Catholic Ethics in Catholic Health Care Systems

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To describe “Catholic Ethics in Catholic Health Care Systems” at this millennial transition point is indeed a herculean challenge. The scope is large and the three terms (“Catholic,” “ethic,” and “system”) are multivalent and open to many interpretations. Almost all U.S. Catholic facilities and services (acute care, specialty facilities, long term care, home health, specialized housing, clinics and cognate social services) relate in some way to one of the over 250 systems listed on the Catholic Health Association website.

These diverse systems (eleven of which are extremely large with four having combined revenues of sixteen billion dollars ranking in the top ten not-for-profit U.S. systems)¹ vary greatly in size, composition, assets, corporate structure and geography. Many of their facilities and services participate in several other systems through a range of membership categories. Several major systems have formed mega systems or consortia to pursue purchasing advantages, to consolidate auditing services, to innovate in palliative care, and to support foundation and fund-raising efforts. As part of both the health care world and the Church-sponsored-services world, all these systems are experiencing pervasive change at an unprecedented rapid, even frenetic, pace. Increased membership fees, bond downgradings, inter-system consolidated services, and declining revenues at the local scene are causing a few to question the “survival by system” wisdom of the 1980s. Others doubt the possibility of maintaining the Catholic ethic because of external challenges from groups like Catholics for Free Choice, Merger Watch, Americans for Separation of Church and State, and even the American Public Health Association.

Two other trends, more insidious and potentially more destructive, threaten Catholic health care from within. While the Ethical and Religious Directives for Catholic Health Care Services (ERDs) provide a baseline ethical statement on clini-

¹Modern Health Care (July 31, 2000), p. 91.
cal, organizational and religious issues for all Catholic services, there is an apparent lack of consensus about ethical priorities within the ministry and the greater Church. The second internal threat is a pattern of catastrophic thinking, which not only threatens the work environment but also distorts the ministry vision. It is legitimate to question if our ministry is truly distinctive, seeking out the needy and most abandoned, and not just a parallel, alternative system. It does not, however, seem respectful of the past or responsible to the future to relinquish our moral and fiscal patrimony because of current difficulties.

Despite these definitional variations, frenetic change, fiscal challenges, hostile environment, conflicting ethical priorities, and a debilitating mindset, the Catholic health care systems in the United States continue to provide extraordinary witness to the mission of the Church and the lived Catholic ethic. While challenged, they are, by and large, in good clinical, fiscal, and ethical health. Because Catholic health care systems integrate quality health care with lived witness to Church values through very sophisticated governance and management structures, it may be helpful to approach this subject of the Catholic ethic in health care from a systemic, wholistic perspective popular in organizational theory today. As we use the terms “Catholic” and “health systems” and “Church,” we are very conscious that not only are we dealing with a multiplicity of structures and relationships, but we are also dealing with a range of definitions and expectations. This article will first, in very broad strokes, explain the pertinence of a quantum organizational approach to the subject; second, it will describe the current “chaordic” cultural context for church-related health systems; and third, it will identify four major ethical challenges confronting Catholic health care systems in this new millennium.

While the opinions expressed here are those of the author, her knowledge and views have been enlarged and enriched through conversations with governance and management leaders of several Catholic systems, and through written surveys completed by ethicists serving in Catholic health care systems across the country.¹

A Quantum Approach

One of the contributions of global age management theory has been to replace management science’s foundational structure of Newton’s “cause-effect” physics with a quantum base in which one and one never equals two and a confluence of actions and situations creates each reaction. In our increasingly interdependent, polyvalent world, the metaphor for organizations, and increasingly systems, has shifted from the carefully calibrated machine to the ever-expanding, quietly changing, liv-

¹Governance and management personnel from several Catholic systems were interviewed for this article and have contributed greatly to its development. In addition, mission and ethics personnel from sixteen of the larger Catholic systems and one diocesan system completed written surveys. The author is especially indebted to the following for their particular graciousness in sharing insights and experience: Diana Bader, Catholic Health Initiative; Mary Ann Carter, Catholic Health East; Thomas Hooyman, Catholic Health Initiative; Robert Lampert, Christus; James McCartney O.S.A., Catholic Health East; Dan O’Brien, Ascension Health; Brian O’Toole, Mercy-St. Louis, John Paul Slosar, Ascension Health; and Patricia Talone, Unity Health.
ing web. Purpose, potential, totality, resilience, and adaptability become central. In popular terms, this approach rejects the philosophy of “trickle down” or “bubble up” and adopts the “rally round” option.

