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Not What Catholic Hospitals Ordered

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Father McCormick sees the revised hospital code as "not what the doctor ordered" and in this article lays his case primarily against the code's Preamble.

NOT WHAT CATHOLIC HOSPITALS ORDERED

by Richard A. McCormick, S.J.

Today's medico-moral concerns and theological perspectives are not the only thing new in Catholic hospitals. Complex changes have affected the very self-image of a 'Catholic hospital.' They call for review of the ethical directives under which hospitals operate. But such a review is exceptionally difficult to bring off.

On November 16, by a whopping margin (232 to 7, with 2 abstentions) the American bishops passed the revised version of the "Ethical and Religious Directives for Catholic Health Facilities." The episcopal unanimity is remarkable in the face of the fact that several earlier attempts to bring the code up to date floundered on medical and theological disagreements.

Obviously, a code drawn up in 1954 needed revision. Since that time there have been many scientific advances, chemical and surgical breakthroughs and rather profound changes in the concept of patient-care. The kinds of medico-moral concerns that now hold center-stage are, therefore, relatively new.

Then there is the recent theological ferment. The Second Vatican Council both reflected and encouraged a theological perspective (especially ecclesiological) in sharp contrast with that which provided the backdrop of the 1954 code. Furthermore, moral theologians have been revising and nuancing their emphases, concepts and vocabulary, sometimes with results inconsistent with earlier conclusions.

Finally, Catholic health facilities

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themselves have undergone subtle but discernible changes in their self-image. Increasingly, they became community hospitals, often with heavily non-Catholic staffs and clienteles. They were frequently financed through public funds or by appeal to the whole community, and still are often enough the only health facility reasonably available to a community. In this climate the concept itself of the "Catholic hospital" became problematic.

The very factors, therefore, that made revision of the ethical directives necessary made this revision extremely difficult. What shape should it take? What practical problems should it attempt to deal with? In light of what certainties?

Developments such as those mentioned cast up a whole series of difficult questions that had to be answered before an ethical code could hope to be effective. For instance, what is the function of the Catholic hospital as agent of moral-decision-making? How far does institutional moral responsibility extend with regard to the practices of a pluralistic medical staff? What is the relationship of a code of professional ethics to individual conscience decisions? To what extent must a Catholic code be enforced? These are but a few of the knotty problems raised by the idea of a Catholic hospital code in our time.

Yet the 775 Catholic health facilities in the United States now have a 1971 version of ethical directives. In light of the enormous problems of composing such a code, what is to be said of the present version?

In an address to general hospital chaplains, theologian Paul McKeever noted: "In these days of intense theological reflection, directives which are rigid beyond the possibility of immediate justification would cause more problems than they would solve. Administrative problems would be multiplied rather than simplified. Informed people are aware of the principles of cooperation, are aware of dissent and are aware of theological ferment. They will bring this awareness to any confrontation they have with hospital administrations." Fr. McKeever concluded that "it is time to suggest that a thorough-going revision of the old directives is premature."

I agree with this judgment. Furthermore, I believe that the 1971 version of the code only proves the point. It is not what the doctors ordered.

This is not to say that it is all bad. Quite the contrary. Some of the individual directives (e.g., on patients' rights, secrecy, experimentation, consultation) are timely and accurate, even if not new. Other directives do not fare so well. For instance, to say (as directive 12 does) that "every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion . . " is to ignore the responsible theological literature of the past year or so. The same could be said of directive 21 which states in part: "The use of the sex faculty outside the legitimate use by married partners is never permitted even for medical or other laudable purpose, e.g., masturbation as a means of obtaining seminal specimens." There are very few established theologians who would support that conclusion.

Be that as it may, the directives themselves are not the chief villain, much as they could be improved by the broad consultation that should go into such documents. It is rather the preamble to the code that could be self-defeating and counterproductive. This preamble lays out the suppositions behind the code and explains how it is to be interpreted. In my judgment these suppositions and

interpretations are open to serious objection — so serious that the revised code fails to face the problems of at least very many contemporary Catholic health facilities.

