The Linacre Quarterly

Volume 39 | Number 4 Article 7

November 1972

Catholic Hospital Ethics

Commission on Ethical and Religious Directives for Catholic Hospitals

CATHOLIC HOSPITAL ETHICS

This is the final Report of the Commission on Ethical and Religious Directives for Catholic Hospitals — a study commission established by the Catholic Theological Society of America in June, 1971. Publication of the Report, which is not an official position of the CTSA, was accepted by the CTSA Board of Directors on September 1, 1972. This study is not presented as the final word on codes of ethics for Catholic hospitals, but is proposed as a moral theological rationale for understanding the purposes and functions of a set of ethical directives in Catholic hospitals, and as a basis for dialogue, research, and the revision and interpretation of policies. Reactions to the Report are welcomed.

As the list at the end of the Report indicates, it is the work of an eminent group of scholars with special insights into medicine and ethics; they in turn consulted others of equal competence in their fields.

Since the directives were approved by the bishops in November, 1971, a number of diocesan meetings have been held to discuss the code. As more meetings are convened, the Linacre *hopes to keep its readers up-to-date on the resulting dialogue.*

Introduction: Crisis Over Hospital Ethics

1. There are almost 800 Roman Catholic hospitals in the United States, housing almost one-third of all the privately owned hospital beds in the country. Catholic hospitals are not only unique in their historical origins and in their generous service to the American public; they are also distinguished by their code of ethics.

2. The *Ethical and Religious Directives for Catholic Health Facilities* [1] — also referred to as a "national code" [2] — is a collection of ethical and religious principles and precepts designed to serve as Catholic hospital policy in those dioceses where the local bishop adopts it for use. The revision of the *Directives,* approved by the Roman Catholic bishops of the U. S. in November, 1971, left the earlier (1955) version virtually unchanged, in spite of some very noteworthy medical, ethical, social and theological developments ex-

perienced in the intervening years. Consequently, the 1971 *Directives* have raised some serious conflicts for the Catholic Church, for the public, for Catholic theology, for many medical personnel, for individual bishops, and for the Catholic hospitals themselves.

3. The result has been no ordinary academic debate or ecclesiastical dispute. For while the *Directives* offer the security of a definite Church policy for those troubled with administrative problems, allegiance to some of its restrictions in the unqualified fashion called for in its Preamble frequently excludes the provision of certain medical and surgical procedures commonly admitted in other hospitals, significantly restricts the freedom of patients and physicians, and causes intolerable institutional problems thus contributing to situations in which the termination of some Catholic health services has been unavoidable. There are ample signs indicating that conformity to the ethical and theological principles and presuppositions of the 1971 *Directives* may well lead to further Catholic relinquishment of health services and perpetuate the conflicts presently being experienced in Catholic hospitals over internal policy questions pertaining to medical ethics.

4. We take the position that Catholic sponsorship of hospitals and other health facilities can be an effective and important means of service even in the present critical circumstances; but we also believe that if this sponsorship is to continue in a way that will respect good morality while acknowledging the rights and dignity of all concerned, there must be certain changes in the attitudes and policies which have been taken in the name of ethics.

5. This Report is not simply a commentary on the new *Directives*, nor does it undertake to analyze systematically each of the specific prescriptions contained in the *Directives*, for this would require a lengthy and detailed analysis of a great number of different topics. Further studies would be necessary to accomplish that. Instead, this Report presents theological and ethical reflections on the major issues involved in the presuppositions of such a set of directives, as well as in its implementation. Any serious attempt to assess the meaning, function and applicability of a code of ethics for Catholic hospitals leads to a discovery of many major questions, few of which have received adequate theological attention:

6. Why should there be Catholic hospitals? What is the identity, accountability and responsibility of the contemporary Catholic hospital in today's American society? What is the Catholic hospital as agent of moral decision-making? What are and what should be the processes of decision-making? What is the function of a code of ethics for a health care facility? Is it a tool for decision-making or a list of ready-made decisions? To what degree can the ethics of a profession or the moral teachings of a

church be "codified"? Who should be responsible for composing and interpreting a hospital's code of ethics — the local bishop? all the bishops of the country? church laity? patients within individual hospitals? community lay hospital committees? theologians? physicians and other health care personnel? hospital officials and personnel? To what kinds of problems should the code be directed? What is the moral binding power of the *Directives*, and is dissent from them possible? Is it possible to set limits to legitimate dissent?

7. We hope that this Report: (1) will provide some helpful principles for hospital administrators, medical personnel and others involved in decision-making; (2) will contribute to the theological basis for a prompt and thorough revision of the new directives; (3) will encourage other theologians, physicians and others to do further theological and ethical studies on the topics touched upon briefly in this Report; and (4) will serve as the basis for further discussion and debate on these important issues. [3]

Part I. Hospital Ethics in a Pluralist Setting

Catholic Hospitals: Moral Accountability

8. In recent years the Catholic hospital — like the practice of medicine itself — has been undergoing social, cultural, and legal changes which profoundly affect its identity, its moral accountability, and its moral responsibility. [4] In common with other non-profit, voluntary hospitals, the Catholic hospital is experiencing increasing involvement with the civic community, with public agencies, and with government; and it is also experiencing increasing limitations on its ownership and its scope of freedom before the law.

9. Because they serve the public at large and are supported by federal and state funds, Catholic hospitals serve the public interest and are accountable to the public in their day-to-day operation, e.g. through federal and state agencies and hospital associations. As Catholic hospitals enter relationships of liaison, cooperation and merger, they become responsible to and/or co-responsible with other medical institutions. As Catholic facilities extend themselves increasingly into community health care programs, it becomes more imperative that they offer comprehensive health care services. On a national level, too, Catholic hospitals are cooperating with various health and social welfare agencies and associations, and this has led to joint programs designed to meet mutual needs. Furthermore, an increasingly substantial segment of the non-Catholic community plays an important role within the Catholic hospital itself: on the board of trustees, in management, on the medical staff,

among other personnel, and among its patients.