In this view, reproductive ethics would not be about sex but about human love and the family; end-of-life ethics not about death, but about the ultimate meaning of human life and human solidarity; employee benefits design not about rewards but about human dignity, stewardship, and work as participation in God’s creative power. Though this has its advantages, it also has its excesses. A negative commercial example, while somewhat strained, may be helpful. In the Newtonian cause-effect relationship model, physicians prescribed medications after careful diagnosis of the individual patient’s needs. The patient then purchased and hopefully took the prescribed medication to respond to the identified need. Today, thanks to over the top marketing and the Internet, the patient bypasses the physician and the diagnosis phase and “demands” a self-prescribed medication more for its Madison Avenue alleged powers than for its clinical appropriateness. Physicians find themselves increasingly peripheral as multiple systems invade the professional relationship and more and more patients are becoming “cyberchondriacs.”

Again, in this “quantum physics” perspective, Catholic health care systems provide quality medical care and health services, live the Gospel, strengthen Church witness, and build the Kingdom through a complex series of activities and relationships with a wide range of other systems and within the greater Church system. This new “evolutionary” management approach stresses the emerging whole rather than the constituent parts; the inherent mission rather than changing goals and strategies; honest retrospection, creative vision, and reasoned adaptation, rather than rejection and withdrawal. It places attention on relationships and connections rather than on structures; it focuses on communication and continuing learning; and it encourages growth through creative dialogue. In a fast, moving industry such as health care which is molded by the pervasive and persistent influences of science and technology, awareness is on sustainability and generativity as well as on moral and social ecology. In short, the ministry is a dynamic sign and vital sacrament of Jesus’ eternal healing mission.

Merging Chaos and Order

Dee Hock’s description of this management consciousness and age as “chaordic” is both daunting and inviting. With obvious biblical overtones, he merges chaos and order as the basis of cosmic and organizational energy. Margaret Wheatley stresses the human community potential of this approach where each person is a creator and co-participant in others’ creations. “We need to be together in our work differently, with greater patience, compassion and courage.” Wheatley, Hock and many other management theorists suggest that knowing one’s own purpose, locating

3Dee Hock, Birth of the Chaordic Age (San Francisco: Berrett-Koehler, 1999).
oneself within other similar or even different purposeful systems, and forging cre­
ative relationships may be the only way of organizational survival and thriving for
knowledge companies, manufacturing firms, and human service providers in the
future.

Catholic health care systems and the Church are indeed evolving, self-orga­
nizing systems with a multiplicity and complexity of relationships, purposes and
responsibilities, very concerned with both survival and thriving. This metaphor­
ic management web is intricately designed and delicately woven, presenting many
challenges of philosophy and knowledge as well as geography. Beyond the web
image, one is tempted to describe these systems as a series of dynamic, interactive
concentric circles, but the multiple and varied overlays and interstices make this not
only inaccurate but visually impossible. In an earlier day, local Catholic facilities
were fairly autonomous. They were linked to the greater Church through a succes­
sion of religious administrators sharing the same formation and charism and through
the occasional ceremonial visit of the ordinary and the sponsor. Today, each health
care facility or service is a self-organizing system but acts within and with a range of
other systems (some non-Catholic), in addition to its own parent system and the
diocese. Because of the emerging complexity of the ethical issues and the growing
prominence of the church hierarchy in the public arena, relationships with the dio­
cesan bishop have become more substantive and less social.

The development of wide-ranging health systems has loosened and modified
but not severed these ties between sponsors and their ministries. However, it is the
local facility, not the sponsor nor the system, which generally relates to the local
diocese, in terms of ethical accountability. No matter its system affiliation or whether
sponsorship, by diocese, by religious congregation or, in a limited number of cases,
as a specialized public juridic person under the 1983 Code of Canon Law, each
local facility has accountability to the local bishop for the lived Catholic ethic.
From mega-co-sponsored systems like Ascension Health (seventy-one hospitals) and
Catholic Health Initiative (sixty-nine hospitals) to small regional systems, the mem­
bers operate in a variety of ecclesial jurisdictions. While the church relationship and
accountability are local, local actions can affect all parts of the system and even the
entire Church for weal or woe.

