can be understood as flowing in three directions; it can be located in God who calls; in the community of faith which commissions; and the health care institution within which the PCP operates. Primarily, one serving as a PCP would have a sense of calling and anointing and can legitimately, proclaim jointly with Christ:

> The Spirit of the Lord is upon me, because He hath anointed me to preach the gospel to the poor; He hath sent me to heal the broken-hearted, to preach deliverance to the captives, and recovering of sight to the blind, to set at liberty them that are bruised, to preach the acceptable year of the Lord.
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> (Luke 4:18)

This is the first-order mandate and authority – located in God. The second-order mandate and authority comes from the community that recognised and confirmed the first-order authority and mandate by ordaining and commissioning such a PCP. It also comes from the institution that hired the PCP.

6. PASTORAL CARE AND THE SYMPHONOLOGICAL ETHIC

Like a nurse who "ought to examine her life … to the point where she comes to an agreement with herself that she will be a nurse" (Husted & Husted 2001:54), a PCP as well has to come to an agreement with him/herself that he/she will be a PCP. However, unlike a nurse who has an agreement with herself as the starting point, the PCP has at least four-directional agreement: with God, community, self and a patient. The PCP agreement with God is foundational to the other agreements.

6.1 PCP/God agreement

In the foundational agreement, a PCP-God agreement, a PCP is called to be a "co-labourer with God" (cf 1 Cor 3:8) in which he/she lays down his/her desire to God – a desire to be a spiritual healer, a comforter, reconciler, sustainer and a guide. A PCP enters, as it were, into a covenantal agreement with God that he/she will first imitate God (*imatatio Dei*) by nurturing, comforting, and tending "God's flock", (the sick, the suffering and the distressed) with all the Christians spiritual resources. This agreement implies that PCPs will make it their goal to acquire all the resources necessary to achieve this desire. In practical terms, this means the formal training a PCP will have to have undergone (theology and programmes such as the Clinical Pastoral Education) in a relevant community context. However, the fact that a PCP enters into this agreement with God does not give him/her (a PCP) an automatic permission to enter into an agreement with the patient. This has to be negotiated.

6.2 PCP/patient agreement

The getting together of a PCP and a patient already presupposes the presence of God because "wherever two or three are gathered in my name, I am in their midst" (Mt 18:20). This implies equal standing for both a PCP and a patient because the quoted Scripture says "wherever two or three are gathered in my name, and NOT when a pastor or PCP is present then, I am their midst." The getting together of God's people, irrespective of their status, invokes the presence of God. "An agreement is a shared state of awareness on the basis of which interaction occurs" (Husted & Husted 2001:61) between two or more people in which neither is forced nor deceived; it "is a process in which two conscious beings create a resolution between them that becomes their strategy for action" (Husted & Husted 2001:79). The mutual understanding between the PCP and the patient is that the patient is only in the health care setting so that he or she will be able "to return to optimal

health". In a PCP-patient agreement, an objective agreement is begun the moment a PCP introduces him- or herself as such and it is further explicated when the patient divulges any sacred story to the PCP. Objective agreement means that both the PCP and the patient are aware of the reasons for the agreement. Why are they both there in the first place? The patient is in pain and may be suffering and therefore in need of reassurance and hope; the primary reason for the PCP's visit/presence is to represent divine presence and grace; thereby bringing hope and reassurance to a patient at hand.

When a patient is conscious and communicative it is clear how an objective agreement – through the bioethical standards – is established between a PCP and a patient. When the patient is non-conscious/ communicative – and does not have a proxy – it is not clear how such agreement is established. The solution to this, is that when a patient comes to the hospital, he/she is in fact saying to the hospital (of which the PCP is a member): "You are a custodian of my trust as far as my health is concerned." In turn, the hospital has already said – by mere existing as such: "Yes, we will be custodian of your trust (fiduciary)."

The PCP is in a unique position to explore (if invited), the deep sources of patients' values, often embedded in their sacred stories, and to help or guide them to produce decisions that will be spiritually and ethically satisfying. "Part of our responsibility includes firstly helping the patient locate reality …. Pastoral care helps people evaluate how the future stories within their core narratives are connected with reality" (Lester 1995:88). Secondly, enabling the patient to uncover these sacred stories about sickness, death or any crises, to help him or her find the resources in his or her own sacred story (Lester 1995:93).