10. In a word, the Catholic hospital has gradually been altered from a strictly private institution to a more pluralistic community health care facility operated under Catholic auspices, although the extent of a pluralist dimension varies widely from hospital to hospital. While the Catholic hospital may be church property ("ecclesiastical patrimony"), with a religious congregation or diocese retaining legal control over it, it is clear that this health facility is becoming a quasi-public, pluralistic institution with multiple social and moral accountability.

11. The Preamble of the current *Directives* offers a defensive, ahistorical response to the pluralistic setting of today's Catholic hospitals. It seems to want to insulate the Catholic hospital, by giving serious acknowledgement only to its "vertical accountability" which is operative solely within the private structures of what canon law calls an "ecclesiastical moral person" (the Catholic hospital). This model of accountability also presumes that Catholic hospitals are univocally identifiable as Roman Catholic, particularly by their being held uniformly accountable to hospital authorities (such as hospital administrators) who, in this regard, are assumed to be acting as agents for ecclesiastical authorities (religious superiors and ultimately bishops) in the implementation of detailed medical-ethical policies established by the church hierarchy. This model of accountability does encourage the fulfillment of what may be called the "conscience demands" of the corporate moral person, but fails to take into account recent socio-ethical developments.

12. It would be appropriate to today's pluralist situation to acknowledge the model of "horizontal accountability" which is also operative in the very identity of Catholic hospitals. The Catholic hospital is no longer on a religious island. As it becomes increasingly involved with the civic community and other health care entities, it becomes more accountable to them, affords them more representation in the affairs of the Catholic health care facility, and takes on more responsibility for providing them with an atmosphere of freedom. Consequently, the Catholic hospital-as-moral-person has gradually experienced a change in its social identity and moral accountability. Because the contemporary description of its responsibility is due to its pluralist setting, its problems related to policy and ethics must be understood against the background of contemporary pluralism.

Pluralism as Ethical Context

13. The empirical fact of pluralism pervades every major dimension of our lives — intellectual, cultural, social, ethical and religious — and it provides the context for today's healing ministry of the Church. We are now being challenged to determine what our response to pluralism should be — how we should articulate the impact our pluralist setting in Amer-

ica has on the mission of the Catholic hospital and on the way in which ethical norms for these hospitals should be explicated.

14. We believe that response should be positive in tone and substance — not because we are forced by legal requirements or financial necessities to submit to the consequences of pluralism, but because contemporary Catholic teaching has shown us the way toward a positive evaluation of pluralism. Prior to Vatican II, official Catholic teaching regarded pluralism as an unfortunate situation which had to be tolerated at best and actively opposed if possible. This view placed Catholicism in a defensive position: guidelines of minimal cooperation governed our civil and religious postures as an institution, lest cooperation in a pluralist setting be taken to mean compromise of religious and ethical principles.

15. A significant development of doctrine took place, however, as pluralism came to be acknowledged in principle as a normative context for understanding the ministry of the Church and her institutions, opening the way for a corresponding difference in institutional practice. The teaching of Vatican II manifests this development of doctrine. The *Declaration on Religious Freedom* [5] not only recognizes the fact of pluralism but accepts it as the historical norm in which Catholic participation in society must be conceived. The *Decree on Ecumenism* [6] affirms the ecclesial reality of other churches and the possibility of learning from the theological and ethical insights developed within other Christian communities. The *Constitution on the Church in the Modern World* [7] affirms the solidarity of the Church with the pluralist world and the need for a mutual learning experience through continuous dialogue.

16. In brief, the principles of Catholic theology emerging from Vatican II call for something more than an attitude which views pluralism as a situation which should be denied acceptance institutionally and resisted operationally. There still lingers within the Church today a preference for reliance upon reinforced institutional policy for the purpose of preserving the complete integrity of all the institution's doctrine and ethical prescriptions against the "onslaught" of a pluralist environment. Yet these conciliar documents seek to orient the Catholic community toward the development of ways in which we can both serve the message of the Gospel which has been handed down to us and minister, in the name of Christ, to the needs of today's mankind through full and active collaboration (which means neither compromise nor betrayal) in the world of our day.

The Pluralist Dilemma of Catholic Hospitals

17. The consequences of pluralism profoundly affect the very notion of our hospital ethics, for they raise the question: Can Catholic hospitals, on religious and ethical grounds, continue to justify the refusal of certain health services

which are legally permitted, commonly accepted in the medical world, and, at least in some cases, not morally harmful according to the judgment of many prudent men?

18. The fundamental dilemma of today's Catholic hospitals is the fundamental dilemma of contemporary pluralism, for in today's pluralistic world there are competing signs of the times. Some push us to broaden our ethical conceptions and practices, while others challenge us to reassert our vision of life. Some pluralist aspects of hospital service, such as community involvement, urge us to be less restrictive of what is permitted in our hospitals; and on the other hand the desire to maintain an "institutional identity" based on certain convictions about the Church's teaching authority accounts for our refusal to condone some actions.

19. In trying to retain a Catholic identity through institutional ethical policies we may violate the rights of others, neglect or harm the social good, and force an abdication of Catholic institutional presence in the hospital world. On the other hand, in seeking to become thoroughly acceptable in a pluralistic world by maximizing the freedom of all parties concerned and by offering all the commonly accepted medical services, we may needlessly violate some important values enshrined in the institutional ethical code, lose a significant Catholic identity, and drift into tacit acceptance of secularist values.

20. To strike the needed balance is a delicate task requiring a deep understanding of why there should be a Catholic presence in the hospital world; an accurate, credible, and usable set of directives; an astute sense of policy-making and decision-making on the local level; and an ability to make discreet adaptation to the contemporary situation (which is the question of "cooperation"). These topics will be treated in the following paragraphs.

