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Cover Page Footnote

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POLICY VS. ETHICS

by Warren T. Reich



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On November 16, 1971, the National Conference of Catholic Bishops (NCCB) approved the new *Ethical and Religious Directives for Catholic Health Facilities*. Far from being a routine administrative decision, this action may well be crucial to the health care professions active in Catholic institutions and for the future of those institutions themselves. There is a real possibility that these *Directives* will cause an acute confrontation of forces in the American Church and in American society, for they establish as *institutional policy* many elements which heretofore have provoked struggles mostly over isolated moral issues.

After noting factors which called for a revision in the Ethical and Religious Directives for Catholic Health Facilities, Father Reich questions the insistence, without exception, of acceptance and application of the norms of the code but sees the major problem as the emphasis of the directives as hospital policy rather than ethical statement.

Criteria For Revision

For many years it has been evident to theologians, physicians, hospital administrators, chaplains, and others that a revision of the 1955 *Directives* was urgently needed. Yet, if one compares the recent revision with the *Directives* issued 16 years ago, there is little that is new, and that itself is alarming. The intervening years have witnessed medical, moral and social developments of major proportions, to which the new NCCB "national code" is largely insensitive. At least six factors called for a profound re-thinking of the *Directives* and their purpose, and should have had a much greater impact on the 1971 revision.

1. Medical progress has raised new ethical questions and put a new twist on some of the old questions. A sampling of the newer problems can be found in the following areas: experimentation with human life; extra-uterine produc-

tion of life; personality control, behavioral control, and genetic engineering; genetic counselling; prolongation of life; and death and dying. If ethical directives are to be credible to today's world of medicine and health care, they should address themselves to today's problems, especially the more urgent ones. It is difficult to understand why the new *Directives* say so much about the ethics of sex and reproduction (15 out of 33 of the ethical directives are dedicated to this topic), and so little about the quality and distribution of health care services. While more and more of the public are agonizing over the problems of "Who shall live?" and "What determines the quality of life?", the bishops have failed to address themselves to some of the most pressing problems in the medical world and in the bio-medical revolution we are now experiencing.

If the bishops do not address themselves to the moral questions related to recent bio-medical breakthroughs and contemporary advances in the practice of medicine (perhaps because a code is not an effective vehicle for such teaching), then it is more apparent than ever that the effective teachers of Christian moral attitudes are found in the midst of the worlds of science, medicine, ethics and social sciences — frequently without even claiming the title of Christian. This first factor, then, which relates to the very heart of medical ethics, raises serious questions about the moral magisterium in medical matters.

2. In the past 16 years Catholic moral theology has undergone a profound renaissance. It is now more centered in the person of Christ, emphasizes the law of love in man's personal response to God, acknowledges that the moral life depends on a process of growth, and admits the uniqueness and significance of the situation in which man makes each of his moral decisions. It should be ex-

pected that some of these developments would be reflected in a revision of medical and hospital ethics.

Yet from a theological and ethical point of view, the new Directives are faulty and one-sided, ignoring most of the developments in moral theology over the past several decades. Consequently, a number of its ethical statements are scarcely tenable in the light of modern ethical and theological advances.¹ Whereas much of the previous *Directives* was identifiable as the natural law teaching of Pius XII, the natural law theory itself has developed beyond the theological sources of Pius, as our knowledge of man and nature have expanded, and as technological advances have made possible a more total and more humane control over "nature." Hence it is most significant that the bishops have closed an eye to the more recent scholarly natural law reflection on the principle of the double effect and the principle of totality — two pillars of traditional Catholic medical ethics.

3. Since at least the early 1960's the Church has experienced among many of its laity, its theologians and its hierarchy, a pronounced and probably irreversible shift on the moral questions of family planning and contraception. On respected theological grounds, many clergy and laity have also commonly rejected the more established Catholic positions on the *intrinsic* malice of masturbation, "artificial insemination," and sterilizing procedures, particularly tubal ligation, at least in some instances. After Pope Paul VI issued his 1968 encyclical *Humanae Vitae*, an unprecedented, outspoken theological dissent against the papal teaching on responsible procreation was followed by a calmer explicitation of the grounds for legitimate dissent. Then the national hierarchies of some twenty-four countries responded

to the papal teaching with noticeable doctrinal and pastoral divergence among themselves — some indicating conditions for conscientious dissent, and some even departing from the pope's teaching.

