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What's New in the Ethical and Religious Directives?

by

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In November 1995, the National Conference of Catholic Bishops unanimously approved the *Ethical and Religious Directives* (hereinafter, ERD).[1] While most recent attention has centered on the "Appendix" where the principle of cooperation is outlined, that seventeenth-century principle is hardly innovative. Rather, there are five places within the directives that any reader would find new.

First, Kevin Wildes, in the *Kennedy Institute of Ethics Journal*, argues that the only innovation in the ERD is that the ecclesiology is from the top down.[2] In these Directives, the local bishop is certainly more evident than any earlier Directives: the bishops assume a highly visible place in the ERD. For instance, in the "General Introduction," the bishop is seen in his office as exercising a classic, three-fold role as pastor, teacher and priest. These three roles in turn lead to three responsibilities that bishops have in health care ministry.

> As the center of unity in the diocese and coordinator of ministries in the local Church, the diocesan bishop fosters the mission of Catholic health care in a way that promotes collaboration among health care leaders, providers, medical professionals, theologians, and other specialists. As pastor, the diocesan bishop is in a unique position to encourage the faithful to greater responsibility in the healing ministry in whatever setting it is carried out in the diocese. As priest, the diocesan bishop oversees the sacramental care of the sick.

Concretely these responsibilities mean, for instance, that the bishop is consulted for the appointment of the pastoral care director (ERD, 21); if the director is not Catholic, the bishop's approval is needed (ERD, 22). Likewise the bishop appoints any priests or deacons to the pastoral care staff (ERD, 21). Wildes is right to recognize the role given to the bishops. That role was established because the bishops understood themselves as the final guarantors of the Catholic identity, mission and values of the health care facilities in their own diocese.

Though the bishops understand themselves as final guarantors of the health care facilities' Catholic identity, mission and values they hardly consider themselves the first guarantors. In the "General Introduction," they recognize that most Catholic health care facilities have been founded by religious women who sought to continue the mission of Jesus in healing and caring for those who are sick. Likewise, they recognize how those religious women and men are now involved in collaborative ministries with lay persons.

Moreover, the bishops also do not consider themselves the more immediate guarantors of the health care facilities' Catholic identity, mission and values. This can be seen, for instance, by comparing earlier drafts on hospital ethics committees with the final, approved text. Earlier, the bishops considered appointing hospital ethics committees or, at least, the committee's ethicists. Instead, after describing the work of these committees in advising and reviewing hospital policies and procedures, they added "there should be appropriate standards for medical ethical consultation within a particular diocese that will respect the diocesan bishop's pastoral responsibility as well as assist members of ethics committees to be familiar with Catholic medical ethics and, in particular, those directives." (ERD, 37) Here we see the health care facility then serving as the responsible agent in carrying out the directives. Those within the facility "must respect and uphold the religious mission of the institution and uphold these directives." (ERD, 9). In fact, the entire first part assumes and underlines that the ones most immediately and directly responsible for shaping, protecting and promoting the Catholic identity, mission and values of the facility are those working within the facility, not the chancery! (ERD, 1-9)

Thus, Wildes is right to note the particular role of bishops, but Wildes misses the real concern: that is, in an age of pluralism and

increasing diversity, the importance of guaranteeing Catholic identity, mission and values. Though the bishops wrote, approved and promulgated ERD, they clearly recognized that they were not the singular guarantors of the Catholic presence in health care. Rather they saw themselves with others who have continuously exercised their own leadership as founders and guarantors of that ministry. Throughout the document, then, we find a call for those working within both health care facilities and chanceries to be in dialogue with one another and sensitive to the respective competencies of each other. Again, we find in the "General Introduction," "The responsibilities will require that Catholic health care providers and the diocesan bishop engage in on-going communication on ethical and pastoral matters that require his attention."

Thus we need to see that while the role of the bishop is vigorously present in the *Directives* that role is a very specific one among others. For this reason, anyone reading part six, "Forming New Partnerships with Health Care Organizations and Providers," will recognize that while the role of the bishop is clearly apparent, his final authority does not compromise the first and more immediate competency of those in the facility. The call to the bishop to be attentive to his responsibility to promote and protect the facilities' Catholic identity, mission, and values is at once a call to the facilities' own administrators and employees to no less guarantee that ministry.