Part II. Catholic Presence in Health Care Institutions

21. There is considerable concern today over the institutional identity of the Catholic hospital and the "visibility" of the health care apostolate, principally for four reasons: (1) the contemporary world of medicine and hospital care is making it necessary for Catholic hospitals to exercise a somewhat less autonomous stewardship over their facilities; (2) legal factors are affecting the very ownership of the Catholic hospital by creating a trend toward less corporate privacy; (3) there is a decrease in the membership of the religious congregations which sponsor Catholic hospitals; and (4) there is not agreement among the membership of the sponsoring religious congregations whether the emphasis of their health apostolate should be on "in-

stitutional management" or "personal witness." Consequently, the question is being asked: Why and how should the Church be involved in the apostolate of health care institutions, and how can it preserve its Christian and Catholic identity?

22. Catholic involvement in health care has deep religious and historical origins rooted in certain beliefs and expressed in service and witness. The apostolate to the sick, the suffering, and the dying has been one of the most distinguished, selfless and tangible services rendered by the servant church to mankind. Like the work of Christ Himself, the Catholic Church's care of the sick and dying is ultimately directed to leading men to the Father. It witnesses to the healing mission of Christ, manifests His work of mercy and reconciliation, and at the same time provides an environment in which human values, such as the dignity of human life, may be more clearly perceived, appreciated and appropriated.

23. This environment may be created by church institutions, but it is sustained primarily by the inner Christian dynamic of dedicated service to the physical, mental and spiritual care of both Catholics and non-Catholics, especially to the poor, the neglected, and the abandoned. In particular, a pastoral concern for the spiritual welfare of the sick, the injured and the troubled should continue to be a distinguishing feature of our Christian witness and a unique kind of Christian presence in the work of maintaining and restoring health in Catholic facilities.

24. Christian acceptance of Christ's commission to care for the sick is adaptable to many forms, methods and institutions, as history testifies. It is true that an important dimension of this apostolate of the Church has been its witness to a moral stability that survives the recurring espousal and rejection of values in many segments of society. Yet the Church has accomplished this moral stability through a diverse succession of institutions and in spite of a certain fluctuation in its own understanding of ethical norms.

25. In contemporary America, the Church's religious and ethical presence in hospital service (aside from the spiritual and pastoral presence mentioned above) may be accomplished in the institutional level, on the personal level, and overlapping these two categories, in a communitarian way. These kinds of presence are not necessarily mutually exclusive. The actual applicability and real impact of a set of ethical directives will vary according to the combination of these factors in an individual hospital.

26. Church agencies such as religious congregations and dioceses have sought to ensure the active presence of a "Catholic philosophy" in health care facilities through institutional sponsorship. Institutional presence may be effected by ownership and/or control. Hospital ownership by a Church agency affords the greatest guarantee that official Catholic teaching will serve as codified hospital policy. Another means of accomplishing the religious and moral

presence of the Church in this ministry in an institutional way is through the model of retaining policy control and control over decisions affecting the charter and by-laws of the hospital. According to this plan, the hospital assets are owned by another corporation, and a contract is arrived at with the religious congregation that operates the hospital, with the agreement that the hospital is to be operated according to the philosophy of the sponsoring group. Some believe that this model is a viable alternative, while others doubt that the "Catholic code" could permanently continue to be institutional policy under this arrangement.

27. Institutional presence of whatever kind is not the only manner of Catholic presence in the hospital apostolate, and a Catholic presence that is only institutional without the dynamism of corporate dedication to moral values is not a religious and moral presence at all. In the absence of such corporate commitment, the adoption of a code would be an act of policy but not an ethical pursuit. If an institutional presence is to have a moral soul, there must simultaneously be a communal Catholic presence which both creates and asserts a Christian goal and purpose based on a religiously motivated covenant of moral values. The patients (for whom the hospitals should exist!) can be expected to benefit by this communal witness as they have in the past. Only if this witness is present will the hospital's code be able to serve an honest declaratory function to the larger community which it serves.

28. It would seem that the essential Christian contribution to health care is facilitated by, without being irrevocably tied to, ownership. Certainly the Church should never willingly abdicate all institutional witness in an area as important as health care. It is true that the autonomy of Catholic hospital ownership is being curtailed, and for some this threatens to place limitations on a distinctively Catholic style of codified and institutional ethical presence. This trend should caution us to reflect more seriously on several factors which, in our contemporary situation, highlight the importance of Catholic institutional presence in the health care field, specifically: (1) the consideration that a distinctive institutional presence makes it possible to influence and direct societal decisions regarding health care; and (2) the fact that, through its institutional presence, a voluntary association of dedicated Christians renders a community service through the investment of many of its resources, not the least of which is its communal witness. On the other hand, this same trend toward a lessened autonomy of the private hospital should move Catholic hospital personnel to a greater and more genuine communitarian witness to the moral and ethical values involved in the care of the sick, and to strive to accomplish this in a way that goes beyond mere conformity to the moral prescripts of a code of ethics.

29. Certain aspects of hospital service are causing more emphasis to be placed nowadays on the personal level of Catholic presence in

Church-sponsored hospitals. In addition to the four general reasons mentioned in par. 21, two more specific causes could be indicated: (1) Responsibility for the affairs of the Catholic hospital is being placed more and more on the local institution itself, which is increasingly diversified in the make-up of its structures. This calls more attention to the individuals involved and raises the question whether they will accomplish an effective Catholic presence in a situation where, at least to some degree, they must compete with a multiplicity of interests. (See par. 47 below.) (2) At a time when impersonal mechanization and depersonalized programming are so much a part of health care, the need for the humanizing dimension of dedicated Christian service is greater than ever before. In fact, this may well be the greatest ethical challenge for today's Catholic hospital. Personal concern and innovative programs relating directly to people's needs are required to counteract this tendency.