These events established a widespread conviction of the right to conscientious dissent in moral matters according to a principle of legitimate diversity within the Church, changed attitudes towards the authority of the moral magisterium, made the role of conscience central to moral decision-making, and pointed to largely untapped (collegial) sources of moral wisdom in the Church. On these questions concerning the tentativeness of non-infallible Catholic teaching, the right to dissent, and the like, the U.S. Bishops have clearly taken a tendentious approach, as will be pointed out more in detail below.

4. American Catholic hospitals have been experiencing pronounced changes in their public-social identity, as various factors make them more pluralistic and more public in character. Some Catholic hospitals are the single facility within the community, thus bearing peculiar obligations to the community as pluralistic, for the patients and physicians have no choice of facilities. Other Catholic hospitals are one among many in the community, and hence could restrict services on ethical grounds presumably without harm to the patient, since a choice of facilities is available. Still other Catholic hospitals are now part of a pluralistic medical complex. Funds which are essential to the support of almost every Catholic hospital derive from public and community sources. And so the questions arise: How exclusively "Catholic" is today's American Catholic hospital? If, in a society that is socially and legally pluralistic the "Catholic hospital" does not have a univocal identity, can one speak in a uni-

vocal way of "its code"? Should the emphasis not be placed on the local hospital's responsibility to incorporate Christian ethical principles into its own code? Particularly in view of federal assistance and the community service rendered by the hospital — but also morally, considering today's factual pluralism — may a Catholic hospital continue to prohibit on the grounds of strictly "Catholic" morality, procedures which are generally considered both medically and legally acceptable? There are some who believe that, depending on the answer to that question, it may soon be necessary for the Church regretfully to discontinue sponsorship of Catholic hospitals.

5. The age-old insistence that in principle all people are obliged by the truth of Catholic moral teachings, and the general refusal to permit Catholics to take an active part in actions contrary to these teachings, have been deeply affected by the Second Vatican Council's teaching on religious freedom, freedom of conscience, and the need for dialogue and cooperation with non-Catholics. Those charged with policy decisions in Catholic hospitals have been faced with a valid and unavoidable question: Why must a non-Catholic physician and a non-Catholic patient be forbidden to follow their own sincere conscience, while making use of a Catholic health facility which serves a pluralistic community, and which subscribes to a code of ethics which is neither revealed by God nor infallibly taught by the Church, and with which many God-fearing professional people do not agree?

The position taken in the bishops' new hospital directives on this type of question fails to reflect the implications of Vatican II's documents on the Church and religious liberty in a pluralistic society, and shows a lack of

awareness of the ethical complexities of today's hospital problems. It is questionable whether the *Directives* accurately reflect "the Catholic hospital" as agent of moral decision-making. Are the bishops' *Directives* equivalent to a *professional code*, and in fact, one which is *directed to* the health care professions and institutions? Why should the code not *arise from* the (Christian) experience of these professions in such a way that they are integrally engaged in formulating and interpreting their own medical and hospital codes?

6. Because of these and other factors, an awareness of religious and moral pluralism has descended upon us belatedly but furiously, and has deeply affected the American Catholic hospital. Catholics in the land of pluralism have been puzzled as to how pluralistic they should be. Those charged with administrative decisions in Catholic health facilities have experienced great difficulty in insisting upon the 1955 *Directives* as policy, for they have been faced with patients and physicians who either felt justified in conscience in departing from the old directives, or were not at all sure what was obligatory in "Catholic health care" practice. Over a period of too many years the "men in the field" of hospital work asked for clarification from the appropriate Catholic agencies,² who by 1971 could no longer postpone giving directives lest they lose the trust and allegiance of Catholic hospital administrations. Thus, *a perplexing set of moral questions had become an acute administrative crisis*. In this situation, I believe moral teaching was subordinated to the pressures of administrative policy-making.

A Question of Obligation

Perhaps the most serious single fault in the *Directives* is its insistence that the norms listed must be followed without

exception by patients and board members, as well as by those accepting staff appointment, staff privileges, or employment in Catholic health facilities.