In this simultaneously connected and disconnected world of Catholic health

care ministry, there are no islands for independence or isolation. No matter the cor­
porate structure, the services provided, or the sponsorship model adopted, Catholic
health care is perceived and experienced as Church, and the Church in turn as Catholic
health care. This remains true even though diversity and pluralism mark personnel
and patient populations, and ecumenism characterizes pastoral care.

Catholic Ethic and Identity in U.S. Culture(s)

Catholic health care systems live and witness to the Catholic ethic while exist­
ing in our pluralistic society and in our very specific medical and service cultures.
While cultural forces are multiple and complex and, therefore, are best judged from
the perspective of history, some generalizations on the dominant culture’s influence
on Catholic health systems can be offered. Over the past several decades choice and
autonomy have reached the pinnacle of the U.S. value system and now rule over the “consumer-oriented, on-demand, pain-free society.” From the absolute evil of abortion and euthanasia, to designer-babies, to pricey pharmaceuticals, to exotic plastic surgery, to conspicuous consumption, individual choice prevails over the common good. It is frequently opined that natural law, the positive law of the Commandments, or even universal standards of civility, are inappropriate in our enlightened era. “Radical inclusiveness of values” and “relative moral standards” can, however, lead to moral and social anarchy.

The convergence of technology advances and the imperative created by the ageing of society exacerbates the situation in health care. Several theologians, including John Kavanaugh, S.J., have written eloquently and extensively on this subject. Kavanaugh has observed that “fear of mortality and fright of fragility” are pervasive in our “social convenience” culture. There is, however, a growing disenchantment with value-free individualistic inquiry.

He and other writers have noted that this shift to relativism in values and the primacy of choice may have been abetted unwittingly by our respect for pluralism and even by our desire for tolerance within our Catholic institutions. Writers caution that when personal choice is the major moral imperative, tolerance of others’ choices, no matter the content, becomes the highest virtue. Tolerance is more easily given and more generous toward the less demanding ethic. Some opinions are privileged while others, like the Church’s, are dismissed. The restrictive reproductive ethic practiced in Catholic facilities is often rejected by the wider culture and frequently ridiculed.

Increasingly, commentators on Catholic identity in health care, and in higher education as well, question if in our post-Vatican II efforts to reject triumphalism, to eschew judgmentalism, and to pursue the inexact science of “reading the signs of the times,” we may have failed to clarify the descriptor “Catholic.” Consequently we have failed to find the language to articulate and communicate the ethic effectively to work communities and to the public. There are obvious gaps not only between rhetoric and practice but also between information and knowledge. In speaking on public policy issues and our deadly moral ecology, Mary Ann Glendon of

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5 John Kavanaugh discussed this theme of “choice and tolerance” in his keynote address at the “Moral Dimensions of Poverty” conference held at St. John’s University, New York, October 1999. Proceedings are forthcoming.

Harvard Law School frequently challenges Catholics to refine the concepts, express them in crisp, precise language and forgo couching arguments in “Churchese.”

Since 1977 when the members of the Catholic Health Association requested their association to clarify “Catholic Identity,” there have been several national efforts toward definition, including one in 1999–2000, as well as sporadic emphasis on leadership development and formation in Catholic ethics. Since the 1970s, the Ethical and Religious Directives has served as the only document consistently and universally operative throughout the Catholic ministry. However, that document continues to be viewed by some within the ministry, as well as those outside it, as a divisive rather than as a unifying force. The sterilization question, first headlined by the Billings Case in the mid-1970s and countered by the U.S. hierarchy on First Amendment, conscience clause grounds, is still painful, particularly when viewed from the choice-and-tolerance perspective.