30. It is by no means the Catholic personnel alone (on the medical and nursing staffs, in the administration and on the board of trustees) who can make this kind of presence felt on a personal level. Individuals of any or no religious creed are also called upon — in an institution pluralistic in its make-up — to give a witness of concerned and personalized care. Yet the Catholic-sponsored hospital should be uniquely prepared to give effective moral leadership to foster this personal kind of presence. Furthermore, personal witness is strongest where a community sense of dedication to values is strongest. The C a t h o l i c - sponsored institution should have a special ability to assist in creating this communal experience which will support a goal-oriented personal witness on the part of personnel who otherwise may find themselves morally isolated in a depersonalized hospital system. Consequently, it should be an objective of prime importance for the Catholic-sponsored hospitals to develop within the individual facilities a community with those values which most surely support the Christian purpose of serving the sick.

31. The question of a Catholic presence — institutional, personal, and above all communal — is a crucial question if health care is to be seen as an extension of Christ's mission of mercy in a pluralistic setting. A unique Catholic presence is made both possible and imperative by the corporate moral convictions of the Church, which should find their expression in the policy of a Catholic hospital. Yet a tenacious and insular conformity to a rigid code of ethics should not be appealed to as a means of "keeping Catholic health facilities Catholic" in the face of the social upheaval being experienced by these institutions. The other Parts of this Report suggest a broader context for the effective use of ethical directives in the accomplishment of this goal. An institutional code should reflect an awareness of why and

how the institution will accomplish this presence and why individuals should want to look to the code for guidance in their personal and corporate moral witness. Educational and formative efforts should be made to develop an appreciation for this fundamental dimension of Christian medical ethics, for the benefit of those engaged in the work of Catholic-sponsored as well as other health care facilities.

Part III. The Code and Ethical Decision-Making

The Code in a Christian Context

32. In attempting to understand and interpret a code of ethics, several fundamental questions present themselves, viz.: What is the purpose of a code of ethics? What is its function in decision-making? What is the purpose of a code in a Christian context? What is its role in the functioning of a Catholic hospital?

33. A code of ethics, whether professional or institutional, can have several purposes, all related to a group's evaluation of behavior. It may be instructional (providing moral and ethical information to the uninformed); declaratory (declaring the group's values, goals and objectives to its own members and to others); conservative (upholding certain essential standards of behavior which conserve the unity and identity of the group); policy-setting (providing a definite method of action to guide and determine decisions and to evaluate behavior once the decisions have been taken); arbitrational (enunciating principles and establishing or allowing for procedures for the resolution of conflicts of duties and conflicts of consciences); and/or coercive (creating varying degrees of social pressure or sanction so as to guarantee adherence to a certain ethical behavior and to provide both internal and external identification). Briefly, a code is a statement of values, an assertion of goals, and/or an expression of rules whose purposes all focus on good decision-making and behavior.

34. The U. S. bishops' "national code" seeks to fulfill most of these purposes. It must be noted, however, that the "group" whose values are being declared, conserved, etc., should not be solely the hierarchical "teachers of morality," but the entire group of all those involved in this endeavor.

35. How does a code relate to decision-making? This depends partly on how the statement of a code is expressed, for a codified statement or the expression of a directive may be either a *moral prescription* or an *ethical principle.* A moral prescription either forbids or commands specific behavior,

usually in an all-inclusive or negative formulation, such as "Sterilization, whether permanent or temporary, for men or for women, may not be used as a means of contraception." (*Directives*, par. 18.) An ethical principle, on the other hand, is a statement — usually in the form of a positive formulation — of the group's understanding of values related to a certain kind of human behavior. It emphasizes general values, but not to the exclusion of specific rules of conduct, for example: "Because the ultimate personal expression of conjugal love in the marital act is viewed as the only fitting context for the human sharing of the divine act of creation, donor insemination and insemination that is totally artificial are morally objectionable. . . . " (*Directives*, par. 21.)

36. These two kinds of directives play different roles in decision-making, depending on norms of interpretation. Moral prescriptions are generally understood as requirements which hold those bound by it to a pre-determined behavior pattern, and consequently tend to be a list of decisions before the fact. They leave little room for interpretation of circumstances, rules or values. Ethical principles, on the other hand, are not so much a list of ready-made decisions as they are a set of guidelines which provide structure and illumination for judgment concerning specific behavior.

37. A hospital code of ethics should necessarily include both types of directives. The U. S. bishops' *Directives* contain both types, but place by far the greater emphasis on moral prescriptions. Yet many of their prohibitions do call for some degree of further interpretation and application, particularly those which are qualified by intention, consent, etc., as in any type of case where the distinction of "direct" and "indirect" has customarily been made. Thus, the prohibition of sterilization would be an instance of a moral prescription which is not in every respect a decision before the fact, for further decisions must be made concerning those sterilizations which in fact should not be prohibited.

38. When a code is used in a Christian institution established for the care of the sick and dying, it is qualified by certain additional characteristics. In this case the code partially expresses the Christian group's vision of the vocation of healing and establishes certain structures which enable the hospital to accomplish and perfect its role of care for the human person. The moral and ethical standards which this institution affirms are understood as partaking in the law of healing which the whole Church seeks to follow in faithful extension of the healing Christ. Moral standards for the Catholic hospital should be looked upon the same way that moral law is viewed in a Christian perspective. The moral law is not held principally to be a legal enactment, codified and promulgated with penalties imposed, for the law of the Christian is Christ Himself in whom we have life and who is therefore the law of our lives. For

the Christian, the moral law is not conceived primarily as a restrictive force but as a liberating force. Its function is to guide and inform Christian love and hence Christian compassion, care and healing; and to aid conscientious judgments in an atmosphere of freedom.