The Preamble of the *Directives* states: "These directives prohibit those procedures which, according to present knowledge, are recognized as clearly wrong." But one would want to know *by whom* they are recognized as wrong, *with what authority* they are so recognized, and *with what degree of certitude* they are "clearly wrong." It is basic to Catholic theology that there are great differences of certitude among its "authentic" teachings, and these differences are also reflected in official, conciliar teaching. Yet the Preamble sets policies on the assumption that all the moral norms of the *Directives* are to be considered equally unexceptionable. Is the prohibition of masturbation for the purposes of obtaining seminal specimens (par. 21) as "certainly wrong" and unexceptionable as the direct destruction of a viable fetus (par. 12)? Why should those who hold teaching offices in the Church be reluctant to acknowledge truthfully the limitations on the certitude of what they teach? To fail to show this minimal honesty is to mislead, to foster incredibility, and to undermine their own authority, for any claim to an exaggerated or undifferentiated certitude in the complex area of medicomorals is easily seen not to be supportable.

The NCCB code is not silent on the question of the obligation in conscience to follow the *Directives*. Because the Preamble gives *some* instruction on the binding force of the ethical directives while excluding *other* instruction, it is misleading for the formation of the consciences of patients, medical personnel, and hospital authorities, and this in at least two ways: first by not applying the principles of religious freedom to at least the non-Catholic personnel in-

volved; and secondly, by not acknowledging that a Catholic may responsibly make a judgment differing from that contained in non-infallible papal teaching.

During the past three years, a considerable consensus has developed among the world's bishops and theologians on the question of legitimate dissent from non-infallible Church teachings. Following these developments within the Church, it may safely be stated that moral decision-makers affected by the new U.S. *Directives* — patients, physicians, hospital directors and others — may, in individual cases and on moral grounds, licitly act contrary to any (non-infallible) ethical directive, provided: (1) the decision is seriously arrived at in good conscience after careful reflection; (2) respectful and open-minded attention is paid to "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) depending on the nature of the action and the functions carried out by these moral agents in the health care facility, due responsibility be shown for the moral welfare of others and the mission and function of the health care facility in the community.³

Actually, the U.S. bishops expressed the principle of legitimate dissent from papal moral teaching in their 1968 statement *Human Life in Our Day*. It is unfortunate that in the bishops' explanation of the binding power of their 1971 statement no reference was made to their 1968 teaching which was so relevant in this case.

"Geographic Morality"

On this crucial question of the force

of the directives, the NCCB's one-sided treatment could very well alienate large numbers of people, because it promotes a most unfortunate "geographic morality." The Canadian Guidelines for Catholic Hospitals, approved by the bishops of Canada just last year, are far less authoritarian, and explicitly refer to the rights of conscience in conflict situations.⁴ It is at least disconcerting that neighboring countries have contrasting standards for espousing "fidelity to Church teachings." While the U.S. bishops insist that all those to whom the *Directives* apply "will respect and agree to abide by . . . these directives" (Preamble), the Canadian bishops state that their Guidelines "should be read and understood not as commands imposed from without, but as demands on the inner dynamism of human and Christian life"; and that they "should serve to enlighten this judgment of conscience. They cannot replace it." (p. 5) It will be puzzling to American Catholics to discover that, as regards hospital ethics, national boundaries also draw boundaries on a theology of conscience.

A peculiar aspect of the *Directives* is the fact that they were approved by the NCCB "as the national code, subject to the approval of the bishop for use in the diocese." Hence individual bishops are not obliged to endorse it and put it to use; indeed, they may accept in its place another "code."

This action allows at least in principle for a second instance of "geographic morality" which is difficult to explain. For the *Directives* are either moral doctrine or ecclesiastical policy or both. If they are "the moral teachings of the Church" (as the Preamble does indeed refer to them), it seems strange that the NCCB should allow that one or another bishop might substitute another teaching. If, on the other hand, the *Directives* are considered primarily as church pol-

icy, it is also puzzling why the NCCB should explicitly allow for a diversity of policies on matters of such crucial importance to Catholic institutions.