The cultural influence on the Catholic identity-integrity of church systems operating within the greater society is also compounded by the subtle seduction of the technological milieu in which we live. Einstein forewarned in 1934 that we had reached a point of perfection of means and confusion of goals. The technological imperative to do all that we can do, independent of its inherent moral value, has intensified with each succeeding generation and the increasingly aged populations. There continues to be a dangerous time lag between action by the scientific community which spawns the technology and the moral reflection and ethical stance articulation by church leadership. The task of shortening this time lag is not easy and demands interdisciplinary teams of highly educated and specialized personnel including philosophers, scientists, physicians, theologians, and even communication experts and political scientists.

In this chaotic age and pluralistic society, the issues are increasingly complex; the time for study increasingly contracted; the prevailing culture hostile to the Gospel; and the rule of unintended consequences dominant. Church resources need to be mobilized to tease out all the subtleties of these emerging questions and their long-term implications. Again it is not easy, because within the Catholic health care provider community, there is an impatience for crisp, immediate, and palatable answers. There is also a lack of common understanding of the value system foundational to the Ethical and Religious Directives which, after all, is the ethical meeting ground of health providers and the bishops within the Church, as well as a legal protection.

Other cultural influences challenge health care professionals and individual facilities and systems seeking to promote the Catholic bioethic. Today, there is grow-

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7Mary Ann Glendon, constitutional lawyer at Harvard University, has written and spoken on this language theme frequently, as has Stephen Carter of Yale University. Dr. Glendon’s cautions on language were presented to Women Affirming Life Conference in Washington D.C., March 25, 2000. In a recent address to the Pontifical Council on the Laity, Dr. Glendon critiqued “the culture of death” as the prevailing influence on much of U.S. culture.

8On the evolution of the ERDs, see Msgr. Orville N. Griese, Catholic Identity in Health Care: Principles and Practice (Braintree: The Pope John Center, 1987).
ing reliance on celebrities to advance ethical arguments. Sometimes, the word of an actor or an athlete in favor of stem cell, spinal cord, or diabetes research can carry greater weight at congressional hearings and in the media than a scientist, physician, ethicist, or theologian who has spent a lifetime in this very complex discipline. It also appears that the litigious character of our culture tends to reduce the moral to the legal.

This can impact ethical practice particularly in the “deep pockets” large systems. Some within the ministry quietly suggest that there may be an “influence imbalance” between attorneys and ethicists because of greater reliance on legal and financial outcomes than on ethical positions. In a bottom-line culture, it is tempting to make decisions through the prism of legal exposure and potential liability rather than through the Catholic ethic based on the dignity of the person, the common good, and personal and corporate responsibility. Advice of legal counsel can be viewed “hard” while the advice of ethicists can be judged “soft.” This alleged “influence imbalance” will be confronted head on as the medical errors and tiered-health-care issues grow in importance. From the early 1980s, perceived conflict between ministry and business has been in the forefront with multiple warnings to faith-based services of the corrosive effects of “the Medical-Industrial Complex.” Stewardship consciousness successfully relates the two.

Health Care Systems and the Hierarchy

Both the health care systems and the hierarchy seek a seamless ethic and seamless witness for the Church even as they perform very discrete and distinct functions. We tend to think and speak of the Catholic health care ministry and the Church as monoliths or as structurally unified entities. In fact, elements of the two exist and relate on a myriad of platforms and in a variety of environments. Historically the Church and the ministry have been enriched by the diversity of sponsors and sponsored works, but today these complicated and unrelated structures can impede communication and even services. While the lines between health and social services are blurring, there is no neat overlay of services and episcopal jurisdictions. In a very limited number of cases, such as Caritas Christi in Boston, health care system lines match those of the diocese or archdiocese. At a time when speed and trust must drive collaboration, this disconnect complicates communication and makes mutual support difficult particularly with the larger health systems. At the national level of Catholic ministry and episcopal authority, the same situation exists. Each does, however, have its own national communication and advocacy group in the National Conference of Catholic Bishops and the Catholic Health Association, but the journey from the place of raising the issue to the site of resolution is long. Some health systems, however, have found that well-staffed State Catholic Conferences are very valuable allies in advancing a range of initiatives, confronting problem issues, and facilitating productive dialogues with the bishops.