39. A number of important elements which constitute a Christian theology of moral law are unfortunately lacking in the Preamble of the U.S. bishops' *Directives*, which offers a predominantly legalistic dimension to the directives. A very different theological explanation is found in the Preamble to the Canadian Catholic *Medico-Moral Guide*,[8] which also adds:

> *The Guidelines . . . should be read and understood not as commands imposed from without, but as demands of the inner dynamism of the human and Christian life. . . . Their application to a particular situation will usually entail a great deal of prudence and wisdom. . . . The Guidelines should serve to enlighten the judgment of conscience. They cannot replace it.*

The differences between the underlying theological presuppositions of the U.S. and Canadian hierarchies in reference to the purpose and function of a set of directives in medical ethics account for the charge of "geographic morality" which is becoming a common cause of consternation among North American Catholics who are concerned with health care institutions and services.

The Code and Magisterial Pronouncements

40. The U.S. *Directives* are not a comprehensive professional code nor simply a set of guidelines as described above. They are predominantly a statement of institutional policy indicating what must not be done by medical personnel if they are to be admitted to practice medicine in Catholic-sponsored health care facilities. These policies are mostly moral norms either taken from or directly supported by papal moral teachings. As such, they are a selective collection of assertions from authoritative, magisterial teachings.

41. Magisterial teachings should call forth deep respect and sincere adherence on the part of Catholics. Yet these teachings do not all enjoy the same degree of certitude and binding power, and none of the concrete norms in the *Directives* is infallible. In particular, there is no longer any good reason (if there ever was one) for concealing the fact of the greater and lesser degrees of certitude enjoyed by official church teachings in moral matters. Magisterial teaching itself acknowledges this variety, and intelligent men and women today can easily see that not all the actions prohibited by the 1971 *Directives* are "clearly wrong" in an undifferentiated way as proposed by the U.S. bishops. Today's situation of pluralism in particular should prod us to more openness and candor, both in acknowledging what can be permitted on occasion even in the face of a general prohibition which the Catholic community is reluctant to abandon, and in firmly supporting the prohibitions of which we are deeply convinced and which seem to strike more deeply to the roots of our faith identity. Simply to re-

peat past magisterial pronouncements does not suffice. Constant scrutiny and wise discretion are required if ecclesiastical moral pronouncements are to be transformed into good hospital policy.

42. A "code" of medical ethics which relies on magisterial pronouncements will require certain precautions and clarifications, several of which are not apparent in the present code. There can be a great distance between the historical and cultural context, the authorship and style of the papal teaching on the one hand and the world of contemporary Catholic hospital problems on the other hand. If the directives are to be effective, this gap must be bridged: the unaltered, precise words of a pope cannot guarantee relevancy to a highly professional world. Since a set of institutional directives can scarcely be an effective tool for medical decision-making if it is not rightly understood, some principles of interpretation and criteria for the resolution of conflicts must be included. The new *Directives* are particularly remiss in this regard. In spite of very extensive magisterial and theological developments since 1955 in the area of law, conscience and freedom, the new *Directives* are more insistent on the certitude and binding power of the norms than the previous *Directives* were. The following important principle for the resolution of doubt, which was contained in the 1955 edition, has been omitted in the 1971 edition:

> *In questions legitimately debated by theologians, liberty is left to physicians to follow the opinions which seem to them more in conformity with the principles of sound medicine.* [9]

That practical principle expressed the notion of freedom in cases of doubt; and because that freedom should still be in effect today, the statement of the 1955 edition is still valid for moral decision-making, but with two qualifications: (1) the "questions legitimately debated by theologians" are now considerably extended, for they may now include questions which have previously been pronounced upon by popes; and (2) the "liberty" spoken of should not be seen as exclusively or even primarily that enjoyed by the physician, for it is the patient who has the first and most basic responsibility to make decisions on his own behalf.

43. Furthermore, ethical directives must make a clear delineation between general principles and their application in more specific rules; should acknowledge that some principles deal with "hard cases" where it is not always clear what may be done; and should indicate whether a prohibition is only given as an instance of a more general and more important principle which it is intended to illustrate (which might explain, for instance, par. 21 of the *Directives*).

44. It may be necessary in some instances to single out for firm affirmation as hospital policy a moral norm derived from official church pronouncements or from theological reflection. A particularly grave threat to deep human values may make this necessary. There is, for

example, a vast difference between the values involved in the prohibition of "masturbation as a means of obtaining seminal specimens" (par. 21) and "directly intended destruction of a viable fetus" (par. 12). The fact that both prohibitions are taught by the magisterium does not make them equally grave, nor does the fact that neither is infallible make them equally unimportant. The principles of dissent, which will be referred to more extensively below, have their limits; and today's situation of pluralism as described above urges us to support certain standards more strongly than others lest our more fundamental moral values — those more surely related to a Gospel-based understanding of man — be lost. To maintain this moral identity it may be necessary to prohibit some behavior more fully in a policy statement and in application than could be sustained in given instances through ethical reflection alone. We believe that this approach to the establishment of an institutional code — in its "declaratory," "conservative," and "policy-setting" functions — is fully warranted in reference to abortion. The field of medicine in particular and society in general, by extending the "indications" for abortion or removing any need for such indications, are admitting abortion on demand, which ought to be opposed on ethical and social grounds by Catholic institutions. The fact that society is abandoning other means of protecting human life itself at its earlier stages of development makes even more urgent a general but clear and firm policy of exclusion of abortion on the part of Catholic health institutions.

Decision-Making:
A Shared Responsibility

45. The existence of a truly adequate code will not provide all the needed direction in ethical questions. Three sorts of problems arise calling for further discernment. (1) Code and policy must be interpreted, to establish, for example, whether exceptions can be made, such as in shared facilities or joint practices. (2) Working policies must be developed to provide for cases not clearly covered in the code or other policy. (3) Decisions must be made in individual cases, to determine, for instance, what can be done in emergency situations or in "hard cases." Many of these questions are highly particularized for individual Catholic hospitals, and those faced with such questions should not lightly abdicate their prime responsibility to make judgments on moral principles as applied to medical and health care problems. In fact, these decisions are being made daily in our Catholic health facilities.