This case is not far-fetched, for in February, 1971, new *Directives* were issued by the United States Catholic Conference and adopted by many bishops. In spite of the fact that the February 1971 code *differs from* that approved by the NCCB in November, the former code may still remain the official code in some dioceses.⁵ This is another issue involving an unfortunate ambivalence on the question of moral teaching vs. ecclesiastical policy.

A similar problem, yet one far more likely to cause frequent conflicts, is the provision of the new *Directives* 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, who has the ultimate responsibility for teaching Catholic doctrine." This triumphalistic statement will give scientists reason to wonder whether the Church really has progressed very far since the days of Galileo. It is indeed sad and unfortunate that the scientific community be alienated from the Church through this action of its bishops.

This is yet another instance of "geographic morality," for the U.S. Bishops state, on *doctrinal* grounds, that each of them is the ultimate authority on the teaching and application of medical ethics: the local bishop "has ultimate responsibility for teaching Catholic doctrine" (Preamble). How can the local Bishop, who may be very ill informed about medical ethics, have the competence to be the ultimate authority on complex questions in this field?

The Canadian bishops, on the other

hand, apparently understand their teaching role in the Church in a very different way. Their recommendation is that, for certain complex situations, *specialists* be called upon to assist in the decisions of conscience of doctor, patient, or administrator, and that these specialists — doctors, theologians, and others — should function in local and regional medico-moral committees. Bishops are not designated as members of these committees nor as final arbiters of the meaning and application of the guidelines.

The implications of this profound divergence can be destructive of our hospitals and the trust we put in them. The Canadian approach places responsibility on the persons most directly concerned and most qualified, and is designed to foster a feeling of mutual trust. The American solution creates distrust and encourages the moral immaturity born of dependency on the chancery, where moral questions concerning people and lives are too easily interpreted to be questions concerning policy and "precedent."

This regional autonomy in moral teaching (or policy-making, whichever the case may be) fosters an unreasonable arbitrariness. At present, some bishops in this country are inclined to interpret the new directives very liberally so they will not have to close their health facilities; while others will interpret them very strictly so as to be staunch defenders of what the NCCB has decided upon as "national code." It is difficult to know why the local *bishop* should be the one principally responsible for determining a diverse local hospital policy, thereby moving the national Catholic discrepancy on moral teachings into the potentially more scandalous area of public church policy.

Policy vs. Ethics

It should be apparent that the major problem raised by these *Directives* is the conflict expressed in the question: Do the *Directives* serve primarily as hospital policy, or as the statement of moral truths? The document can serve both purposes — for there need be no ultimate contradiction between them — but the interpretation of the *Directives* depends in large measure on the emphasis that is given to the one or the other.

On the one hand, it is clear that the directives intend to teach and inculcate good medical morals. If one looks to the expectations of Catholic physicians, theologians, and the like, it can safely be said that the *Directives* are and have been commonly regarded as an expression of approved *Catholic medico-moral teachings* applicable as a moral guide to the *people* in the health care professions, and not just to the health care facilities as *institutions*. Now if the expression of moral truth is their purpose, this gives rise to a certain set of expectations and interpretative attitudes toward the directives; for as an expression of teaching, they must show an openness to truth and to the search for truth, and not simply set forth a static code of obligatory precepts.

In fact, however, the Preamble places greater emphasis on the "code" as institutional *policy*:

It should be understood that patients and those who accept board membership, staff appointment or privileges, or employment in a Catholic health facility will respect and agree to abide by its policies and these directives. 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.

There are benefits in establishing clear directives, especially during a period of obvious transition. Without them, institutions languish and individuals become directionless. However, to make ethical norms into institutional policy is not a simple matter.

Institutional policy (such as policy for Catholic hospitals) is not the same as criteria for the socio-ecclesial goodness which should characterize the life of Catholics and the public witness given by Catholic institutions. The public policy and moral witness of the health facility cannot simply be identified with the uniform moral behavior of the individuals engaged in these facilities, for this would assume that preferred standards of morally acceptable personal behavior, generically formulated, can simply be asserted as policy *to be uniformly applied to all applicable cases*, while overlooking such variable factors as: the complexity of the modern hospital, the right to a free exercise of conscience, and the fact of changing norms.⁶ When policy questions become a preoccupation, there is a tendency to attempt to shut out the variable factors, to the detriment of truth and of the *individual*.