This insight leads then into an appreciation of the second innovation which John Gallagher describes in a wonderful essay in *Review for Religious*.[3] There he comments on the five narrative sections of ERD. While these narrative sections are certainly a major innovation, Gallagher recognizes that they are not simply stylistic changes. Rather he comments on the ecclesiology that is provided in these sections. He contends that there is a considerable shift from earlier ideas of the Church that described priests and religious working the Church's ministry while lay people worked in the world's political work. This dichotomy is overcome in the directives where lay ministry is integrated into the Church's mission.[4] Rightly, Gallagher insists that this extension of the laity into ministry is not "regrettable" or some "last resort" measure, but rather an attempt to follow the Spirit: the shared ministry is not a pragmatic patchwork, but a vision of the Church's proper ministries. Thus, he suggests that this more inclusive

ecclesiology ought to guide those sharing in this ministry to develop a new self-understanding of their own roles as "Heralds of the Gospel."[5]

Gallagher provides, then, a healthy and insightful corrective to Wildes' complaint: the protection and promotion of Catholic identity, mission and values in the health care arena is a task for all who share in the labor of Catholic health care facilities. Finally, the Catholic Health Care Association developed this insight with extraordinary vision in their 1996 Annual Conference entitled, "Enacting the New Covenant."

Third, Gallagher also notes a nod to the common good in ERD insofar as certain directives (56 and 57) say that excessive expenses to the family or the community could make a proportionate burden a disproportionate one. While this is an astute observation, Gallagher's recognition needs to be tempered by certain other concerns that the National Conference of Catholic Bishops recognized. Notably, in order to protect patients, ERD anticipated the attempts of certain managed care insurers who would try to deny payments to a patient precisely by invoking these directives. Thus, these same directives (56 and 57) as well as an earlier one (32) insist that the arbiter who determines a disproportionate mean is the patient alone. No one else can make this election. Thus, if the patient considers the services being delivered to her as unreasonably expensive for her family or her community, then she alone may reasonably opt to consider the means as disproportionate. The innovation then is not simply a nod to the common good. Rather it is an attempt to achieve a prudential balance: in the era of HMOs, ERD does not shrink from upholding concern for the common good as part of the calculus of extraordinary versus ordinary care, but it also does not fail to protect the patient's own health care and own obligation to make right moral decisions in conscience.

Fourth, this leads to what I consider the most important shift in the revised directives: this is a remarkable change from a best interest model of decision making to the responsible patient wishes model. The former model is based on the premise that only those who are medically competent determine a patient's course of treatment. This model predominated in much of Catholic medical ethics. It meant basically that a physician (and sometimes a priest or ethicist) determined what constituted extraordinary or ordinary care.

In ERD, the patient and not the health care provider is the

primary decision maker. Three steps are taken to insure a responsible patient wishes model. First, ERD stipulates repeatedly in directives 24 and 28 (and implicitly in 25 and 59) that no Catholic Health Care facility is obliged to provide to any patient services that conflict with ERD or Catholic moral principles. These prohibitions, however, are fewer than we realize, e.g., abortion, sterilizations, assisted suicide, certain reproductive technologies. If the prohibited are few and specific, then the parameters of the permitted are considerably broad. Thus, second, within the context of the permitted, the patient singularly decides about her care. This is reiterated repeatedly (ERD, 25, 26, 27, 28, 32, 56, 59). Thus, it is the patient who determines what constitutes extraordinary means. We read, "While every person is obliged to use ordinary means to preserve his or her health, no person should be obliged to submit to a health care procedure that the person has judged, with a free and informed conscience, not to provide a reasonable hope of benefit without imposing excessive risks and burdens on the patient or excessive risks and burdens on the patient or excessive expense to family or community." (ERD, 25)

Moreover, ERD explicitly imposes on designated surrogates the primary responsibility of representing the patient's wishes and not to make "best interest" decisions. Thus, if a physician, nurse, priest or ethicist advise a surrogate that a particular course of treatment is from their point of view preferable, the surrogate must in conscience adhere to the patient's wishes, provided that they do not conflict with ERD or any other Catholic moral teaching. The surrogate can only turn to the claims of best interest when there is no evidence of the patient's own wishes (ERD, 25).

Furthermore, ERD upholds this shift even in the event that a surrogate has not been appointed and no advanced directive is available[6], then "those who are in a position to know best the patient's wishes - usually family members and loved ones - should participate in the treatment decisions for the person who has lost the capacity to make health care decisions." (ERD, 25).