46. It would be mistaken to think that medical-ethical decisions can simply be referred to some other agency such as the local bishop. The Preamble of the new *Directives* states that debated questions in medical ethics "must be finally submitted to the teaching authority of the Church in the person of the local bishop, who has

the ultimate responsibility for teaching Catholic doctrine." This unqualified statement of the local bishop's competence in medical ethics has been questioned on theological grounds, on legal-medical grounds, and for reasons of common sense. In any event, the bishop is rarely consulted; and when he is consulted he frequently appeals to a theologian who is competent to give an ethical reply. This pattern of referral seems to amount to an acknowledgment of the principle of consultation in practice if not in stated policy. Although the bishop should not be considered the sole ultimate authority in the field of medical ethics and should not be cast into the role of final consultant in the treatment of a patient, this does not imply that the moral authority of the Church should be jeopardized, or that the bishop has no leadership role to play. Certainly the formulation of local hospital policy should not be made in isolation from the whole Church or from the hierarchical church. This unity of local policy with the Church at large can be accomplished in several ways; but certainly the teaching of the local bishop who is in communion with the whole Church is an important factor. By his word he makes the power of the healing Christ present in a unique way. Furthermore, due to peculiar local circumstances, some of the decisions taken in hospitals can have pastoral significance for the diocese as a whole, thus involving the interests of the episcopal office. The ministry of Catholic hospitals has more to gain today than ever before from the enlightened leadership of the local bishop because of the way in which health care service participates both in secular society and in the life of the Church.

47. In fact, however, both moral and legal responsibility for Catholic hospitals is being focused more and more on the structure of the local institution: its board of trustees, its administration, its medical staff, etc. Giving the local health care facility more autonomy is more appropriate to the notion of shared responsibility within the Church and more in conformity with the principle of subsidiarity. The same principle of subsidiarity may indicate in some instances that certain key decisions affecting the total hospital involvement of the entire sponsoring group (the religious congregation) should be relegated to the decision-makers of the sponsoring or corporate group, thus determining in advance some of the institutional policy for many Catholic hospitals. Even so, many decisions will consistently and most appropriately be those of the local institution where the basic task of decision-making resides. Many important decisions, including policy decisions, should rightly be made at the local level, because of the increasingly complex nature of the questions arising in medicine today and the need for special competence in responding to them as they arise in individual cases. Thus, the complex responsibility of ethical decision-making goes beyond without nullifying the "national code" which seeks to establish a

uniform national list of ethical and religious standards. Some procedures are needed at the local level to facilitate proper consultation among those who are the principle moral agents: the patient, the physician, medical staff, administrative staff, and so on.

48. Various parties should be involved in the decision-making process, so as to draw on appropriate competencies according to the complexity of the case. It is difficult to state — in reference to varying hospital situations and varying categories of problems to be solved — precisely which competencies should be represented. They might include some combination of the following: physicians, members of the medical staff, nurses, medical social workers, department heads, administrators, ethicists, and those holding pastoral positions (bishop, parish priest, or chaplain). The key party in these decisions is the patient; and, depending on the kind of decision to be made, spokesmen representing the civic communities which the hospital serves should also be included. The principle involved is that of broad consultation, so that all those with a direct claim in the decision to be made may be permitted and encouraged to share in the decision. In some instances this should be accomplished more formally such as through a committee; in other instances, less formally. It would seem, however, that some of the policy questions listed above would best be handled through an ethics committee, at least for purposes of seeking recommendations. Medico-moral committees (whether institutional or inter-institutional or both) could fill an essential need for the solution of cases, serve as a means of exercising and enhancing the moral agency of the hospital as a corporate moral person, foster continuing education in medical ethics, and provide a much needed structure for a continuing revision of the present *Directives*.

49. Some working principles are important for hospital decision-making which involves the code and multiple moral agency. The central agency of the patient must be acknowledged and his freedom should be maximized, though not to the exclusion of other considerations. The patient has the right to the fullest amount of information (medical and ethical) necessary for informed and responsible consent, and often he has the right to determine medical practice in his regard on the basis of his consent or dissent — but this latter right is not without limit. (See par. 44 above and pars. 52 and 63 below.)

Part IV: Conscience and the Directives

The Directives and Religious Liberty

50. The foregoing sections on the meaning of the *Directives* and the problems of institutional decision-making only take on their full meaning in the context of individual decision-making where the role of conscience comes into play. Against the background of Part I of this Report, the question arises: How does the context of pluralism affect the application of our ethical norms? Or, more specifically, must non-Catholic physicians and patients conform totally to the Catholic code of ethics in spite of their own sincere convictions of conscience to the contrary if they choose or are forced by circumstances to make use of a Catholic health facility which serves a pluralistic community?

51. The normative framework governing this relationship is the right to religious liberty, which means that no one is to be coercively constrained into belief or action contrary to his own convictions; and conversely that no one is to be coercively restrained by civil power from action (worship, witness, practice) according to his convictions. The dictates of this right should be applied analogously to the realm of Catholic hospital practice, with implications particularly for non-Catholic patients and staff.

52. The non-Catholic patient enjoys the right to religious liberty. In his case, as in the case of all men, the basis of the right is the dignity of the patient as person. The exercise of this right cannot be absolute; it is limited: (1) by the patient's responsibility to seek competent professional advice; (2) by the need to protect the rights of other innocent persons; (3) by the patient's obligation to respect his own duties toward others; and (4) by his obligation not to disturb the public order (or the larger social good) disproportionately. [10]

53. The basis for extending the right to religious freedom into questions of professional practice is the expertise enjoyed by professionals; and the implication of this application is that physicians have both a right and a duty to follow their well-formed conscience in the treatment of patients. The exercise of this right is limited, even outside of church-sponsored institutions, by the personal and social responsibilities mentioned in par. 52. These limitations may be expressed: (1) by society at large through the law; (2) by peers through professional ethics; and (3) by the patient's giving or withholding of consent.