6.3 PCP-community agreement

Although it is true, that "every person who enters the health care system … enters as an ethical individualist" (Husted & Husted 2001:30), such a person exists and lives in relation to others (a community, religious or civil). Personal choices of individuals have an impact on members of their communities, whether it is directly or indirectly. It is therefore important that individual personal choices, at times, be considered within a larger community context. This is beneficial not only to the community but to the individual concerned as well. The PCP-community agreement is only adjunct to the PCP-patient agreement – while the PCP-God agreement helps define and prescribe the nature, structure, and parameters of the PCP-patient agreement – and comes in handy. For example, when the desires of the patient (with no traceable family members or friends) are not known. It is common in such cases to

appeal to the standard practice of the profession (statements like, "what would a *reasonable* physician or patient do in a situation like this?" thereby including both the so-called substituted judgment and the best interest standards).

7. THE APPLICATION OF BIOETHICAL STANDARDS TO PASTORAL CARE

There are six standards upon which the SBT is based, namely, Autonomy; Self-Assertiveness; Freedom; Beneficence; Objectivity and Fidelity, that under gird the SBT. These standards are relevant to pastoral care practice and they require that PCPs first have a clear self-understanding of, and satisfaction with, their own level of spiritual and religious knowledge. Without such self-understanding and satisfaction, a PCP will feel the need to either proselytise or correct someone's "wrong understanding" of the Bible, dogma or belief.

7.1 Autonomy[11]

The idea of *imago Dei* in each person points to the standard of autonomy. It implies that while each person is of equal value because each is *equally* made in the image and likeness of God, each is *uniquely* made in this image and likeness. Two themes immediately emerge from this understanding: autonomy as both uniqueness and as ethical equality. As a bioethical standard in pastoral care, autonomy means that a PCP will refrain from imposing his or her own religious beliefs that are opposed to the patient's with the goal of changing the patient's belief system; but allow a patient to express personal stories any way, in whatever language (symbols) is comfortable to him or her, without judging.

Patients will often tell what sounds like a bizarre story; stories like, Jesus came to visit my room and was sitting on my bed. While a PCP may not believe this, it is important for the PCP to hear the underlying message of this patient. This may be a message of hope and comfort or even fear. So instead of rejecting this as whimsical, a PCP may explore further with the patient to "decode" the patient's story. Something like, "sounds like you were comforted

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[11] Autonomy, as the derivative right of individuals to control personal information, has limits though. Two principles limit personal autonomy. The "harm principle" requires moral agents to refrain from acts and omissions which would foreseeably result in preventable harm to innocent others and the "vulnerable principle." This principle calls for duty to protect against harm especially in a context where a patient is especially dependant on others. Being vulnerable is a condition which involves both a relative inability of the vulnerable person (patient) to protect oneself from harm and a correlative ability of another individual (PCP) to act or refrain from actions which would foreseeably place a vulnerable person in a position of harm or risk.

by Jesus' presence with you. Would you like to talk more about that?" or simply ask, "what did that mean to you?"

7.2 Self-Assertiveness

The right to control one's time and effort is important to any person. The PCP should remind the patient of his or her right to self-assertiveness and independence. This means that a patient should be empowered to make a stand; even against the traditions of his or her own faith tradition, if that holds him or her captive and stalls their progress. This is modelled by the invitation God makes: "come let us reason together…" (Is 1:18). Here God gives his people permission to be self-assertive.

7.3 Freedom

The patient must be enabled to face the reality of any given situation and challenged to start building revised future stories from that point. Staying in touch with reality means accepting one's freedom to make projections into the future and create one's own future stories. The PCP, as one trained in theology and as a spiritual leader, should offer an array of spiritual resources from which the patient may choose. Although the patient has freedom by virtue of being a person, freedom is enhanced when there are numerous options from which to choose, without duress or pressure. Freedom also means that the patient feels accepted for who he/she is by the PCP and that he/she can express his/her displeasure and/or anger at God without fear of sanction or being labelled one way or another.