Health care systems then, particularly the larger ones which exist in a number of different dioceses, must relate and respond to a range of episcopal priorities and diocesan personalities. The structures are not uniform; the expectations are diffuse. Many bishops have appointed full-time or part-time diocesan moral theologians who may or may not be engaged by the local Catholic hospitals. Some dioceses also
have a priest or lay director of health affairs, not necessarily trained in ethics, who holds liaison responsibility with the Catholic hospitals.

At the system level, almost all Catholic systems have at least one staff ethicist, although in some of the smaller systems this role may be merged with the Mission role. At the system level the Ethics staff member may report to the Mission service person, the sponsorship person, or directly to the CEO. The system ethicist generally "oversees" ethics at the local level by providing consultation and educational services, but he or she generally has no supervisory responsibility for the local incumbent, who may be a full-time employee, a chaplain-ethicist or an on-call consultant. However, in at least one geographically narrow system, local ethicists do report directly to the system ethicist responsible for organizational ethics.

At the local level, depending upon facility size, sponsor’s policy, or CEO preference, the individual who serves as senior Mission person may also be responsible for ethics and specifically for the mandated ethics committees. Since the 1980s when Mission positions became popular, the trend in many systems has been for an individual of the sponsoring congregation to assume that role independent of formal ethical training or theological competence. There is growing recognition within systems that, despite some overlay, the two roles of mission and ethics are distinct and require different preparations and competencies. There is consensus that each should be considered an executive management position. Many local institutions have already separated the mission-charism-heritage function generally assumed by a member of the sponsoring group from the ethics function, but dual responsibility is still operative in many situations. Still, a platform for their mutual goals is required. Both positions generally report to the local CEO and not to their system counterpart. Because of this, leadership ethicists at the system level perceive a need for revamping standards and protocols for local ethics committees to assure consistency and system protection.

It is generally agreed that the role of ethicist has grown in importance and has risen in organizational stature within systems. Currently in some situations where hospitals engage ethicists from local seminaries or universities, the system ethicist generally helps in the selection process of the local ethicist. In others the local CEO and mission person make the personnel decision. No matter the arrangement however, most system ethicists maintain a communication relationship with local ethicists, especially in cases where diocesan ethicists have been appointed to serve all facilities. The communication is characterized as "mutually beneficial."

Communication gaps do exist between the provider community and the diocesan bishop. Generally at the local level, ongoing communication with the bishop involves the Sponsor representative, the board chair, and the CEO, although in some larger dioceses special convenings may include mission and ethics personnel. In some systems, it appears that the sponsors and system management have a larger role in general ethical decision making than do corporate and local boards and ethicists. Function and structure sometimes collide in the high profile ethical issues which draw together the bishop and the local facility and, unfortunately, the media as well. The bishop as the moral teacher of the diocese holds responsibility for the lived teaching within his jurisdiction, but as noted above there generally is no direct com-
communication line between the corporate offices of systems and the dioceses in which they participate in Church ministry. After the bishop’s general approval of local implementation of the ERDs, his involvement is issue-specific and often, unfortunately, problem-oriented. Bishops recognize the challenge to keep updated in this fast-moving medical world and acknowledge their need for competent diocesan ethicists and productive local and system communication. There have been, however, some apparent inconsistencies in interpretation of a few of the directives such as end-of-life care, uterine isolation, and joint ventures. Thus, a system with multiple facilities may experience post facto variations on interpretations of the ERDs among its locations. It may also find divergent perspectives among its ethical consultants. While the bishops maintain the right to exercise “prudential judgment,” diverse applications have given rise to the charge of geographic morality and have created public relations problems as well as serious financial and legal complications. These perceived conflicts in teaching have confused some and antagonized other system personnel.

Ethical Challenges to Catholic Multi-Systems

This twenty-first century may indeed be “the best of times and the worst of times” for Catholic health care systems. Despite challenges, the ministry remains strong, respected, and appreciated across the Church. While the Catholic ethic has the potential to contribute to the humanization of our chaordic culture, serious communication, research, scholarship, and education gaps exist. To capitalize on the strengths of the Catholic system and to bridge the gaps, it appears that Catholic health care systems, in concert with the larger ministry and Church leadership, need to reflect creatively and respond responsibly in four general areas: Ethical literacy, specific ethical challenges, integration of clinical and organizational ethics, and research/communication/learning circles.