54. The critical question is whether the exercise of the right of religious liberty should be limited also by the fact of administering or seeking treatment in a Catholic hospital. From the hospital's perspective the issue is whether it can allow a course of action dic-

tated by the conscience of the patient, or of both the patient and the physician, but contrary to the professed institutional code (or institutional "conscience") of the hospital. If the hospital invariably insists on the execution of its moral norms, it will presumably be acting according to its own moral standards, but it may also be disproportionately infringing on the rights of other people in our society. The moral principles governing the resolution of this conflict, whether on the institutional or the personal level, are the principles of "cooperation."

55. The theology of cooperation has varied according to progressively different cultural and religious views on the relation of the Catholic to the world around him. Today a theology of cooperation must be formulated and interpreted in light of the Church's affirmation of the right of religious liberty, its acceptance of pluralism in principle, and its teaching of ethical norms with varying degrees of affirmation according to a scale of moral values. Coordinating these three elements is not a simple task: it is more a task of the prudential art of Christian living than of theological speculation. Norms, no matter how detailed, cannot supply the answers. To arrive at decisions concerning cooperation requires a good ethical sense, consultation with those directly involved, and a knowledge of the local situation. Also helpful is an understanding of the working principles of a theology of cooperation.

56. Traditionally, the principles governing "cooperation in evil" sought to solve problems associated with the permitted degree of cooperation in another person's action which was taught and presumed to be morally evil. The degree of "material cooperation" tolerated was relative, for it involved a balancing of good and evil effects and took account of degrees of necessity for permitting the action itself. In today's circumstances, and particularly since the more recent development of the doctrine of religious liberty, the question of "cooperation" is not simply whether one may participate in the (presumably objectionable) *act* of another, but whether one may cooperate with another *person* who may or may not have a right to engage in certain actions. Consequently, a correct understanding of cooperation (which cannot be extensively elaborated in this Report) should be broadened so as to take into account the following criteria which refer to the individual and the institution, and which have taken on special ethical significance in recent times: (1) assuring the fulfillment of the individual's right to adequate medical care; (2) protecting the right to religious liberty; (3) avoiding scandal in the sense of true moral harm in a pluralistic setting; and (4) being aware of the changed significance of moral agency and moral responsibility. This latter point will now be explained in the context of today's Catholic hospital.

57. Medical technology and medical resources have made medical

services more available. However, these advances have been accomplished through a re-structuring of medical services and institutions in such a way that those engaged in delivering these services now frequently enjoy fewer options and less autonomy in the performance of their essential work. Consequently, the reality of a more highly organized *functional* cooperation in health care delivery frequently shifts the *ethical* question of cooperation from the person-to-person level where it was previously almost exclusively seen (the doctor-patient relationship) to levels involving larger groups and even entire institutions. Examples of this would be shared facilities among hospitals and group medical practices.

58. These changes in the moral agency, i.e. in the way in which different parties are responsible for the medical, surgical, or health care actions, signify that pluralism is more than a context: it has inherently affected the very meaning of the actions, and this in turn affects the degree of "cooperation" which can be permitted (without, of course, deliberately consenting to a moral disvalue). Catholics in a pluralist country have long been "cooperating" in collective actions which have moral effects at the social level which they would not want to initiate from their own moral conscience. We suggest that Catholic physicians in group practices and Catholic hospitals involved in shared facilities (to mention but two examples), where they do not have autonomous control over what happens in these collective situations, may operate under comparable principles of cooperation according to the criteria set forth above. The actual determination of what can be permitted by way of "cooperation" and still be within the scope of the hospital's responsibilities will depend very much on circumstances which alter the scope of the hospital's responsibilities in reference to the rights of the patient. For instance, it may be necessary to permit a procedure in a Catholic hospital which is the community's only health facility, while the same action would not have to be admitted in a Catholic hospital located in a large metropolitan area where other facilities are available. Medical or surgical treatment may be morally permissible in an emergency situation where a delay might involve grave risks, while the same kind of treatment may be excluded in elective situations.

The Directives and the Right of Dissent

59. The normative framework governing the relationship of the conscience of the Catholic to official Church pronouncements contained in the *Directives* is the teaching of the Church on freedom of conscience and on the right of legitimate dissent.

60. Conscience provides man with a personal and concrete moral dictate concerning what is to be done and what is to be avoided. It cannot be the sole arbiter of truth nor is it a law unto itself. It

must be formed through openness to the Spirit in love and through docility to objective moral norms. However, once the dictate of conscience is prepared for in mind and in heart and is perceived with sufficient moral certainty, it provides the ultimate norm of moral conduct and must be obeyed even if erroneous. "In all his activity, man is bound to follow his conscience faithfully, in order that he may come to God for whom he was created." [11]

61. The hierarchical teaching office of the Catholic Church has asserted its authority to teach in the area of "faith and morals," even though the precise meaning of these terms, especially the term "moral," has never been clearly defined. The moral norms of medical ethics taught by the authoritative, papal and hierarchical magisterium — no matter how specific and clear these teachings may be — are not infallible, nor do they require the full acceptance of an act of faith on the part of Catholics. They call for a "religious assent," the precise nature of which is still very much debated among theologians. It should involve reverential acknowledgment of the (papal) teaching office and "sincere adherence" to the pope's judgments, "according to his manifest mind and will." [12]

62. The reactions of bishops, theologians and laity to the papal encyclical *Humanae Vitae* have more firmly than ever established the right of dissent from such papal teaching when there are sufficient reasons for so doing. Consequently, to uphold the "right of dissent" is a position that is theologically supportable and definitely within the pale of the Roman Catholic faith commitment.

63. Following these developments within the Church, it may safely be stated that moral decision-makers affected by the new U. S. *Directives* — principally patients and physicians, but not excluding administrative and medical staff, as well as ethical advisors of the foregoing (clergy, chaplains, etc.) — may, in individual cases and on moral grounds, licitly act contrary to the concrete (and hence non-infallible) ethical directives, provided: (1) the decision is seriously arrived at in good conscience after careful reflection; (2) respectful and openminded attention is paid to the authoritative teaching of the hierarchy, as well as other sources of moral wisdom, in the light of the Gospel; (3) no undue harm is done to the life, well-being or rights of a third party; and (4) scandal avoided. This last condition means that precautions must be taken to prevent this exception from causing more harm than good, so as not to significantly and unnecessarily hinder the community role of the Catholic health facility and the moral welfare of others.