Finally, this shift is based on the premise that the patient's decision-making is not an action based on a freedom from the truth, but on an obligation to pursue the true:[7] the patient is not free in conscience to pursue whatever she wishes, rather she is required to make a responsible decision. Therefore, the health care professionals

are required to inform her properly to accomplish this task: "Free and informed consent requires that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all." (ERD, 27).

Readers of ERD should see that the assertion of an individual as the proper decision-maker is not rooted in the ubiquitous American principle of autonomy. That principle argues that the agent should be free from all sorts of encroachments. Rather, Catholic teaching is rooted in the dignity of the human person. From that dignity, a person is obliged in conscience to determine what God wants from her. The primacy of our obligation to conscience drives this turn to patient wishes. "The inherent dignity of the human person must be respected and protected regardless of the nature of the person's health problem or social status. The respect for human dignity extends to all persons who are served by Catholic health care." (ERD, 23).

ERD's final innovation is the actual crafting of the particular directives. Recognizing that the articulation of moral judgments is an on-going process of trying to determine the truth as we come to understand more clearly the complexities that lie before us,[8] ERD often set the parameters for right action, rather than actually determining specific procedures. One such instance is the question of whether artificial hydration and nutrition for patients in persistent vegetative constitutes extraordinary versus ordinary means. Rather than "settling" this question, we find ERD, in the narrative of part five, "Issues in Care for the Dying," presenting on the one side the wrongness of euthanasia and on the other side instances when such means are clearly extraordinary. Then, turning specifically to the question, ERD reminds the reader of the distinction between those "questions already resolved by the magisterium and those requiring further reflection." While stating the "presumption" to provide such means, ERD clearly recognizes that this is not an absolute requirement (ERD, 58).

ERD also faced the question of ending the life-threatening ectopic pregnancy. Not wanting to persist in invoking the principle of double effect which led to an unnecessary tubal ligation,[9] ERD simply wrote, "In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion." (ERD, 48). Undoubtedly,

Catholic moralists will try now to find a proper way of responding to an extrauterine pregnancy that on the one hand does not constitute a direct abortion and on the other hand avoids harming the woman's body.[10]

This method of "outlining" determinations, by stipulating the boundaries of what is prohibited, but encouraging health care facilities and ethicists to find proper resolutions congruent with Church teaching can be found throughout the document. In particular, it is evident in the rape protocol (ERD, 36), prenatal diagnoses (ERD, 50), and medical research on children (ERD, 51). But also it governs the entire section on dying as well as the entire section on cooperation. ERD requires then an attentive eye and a willingness to pursue right courses of action responsibly within licit ambits. It is a document for the times we live in.

References

1. National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (Washington: USCC, 1995).

2. Kevin Wildes, "A Memo from the Central Office: The 'Ethical and Religious Directives for Catholic Health Care Services'," *Kennedy Institute of Ethics Journal* 5 (1995) 133-140.

3. John Gallagher, "The Ecclesiology of the U.S. Bishops' 1994 Health Care Directives," *Review for Religious* 55 (1996) 230-248.

4. For further insight, he refers us to Yves Congar, *Lay People in the Church*, trans. Donald Attwater (London: Bloomsbury Publishing Co., 1957); Philip Murnion, "The Next Steps for the Laity," *Origins* 25.2 (1995) 28-32; Ladislas Orsy, "Structures for the Vision," *America* 173 (7 October 1995) 10-15.

5. From Avery Dulles, *Models of the Church* (New York: Doubleday, 1974).

6. On advanced directives see my "Living Wills" *The Tablet* (September 17, 1994) 1157-1159.

7. See *Veritatis Splendor* 31-35, 59-65.

8. See the important essays, John T. Noonan, "Development in Moral Doctrine," and Thomas Kopfensteiner, "Science, Metaphor and Moral Casuistry," in *The Text of Casuistry* James Keenan and Thomas Shannon, eds. (Washington, D. C.: Georgetown UP, 1995) 198-204 and 207-220, respectively.

9. On the question of the principle and ectopic pregnancy, see my "The Function of the Principle of Double Effect" *Theological Studies* 54 (1993) 294-315.

10. See, for instance, John Tuohey, "The Implications of the *Ethical and Religious Directives for Catholic Health Care Services* on the Clinical Practice of Resolving Ectopic Pregnancies," *Louvain Studies* 20 (1995) 41-57.