1. Ethical Literacy. As the complexity and seriousness of ethical questions intensify, no one can rely on past collegiate courses, professional ethics continuing education programs, or new-hire ERDs orientation sessions to make operational a lived Catholic ethic within systems. Our sound-bite, celebrity-expert culture is not friendly toward the time commitment required for rigorous analysis and robust discourse. Too often, time pressures and inadequate reflection can cause ethical decisions to be made on the basis of short-term exigencies rather than on long-term mission integrity. It seems to be an injustice to ask trustees, managers, and physicians to become “guarantors of the mission” and to ask employees to be “carriers of the culture” unless each learns and appropriately internalizes the long ethical and moral tradition of the Church which forms the organizational spine of institutions and system. Many otherwise very sophisticated trustees and managers openly express their ignorance of Catholic ethics and indicate their reliance on the religious at the board or management tables.

At the same time, those rapidly disappearing religious express concern and discomfort that their opinions are so respected and relied upon. Both groups acknowledge that some painful and expensive lessons have been learned because of a lack of familiarity with Church teaching and diocesan expectations. Universal ethical literacy within systems is necessary and will become more so in situations where
recruitment of Catholic personnel to faith-based institutions and systems is not seen as a priority. This is not surprising. Even the New York Times has added a weekly ethics columnist, and a PBS program regularly addresses ethical dilemmas to heighten such literacy and competence in the secular world.

Several systems have already introduced projects to advance ethical literacy. They have recognized that an increasing number of leaders in the field at both the local and system level have had little or no education in the philosophical and theological underpinnings of the Catholic ethic and morality. They know that outsourcing as a way of preserving capital and the reliance on temporary help, especially “traveling nurses,” will diminish the sustained understanding of mission and the corporate ethic. Other personnel, while generally well-informed, have not been updated in more contemporary issues like fetal tissue transplant and genetics.

Responding to the need for an institutionalized formal approach to ethics, some system ethicists report that they have developed and implemented ethical decision-making models to guide both governance and management. Others report that they format policies in such a way that an ethical rationale or value orientation introduces each policy, whether it be on executive compensation, data release, post-rape protocols, or socially responsible investments. System ethicists also have reported that extensive educational materials on the revised ERDs have been developed and are regularly presented to new-employee and physician groups in a variety of modules and media.

Others prepare ethical columns or cases to appear in system publications or for local newsletters. Still others find extremely beneficial the development of case files for staff development programs at system and local levels. Locally, professional and clinical ethical components within medical rounds are commonplace and are increasingly supported by physicians. While staffing these rounds with competent ethicists may be problematic, ethics rounds nonetheless serve as a formation vehicle and make a statement about institutional identity and values.

Another system will soon have on-line a “Virtual Ethics Center,” which will assure immediate access to educational materials (and perhaps cases) across the system. Another system concerned about the unevenness in preparation and qualifications within the institutional ethics committees has developed core competencies for committee members and established regular meetings of all the chairs of local ethics committees within the system. However, one system ethicist even questioned the current need for institutional ethics committees because of the need to resolve clinical cases as close as possible to the bedside and in a timely fashion.

One system has developed a glossary of terms central to Catholic moral theology. Another is working intensively on labor issues and social justice. A very experienced board member of a very large system has proposed a Catholic ethics text in the style of the “For Dummies” series which has taken so many through the intricacies of computers and software. She also observed that in the field of joint ventures, it is essential to know what you don’t know and when to call in the experts and the bishop. A basic text, complemented by regular in-service programs, could go a long way in creating the climate of respect for and understanding of the lived Catholic
Ethic in a pluralistic society and the world-wide Church. A sister-trustee of a very large national system urged giving ethics the same attention and equal time as finance on board agendas, although she admitted the fiscal pressures of today make this recommendation difficult to implement and preferred a more wholistic approach to ethics.

It is not surprising that several system ethicists indicate that the best preparation for their role as “formators” is a strong, broad theological background in moral and historical theology and ecclesiology. A high level of pedagogic skill is also needed to distill complex church teaching into effective student learning modules. Ethicists, local and system, concur that the greatest support for ethics comes through system and local leadership, and that a seat at the table with top management is required for its real and symbolic value.