First of all, there is the ecclesiology implicit in the code's preamble. The preamble states: "The moral evaluation of new scientific developments and legitimately debated questions 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." That the local bishop has the "ultimate responsibility for teaching Catholic doctrine" may be true enough; but it is not enough of the truth. The contemporary question is not precisely the juridical question about who has the ultimate right and responsibility to teach, but rather what means must be used, what processes employed, if teaching is to be done responsibly and effectively.

In a day of diversification and specialization, authoritative position is no longer the *locus* of many competencies. Competence has been cut up and spread around. Hence the responsibility to teach does not eliminate, but implies the duty to learn. In a highly juridical notion of the Church and the magisterium, the responsibility to teach translates as the "right to decide." It is simply not within the competence of a bishop to solve difficult moral questions by fiat. In this sense ultimate responsibility to teach may mean considerably less than the ultimate voice.

If the guidance of the bishop is not informed by the best contemporary wisdom — not excluding theological — then the authority of that decision is all but nil. Concretely, a code which suggests that "the moral evaluation of new scientific developments and legitimately debated questions must be finally submitted to the teaching authority of the Church in the person of the local bishop" is speaking out of a different century. Why must moral evaluation of new scientific developments be submitted to the local bishop? Bishops are beleaguered enough without asking them to assume yet another competence. Furthermore, if a theological question is "legitimately debated," it is beyond the competence of a bishop to settle the question. To suggest otherwise is to reveal an ecclesiology that is at best quaint, at worst erroneous.

Secondly, there is the matter of the hospital's responsibility. The code states: "The Catholic-sponsored health facility and its board of trustees, acting through its chief executive officer . . . carry an overriding responsibility in conscience to prohibit those procedures which are morally and spiritually harmful. . . ." This is not at all clear in the sweeping and unqualified sense in which it is stated. And for several reasons.

First of all, in the moral sphere the hospital is neither a parent nor a guardian. It is a facility. It seems that the primary (not the sole) responsibility in any given action rests with the person or persons principally involved. In many cases in which the hospital will be faced with a moral decision, the principal agent will be the patient and/or the physician attending the case. In these instances, the hospital administrators and personnel who provide the necessary facilities or render other services will find themselves playing what must be considered, at least from a moral standpoint, an auxiliary role.

If a patient and a doctor become involved in some procedure judged immoral, the hospital (administration) certainly has obligations. But that these duties are "overriding" and that they always involve "prohibition" does not

follow. It will be up to the hospital to decide, according to the well-known principles of cooperation, whether it can assist or even tolerate such procedures. These principles dictate that if more harm than good would follow upon enforcement, the hospital may and should tolerate the violation. In many cases, as in the past, the hospital will find that fidelity to its mission will forbid even material cooperation in these procedures. But there may be situations, perhaps frequent, in which a hospital will not be able to refuse its service without inviting greater evils than the one it is trying to prevent, thus jeopardizing its over-all mission.

Second, on the basis of the notion of "overriding hospital responsibility" the code concludes: "Any attempt to use a Catholic health facility for procedures contrary to these norms would indeed compromise the board and administration in its responsibility to seek and protect the total good of its patients, under the guidance of the Church." The obvious implication here ("any") is that cooperation in procedures contrary to the code is never permitted. Even according to traditional principles of cooperation, this implication is false. And it is false for the very reason adduced for its validity. That is, if more harm than good would result, then the protection of "the total good of its patients" would be compromised. If, for example, the absolute prohibition of selective postpartum sterilization resulted in the emigration and disappearance of a qualified obstetrics-gynecology department, is this really for the good of the patients in the long run?