7.4 Beneficence

In a PCP-patient relationship, a PCP's actions and goodwill are directed toward the patient. The standard of beneficence requires that a PCP be conversant with diverse religious viewpoints, including that of his/her patient. But this knowledge is not enough; he/she must be committed to respecting different religious viewpoints of the patient; helping a patient see how the resources of his/her own religion can help him/her cope with his/her current situation. Beneficence requires a PCP to employ religious resources in a way that will be helpful to the patient. This would mean using spiritual resources such as prayer, sacraments and other rituals that may be meaningful to the patient; all these with the goal of benefiting a patient. Beneficence for example would demand that, if a patient voices a preference for a religious leader of a different (from PCP's) religious or spiritual persuasion, a PCP will make an effort to locate such a leader for the patient.

7.5 Fidelity

While autonomy is the umbrella of the agreement – everything stems from one's core identity – fidelity is the foot of the agreement – if there is no intention to be faithful, the agreement never was. This standard gives rise to promises. As such, it means both a PCP and a patient owe each other this trust. A trust, for example, that each party will keep promises. The PCP should make it clear to the patient what a PCP can or cannot do in the health care setting. Further, this standard forms the basis for confidentiality; the patient must understand that what is discussed with the PCP is a privileged communication and will therefore be treated with confidentiality.

7.6 Objectivity

When a PCP realises that there is no formula of how God works with His children, the PCP would not be dogmatic on matters spiritual. It means being able to say, "I don't know" to questions such as "why did God allow my son to die?" Objectivity communicates to the patient "although I am a PCP, I am mortal like you are, my knowledge of God is limited" and that "God, and His workings are as equally mysterious to me as they are to you". For a patient, objectivity means that he/she realises that the PCP does not have any magic prayers that would drastically change his/her condition or situation, that the PCP is equally a frail human being. It also means that when hearing a person's sacred story, a PCP must respect the language and symbols the patient chooses to convey his/her sacred story. Objectivity means that the future is quite open; God could work in either way. God may choose to heal and may choose not to heal (physical healing). This standard requires a PCP to never give false hope (such as the promise of physical healing over against what those in the medical community are saying).

Finally, objectivity for the PCPs means that they are able to hold in creative tension both the physical and spiritual realities. This, for example, means that at times when patient's prognosis may be grave, a PCP may have to help a patient face up with this reality while at the same time upholding the reality of life to come and thus giving a patient hope beyond this life.

8. CONCLUSION

Respect for human rights and personal autonomy is increasingly important in today's professional pastoral care practices. This article elaborated upon a recently developed theory in the nursing profession (symphonology bioethical theory: SBT) and showed how the application and adaptation of the SBT to the pastoral care practice can rid pastoral care practice of its overly traditionally paternalistic tendencies; while at the same time help restore

patients' dignity by respecting their personal autonomy and upholding their human rights, cognisant of the fact that, given the derivative Latin meaning of the word patient, PCPs are also patients (Patridge 1966:475 & Patton 2005:62).

The question, "can the two walk (work) together unless they are *in agreement?*" posed at the onset served as the springboard for the discussion of agreement between a pastoral care practitioner and a patient/counselee in pastoral care and counselling situation. A definition of the word symphonology (from Greek word, *symphonia*, meaning agreement) was provided from Husted and Husted (2001:xviii) as "the study of agreements in the health care arena between health care professionals and patients." It is a study of the ethical implications of the health care professional/patient agreement. It was further indicated from the SBT perspective, that the professional-patient agreement is structured, guided and defined by the six bioethical standards of autonomy, freedom, objectivity, self-assertion, beneficence and fidelity.

Therefore properly understood and applied in pastoral care, SBT gives not only meaning and structure to this PCP-patient agreement but it also restores patients' dignity and respect by upholding their human rights and personal autonomy in decision-making. It answers the question, "how can a PCP *be* in relation with the patient, the community (this includes both the practitioner and or religious or civil communities) and God for the benefit of a particular patient?" Therefore, to the question, "can the two walk together unless they agree?" The answer is a resounding NO, they cannot! For them to work/walk together, they have to agree!

I would like to conclude with a caveat. This article has focused on the adaptation and application of the SBT in pastoral care practice; it was my idea to supply a case study to illustrate how the adaptation and application could be done. However, due to the space limitation, in the end I decided to leave out the case study. In addition, since I am writing as an African, incorporating the often-mentioned notion of *ubuntu* would have been in order. However, I left it out for the same reason I left out a case study. I hope to incorporate it in a sequel article to this one.

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