On the other hand, in identifying challenges to their effectiveness, ethicists cite polarization within the Church, a dismissive attitude toward ethics and religion, minimal enthusiasm of some CEOs, religious pluralism of boards, unevenness in preparation and qualifications of local ethics committee members, tardy interventions by bishops, and time pressures. Several also anticipate the immediate challenge of quantitatively demonstrating the contribution of system ethicists, if finances continue to deteriorate and budgets are reduced. This is a challenge similar to that which pastoral care has confronted.

2. Critical Ethical Policy and Education. There appears to be consensus about the major ethical issues which will need to be addressed by Catholic health systems and the larger Church over the next few years. Although some distinguished the high profile, high volume issues (sterilization and medical futility) from the exotic (cloning embryos and transplant therapies), a representative sample of ethicists, trustees, and managers concur that in the clinical fields, the reproductive and end-of-life issues, particularly the sterilization question and withdrawal of treatment, will need ongoing attention as new technologies, judicial decisions, and new legislative initiatives emerge. Those in acute care see the genetics issues, post-rape protocols, emergency contraception, clinical trials, and human subject research as becoming increasingly important. Several cited “the Holy Grail of Human Biology,” specifically genetic privacy, discrimination, and pharmacogenomics. Others indicted that the autonomy of geriatric patients is increasingly important.

At the organizational level, system ethicists emphasize partnerships, resource allocation, cost of technology investments, clinical versus business conflicts, medical errors, workplace issues (collective bargaining and unions, executive compensation, effects of outsourcing on morale and mission, equitable benefit designs for all personnel, defined contribution health plans, and personnel retrenchment). A few system ethicists cited social justice in systems themselves and the transitioning of sponsorship from traditional Church entities like religious congregations to lay groups. Two cited the inadequate reimbursement for behavioral health services and the discrimination against mental illness. Others cited internal church discord, competition between and among church institutions, including Catholic Charities, mandated continuum of service, physician collaboration, professional obligations, and the goal of overall evangelization of society in the spirit of Evangelium vitae.
A few ethicists cited medical errors as a central issue which will induce healthy ethical conversation at all levels of their system and merging of clinical and organizational ethics. While in the past, some facilities simply and openly admitted errors, others may have maintained a liability-induced silence counseled by attorneys and insurers. A new response is demanded, not just to the recent Institute of Medicine’s study, “To Err is Human: Building a Better Health System,” but from a growing social and moral consciousness. Personal responsibility and institutional integrity require the offending provider or institution to take the initiative in dealing with indisputable error.

3. The Relation of Clinical Ethics to Organizational Ethics. While this bifurcated cataloging of ethical issues is still a helpful distinction, many of the system ethicists indicate that in their experience the separation is artificial and becoming less useful. They affirm that clinical issues have organizational implications and that organizational decisions penetrate the clinical areas. Examples abound from medical waste to confidentiality. Even the philosophical access-to-care issue with its political and economic focus, has profound clinical and organizational implications. The Genome Project will be fertile soil as well for many years to come.

The relationship of these two ethical areas varies greatly across the ministry. In one system there are two distinct ethicist roles, with one taking the lead on clinical and the other on organizational ethics. In another very large system, the facilities are arranged by region with each ethicist “covering” all the issues in a given geographic region, but having recognized expertise in at least one of the two areas. In several systems with regions, the role of ethicist is limited to the corporate office where heavy emphasis is laid on the organizational issues, but where some oversight is provided for local clinical committees and for clinical consultations. One system has taken a completely integrated approach and is in the process of replacing its Integrity Program (compliance and core values) and its Ethics Program with a comprehensive Code of Ethics Program. This Program encompasses Compliance with Governmental Regulations, JCAHO standards on Patient Care and Organizational Ethics, and the ERDs. This particular system also has Integrity and Ethics Committees in place at the local levels. One ethicist pointed out that any institutional or system compliance committee should have fair representation from the legal, financial, and ethical areas. Another system has a Corporate Ethics committee which includes the Corporate Compliance Officer and an ethics representative from each system entity.

