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Evangelizing Health Care

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by

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I. Introduction

Health care is in crisis for a variety of reasons, cost being only the currently most visible reason. Other, perhaps more important reasons are the medical and ethical dilemmas, not only the ancient ones of abortion and euthanasia, but also the contemporary ones of gene research and reproduction technologies. In addition, an unquestioned medical technology imperative has further marginalized the unmet psychological and spiritual needs of patients. The purpose of this paper is to review these problems and to suggest that the Ethical and Religious Directives of the National Conference of Catholic Bishops may be a means of evangelizing health care.

II. Background

Health care, given man's inherited tendency to illness and inevitable death, has been a human vocation since the dawn of history. From the beginning, health and sickness have had religious overtones inasmuch as primitive man had a sacred orientation. While scientific medicine began with the Greeks and Romans they also acknowledged the sacral elements of healing, much of it taking place in temples.

Christianity had an important healing dimension. Christ was a physician in that healing physical illness was a major aspect of His public ministry. Indeed, two-thirds of His recorded miracles described the care of serious disease. Christianity, even while enduring the persecutions,

promoted health care. It pioneered a system of hospitals from the earliest times for the care of the sick poor.

III. The Patient: Body and Soul

Christ's healing miracles were performed in part to promote His message of salvation. They were also performed out of compassion for those suffering. Christ was clearly concerned about the whole person and pointedly ministered to the mind and soul as well as the body.

This holistic approach has been ignored by modern medicine, which focuses on the material. Medicine has been depersonalized, clearly by an overemphasis on technology, but also by the materialism of our consumerist culture.

The tradition of Catholic medicine has tended to emphasize the spiritual needs of the sick person. This was clearly the case prior to the scientific developments in medicine simply because there was little else to offer. This was especially true in the United States when religious orders, particularly of women, founded hospitals usually to minister to the sick, poor immigrants. The nuns saw to it that patients received the sacraments and spiritual care, especially at the critical times of birth and death.

Unfortunately, the last thirty years have witnessed significant changes in Catholic health care, many of which militate against the traditional holistic approach to the patient. Catholic hospitals are losing their unique identity because of marketplace economic pressures, a switch to ambulatory care, and perhaps most importantly because of the disappearance of the religious orders of women who ran the hospitals and saw to it that spiritual care was available.

IV. Ethical Changes

Beginning with the Enlightenment, science slowly disengaged from religion until twenty-first century medicine is now considered scientific and value free. This is a profound change from what has been a Hippocratic tradition that was profoundly moral in the Aristotelian-Thomistic tradition of virtue ethics.

The change began with the break with the natural law concept of realist philosophy. Both Descartes and modern idealism, as well as Locke and Empiricism, contributed. Utilitarianism was a logical consequence and this in turn spawned contemporary proportionalism and consequentialism. These latter ethical schools consider intention more important than the

act itself. There are no intrinsically evil acts because the agent's intent is determinative. Since the end justifies the means, formerly intrinsically disordered behavior such as the killing of innocent life in abortion or disordered sexual activity in homosexual behavior become acceptable. Postmodernism has continued the deconstruction of traditional ethics and has reinforced the regnant utilitarianism.

V. Medical Ethics

The area of medical ethics is similarly influenced. This is nowhere more apparent than in euthanasia, both active and passive. Active euthanasia is an obvious violation of the Hippocratic oath, but is justified for a patient with pain by arguing from utilitarian ethics that the quality of life requires the termination of life. Passive euthanasia is less direct and more insidious. To withhold nutrition and hydration because a person is in a persistent vegetative state, and therefore no longer a "person", is similarly utilitarian.

VI. Ethical and Religious Directives

Responding to the two-fold problem of the psychological and spiritual needs of the patient as well as the deficiencies of modern medical ethics, the Catholic bishops of the United States developed a series of directives to be adhered to by Catholic health care systems.

Prior to 1915 there was no uniform ethical code for Catholic hospitals because they were not united into any national organization. In that year the Catholic Hospital Association (CHA) was founded and it became apparent that uniform ethical guidelines were needed. In the first issue of the CHA journal, *Hospital Progress*, Father Bourke published "A Surgical Code", outlining surgical procedures not permitted in Catholic hospitals (see Appendix). It essentially proscribed abortion and sterilization.[1]

Hospital Progress continued to publish articles on ethical issues and in 1949 the CHA published a code of ethics, authored by Father Gerald Kelly, SJ, entitled "Ethical and Religious Directives for Catholic Hospitals."[2] The religious needs of patients were addressed by eight of the 52 directives.