64. Beyond the four conditions mentioned, the obvious theoretical limit to legitimate dissent is the truth itself as expressed in the reasons for the dissent from a particular teaching. The discussion among theologians who are freely and responsibly carrying out their function and in dialogue with

people in the medical profession can serve as an indication of the practical limits of dissent. As mentioned above (par. 44), the limits to dissent should be taken very seriously, particularly for societal reasons. The total Catholic community has not reflected seriously enough on what the limits to dissent should be on specific questions (such as sterilization, for example), so as to protect the rights of innocent people (particularly the disadvantaged) and to preserve public order (see pars. 52-54 above). Further multi-disciplinary studies on these matters are urgently needed. Because both the basis for dissent and the need for limits to dissent are valid and important, and because policy guidelines — whatever they may be — should be taken seriously, Catholic hospital directives need to be devised which will take both kinds of factors into account. For otherwise they will either be exaggerated or ignored, and both of these extreme consequences should be avoided at all costs.

Additional Recommendations

65. We recommend research by theologians, ethicists, medical scientists and physicians, jointly when possible, on many of the topics touched upon throughout this Report. High priority should be placed on this research.

66. Just as inferior medical training or inadequate hospital management will produce poor hospital service, a lack of a knowledge and appreciation of the ethics of medicine and health care can lead to bad policy and harmful decisions. Education in medical ethics should be promoted within individual Catholic-sponsored institutions and on a diocesan or regional basis.

67. We urge that steps be taken toward a prompt revision of the 1971 *Directives*. Procedures should be established for a thorough and systematic revision, which should involve all of the pertinent competencies.

68. It does not seem to be in conformity with the function of a code of ethics for Catholic hospitals that it should take into account the more perplexing ethical questions on the frontiers of bio-medical research, except insofar as they relate to medical and hospital practice. However, experimentation in these areas may indeed relate to hospital ethics. The Church should be more actively involved in ethical research into the newer questions of bioethics.

69. In the present *Directives*, questions related to sex and reproduction have received too much emphasis. More stress should be placed on the positive aspects of responsible parenthood. It should also be noted that a substantial number of Catholic theologians believes that there can be legitimate dissent from several of the specific paragraphs in the recently promulgated code, including the following: the condemnations of contraception, direct sterilization, masturbation for seminal analysis, and artificial insemination with the husband's seed; the processes for-

bidden in the handling of extrauterine pregnancies; and the distinction between direct and indirect which is stated in terms of physical structure of the act itself. Each of these topics deserves more research and extensive dialogue within the Church.

70. The following are some topics that require more attention than has heretofore been given them in the ethics of Catholic health care facilities: (1) The Catholic hospital's service to the poor and underprivileged. (2) The ethics of power in the Catholic hospital, especially as this relates to the control over medical services by the medical profession, the "consumer," etc.; and the determination of fees. (3) Quality of health care in Catholic institutions as an ethical issue. (4) Racial segregation and discrimination. (5) A just family wage, educational and career advancement opportunities, and the other benefits which can rightly be expected from employment in Catholic health facilities. (6) Clearer guidelines on the right to die in dignity, the prolongation of human life, the definition of "extraordinary means" for preserving life, the ethics of medical heroics and the understanding of death as part of life. (7) The importance of obtaining informed consent and the efforts required on the part of the professionals involved. (8) Transplantation: informed consent, use of children as donors, etc. (9) Human experimentation: safeguards, informed consent, use of children in experimentation, etc. (10) Genetic counseling: its necessity, its limitations, limits on "right to procreate" vs. freedom of choice. (11) The extent of the rights of the retarded to be cared for in a manner commensurate with their needs.

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Footnotes:

1. Washington, D. C.: United States Catholic Conference, 1971.

2. Of the two, the term "directives" seems preferable; but the term "code," which is used both officially and unofficially, is to some extent appropriate, since the bishops have presented ethical standards in codified form, the norms are given a legalist explanation in the Preamble, and this "code" also has institutional implications which are singled out for special emphasis by the bishops. In this Report both terms are used in reference to the same document.

3. This Report does not offer bibliographical documentation beyond a few minimal references because of the nature and purpose of the document and the inter-relation of the themes treated. This is not a scientific monograph intended for a single group of specialists or scholars, but the scholarly report of a study commission which has been drawn up for consideration by several publics. It draws on multiple expertise, extensive study, and broad consultation. Explanations of the development of many of the themes treated here have been amply offered elsewhere and in many cases are well known. Because the bibliographical and scholarly needs of the various professions will vary, this Commission will welcome requests for background readings in any of the themes treated in this Report.

4. For a detailed and informative analysis of the changing situation of Catholic sponsored health care facilities in a time of rapid social and cultural transformation, see *Study of the Future Role of Health Care Facilities under Catholic Auspices in the United States* (CHA Task Force, Phase II Report, Findings and Summary); St. Louis: The Catholic Hospital Association, 1969.

5. *The Documents of Vatican II*, edited by Walter M. Abbott and Joseph Gallagher; New York: Guild Press/ America Press/ Association Press, 1966; pp. 675-696.

6. *Ibid.*, 341-366.

7. *Ibid.*, 199-308.

8. Ottawa: The Catholic Hospital Association of Canada, 1970.

9. *Ethical and Religious Directives for Catholic Hospitals*; St. Louis: The Catholic Hospital Association, 1955; par. 3.

10. Cf. *Declaration on Religious Freedom*, par. 7.

11. *Ibid.*, par. 3.

12. *Constitution on the Church*, par. 25.