This thrust toward an integrated approach to clinical and organizational ethics is seen in system efforts to weave together the moral and social justice aspects of a range of issues, for example: technology acquisition, access, and palliative care. A few ethicists expressed regret that the ministry, despite successes in child-health, has not been successful in developing public awareness of the overall pathogenic nature of poverty and in advancing a national health policy for all.

Several ethicists also noted with great regret that, despite the richness of the Church’s teaching, many persons overlook the rich social justice tradition and re-

roduce it to sexual ethics. Some suggest that the church’s teaching on the dignity of the human person, the sanctity of life, the family as the basic community, and stewardship, provide the unifying basis for educational programming and clinical policy development. A few indicated that the social encyclicals have not received a prominent place in personnel formation and are not in the forefront of policy formation. The anniversary of the Pope Leo XIII’s 1891 encyclical *Rerum novarum*, together with consideration of its succeeding documents, offered and continues to offer a unique opportunity.

A few trustees noted that current efforts to downsize boards and impose strict term limits have created a loss of corporate memory—a deleterious effect. A few also noted that trustee selection that looks to public relations benefits and donation potential, without regard to commitment to the Catholic ethic, can weaken the special mission of Catholic health care.

4. Communication and Learning Circle. Throughout this article, the lack of a structural connect between the two diverse, nonparallel but interrelated entities of Catholic health care systems and the church authority structures has been cited as a potential source of misunderstanding and conflict, and of inefficiency in making the Catholic ethic pervasive. Unless health care becomes a totally diocesan controlled ministry, and that probability is minimal, this disconnect will continue to be problematic and may dissipate energy and resources as the ethical challenges increase in numbers and intensity. There is also a disconnect between the few Catholic research centers, some of which are located at the system level, and the overall ministry and hierarchy. Catholic universities, except for the few with medical schools, are also on the periphery.

Furthermore, the theme of ongoing communication among all interested and responsible parties to assure mutual purpose and the need for reasoned, rigorous, and timely responses to critical ethical issues were cited repeatedly by governance and management persons interviewed. In the quantum world of Catholic health care, the whole becomes the part and the parts become the whole, emerging as “leaven and leverage,” lived values and advocacy. Cardinal Bernardin often used that expression to focus the ministry mandate of service, witness, and advocacy.

While it is always presumptuous and usually unpopular to suggest the creation of another committee, especially if the recommended committee has no power or policy potential, a new conversation group seems appropriate now. Too often in the past, church groups have been convened to react to already prepared documents or to manage already entrenched conflicts which allow no wiggle room. As a result, there is much parallel talking that silences reason and breeds myopia.

For the continued generativity of a very valuable ministry in the Church, it would seem helpful for a representative committee, drawn from bishops heavily involved in health care, system executives, local CEOs, and system ethicists, as well as personnel from ethics centers, research institutes, and universities, to come together twice a year for one full day in a communication and learning circle marked by depth thinking, simplicity, respect, and confidentiality. In such a forum, the concentric, the overlay and even the outlying circles in the Church and the ministry web may be freely and creatively drawn together and their wisdom woven for the Mis-
sion. These conversations could assist in nurturing, sustaining, and transmitting the ethic inherent in the Gospel and intrinsic to Catholic health care.

“The Widening Gyre” and “Bright Wings”

While many pressures, fiscal and moral, continue to confront Catholic Health Care Systems in the United States, mission consciousness and Catholic identity have never been more central. These systems hold significant material assets and offer extraordinary public witness to the healing ministry of Jesus and the Gospel of Life. The fabric of moral consensus has indeed frayed, and many choose to lament with William Butler Yeats that in this “widening gyre” “things fall apart, the Center cannot hold.” They question “What rough beast slouches towards Bethlehem to be born?”10 But a thoughtful look back into the history of Catholic health care in the U.S. and its constant upward spiraling and expanding web suggests that G. M. Hopkins S.J., a crucibled poet, is the preferred authority here. Chaos challenges, but order beckons. While the ministry “has mountains, cliffs of fall frightful, sheer, no-man-fathomed”11 to scale, “the Holy Ghost over the bent world broods with warm breast and with ah! bright wings.”12

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12Ibid., “God’s Grandeur,” p. 27.