Good morals and good institutional policy should ideally be seen as mutually dependent and complementary elements in bringing about the formation, guidance and fulfillment of the individual Christian and of the Church as a whole. Yet there is a distinction, and in some instances a painful struggle between the two. Those acquainted with Catholic moral theology and canon law know of the polarity between "internal forum" and "external forum." I believe that in these *Directives* and its Preamble, the bishops of this country reveal that they are engaged in a great struggle between the internal forum of conscientious medical practice and the

external, public forum where they believe health facilities retain their unique identity as Catholic in the midst of a changing world.

It is my opinion that the recent decision of the NCCB on the binding power of the *Directives* was primarily (though not exclusively) a *policy decision* employed as a stop-gap to hold back what they anticipated might be the institutional implications of the *moral theological* issues involved in a more tolerant notion of religious freedom of conscience and in the mounting social and legal pluralism deeply affecting the identity of today's Catholic hospital. Thus, the "threat" of the possible loss of institutional Catholic identity, of Catholic sponsorship, and of the allegiance of the administrative personnel were extremely decisive factors in the bishops' decision to opt for a very restrictive moral teaching. Yet, what good is accomplished if a new national code is claimed as hospital policy and bolstered by a strong statement of moral obligation, while the staff, aware that a number of the directives are not infallibly true and are not insisted upon by Catholic priests, will frequently, in the face of suffering and life-and-health dilemmas, make exception to the *Directives*? At all levels the policy will be uniform, but honesty will be worn thin because of the great discrepancy between the *Directives* and today's medical, social, theological and ecclesial worlds. Ecclesiastical institutions require policies, but not at such a price.

Conclusion

The new *Directives* are clearly an example of conflict between the roles of bishops as administrators and bishops as teachers. A preference for the former at the expense of the latter has, in this instance, led to: (1) a "hard line" on

ethical guidelines as institutional policy; (2) an unfounded exaggeration of the *Directives*' binding force; (3) the neglect of important questions in medical ethics; and (4) an insensitive attitude toward the decisions and decision-making processes of the medical world. It is of the utmost importance that the *Directives* become, in the future, more a teacher of morality and less a policy-maker, if these ecclesiastical pitfalls are to be avoided.

One result of the promulgation of the national code will be a harmful and unnecessary intensification of the alienation of American hierarchy from both the medical world and the theological world. It is to be regretted that a wedge has been placed where a bond might have been secured. As Catholic hospitals experience the now heightened struggle of policy vs. ethics in their many rooms and corridors, at the minimum it is to be hoped that, in the wake of these *Directives*, newer understandings of Catholic health care institutions, of the medical professions, of medical ethics, and of patients will emerge in every segment of the American Church.

This paper began with six signs of the times bearing on the revision of a hospital code. Perhaps a seventh could be added. I believe we are now in an era when more and more Christians are less and less interested in ecclesiastical power struggles and academic disputes. They are personally faced with stark human decisions concerning life and death, and do not want to be put down by authoritarian dicta. In a word, they desperately want their life-problems to be solved with compassion and their lives of illness and suffering to be suffused with love. When and how will the Church in America speak a satisfying word to these needs through its health ministry?

Footnotes

1. It is not the purpose of this paper to analyze the ethical directives individually, for this would entail too long a commentary.
2. The Catholic Hospital Association, but more officially, the Department of Health Affairs of the United States Catholic Conference.
3. This last condition, addressed to the classic question of "scandal," expresses the notion that the "dissenter" spoken of may indeed be convinced that such a code is necessary and deserves respect as hospital policy; but that in dissenting he will take precautions 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.
4. *Medico-Moral Guide*: Ottawa: The Catholic Hospital Association of Canada, 1970; pp. 4-5; 9 (par. 19).
5. The February 1971 *Directives* explicitly allowed tubal ligation whenever hysterectomy is ethically justified. The November 1971 *Directives* omitted that paragraph, but its present par. 20 would seem to implicitly approve the same procedure.
6. The Preamble states (par. 6) that, aside from the moral absolutes underlying the directives, the "particular applications" contained therein are subject to modification. When it becomes apparent on convincing theological grounds that a particular norm is not accurate and ought to be changed, there is thereby present a doubt as to its moral applicability, even prior to its official modification.