In the past when the position of the Catholic hospital was relatively uncomplicated, securing adherence to moral directives was comparatively easy, so that material cooperation with procedures that violated them would rarely have been justified. But today the situation in many places has changed, sometimes drastically as noted above. In such situations, a hospital may have to face the issue of material cooperation more frequently than in the past.

Conceivably, of course, opposition to the guidelines of the code in a particular community could become so destructive that the Catholic hospital would be untrue to its basic mission if it were to continue to cooperate with it. In these critical circumstances it might have to question the value of its continued existence in that community as a Catholic health facility. Ultimately, however, traditional principles, far from imposing — as the preamble implies — an obligation to enforce the guidelines in all situations, allow for material cooperation with procedures that might go against the guidelines where failure to provide such cooperation would do more harm than good. Any attempt to apply the guidelines as strictly as in the past will not be realistic and might well undo much of the good that a particular Catholic hospital has achieved in a community for many years, and would hope to continue.

In summary, the revised code does not deal adequately with the phenomenon of cooperation.

Third, the new directives do not deal adequately with the phenomenon of dissent. Sincere and responsible dissent, especially on the teaching of *Humanae Vitae,* is widespread in the Catholic and non-Catholic community. Dissent rooted in sincerity and good faith does not, of course, of itself justify cooperation on the part of the hospital. There are other important considerations that must be made in assessing the morality of cooperation — and among these the danger of scandal would rank high. In this respect, the directives state: "Any

facility identified as Catholic assumes with this identification the responsibility to reflect in its policies and practices the moral teachings of the Church, under the guidance of the local bishop." Does "reflect in its practices" mean that *any* departure from the guidelines would be a source of scandal? If it means this, it has gone too far. For it is clear that much can be done to prevent scandal by explaining that cooperation need not and often does not mean approval of a procedure judged immoral. In other words, there are times when policies and practices need not converge.

Fourth, the new directives are said to be based on "moral absolutes." Thus: "The basic moral absolutes which underline these directives are not subject to change, although particular applications might be modified as scientific investigation and theological development open up new problems or cast new light on old ones." It is difficult to know what the authors of this sentence meant.

If "moral absolutes" refer to statements such as "human life must be respected," "all patients must be treated justly," etc., then the statement is eminently true — but also eminently general and indefinite. If, however, "moral absolutes" refer to concrete pieces of human conduct described in advance of their context and circumstance (e.g., contraception), then the best contemporary theological writing would question the theoretical existence of such absolutes. (Cf. the writings of Joseph Fuchs, Bruno Schüller, Franz Böckle, to name but a few.)

The authors of the preamble seem, therefore, to draw upon a single theological position and to enshrine this interpretation practically as the "teaching of the Church."

There are many practical problems faced by Catholic health facilities in our day. Some of these (e.g., genetic planning) touch areas where viable norms have not as yet been generated by interdisciplinary exchange. One of the most persistent problems, however, is the posture of the hospital vis-a-vis procedures prohibited by the directives.

At the bottom, this problem is, of course, one of the meaning and validity of the directives. But more practically it is a problem in the morality of cooperation, and since the moral assessment of cooperation demands a careful weighing of the good and harm involved, it is clear that these decisions cannot be made automatically by a code. They must be based on careful prudential considerations. This means that the initial judgment must be made on the local level, since only those on the scene will be in possession of the information necessary to make a moral assessment of the situation.

This assessment calls not only for factual knowledge of a case, but also for expertise in such fields as medicine, law and moral theology. Hospital decisions should be made by groups representing these competencies, but in full awareness of the fact that local decisions may well have a wider impact than was intended or foreseen. If individual hospitals take this responsibility seriously, they are doing all that can be expected of them, and all that any code can demand of them.

The preamble to the new directives states: "The Committee on Health Affairs of the United States Catholic Conference, with the widest consultation possible, should regularly receive suggestions and recommendations from the field, and should periodically discuss any possible need for an updated revision of these directives." This periodic discussion of an updated version of the 1971 directives should begin now. It is already overdue.