The guidelines were revised and in 1955 for the first time were approved by the US bishops as a group.[3] Guidelines in areas other than abortion and sterilization, such as psychiatry and human experimentation, were added. Revisions were again approved by the National Conference of Catholic Bishops in 1971.[4] Religious concerns of non-Catholics were now addressed. These revisions, following Vatican II, elicited criticism

because some theologians felt that in a pluralistic American culture not enough recognition was accorded the concept of the freedom of conscience.

The Directives were last revised in 1995 and now include changes acknowledging 1) the bishop's role in implementing the directives 2) the patient's autonomy in decision making, but also 3) emphasizing that the patient's decision must be based on morally true norms and not simply on capricious individual choice.[5] Addressing the issues of collaboration between Catholic and non-Catholic institution, a section on cooperation was included.

The various revisions of the Directives have attempted to address the changing ethical and social health care scene in the United States. These guidelines address the moral relativism rampant in contemporary medical ethics, but more importantly they attempt to maintain the Catholic identity, formerly fostered by women religious, that ministers to the psychological and spiritual needs of patients treated in the Catholic health care system.

VII. Conclusion

We live in an increasingly more complex modern world. However, humans continue to become ill and inevitably die. The Catholic tradition reasonably successfully addressed the whole person in times of medical need. Since World War II, forces at work in modern cultures have impacted negatively on Catholic health care. The psychological and spiritual needs of the whole person have been less adequately addressed and medical ethical standards have eroded. The Ethical and Religious Directives have been developed to meet these needs.[6] Hopefully their conscientious implementation will maintain the Catholic identity of Catholic health care as well as the spiritual and ethical well-being of our patients.

The objective of the Second Vatican Council was not only renewing the Catholic Church, but also the evangelization of all aspects of human activity. With the commercial and technological imperative encroachment on medical care the mandate of Vatican II to renew the moral and pastoral aspects of medicine becomes all the more compelling. The implementation of the Ethical and Religious Directives will assist us to that end.

Appendix

United States Catholic Hospital Ethical Codes

DATE/ CODE	SECTIONS/ #DIRECTIVES	SIGNIFICANCE
1915	_	Catholic Hospital Assoc. founded
1921 Bourke	1.Abortion 2.Sterilization **13**	Code of Surgical Procedures
1949 CatholicHospital Assoc.	1.General Directives 2.Specific Procedures 3.Religious Care **52**	General Principles & Specific Applications
1955 NCCB	1.Introduction 2.LifeThreatening Procedures 3.Reproductive Procedures 4.Other Procedures 5.Religious Care **60**	Binding by Local Bishop Psychiatric Care Guidelines Experimentation
1971 2nd Revision	1.Preamble 2.General Principles 3.Reproductive Procedures 4.Other Procedures 5.Religious Care **43**	Binding on all Catholic Hospitals Pastoral Care of Non-Catholics
1995 3rd Revision	1.Social Responsibilities 2.Pastoral Care 3.ProfessionalPatient Relationships 4.Beginning of Life 5.End of Life 6.Partnerships **70**	Expands Episcopal Responsibility Emphasizes Patient Autonomy Cooperation with Non-Catholic Institutions

References

1. R.M. Bourke, "A Surgical Code", *Hospital Progress* 1:36-37, 1920.

2. *Ethical and Religious Directives for Catholic Hospitals*, 1949, CHA, St. Louis, MO.

3. *Ethical and Religious Directives for Catholic Hospitals In: Medical Ethics*, Edwin Healy, S.J., Loyola University Press, Chicago, IL 1956.

4. *Ethical and Religious Directives for Catholic Health Facilities*, Publ No. 532-1, United States Catholic Conference 1971.

5. J. Keenan, "What's New in the Ethical and Religious Direction", *Linaria*, Feb. 98:33-40, 1998.

6. *Ethical and Religious Directives for Catholic Health Care Services*, Pub No. 5-034, United States Catholic Conference, 1995.